

PUBLIC RECORD**Dates:** 21/09/2026 - 29/09/2026**Doctor:** Dr Yakubu BENJAMIN**GMC reference number:** 7592057**Primary medical qualification:** MB BS 2010 University of Maiduguri

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

Summary of outcome
Suspension, 3 months**Tribunal:**

Legally Qualified Chair	Ms Ruona Iguyovwe
Lay Tribunal Member:	Dr Caroline Friendship
Registrant Tribunal Member:	Dr Laura Florence

Tribunal Clerk:	Joel Taylor-Garratt
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Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Gavin Irwin instructed by Erin McIver
GMC Representative:	Jennifer Ferrario

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 and Impairment - 25/09/2026

1. The Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration or heard as evidence were confidential. This determination will be handed down in private but as this case concerns Dr Benjamin's alleged misconduct a redacted version will be published at the close of the hearing.

Background

2. Dr Benjamin qualified in 2010 from the University of Maiduguri, Nigeria. Prior to the events which are the subject of the hearing, Dr Benjamin worked as a junior doctor in Nigeria until coming to the UK in 2019 to work as Specialty Registrar in Integrated Sexual Health. He subsequently worked as a GP registrar at several employers from 2021. At the time of the events, Dr Benjamin was practising as a salaried GP at the Yarm Medical Practice ('Yarm').

3. The allegations that have led to Dr Benjamin's hearing relate to his conduct arising from three patient consultations. It is alleged by the General Medical Council (GMC) that Dr Benjamin made false records in relation to three patients between 1 – 11 November 2024. These records included that in respect of two patients that Dr Benjamin had conducted physical examinations that had not been performed and had held discussions with the patients that did not take place. The third patient's case arose from a telephone consultation in which Dr Benjamin had recorded that the patient was "happy with analgesia" and that

safety netting advice had been given when those were not supported by the content of the recorded telephone consultation.

4. The background to the events included that Dr Benjamin's position at Yarm was his first as a salaried GP, having started on 30 September 2024. XXX.

5. The initial concerns were raised with the GMC by Ms D, following concerns raised by patients that the records of their consultations with Dr Benjamin did not match their recollection of events. Dr Benjamin cooperated with a local investigation but his contract was terminated on 27 November 2024. He officially left the practice on 25 December 2024.

The Outcome of Applications made during the Facts Stage

6. An application was made on behalf of Dr Benjamin pursuant to Rule 41 for the hearing to be conducted in private when discussing XXX. Mr Irwin submitted that the Registrant would invite the Tribunal to take that personal context into account when considering his case.

Rule 41 of the General Medical Council (Fitness to Practise) Rules Order of Council 2004

'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 Medical 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.

(4) Where it is considering an allegation or a non-compliance matter, the Medical Practitioners Tribunal may revoke an interim order in public.

(5) A Tribunal shall, where it is considering matters under paragraph (3)(a), sit in public where the practitioner requests it to do so.

(6) Subject to paragraph (5), the Committee or Tribunal may, where they are considering matters under paragraph (3)(a) or (b), hold a hearing in public where they consider that to do so would be appropriate, having regard to- (a) the interests of the maker of the allegation (if any); (b) the interests of any patient concerned; (c) whether a public hearing would adversely affect the health of the practitioner; and (d) all the circumstances, including the public interest.

(7) The Committee or Tribunal may deliberate in camera, in the absence of the parties and of their representatives and of the public, at any time.'

7. The GMC did not oppose this application, but Ms Ferrario indicated that it was for the Tribunal to determine if there was a link between these issues and the allegation as required by the MPTS Guidance. The GMC'S Counsel referred to Paragraph 70 of the MPTS Guidance which deals with the impact of personal context.

"Assessing the impact of personal context

70. For personal context to be relevant to the 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".

8. The Tribunal was given legal advice that under Rule 41 members of 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.

9. XXX

10. In accordance with Rule 41(2) of the Rules, the Tribunal decided that the public shall be excluded from the proceedings or any part of the proceedings, during the discussions of those matters outlined as the particular circumstances of Dr Benjamin's case outweighed the public interest in holding the hearing of the matters under consideration in public. The Tribunal determined that even though the issues were not specifically related to XXX that matters relating to XXX reached the threshold to be discussed in private. It therefore granted the application for privacy for the matters relating to XXX.

11. The Tribunal also considered the GMC's submission about whether there was a direct link between the personal context described and Dr Benjamin's behaviour. The Tribunal concluded that it was relevant context and that there was a direct link as required by paragraph 70 of the Guidance.

The Allegation and the Doctor's Response

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

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

Patient A

1. On 1 November 2024 you consulted with Patient A, and you recorded that you had examined Patient A's:
 - a. knees; **Admitted and found proved**
 - b. hips. **Admitted and found proved**
2. You knew that one or more of the records you made, as set out at paragraph 1, were untrue because you had not examined Patient A's knees and/or hips. **Admitted and found proved**
3. Your conduct as described in paragraph 1 was dishonest by reason of paragraph 2. **Admitted and found proved**

Patient B

4. On 6 November 2024 you consulted with Patient B by telephone, and you recorded the following in Patient B's note:
 - a. 'happy with pain control now'; **Admitted and found proved**
 - b. 'Safety net advice given'. **Admitted and found proved**
5. You knew that one or more of the records you made, as set out at paragraph 4, were untrue because you did not have a discussion with Patient B about pain control and/or safety netting. **Admitted and found proved**
6. Your conduct as described in paragraph 4 was dishonest by reason of paragraph 5. **Admitted and found proved**

Patient C

7. On 11 November 2024 you consulted with Patient C, and you recorded that you had examined Patient C's:

- a. gait; **Admitted and found proved**
 - b. hips. **Admitted and found proved**
8. You knew that one or more of the records you made, as set out at paragraph 7, were untrue because you had not examined Patient C's gait and/or hips. **Admitted and found proved**
 9. Your conduct as described in paragraph 7 was dishonest by reason of paragraph 8. **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

13. At the outset of these proceedings, through his Counsel, Mr Irwin, Dr Benjamin made admissions to the entirety of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced the Allegation as admitted and found proved.

Witness Evidence

14. 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:

- Patient A, dated 11 March 2025,
- Patient C, dated 25 February 2025,
- Miss D, dated 12 March 2026.

15. Dr Benjamin provided his own witness statement dated 13 August 2026 and also gave oral evidence at the hearing at the impairment stage.

16. In his evidence, Dr Benjamin told the Tribunal of the circumstances of his learning about XXX. He said that he had a video call XXX on 31 October 2024 and XXX. Dr Benjamin said that he had thought that perhaps he should not have gone to work that day but that he was new to his practice and role and did not want to let his new employer down or give a bad impression. He said that, at that time, he exercised poor judgement because of the news he had received about XXX and that *'everything else did not seem interesting.'* Dr Benjamin told the Tribunal that he had thought he could cope and so did not XXX, nor did he seek formal

support from the practice at the time. He said that he was destabilised and frustrated and that his mind was divided as he was only thinking about XXX.

17. Dr Benjamin told the Tribunal that the consultation with Patient A took place the day after he heard the news of XXX. He said that, when he realised he had not performed parts of the examination of Patient A, he took the wrong decision to falsify the patient's record to try and cover up his mistake. Dr Benjamin said he recalled the call with Patient B but that he was not in a right state of mind and not thinking straight. He said he had realised his oversight regarding the discussion of analgesia but falsely recorded that discussion because that is what should have been recorded for that type of case. Dr Benjamin said that the consultation with Patient C happened on the same day XXX and that he was rushing things to have some time to himself.

18. Dr Benjamin told the Tribunal that he should not have worked at all during the period in question and should have sought support but that he was eager to impress his new employer and demonstrate that he was hard working. He said that he knew at the time of the events of the need for honesty, but that had been further developed through his remediation work, particularly a medical ethics course with Mr E. Dr Benjamin said he had reflected on how his actions had impacted patients, his family, the profession and wider society. He said he had let himself down and he had also let his family down. XXX. He said that patients would have lost trust in the medical profession because of his dishonesty, that he abused his position of trust as a doctor.

19. Dr Benjamin told the Tribunal of his efforts to remediate, and that they were ongoing. He gave examples of how his practice has now changed, including taking time off when XXX and recalling a patient when he realised that he missed part of their examination. He also told the Tribunal that XXX and was continuing in his efforts to remediate and develop his insight. He said that he had undergone two series of six sessions with Lyra Health to work on subjects including ethical and professional standards, professional integrity and XXX.

Documentary Evidence

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

- Various correspondence between Yarm and Patients A and C,
- Audio recording and transcript of Patient B's consultation,
- Patient records,
- Curriculum Vitae (CV) of Dr Benjamin;

- A reflective statement;
- XXX;
- Letter Mr E, medical ethics trainer dated 23/6/26;
- Certificate of completion of medical ethics course with Mr E dated 23/6/26;
- Material relating to a Professional boundaries course on ethics and probity dated 28/5/26;
- LYRA Booking confirmation;
- XXX;
- XXX;
- Personal Development Plan for Dr Benjamin dated 20/10/25. It covers a number of areas including improving on record keeping and documentation, work life balance and well- being;
- Letter relating to the outcome of the Professional Standards Group 11 December 2025;
- Weightman’s Solicitors’ letter dated 22 July 2026 requesting testimonials. The letter attaches the GMC Allegation;
- Email from Dr K dated 12/8/26 confirming earlier reference provided on 12/9/25;
- Testimonial from Dr F dated 27/7/26;
- Testimonial from Dr H dated 23/7/26;
- Feedback from colleagues – April – May 2025;
- Feedback from colleagues – July 2026;
- Feedback from patients – May 2025;
- Continuous Professional Development learning in various courses including:
 - i) Medical records in primary care 28/1/25
 - ii) Medication errors and safer prescribing 5/5/25
 - iii) Probity and ethics – 2/2/25
 - iv) Probity and ethics – 4/2/25
 - v) Probity and ethics in practice - 28/5/26
 - vi) Medical ethics – 23/6/26; and
- Termination of contract – 27/11/24

Submissions

Submissions on behalf of the GMC

21. Ms Ferrario, Counsel, submitted that Dr Benjamin’s dishonesty amounted to serious misconduct and that his fitness to practise was subsequently impaired. She submitted that Dr Benjamin’s dishonest conduct amounted to a serious departure from the professional

standards and that he had breached various paragraphs of Good Medical Practice (2024) ('GMP').

22. Ms Ferrario submitted that Dr Benjamin's dishonesty was at the higher end of the spectrum of seriousness, having occurred within his professional position. She said that the seriousness was further increased because it had been repeated across three different patients, was an abuse of trust and demonstrated a deliberate disregard for patient safety and professional standards. She also submitted that Dr Benjamin had undermined a system designed to protect patients, namely medical records, had put his own interests before those of his patients and had not declared his dishonesty – it had been discovered by scrupulous patients checking their records.

23. Ms Ferrario acknowledged that Dr Benjamin was experiencing very difficult circumstances at the time of the events but rejected the idea that they were unique. She also reminded the Tribunal that this was not a case of notes being misplaced or incomplete, Dr Benjamin had deliberately falsified patient records to conceal his mistakes in order to impress his employer. Ms Ferrario submitted that, whilst this may have been Dr Benjamin's first role as a salaried GP, it was not his first role in the UK and he was well aware of the need to complete patient notes accurately and truthfully.

24. Ms Ferrario submitted that Dr Benjamin had declined to take opportunities to ask for support from his colleagues. XXX.

25. She submitted that Dr Benjamin had not provided any medical evidence to show that his judgement was impaired at the time of events. She submitted that the Tribunal was invited by the GMC, on the evidence, to conclude that at the time of his dishonesty, Dr Benjamin knew what he was doing. She stated that he had admitted as much by admitting the dishonesty. She invited the Tribunal to make a finding on the issue because in her submission, Dr Benjamin had given evidence that his judgment was impaired.

26. In relation to insight, Ms Ferrario submitted that Dr Benjamin had shown only partial insight. She submitted that Dr Benjamin's reflections lacked specific reference to and consideration of how his dishonesty impacted patients and colleagues. She said that his reflections did not go beyond his personal impact and that his insight was only partial. In relation to steps taken to remediate, she said that Dr Benjamin had made efforts to remediate but had still not given sufficient consideration to the impact of his actions on others.

27. In relation to whether Dr Benjamin poses a current and ongoing risk to the three limbs of public protection, the GMC's position is as follows,

- (a) In terms of whether Dr Benjamin poses a current and ongoing risk to patient safety, the GMC is neutral on this issue.
- (b) The risks however to public protection in terms of the second and third limbs of the statutory objective are current and ongoing. The dishonesty sits at the higher end of the seriousness spectrum and therefore evidence of context, and Dr Benjamin's response ought to carry less weight.
- (c) Dr Benjamin is currently on a journey of insight and remediation. The public interest limbs of the statutory objective are such that he ought to be able to demonstrate full insight and remediation before public confidence may be redressed.
- (d) In light of his incomplete journey, the GMC submits that the second and third limbs of the statutory objective are clearly engaged. The current and ongoing risk that he poses in relation to the wider public protection ought to justify a restrictive response by the Tribunal. She submitted that a reasonable, well-informed member of the public would likely be "shocked" and/or "appalled" by Dr Benjamin's conduct.
- (e) Where the Tribunal finds that Dr Benjamin has fully remediated himself on a personal level, the Tribunal is invited to conclude that a finding of current impairment is necessary and appropriate, to uphold proper professional standards and/or promote and maintain public confidence in the profession.

28. She submitted for all of these reasons, that the Tribunal ought to make a finding that Dr Benjamin's current fitness to practise is impaired.

Submissions on behalf of Dr Benjamin

29. Mr Irwin, Counsel, stated that Dr Benjamin had admitted all the allegations in relation to Patients A, B and C. He said having admitted acting dishonestly in relation to the records he made on 1, 6 and 11 November 2024, it was accepted by the defence that serious misconduct was established. However, he submitted that Dr Benjamin's fitness to practise was not currently impaired by reason of his misconduct.

30. Mr Irwin referred to the *“unique nature of the stress experienced by the Registrant in November 2024”*. Mr Irwin submitted that, whilst XXX is not a unique experience, as submitted by Ms Ferrario, on behalf of the GMC, he said XXX in the particular circumstances of this case was a unique experience for Dr Benjamin. Mr Irwin said that prior to the matters that gave rise to these proceedings, no other regulatory concerns had been raised about Dr Benjamin across 16 years of practice and none have been raised since. He submitted that this was significant and therefore that Dr Benjamin’s dishonesty should be looked at through the context of his circumstances at the time.

31. Mr Irwin then went on to outline briefly Dr Benjamin’s practice in the UK between August 2021 and August 2024 and testimonials, which described him as a highly respected and capable doctor.

32. Dr Benjamin had qualified in Nigeria in 2010, where he worked as a doctor until 2019 before moving to the UK with his immediate family leaving his extended family, XXX He had been working continuously as a doctor in the UK since then. He has been in practice for 16 years and has no regulatory history with the GMC.

33. He worked as a GP Registrar at various hospitals and practices between August 2021 and August 2024. The testimonial provided by Dr F, GP Partner at the Zetland Practice (“Zetland”), dated 27 July 2026, Dr Benjamin’s clinical supervisor between August 2023 and August 2024 describes Dr Benjamin as: *“... a highly capable doctor. Of all the GP trainees I have had he was the most professional, most clinically able and hardest working. He knew his limits but was a safe pair of hands and a respected colleague ... I have never seen any inaccuracies in his record keeping – and we did review this as part of the work based placed assessments he had to complete ... If we had had space, I would have offered him a partnership at the surgery ...”*

34. The testimonial provided by Dr I, GP partner and trainer at the Zetland Practice (undated, relating to the same period), describes Dr Benjamin as:

“... diligent and extremely reliable ... He actively sought help and earned our trust and respect by demonstrating a high level of clinical skill and decision-making, backed up by excellent record keeping ...”

35. Dr Benjamin joined the GP Register in August 2024 and took up his first salaried GP post at the Yarm Medical Practice (“Yarm”) on 30 September 2024.

36. On 31 October 2024, just one month after starting at the Yarm Medical Practice, Dr Benjamin learnt that XXX.

37. Dr Benjamin's reflective statement describes how receiving the news of XXX was, *"devastating ... the emotional weight was unbearable"*. Further, he accepts that, *"if I could rewind time, I would have taken some time off and given myself space [XXX]. But I didn't. I couldn't. And now, I live with the double regret of failing [XXX] and my patients" ... "*

38. He said, in giving evidence during the proceedings on 21 September 2026, Dr Benjamin had said:

"I struggled, should I go? It was a new place, didn't want to start taking gaps... It affected me because nothing was interesting to me... I was totally destabilised...my mind was divided totally ... it affected my judgement and thinking ... I thought I could cope, I didn't realise how it had impacted me ..."

39. After leaving Yarm, Dr Benjamin took up a new post at the Thornaby and Barwick Medical Group ("Thornaby") on 2 January 2025 where he worked as a salaried GP until 28 November 2025. He now works as a locum GP at practices in the Teesside area. The testimonial provided by Dr K, GP Partner and Trainer at Thornaby describes Dr Benjamin as:

"punctual, reliable and [with] a positive approach to work ... His clinical record keeping is good and we have noted that he documents adequate history, examination and management details in patient records appropriate to the GP setting ..."

40. Mr Irwin submitted that, other than the period in early November 2024, XXX, no concerns had been expressed in relation to Dr Benjamin's clinical practice and/or probity.

41. Mr Irwin submitted that it was accepted that Dr Benjamin's fitness to practise was impaired during that period - he was distracted and unable to give his patients the care they deserved but directed the Tribunal to the work done by Dr Benjamin after the events in November 2024, his insight and the steps taken to remediate. Since the events in November 2024, Dr Benjamin has engaged in professional ethics CPD courses, CPD courses on Probity and ethics and Professional ethics remediation course.

42. He submitted that Dr Benjamin's reflections demonstrate his understanding of the impact of his dishonesty on others and the consequences of a doctor acting dishonestly, it has consequences beyond the individual case. It risks undermining confidence in doctors generally.

43. In relation to risk of repetition, he submitted that the risk of repetition was low. The reasons given for this assessment of a low risk of repetition are:

- 1) Dr Benjamin's unblemished record before the events in November 2024;
- 2) The unique circumstances pertaining to the period 31 October 2024 and 5 December 2024;
- 3) There having been no similar concerns raised since then;
- 4) The fact that Dr Benjamin has reflected and admitted the allegations in full – he has not sought to justify or to excuse his conduct;
- 5) The fact that Dr Benjamin has engaged in meaningful remediation steps;
- 6) The fact that Dr Benjamin recalled a patient in October 2025, on realising an omission during a consultation; and
- 7) The fact that Dr Benjamin dealt differently with XXX in August 2026, by taking time off work.

44. Mr Irwin directed the Tribunal to the testimonial evidence that had been provided and submitted that these were relevant, all speaking very highly of Dr Benjamin.

45. In relation to Step 2b: where on the spectrum of seriousness the allegation lies

46. Mr Irwin submitted that it was accepted that, by reference to the MPTS Introduction Guidance (paragraphs 28 to 33), dishonesty in the workplace usually falls at the higher end of the spectrum of seriousness.

47. However, paragraph 33 provides that:

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

48. He submitted that although Dr Benjamin's dishonesty occurred admittedly in the workplace, it took place over a very short period of time and in unique circumstances. He submitted that it should not therefore be determined to be at the higher end of the spectrum.

49. In relation to Step 2C - consider the impact of any relevant context

50. In relation to “*personal context*”, he referred the Tribunal to paragraphs 70 – 73 of the Guidance which provide:

‘(70) For personal context to be relevant to the 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.

(72) Where the relevant personal context was out of the doctor’s control, or where they were taking reasonable steps to minimise the impact, this will usually have more of an impact on the assessment of risk. However, where there is an ongoing impact arising from the doctor’s personal context and steps are not in place to manage this, the MPT might conclude, depending on the facts of the case, that there may be a risk of repetition which means the level of current and ongoing risk to public protection may be increased.

(73) In cases where there is evidence of personal context that may decrease the level of risk the doctor poses to one or more of the three parts of public protection, this will usually have less impact, and therefore carry less weight, 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. This is because the risk to public protection arising from these concerns is generally more difficult to mitigate.’

51. He submitted that Dr Benjamin’s personal context as outlined above was relevant to the Tribunal’s assessment of current and ongoing risk to public protection because there was a direct link between that personal context and Dr Benjamin’s misconduct. He reminded the Tribunal of the context surrounding Dr Benjamin’s dishonesty, namely that it all occurred within a short space of time surrounding the news of XXX, all of which was highly destabilising and devastating for Dr Benjamin. Mr Irwin said that Dr Benjamin did not claim that his

judgement had been XXX, but rather that it was impaired because of the circumstances that would throw any reasonable person into turmoil. He said that this did not excuse Dr Benjamin's conduct but clearly explained the difficulty he was dealing with at the time.

52. He stated it was unique for the reasons set out in his submissions. He did not, 'have a normal sense of himself' and did not, 'want to let the Practice down'.

53. In relation to Step 2d: consider how the doctor has responded to the allegation(s).

54. Mr Irwin accepted that dishonesty is difficult to remediate but submitted it was not impossible. He submitted that Dr Benjamin posed no risk to public protection as he had developed full insight. The specific circumstances that led to his dishonesty were now over. He had taken steps to ensure that any similar conduct would not occur again and had demonstrated that by recalling a patient in October 2025, on realising an omission during a consultation and by dealing differently with XXX in August 2026, by taking time off work. He said while it was accepted that it was difficult to remediate dishonesty, it was not impossible. He submitted that Dr Benjamin had done so for the reasons outlined above.

55. Mr Irwin submitted that the various medical ethics courses that Dr Benjamin had completed, in particular the course with Mr E, together with his reflections, demonstrated his good level of insight. He stated that Dr Benjamin has acknowledged that insight and remediation are never complete and that he continues to work towards both of these goals. Mr Irwin submitted that Dr Benjamin has also booked to go on a further course on insight and remediation on 1 October 2026, which shows his ongoing commitment to remediation.

56. Mr Irwin submitted that the ethics courses were significant pieces of work that required Dr Benjamin to engage with the learning in very meaningful ways and to reflect on his conduct. He submitted that Dr Benjamin had reflected that the concealment of his mistakes destroyed the trust placed in him as a doctor. Dr Benjamin had also reflected on the fact that his personal actions risked undermining public trust in the wider profession.

57. Mr Irwin submitted that Dr Benjamin had provided examples of how his practise has changed, that he has recognised his limitations in relation to XXX and had taken steps to address this. Mr Irwin submitted that the Ethics courses and significant engagement with Lyra demonstrated that Dr Benjamin was willing to engage with remediation, to develop strategies to improve his resilience and demonstrated his commitment to ongoing remediation work.

58. Finally in relation to Step 2e: on the basis of the conclusions reached in steps 2b, 2c and 2d decide if the doctor poses any current and ongoing risk to public protection and make a finding on impairment. He referred the Tribunal to the MPTS Guidance on Impairment which provides as follows:

*‘(3) The MPT **will only make a finding of impairment 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 requiring restrictive action in response. This assessment must be made with reference to the facts found proved at the first stage of the hearing and any further relevant evidence presented to the MPT.*

*(4) The decision on impairment is one for the MPT alone, exercising their judgment. **There is no burden or standard of proof.***

(6) an MPT will consider:

- *the **seriousness** of the facts found proved,*
- *any relevant **context** known about the doctor and/or their working environment, and*
- ***how the doctor has responded** to the allegation(s).’*

59. In conclusion, he submitted that on the totality of the evidence Dr Benjamin no longer posed a risk to public protection and the Tribunal should not find that his fitness to practice is impaired.

The relevant legal principles

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

61. 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.

62. To assess whether Dr Benjamin poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will follow the steps set out in the *MPTS Guidance for Tribunals (Section three: MPT Hearings > Part B > Stage 2: Impairment > Steps 2(a) to (e)* ('the Guidance'). It will consider:

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

63. Where appropriate, the Tribunal will also have regard to the *MPTS Guidance for Tribunals > General introduction > Protecting the public in specific case types* ('the Guidance Introduction'). The relevant case type in Dr Benjamin's case is: Dishonesty.

64. The Tribunal had regard to the case of *Roylance v GMC (No.2) [2000] 1 AC 311*:

'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 will qualify. The professional misconduct must be serious.'

65. The Tribunal noted the case of *Nandi v General Medical Council [2004] EWHC 2317 (Admin)* (04 October 2004):

'31 [misconduct is observed] 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, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners. It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree.'

66. The Tribunal also had regard to *Cheatle v General Medical Council* [2009] EWHC 645 (Admin) (27 March 2009):

‘22 In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct.’

67. The Tribunal had regard to the test for impairment that was set out by Dame Janet Smith, and adopted and cited in the cases of *CHRE v Grant and NMC*, [2011] EWHC 927 (Admin):

‘a) Whether the registrant 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;

b) Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;

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

d) Whether the registrant has in the past acted dishonestly and/or is liable to act dishonestly in the future.’

Also:

‘74 In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.’

The Tribunal's determination on impairment

2a - Is there a legal basis for considering impairment?

68. The Tribunal began by considering whether there was a legal basis for considering impairment. The Tribunal went on to consider if the proven facts engage one or more grounds of impairment. In this case the ground of impairment relied on by the GMC is “Misconduct”.

69. In considering whether Dr Benjamin's conduct amounted to Misconduct, the Tribunal had regard to the cases of *Roylance v GMC (No 2)*[2000] 1 AC 311 and *Nandi v General Medical Council* as set out above. The Tribunal then went on to consider whether the Misconduct was “serious”.

70. The Tribunal reminded itself of Dr Benjamin's conduct, namely that he had falsely recorded information in the medical records of three different patients. He had done so to cover up omissions that he had made during the patients' consultations, which were dishonest. He had documented discussions and examinations that had not taken place. These were acts and/or omissions which were not proper in the circumstances and therefore amounted to misconduct. The Tribunal then went on to consider if the Misconduct found was “serious”. The Tribunal reminded itself of the case of *Martin v GMC [2011] EWHC 3204 (Admin)* where it was held that a finding of misconduct did not automatically mean that a registrant's fitness to practise was impaired and that a sanction was needed. There was no blanket rule created in *Grant*. Each case turns on its own facts, and an assessment must be made of the relevant factors in the case. The public interest requirements will differ from case to case.

71. The Tribunal had regard to GMP 2024 and considered that the following paragraphs were relevant in this case:

‘6 *You must provide a good standard of practice and care. If you assess, diagnose, or treat patients, you must work in partnership with them to assess their needs and priorities. The investigation or treatment you propose, provide or arrange must be based on this assessment, and on your clinical judgement about the likely effectiveness of the treatment options.*

7 *In providing clinical care you must:*

...

b carry out a physical examination where necessary

...

69 *You must make sure that formal records of your work (including patients' records) are clear, accurate, contemporaneous and legible.*

...

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'

72. The Tribunal considered that Dr Benjamin's conduct fell short of the standards set out in each of these paragraphs of GMP. Dr Benjamin had failed to carry out appropriate examinations in relation to Patient A and Patient C, in relation to Patient B he had failed to have appropriate discussions about their care and symptoms.

73. Dr Benjamin had dishonestly made false entries in patient records, which the Tribunal considered breached paragraphs 6, 7(b), 69, 81, 88 and 89 of GMP, as set out above. This behaviour fell far short of what was expected from a medical practitioner.

74. The Tribunal considered that these breaches of GMP were serious departures and amounted to serious professional misconduct. As such, the Tribunal determined that Dr Benjamin's actions constituted serious misconduct and therefore concluded that there was a legal basis for considering impairment under Section 35C(2)(a) of the Medical Act 1983.

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

75. The Tribunal went on to consider where Dr Benjamin's misconduct fell on the spectrum of seriousness. It was submitted by Ms Ferrario on behalf of the GMC that the misconduct in this case fell at the higher end of the spectrum of seriousness, having occurred

within Dr Benjamin's professional position. She submitted that there were factors present that further increased the seriousness of the case as outlined above. It was submitted by Mr Irwin that it was accepted that, by reference to the Guidance (paragraphs 28 – 33), dishonesty in the workplace usually falls at the higher end of the spectrum of seriousness. However, he submitted that although Dr Benjamin's dishonesty occurred in the workplace, it took place over a very short period of time and in unique circumstances. He submitted that it should not therefore be determined to be at the higher end of the spectrum. He submitted that dishonesty can involve a wide range of behaviour and said it was for the Tribunal to decide where on the spectrum of seriousness the dishonesty in this case sits.

76. The Tribunal had regard to paragraphs 87 and 90 of the MPTS Introduction Guidance that deal with Case Type 2 - Dishonesty:

'87 Whilst a range of behaviour can be seen, the nature of the departure from the standards expected may mean that a concern or allegation relating to dishonesty falls at the high end of the spectrum of seriousness. Even a single incident of dishonesty can have a significant harmful impact and pose a risk to public protection.

...

90 Many allegations relating to dishonesty fall at the higher end of the spectrum of seriousness. Where they do, the starting point for assessing current and ongoing risk to public protection will be high.'

77. The Tribunal also had regard to paragraph 31 of the Guidance:

'31 Allegations that are likely to fall at the higher end of the spectrum of seriousness include, but are not limited to:

...

- dishonesty, other than where it occurred outside of the doctor's professional role and was not persistent or repeated, and the value or other benefit derived was not significant.'*

78. The Tribunal reminded itself that Dr Benjamin's dishonesty occurred within his professional role. It reminded itself that the guidance indicates that many allegations relating to dishonesty fall at the higher end of the spectrum of seriousness.

79. In assessing seriousness, the Tribunal referred itself to paragraphs 34 – 37 of the Guidance. Paragraph 36 sets out features that may increase the seriousness of an allegation.

'Features which may increase the seriousness of an allegation

34. *In all cases, there may be specific features about the allegation and departure from the professional standards which may increase its seriousness. These features may be seen in any type of case and where present may increase where on the spectrum of seriousness the allegation lies.*

35. *The MPT should identify any relevant features and consider the extent to which they are present to decide how much weight to attach to them. This will help the MPT explain what, if any, impact each relevant feature has and decide where on the spectrum of seriousness the allegation falls.*

...

37. *The MPT's decision on where on the spectrum of seriousness the allegation lies must reflect:*

(a) the starting point for assessing seriousness based on the nature of the allegation and

(b) the impact of specific features about the allegation which may increase seriousness.'

80. The Tribunal concluded that there were features present in Dr Benjamin's case which increased the seriousness of his misconduct:

- 1) Dr Benjamin's dishonest behaviour was repeated across three patients;
- 2) Dr Benjamin's behaviour included deliberate acts of dishonesty.
- 3) Dr Benjamin's actions showed a reckless disregard for patient safety and professional standards. He ought to have known that writing that he had examined Patients A and C and stating that he had given safety netting advice to Patient B when he knew that was false risked causing them harm. He closed his mind to the existence of such a risk. A reckless disregard for professional standards is where a doctor knew, or ought to have known, they should have followed professional guidance and chose not to do so without having first considered any associated risks and taking reasonable steps to mitigate them. This may include failing to take reasonable steps to check that information provided to others, or written in documents for example in Dr Benjamin's case, the patient records were incorrect and that relevant information has not been left out.
- 4) Dr Benjamin's actions had the effect of undermining collaborative working by leaving his colleagues to work from the inaccurate records he had created of the patient consultations. How doctors treat their colleagues, and how they work together in the interests of patients, is essential for good healthcare. Behaviour that undermines colleagues or is otherwise obstructive to effective team working, can directly or indirectly have a negative impact on patient safety. Dr Benjamin

undermined collaborative working by writing false information in the patients' records.

- 5) Dr Benjamin put his own interests before those of patients. He wrote the records to give others the impression he had carried out examination which he had not carried out so that he could make good impression at the new practice rather than owning up to omissions he had made in patient consultations.
- 6) Finally, the Tribunal concluded that Dr Benjamin had attempted to hide his mistakes and/or avoid taking responsibility for his behaviour by creating false records. His actions were only discovered because two patients raised concerns after they realised that the records of their consultations were inaccurate. Dr Benjamin's unacceptable behaviour could have had a negative impact on patient safety and/or workplace culture.

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

81. The Tribunal then moved on to consider the impact of any relevant context known about Dr Benjamin. First it identified if there was any relevant context – working environment, role and experience or personal context. Next it considered whether any relevant context directly or indirectly affected the doctor's behaviour. If so, whether it was appropriate to take that context into account. If so, to confirm what impact it has on the level of risk (decreases, no impact or increases).

82. The Tribunal considered the parties' submissions.

83. It was submitted by Ms Ferrario that it is for the Tribunal to assess the context; Dr Benjamin's working environment; and his personal circumstances and to determine whether this impacts on the seriousness. The GMC recognises that this was Dr Benjamin's first role as a salaried GP in England. She stated that the GMC also recognised that Dr Benjamin had difficult personal circumstances in November 2024. The Tribunal was however reminded of and referred to the following,

- (a) This is not a case where due to inexperience or challenging personal circumstances, Dr Benjamin's notes were incomplete. This is a case where he fabricated information when there was absolutely no need for him to do so. He realised his earlier errors and wanted to rectify them to impress his employer.

- (b) Dr Benjamin came to England as an experienced practitioner. This was pointed out during his evidence. The GP surgery may have been new to him, but he was well versed in the requirement to prepare detailed accurate patient notes.
- (c) Paragraph 69 of the Guidance: Dr Benjamin should have asked for support as soon as he realised that his personal circumstances were presenting difficulties for him to deliver good medical practice.
- (d) Paragraphs 70 – 73 of the Guidance: There must be a direct link between the doctor’s personal context and behaviour in order for it to be relevant to the assessment of current and future risk to public protection. Paragraph 73 highlights that where the misconduct falls at the higher end of the seriousness spectrum, personal context will carry less weight in terms of assessing risk.

84. It was also submitted by Ms Ferrario that during his evidence, Dr Benjamin said that at the time of all the dishonesty, his judgment had been impaired. The Tribunal has no professional evidence to support this referring to XXX.

85. Mr Irwin invited the Tribunal to take the relevant context into account. He submitted that there was a direct link between the doctor’s personal context and behaviour in this case and that the personal context was relevant to the assessment of current and future risk to public protection.

86. He referred to as the *“unique nature of the stress experienced by the Registrant in November 2024”*. He submitted said that, whilst XXX is not a unique experience, as submitted by Ms Ferrario, on behalf of the GMC, he said XXX in the particular circumstances of this case was a unique experience for Dr Benjamin. Mr Irwin said that prior to the matters that gave rise to these proceedings, no other regulatory concerns had been raised about Dr Benjamin across 16 years of practice and none have been raised since. He submitted that this was significant and therefore that Dr Benjamin’s dishonesty should be looked at through the context of his circumstances at the time.

87. In relation to the submissions made by the GMC regarding XXX, he stated Dr Benjamin was not inviting the Tribunal to find that his judgment had been impaired at the relevant time due to XXX. He was merely submitting that the context surrounding Dr Benjamin’s dishonesty, namely that it all occurred within a short space of time surrounding XXX, all of which was highly destabilising and devastating for Dr Benjamin. Mr Irwin said that Dr Benjamin did not claim that his judgement had been XXX, but rather that it was impaired because of the circumstances that would throw any reasonable person into turmoil. He said

that this did not excuse Dr Benjamin's conduct but clearly explained the difficulty he was dealing with at the time. Dr Benjamin did not "have a normal sense of himself" and did not want to let the Practice down.

88. The Tribunal also reminded itself of Paragraphs 43 and 44 of the Guidance outlined below:

Higher end

42. ...

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

44. *In all cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context known about the doctor and/or their working environment and evidence of how the doctor has responded to the concern that decrease risk, will usually have less impact and carry less weight. This is because the risk to public protection arising from allegations at the higher end of the spectrum of seriousness are generally more difficult to mitigate and address.*

89. The Tribunal considered that in Dr Benjamin's case, there was relevant professional context in relation to Dr Benjamin's work, role and experience and that there was also some relevant personal context.

90. The Tribunal concluded that, whilst Dr Benjamin was an experienced doctor, he was newly qualified as a GP at the time of events and only a month into his first position in that role. He was working with less supervision than he had been previously for a new employer. The Tribunal considered that the step up to being a salaried GP was not trivial.

91. The Tribunal also considered that there was significant personal context in this case. It determined that it was highly relevant that Dr Benjamin had learned of XXX, all of which was very shortly after starting his new role.

92. Dr Benjamin in his witness statement said:

'On the 31 October 2024, I received the most devastating news of my life, [XXX]. This tragic revelation came barely a month into my new job, and it shook me, not least because I was so far away from her.

Tragically, [XXX]. If I could rewind time, I would have taken some time off and given myself the space [XXX]. But I didn't. I couldn't. And now, I live with the double regret of failing [XXX] and my patients.

Looking back, I wish I had had the strength to step away, even temporarily. With hindsight, it is clear to me that it was my responsibility to ensure that I was in a fit state to work, in light of what was going on in my personal life. I have reflected on [XXX] "

At the time, my performance led to a series of clinical concerns, inaccurate documentation and, ultimately, dishonesty. I recognise that although I was experiencing significant emotional distress because of [XXX], this does not excuse my dishonesty. I have undergone [XXX] on this including how to be scrupulously honest, truthful and maintain professional integrity. Those circumstances may explain my reduced resilience at the time, but they cannot justify what I did.

One of the most important lessons I have learned is the need to seek support early whenever personal circumstances begin to affect professional performance. My greatest insight has been recognising that the principal failing was not the original clinical omissions, but my dishonest documentation and recording of events. Clinical mistakes can occur, but professionalism is defined by responding with honesty, openness and accountability.'

93. The Tribunal accepted the submissions of Mr Irwin that what happened in the circumstances of this case was a unique experience for Dr Benjamin, which had a profound impact on him. During the proceedings, Dr Benjamin was seen by the Tribunal to be visibly affected by the circumstances relating to XXX. The Tribunal took account of Mr Irwin's submissions that nothing like this had happened in Dr Benjamin's practice prior to this incident and nothing had happened since. It concluded that the relevant context directly or indirectly affected Dr Benjamin's behaviour at the time.

94. The Tribunal then went on to consider whether it was appropriate to take that context into account and if so to confirm what impact it has on the level of risk (decreases, no impact or increases). In doing so, the Tribunal reminded itself of Paragraph 44 of the Guidance set out above which notes that evidence of personal context known about the doctor and/or their working environment and evidence of how the doctor has responded to the concern that decrease risk will *usually* have less impact and carry less weight in cases where the allegation falls at the higher end of the spectrum of seriousness. This is because the risk to

public protection arising from such allegations are generally more difficult to mitigate and address.

95. The Tribunal concluded that it was appropriate given the circumstances of this case to take the relevant context in Dr Benjamin's case into account. In terms of his personal context, the Tribunal took into account that what happened to him in relation to XXX was a unique set of circumstances, the misconduct happened in the same period. It also concluded that the personal context had an impact on the level of risk, it decreases the risk but due to the seriousness of the Allegation faced by Dr Benjamin (which involved positive and deliberate acts of dishonesty repeated across three patients and the other aggravating features outlined above which increase the seriousness), the level of risk to public protection remains high.

96. Dealing with the submissions made by the GMC about XXX. Dr Benjamin has admitted that at the time of his dishonest conduct he knew what he was doing. In response to the GMC submission, Mr Irwin accepted that the defence are not advancing that argument in this case so the Tribunal consider that there is no need for the Tribunal to make a specific finding in respect of that in these proceedings.

97. The Tribunal considered that Dr Benjamin's misconduct occurred within an 11-day period and in response to his unique personal circumstances. However, the Tribunal noted that Dr Benjamin's response to the difficult circumstances was to act in a dishonest manner.

98. The Tribunal considered that Dr Benjamin's dishonesty occurred because of the relevant context including XXX. However, this did not excuse his acting dishonestly.

2(d) - How has Dr Benjamin responded to the allegation?

99. The Tribunal considered how Dr Benjamin had responded to the allegation. It considered what evidence there was relating to insight. It assessed if any insight shown was genuine. It also considered what evidence there was relating to remediation and assessed if the allegation was remediable, if it had been remedied and the likelihood of repetition. The Tribunal also considered if Dr Benjamin had kept his knowledge and skills up to date. It then considered what impact these factors had on the level of risk (decreases, no impact or increases).

Insight

100. In relation to insight, the Tribunal considered the submissions of the GMC and the Registrant as outlined above. It was submitted by the GMC that Dr Benjamin had shown only

partial insight. She submitted that Dr Benjamin's reflections lacked specific reference to and consideration of how his dishonesty impacted patients and colleagues. She said that his reflections did not go beyond his personal impact and that his insight was only partial. Mr Irwin did not accept the GMC's submissions. He directed the Tribunal to parts of the defence evidence which showed the level of insight shown by Dr Benjamin. He submitted that Dr Benjamin's reflections demonstrate his understanding of the impact of his dishonesty on others and the consequences of a doctor acting dishonestly, it has consequences beyond the individual case. It risks undermining confidence in doctors generally.

101. The Tribunal considered that Dr Benjamin had recognised his wrong doing and had shown remorse. He had also shown an understanding of the impact of his dishonesty on patients and the loss of trust that his actions will have caused, both towards himself and the profession as a whole. Dr Benjamin also gave evidence at the impairment stage relating to his insight into his conduct. Extracts from Dr Benjamin's witness statement are outlined below:

"One of the most important lessons I have learned is the need to seek support early whenever personal circumstances begin to affect professional performance.

My greatest insight has been recognising that the principal failing was not the original clinical omissions, but my dishonest documentation and recording of events. Clinical mistakes can occur, but professionalism is defined by responding with honesty, openness and accountability. When I input my assumptions into a medical record, as a result of my own failings, it is not only inappropriate and unacceptable but dishonest. I can now see that this was a serious breach of the trust placed in me by my patients, colleagues, employer, the profession and the general public. I deeply regret and am profoundly ashamed of my conduct. I recognise that I caused patients to question the honesty of their doctor and compromised colleagues' ability to rely on my documentation. I have come to understand that honesty is not simply one professional duty among many - it is the cornerstone on which the other duties rest".

102. The Tribunal does not accept the GMC's submissions in relation to insight shown by Dr Benjamin. Dr Benjamin has shown insight into his wrong doing. He has demonstrated remorse and has reflected on the impact of his dishonest conduct on patients, members of the public including his family members and on the wider medical profession. The Tribunal reminded itself of the need for cultural awareness when dealing with people from different backgrounds as they may express insight in different ways. The Tribunal concluded that Dr Benjamin had shown a good level of insight. The Tribunal assessed the insight shown by Dr Benjamin to be genuine. He had given oral evidence and had explained as well as he could his

understanding of his dishonesty and its impact. He had also provided reflections on what had gone wrong and how to avoid repeating his dishonesty in the future.

Remediation

103. In relation to remediation, the Tribunal considered what evidence there was relating to remediation and assessed if the allegation was remediable, and if it had been remedied. The Tribunal reminded itself that dishonesty can be difficult to remediate. It also considered the parties' submissions. It was submitted by the GMC that Dr Benjamin had made efforts to remediate but had still not given sufficient consideration to the impact of his actions on others. Mr Irwin submitted that Dr Benjamin acknowledges that insight and remediation are never complete, he had taken extensive steps to try to remediate his conduct. He directed the Tribunal to the evidence in the defence bundle and that given by Dr Benjamin during the proceedings. He submitted that Dr Benjamin had engaged in meaningful remediation steps including an intensive face to face ethics course with Mr E.

104. The Tribunal considered evidence relating to steps taken by Dr Benjamin to remediate the misconduct. He had provided a reflective statement.

105. Since the events in November 2024, Dr Benjamin has engaged in professional ethics CPD courses on Probit and Medical ethics. He had provided reflections from the learning undertaken.

106. XXX

107. XXX

108. The documentary evidence submitted on behalf of Dr Benjamin included a letter relating to the outcome of the Professional Standards Group meeting of 11 December 2025 - Following a meeting of the NHS Professional Standards Group (PSG) held on that date, Ms J wrote to Dr Benjamin to advise him of the group's decision. She states in the letter that the members of the PSG had sight of his Professional Development Plan (PDP) and agreed that the document demonstrates a significant amount of learning. In light of the update, the members of the PSG agreed to continue to maintain a watching brief over the GMC proceedings without the need for any further local action at that stage. She reflected she appreciated it can be a difficult time and reiterated the support that was available for Dr Benjamin and gave him the contact details for XXX..

109. The Tribunal was satisfied that Dr Benjamin had shown good insight, that he had taken meaningful steps to attempt to remediate his misconduct. Whilst acknowledging that dishonesty can be difficult to remediate and remediation is never complete, the Tribunal concluded that Dr Benjamin had taken considerable steps towards remediation in this case and that he had done as much as could be expected of him to attempt to remediate.

Risk of repetition

110. The Tribunal considered the likelihood of repetition.

111. In relation to risk of repetition, Mr Irwin submitted that the risk of repetition was low. The reasons given by him for this assessment of a low risk of repetition are:

- a. Dr Benjamin's unblemished record before the events in November 2024;
- b. The unique circumstances pertaining to the period 31 October 2024 and 5 December 2024
- c. There having been no similar concerns raised since then;
- d. The fact that Dr Benjamin has reflected and admitted the allegations in full – he has not sought to justify or to excuse his conduct;
- e. The fact that Dr Benjamin has engaged in meaningful remediation steps;
- f. The fact that Dr Benjamin recalled a patient in October 2025, on realising an omission during a consultation; and
- g. The fact that Dr Benjamin dealt differently with XXX in August 2026, by taking time off work.

112. The Tribunal noted that dishonesty was difficult to remediate but that Dr Benjamin had made significant efforts to do so. He had made early admissions to his dishonesty. He fully engaged with the regulator throughout the misconduct proceedings. He had also attended numerous relevant courses, which he had meaningfully engaged with. He has reflected on his conduct and has now adopted strategies on how to act differently in the future. Dr Benjamin has 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 XXX when confronting issues and work-life balance.

113. The Tribunal took account of the submissions made about Dr Benjamin's unblemished record before the events in November 2024, the circumstances pertaining to the period 31 October 2024 and 5 December 2024 in which these matters arose and the fact that there had been no similar concerns raised since then. The Tribunal had regard to Mr Irwin's submissions and the testimonials submitted on behalf of Dr Benjamin relating to his training

and practice. The Tribunal considered that Dr Benjamin had demonstrated that he did not have a deep-seated attitudinal issue with honesty and probity.

Keeping knowledge and skills up to date

114. The Tribunal also considered if Dr Benjamin had kept his knowledge and skills up to date. No issue has been raised about lack of knowledge and/or skills. Dr Benjamin has submitted evidence in the defence bundle of how he has kept his knowledge and skills up to date. The Tribunal took into account that Dr Benjamin has remained in practice since the events that gave rise to the proceedings and has also provided evidence of CPD learning relating to clinical knowledge and skills. The Tribunal concluded that Dr Benjamin had kept his knowledge and skills up to date.

Impact of Dr Benjamin's response on the level of risk to public protection

115. The Tribunal then considered what impact these factors had on the level of risk (decreases, no impact or increases).

116. The Tribunal considered the submissions made by the parties.

117. The Tribunal bore in mind the seriousness of Dr Benjamin's misconduct and the following paragraphs of the Guidance:

'79 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. In many cases, as it can reduce the risk of repetition, it can significantly decrease the level of any current and ongoing risk to public protection posed by the doctor.

80 However, in cases 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, evidence of insight and remediation will usually carry less weight and therefore will have less impact, if any, on the assessment of current and ongoing risk to public protection. This is because the risk to public protection arising from these allegations is generally more difficult to address, particularly where the allegation is connected to deep seated attitude issues and beliefs.'

118. The Tribunal has already concluded in Dr Benjamin's case that this is not a case in which the allegation is found to arise from deep seated attitude issues and beliefs. The Tribunal has concluded that he has shown a good level of insight and has taken meaningful steps towards remediation. The Tribunal has also come to the conclusion that even though dishonesty allegations can be more difficult to remediate, for the reasons set out, there is unlikely to be a risk of repetition in Dr Benjamin's case. Each case is to be treated on its own merit. Accordingly, in this case the Tribunal concluded that evidence of insight and remediation should be given some weight. Accordingly, the Tribunal's decision in Dr Benjamin's case is that the impact of his response on the risk to public protection is that it decreases the risk from high to medium.

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

119. At this stage, on the basis of the conclusions reached in steps 2b, 2c and 2d the Tribunal went on to decide if Dr Benjamin poses any current and ongoing risk to public protection and to make a finding on impairment. If there is no current and ongoing risk, it will make a finding of no impairment. If there is a current and ongoing risk to public protection, it will decide to which parts, state the level of risk (low, medium, high) and make a finding of impairment. The Tribunal should give reasons for its decision.

120. The Tribunal referred to the parties' submissions.

121. It was submitted by the GMC that the conduct having regard to all the circumstances falls at the higher end of the seriousness spectrum, the starting point for assessing current and ongoing risk to public protection ought to be high.

122. When considering whether Dr Benjamin poses a current and/or ongoing risk to public protection, she referred to the case of *GMC & PSA v Dugboyle* [2024] EWHC 2651 (Admin), and submitted that the Tribunal ought to consider all three limbs of the statutory objective namely,

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

123. She stated in conclusion the GMC's position is as follows,

- (a) In terms of whether Dr Benjamin poses a current and ongoing risk to patient safety, the GMC is neutral on this issue.
- (b) The risks however to public protection in terms of the second and third limbs of the statutory objective are current and ongoing. The dishonesty sits at the higher end of the seriousness spectrum and therefore evidence of context, and Dr Benjamin's response ought to carry less weight.
- (c) Dr Benjamin is currently on a journey of insight & remediation. The public interest limbs of the statutory objective are such that he ought to be able to demonstrate full insight & remediation before public confidence may be redressed.
- (d) In light of his incomplete journey, the GMC submits that the second and third limbs of the statutory objective are clearly engaged. The current and ongoing risk that he poses in relation to the wider public protection ought to justify a restrictive response by the Tribunal. At the very least the Tribunal should ask itself, how would a reasonable, well-informed member of the public react to Dr Benjamin's conduct? Dr Benjamin said that they would be 'disappointed.' The GMC invites the Tribunal to find that the response is more likely to be 'shocked' and/or 'appalled.'
- (e) Where the Tribunal finds that Dr Benjamin has fully remediated himself on a personal level, the Tribunal is invited to conclude that a finding of current impairment is necessary and appropriate, to uphold proper professional standards and/or promote and maintain public confidence in the profession.

124. For the above reasons, the GMC submitted that the Tribunal ought to make a finding that Dr Benjamin's current fitness to practise is impaired.

125. It was submitted by Mr Irwin that while it is accepted that it is difficult to remediate dishonesty, it is not impossible. It was submitted that Dr Benjamin had done so for the reasons previously outlined. In conclusion, Mr Irwin submitted that on the totality of the evidence, Dr Benjamin no longer posed a risk to public protection and the Tribunal should not find that his fitness to practice is impaired.

126. The Tribunal referred to Paragraphs 131- 134 of the Guidance and the relevant parts of MPTS Introduction Guidance dealing with Case Type 2 – Dishonesty.

- '131. The MPT's view on whether the doctor poses any current and ongoing risk to public protection, and if so, what level of risk (low, medium, or high), is based on considering the answers to the questions at steps 2b to 2d: □ Where on the spectrum of seriousness does the allegation lie – lower end, mid-range, higher end? □ This provides the starting point for assessing current and ongoing risk to public protection – low, medium or high. □ Is there relevant context known about the doctor or their working environment that impacted on the doctor's behaviour, performance or health and what impact does this have on the assessment of current and ongoing risk – decreases risk, has no impact on risk, increases risk? How has the doctor responded to the allegation and what impact does this have on the assessment of risk – decreases risk, has no impact on risk, increases risk?*
- 132. Each of the answers will need to be carefully considered and balanced against one another to inform the MPT's view on risk.*
- ...
- 134. In cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context that decreases risk and evidence of insight and remediation that decreases risk may have less impact and carry less weight because these types of allegations can be more difficult to remediate. Evidence of the doctor having kept their knowledge and skills up to date may also be less relevant. This should be considered by the MPT when they are reaching a view on risk and a conclusion that the doctor poses a current and ongoing risk to one of more of the three parts of public protection requiring restrictive action in response may be needed, particularly as the allegation is likely to engage public confidence.*
- 135. Although cases of violence and dishonesty usually fall at the higher end of the spectrum of seriousness, they can involve a range of behaviour, with the circumstances giving rise to the allegation often occurring outside the doctor's professional practice. In deciding whether there is any current and ongoing risk to public protection requiring restrictive action in response, the MPT will need to decide where on the spectrum of seriousness the violence or dishonesty sits. Where the violent or dishonest behaviour is at the lower to mid-range of the spectrum of seriousness, evidence of relevant context that decreases risk and evidence of insight and remediation that decreases risk may carry more weight and have more impact. 5*

136. *The MPT must record reasons for their conclusion on whether the doctor poses any current and ongoing risk to one or more of the three parts of public protection requiring restrictive action in response, to explain their decision on impairment.*
137. *Where the MPT reach a view that the doctor poses a current and ongoing risk to public protection requiring restrictive action in response, they should make a finding that the doctor's fitness to practise is impaired. In doing so, they should be clear about which parts of public protection – patient safety, public confidence and/or upholding professional standards – are engaged, making reference to the general guidance and specific case types sections in the Introduction, as appropriate.*
138. *The MPT should also state the level of risk they've identified – low, medium, or high. This is because the level of current and ongoing risk will be relevant to the MPT's decision on what is a proportionate response. The MPT should then apply the guidance in Part C Step three: Decide on sanction to decide what action is needed to protect the public. 139. In cases where the MPT decides that the doctor's fitness to practise is not impaired, they may give the doctor a warning as to their future behaviour or performance where the allegation falls below the professional standards expected. To decide whether a warning is a proportionate response, the MPT should apply the guidance in Part D: Decide if a warning is required.'*
127. The Tribunal was reminded of the Guidance on Case Type 2 – Dishonesty and decision on impairment and Impact on public protection in dishonesty cases and decision on impairment and warnings.
128. Paragraph 87 of the Introduction Guidance
- '87. Whilst a range of behaviour can be seen, the nature of the departure from the standards expected may mean that a concern or allegation relating to dishonesty falls at the high end of the spectrum of seriousness. Even a single incident of dishonesty can have a significant harmful impact and pose a risk to public protection.*
- Protecting, promoting and maintaining the health, safety and wellbeing of the public (patient safety) Dishonest behaviour may impact the physical, emotional and/or psychological wellbeing of a patient or member of the public, including colleagues, or cause financial harm. These impacts can be long lasting and may affect how a person accesses health services in the future. Where dishonest behaviour has impacted, or*

could impact on patient care, there is a clear risk to patient or public safety. Examples include: v falsifying records

*Promoting and maintaining public confidence in the profession (public confidence)
Patients and members of the public must have confidence in doctors to behave professionally and act with honesty and integrity. Dishonesty arising inside, or related to, a doctor's professional practice may result in a breakdown of trust and undermine public confidence.*

The public having confidence in the profession is more important than the interests of an individual doctor.

Promoting and maintaining proper professional standards and conduct (upholding professional standards) Good medical practice requires that doctors are honest, trustworthy, act with integrity and uphold the law.

As doctors are expected to be honest and act with integrity, dishonest behaviour will usually amount to a significant breach of the professional standards.

Decision on impairment

90. Many allegations relating to dishonesty fall at the higher end of the spectrum of seriousness. Where they do, the starting point for assessing current and ongoing risk to public protection will be high.

91. In these cases, evidence of relevant context known about the doctor and/or their working environment and evidence of insight and remediation that decrease risk may have less impact because dishonesty allegations falling at the higher end of the spectrum of seriousness can be more difficult to remediate.

92. In such cases the MPT's decision on risk should reflect this and a conclusion the doctor poses a current and ongoing risk to public protection may be needed even in cases where the doctor has shown insight and taken steps to try and remediate. Where the MPT concludes that the doctor poses a current and ongoing risk, this will result in them finding that the doctor's fitness to practise is impaired.

93. The level of risk associated with a dishonesty allegation will often be medium or high. However, where there is a single incident of dishonest behaviour which falls at the lower end of the spectrum of seriousness, the level of risk may be lower.

94. Where a dishonesty allegation leads to a finding of impairment, it may engage one or more of the three parts of public protection. Whilst the MPT must consider the individual circumstances of the case, it will be unusual for a proven allegation of dishonesty not to undermine public confidence in the profession.

Decision on whether a warning is required

95. Where a dishonesty allegation falls at the higher end of the spectrum of seriousness, a conclusion that the doctor poses a current and ongoing risk to public protection will often have been made. However, where the specific type of behaviour amounting to dishonesty is found to have just fallen short of a finding that the doctor's fitness to practise is impaired, and there are no other proven allegations that require restrictive action to be taken, a warning will usually be appropriate to maintain public confidence in the profession and uphold professional standards.'

129. The Tribunal considered the Guidance and the impact on public protection in dishonesty cases as outlined above. The Tribunal then went on to consider whether in the circumstances of this case Dr Benjamin poses a current and/or ongoing risk to public protection. In doing so, the Tribunal considered all three limbs of the statutory objective. The Tribunal reminded itself of its decisions at steps 2b to 2d. It had determined that Dr Benjamin's dishonesty falls at the higher end of the spectrum of seriousness. It had concluded there was relevant context in Dr Benjamin's case that had an impact on his behaviour and that it was appropriate to take that context into account in his case. It had decided that the impact of the context on the assessment of current and ongoing risk was to decrease the risk but that it remained high. It considered how Dr Benjamin had responded to the allegation. It determined that Dr Benjamin had shown good insight and had taken meaningful steps towards remediation and accepted the Defence submissions that Dr Benjamin was unlikely to repeat the misconduct which gave rise to these proceedings. It decided that the impact of Dr Benjamin's response on the assessment of risk was that it had decreased the risk to public protection from high to medium. In doing so the Tribunal reminded itself of Paragraph 134 of the Guidance which states that where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context that decreases risk and evidence of insight and remediation that decreases risk may have less impact and carry less weight because these types of allegations may be more difficult to remediate.

130. The Tribunal has found that Dr Benjamin has taken meaningful steps towards remediation in this case. It had determined that it was appropriate to give weight to Dr

Benjamin's response reducing the impact of the risk to public protection from high to medium in his case.

131. It has concluded that due to the seriousness of the allegation involving dishonesty Dr Benjamin poses a current and ongoing risk to one or more parts of public protection which require restrictive action in response.

132. The Tribunal determined that all three parts of public protection were engaged in this case.

Patient safety

133. This was a case where Dr Benjamin had written false records relating to patient consultations. It had the effect of undermining collaborative working if other medical professionals had placed reliance on those records. There was risk of harm but there was limited harm that arose in this case due to the actions of the two patients who raised concerns about the records at a very early stage.

Public confidence in the profession

134. Dishonesty is a fundamental tenet of the profession.

135. The Tribunal reminded itself of the case of *Yeong v General Medical Council [2009] EWHC 1923 (Admin)*. In that case it was stated that there will be occasions where impairment of Fitness to Practise must be found as a matter of public policy, to uphold public confidence in the profession, where to make no such finding would have an adverse impact on public confidence in the profession and the GMC/ MPTS.

136. The Tribunal considered that a member of the public would be shocked to learn that no finding of impairment was made in relation to a doctor who had dishonestly completed patient records. The Tribunal considered that the need to uphold public confidence in the profession meant that a finding of impairment was necessary in Dr Benjamin's case.

Promoting and maintaining proper professional standards

137. The Tribunal determined that, in Dr Benjamin's case, his dishonest conduct represented serious departures from the professional standards laid out in GMP. The Tribunal therefore concluded that Dr Benjamin poses a current and ongoing risk to the promotion of proper professional standards in the medical profession.

138. The Tribunal determined for the reasons set out above that Dr Benjamin poses a current and ongoing risk to public protection requiring restrictive action in response. It determined the level of risk to be medium.

139. The Tribunal reminded itself of the Guidance, which states that, in cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing the risk to public protection is high. The evidence of context and Dr Benjamin's response will usually carry less weight. In this case, the Tribunal determined that it was appropriate, given the circumstances of this case, to give some weight to the context and Dr Benjamin's response as outlined above.

140. The Tribunal has therefore determined that Dr Benjamin's current fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 29/09/2026

141. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

The Evidence

142. Dr Benjamin gave oral evidence and detailed his personal circumstances, including XXX and the impact this has had on his family life along with the financial difficulties, XXX.

143. Dr Benjamin told the Tribunal that he had previously worked as a salaried GP and undertook occasional ad hoc work with local medical agencies. And he does not have any other income besides his medical work. XXX. He stated that if he were to be suspended then this would have a significant impact on his ability to support his family.

Submissions on behalf of the GMC

144. On behalf of the GMC, Ms Ferrario submitted that the appropriate and proportionate sanction in Dr Benjamin's case was suspension.

145. Ms Ferrario submitted that taking no action would be inappropriate and disproportionate as there were no exceptional circumstances in this case. She told the Tribunal that Dr Benjamin's personal circumstances at the time of the dishonesty were difficult but not exceptional.

146. Ms Ferrario submitted that conditions of practice may be considered potentially workable, particularly given that the dishonesty concerned record-keeping and patient notes. However, Ms Ferrario submitted that conditions would not adequately address the public confidence and professional standards aspects of the statutory overarching objective, particularly given the Tribunal's finding of a medium level of ongoing risk.

147. Ms Ferrario submitted that suspension was the only appropriate sanction. She stated that suspension would appropriately address the ongoing risk to public confidence and the maintenance of proper professional standards, while restricting Dr Benjamin's registration.

148. In relation to erasure, Ms Ferrario submitted that this was acknowledged as an available outcome for those cases where a doctor's behaviour is incompatible with continued registration. It means where the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise. She submitted that the circumstances of this case do not meet that criteria but that it was a matter for the Tribunal to come to its own conclusion.

149. Ms Ferrario referred the Tribunal to the relevant sanction guidance and submitted that the appropriate period of suspension for the dishonesty fell within the 3-to-9-month band. She further stated that if the Tribunal imposed a suspension of more than 3 months, then it may wish to consider a review hearing to determine whether Dr Benjamin could safely return to unrestricted practice. She stated that if the suspension were 3 months or less and imposed solely on public-confidence or professional-standards grounds, the GMC accepted that a review hearing might not be necessary.

150. Ms Ferrario referred the Tribunal to the case of *Sawati v GMC [2022] EWHC 283 (Admin)* concerning dishonesty, and stated that honesty is a fundamental tenet of the medical profession. She submitted that the Tribunal had already found Dr Benjamin's dishonesty to be serious and to have breached a fundamental professional tenet.

151. In relation to the impact which suspension would have on Dr Benjamin's personal and financial circumstances, Ms Ferrario referred to *Bolton v Law Society [1994] 1 WLR 512*. She submitted that sanctions in professional disciplinary proceedings are primarily intended to protect the public and maintain confidence in the profession rather than to punish the

individual. She further stated that while the consequences for Dr Benjamin and his family were relevant, she stated that those consequences could not outweigh the need to maintain public confidence in the integrity, probity and trustworthiness of members of the medical profession.

152. Ms Ferrario concluded that, having regard to all the circumstances, suspension was the appropriate and proportionate outcome.

Submissions on behalf of Dr Benjamin

153. Mr Irwin submitted that an order of conditions on Dr Benjamin's registration would be the appropriate and proportionate sanction. Mr Irwin outlined some conditions that he submitted may be appropriate to consider in Dr Benjamin's case. He stated that a condition requiring a workplace reporter may be appropriate. This would enable Dr Benjamin to meet on a regular basis with his workplace reporter to discuss his work and review records. If appropriate, the workplace reporter may monitor the fact that Dr Benjamin is XXX. This would also allow Dr Benjamin's note making and record keeping to be monitored and ensure the completion of and reflection on the CPD targeted at the concerns that have been raised and found proved by Dr Benjamin's own admission.

154. In relation to suspension Mr Irwin referred to the Guidance, and submitted that none of the factors set out in paragraph 45 are present in this case and stated that the findings of misconduct and impairment are, in themselves, sufficient signalling in relation to Dr Benjamin's unbecoming conduct. He reminded the Tribunal that Dr Benjamin's conduct has not been assessed to fall at the higher end of the spectrum of seriousness and there are no outstanding patient safety concerns. Mr Irwin stated that if the Tribunal considered a period of suspension necessary, it should be limited to three months or less, and that there would be no need for a review.

155. Mr Irwin submitted that erasure is reserved for cases where a doctor's conduct or performance is incompatible with continued registration because the doctor presents a sufficiently significant current and ongoing risk to public protection. He reminded the Tribunal that the GMC does not contend that Dr Benjamin's dishonest conduct in November 2024 warrants erasure. Mr Irwin stated that, in the circumstances prevailing at the time, the conduct was not incompatible with continued registration.

156. Mr Irwin referred to the case of GMC v Gilbert [2025] EWHC 802 (Admin), particularly paragraph 109, which stated:

“The Sanctions Guidance is not to be read as though it were a statute. It lists certain factors which may indicate that erasure is appropriate. Nor does the guidance mandate a particular outcome, as any decision on sanction is necessarily fact specific. The Tribunal found that Mr. Gilbert's misconduct was serious and that it impaired his fitness to practice. It was then for the Tribunal to reach an evaluative decision as to what was necessary to protect the public.”

157. Mr Irwin made reference to the Tribunal’s previous findings on Impairment and stated that Dr Benjamin has been found to have good insight and there is evidence of remediation and ongoing reflection. He stated that Dr Benjamin has made a commitment to XXX and has confronted difficult issues in his personal life. Mr Irwin further stated that Dr Benjamin has continued to practise for nearly two years without any repetition of similar behaviour.

158. Mr Irwin submitted that in relation to Dr Benjamin’s personal and household circumstances, he stated that the Tribunal should take into account the evidence concerning XXX, together with the exhaustion of his savings and the level of household debt. Mr Irwin acknowledged that it is accepted that such evidence may have limited weight, particularly in the context of sanction in a dishonesty case, however, he submitted that it remains relevant to the duration of any suspension.

159. Overall, Mr Irwin submitted that the level of current and ongoing risk to public protection does not justify erasure or a lengthy period of suspension and conditions on Dr Benjamin’s registration would provide a proportionate response.

The Tribunal’s legal approach

160. The Tribunal was referred to Guidance Part C Stage 3 – sanction. At Stage 3 of an MPT hearing the Tribunal will consider what regulatory action, if any, is needed to protect the public.

This stage outlines the outcomes which are available to the Tribunal which are:

- Take no action;
- Impose conditions on the doctor’s registration for up to three years;
- Suspend the doctor’s registration for up to 12 months; or
- Erasure of the doctor’s name from the medical register

161. The Tribunal is required to review the decision on impairment and consider the level of current and ongoing risk the doctor poses to public protection.

162. As the Tribunal has decided that the doctor's fitness to practise is impaired at stage 2 of the hearing, it will then need to go on to consider what is a proportionate regulatory response to protect the public. It would need to consider public protection, the MPTS'S legal duty to protect the public. It means the Tribunal must act in a way that:

- a) 'Protects, promotes and maintains the health, safety and wellbeing of the public.*
- b) Promotes and maintains public confidence in the profession, and*
- c) Promotes and maintains proper professional standards and conduct for members of the medical profession.*

When reaching a view on what is a proportionate sanction, the MPT must demonstrate they have considered any submissions made by the parties".

163. In making a decision on sanction, the Tribunal will consider what sanction is proportionate to meet the level of current and ongoing risk posed to public protection. The Tribunal will decide on the type and length of sanction and stand back and check if it is proportionate

164. This case involves an allegation of dishonesty. The Tribunal was referred to the relevant sections of the MPTS Introduction Guidance which deal with decision on sanction in dishonesty cases.

165. In this case sanctions bandings are available for cases of dishonesty and clinical concerns. The Tribunal is directed to consider those bandings when reaching its decision as to the appropriate sanctions.

166. The bandings are a guide. Sanction, if any, is a matter for the Tribunal exercising its own independent legal judgment. In reaching its decision, the Tribunal has to take account of the MPTS Guidance and of the overarching objective and any relevant caselaw.

167. The Tribunal in deciding on the appropriate sanction will consider all relevant evidence and decisions reached at both the fact finding and impairment stage of the proceedings. It 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.

168. As sanctions bandings are available in this case, the Tribunal was directed to the sanctions' bandings.

169. The sanction bandings are a guide. It will be for the Tribunal to exercise its discretion and to decide on the most appropriate sanction but should it decide not to follow the laid down guidance, it will need to specify the reasons for choosing to depart from the guidance.

170. The Tribunal was also referred to some relevant principles derived from decided cases.

171. Tribunals should not only refer to the guidance on sanctions, rather they should also apply the guidance as an authoritative steer. This was noted in the case of *GMC v Khetyar [2018] EWHC 813 (Admin)* – this case referred to the GMC Sanctions Guidance, but the same principles apply to the MPTS Guidance for Tribunals, Medical Practitioners tribunal hearings; Part C: stage three - sanction - MPTS for hearings post 24 November 2025.

172. *Bolton v Law Society [1993] EWCA Civ 32*, Paras 15 & 16 of the judgment state: "the reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits but that is part of the price." The court in that case elaborated on the fundamental importance of integrity, probity and trustworthiness in solicitors, stressing that severe sanctions are necessary to maintain public confidence. It explained that whilst disciplinary orders are not primarily punitive, they serve to protect the public and uphold the profession's reputation. Mitigating factors and testimonials have limited weight compared to the need to maintain trust in the profession.

173. *General Medical Council & v Gilbert & and the Professional Standards Authority [2026] EWCA Civ 53* When assessing seriousness, there is a distinction between conduct capable of imperilling patient safety, and conduct which actually imperils patient safety. That distinction is not an artificial one and could rationally make a difference when deciding what sanction is necessary and proportionate for the protection of the public and maintenance of professional standards; Paragraph 109 of the Sanctions Guidance should not be approached as a "score sheet" against which the tribunal should place ticks or crosses and then count up the number of ticks; the decision should be based on an evaluation of the overall gravity of the matter. The substance of the conduct matters far more than any labels.

174. in *NMC v Persand [2023] EWHC 3356 (Admin)* it was decided that tribunals should be cautious of reaching conclusions that are contrary to the guidance, eg where factors indicative of erasure were all acknowledged to be present, but despite this, the tribunal came to a contrary conclusion, further, without reasons being given for the departure.

175. The *General Medical Council and The Professional Standards Authority for Health and Social Care v Bramhall* [2021] EWHC 2109 (Admin) If departing from the Sanctions Guidance, a tribunal has a duty to state more clear, substantial and specific reasons for the departure, than if the Guidance was being followed.

176. Generalised assertions that a registrant's actions are not fundamentally incompatible with continued registration, and that erasure is not proportionate or appropriate, are inadequate. Unusual facts or features of a case and public prominence make it especially important that a careful, structured, and transparently accessible approach to regulatory decision-making is demonstrably taken and potentially for the Sanctions Guidance to be applied sensitively, thoughtfully and flexibly to the facts.

177. Tribunals must properly assess and/or articulate the gravity of conduct before them. Motivation potentially goes to gravity and is relevant to candour, insight and remediability, and therefore sanction; as such it needs to be explored and resolved by a Tribunal.

178. In *Sawati v General Medical Council* [2022] EWHC 283 (Admin), it was decided that the sanction must be proportionate to the gravity of the misconduct and impairment found. Erasure for dishonesty is not automatic, so these cases are not exempt from the general requirement to assess the seriousness of misconduct in every case before a sanction is imposed. Tribunals should also objectively and appropriately evaluate the offending behaviour by reference to the relevant aggravating and mitigating factors. The nature and extent of dishonesty may be variable and must be evaluated on a case-by- case basis.

179. In *Owusu-Yianoma v Bar Standards Board* [2023] EWHC 2785 (Admin). It was decided as to consistency of tribunal decisions in cases with similar allegations that each case is different and has to be determined on its own facts.

180. In *PSA v NMC & another* [2025] EWHC 3132 (Admin) a case involving dishonesty, decision handed down on November 29, 2025 the High Court allowed an appeal, ruling that the regulatory panel's sanction was insufficient to protect the public and maintain confidence in the profession. It found that the panel had misapplied the relevant guidance on sanctions by giving insufficient weight to the seriousness of the dishonesty and the breach of regulatory conditions. The Court emphasised that dishonesty, particularly where it is linked to professional practice or regulatory obligations, strikes at the heart of public trust in the nursing and midwifery professions.

The Tribunal's Determination on Sanction

181. The Tribunal was mindful of the procedure to be adopted under the Guidance (MPT Hearings > Part C: stage three – sanction > Step 3: decide on sanction). It noted that the reason for imposing sanctions is to protect patients and the public. Sanctions are not imposed to punish doctors, although they may have a punitive effect.

182. In making its decision on sanction, the Tribunal has reviewed its decision on facts and impairment and has considered the level of current and ongoing risk the doctor poses to public protection. It was mindful of paragraph 5 of the Guidance which stated:

‘When making their decision, the MPT should always remind themselves of their earlier conclusions at the facts and impairment stages to ensure that they have been, and remain, consistent with previous findings and have regard to the level of current and ongoing risk to one or more of the three parts of public protection posed by the doctor (low, medium, or high)’

183. The Tribunal considered the sanctions bandings within the Guidance when making its decision as to the appropriate sanction, it noted that the sanctions bandings are a guide. The decision on the appropriate sanction if any, is a matter for the Tribunal exercising its own independent judgment. In determining the appropriate outcome, the Tribunal must impose the least restrictive sanction it considers necessary in the circumstances of the case, which meets the over-arching objective of protecting the public.

184. In reaching its decision, the Tribunal has to take account of the parties’ submissions, the Guidance and 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.

No action

185. The Tribunal first considered whether to conclude the case by taking no action. It considered paragraphs 13 – 16 of Section 3 of the MPTS Guidance which relate to consideration of ‘Taking no action’. It noted in particular paragraph 13 which states:

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

186. The Tribunal did not identify any exceptional circumstances in this case such as to justify a decision to take no further action. The Tribunal concluded that given the nature and seriousness of its findings on Impairment, taking no action would not be an appropriate nor a proportionate response and would fail to uphold the three limbs of public protection.

Conditions

187. The Tribunal reminded itself of the submissions made by the parties. Mr Irwin had submitted that, given Dr Benjamin's personal circumstances at the time of the events, his level of insight and remediation and the Tribunal's finding that there is a low risk of repetition, this is a case where conditions are suitable. It also noted the GMC submissions. Ms Ferrario had submitted that given the Tribunal's findings at fact-finding and impairment stage, conditions would not be an appropriate and proportionate response and would not meet the statutory overarching objective.

188. The Tribunal considered carefully whether conditions would be an appropriate and proportionate response. It was mindful of the Guidance, and it considered paragraphs 28 and 30 of the Sanctions Guidance and Paragraphs 96 and 97 of the Introductory Guidance dealing with dishonesty allegations.

Paragraph 28 of the Guidance states: *"Conditions may be proportionate in cases where the doctor has shown a degree of insight into the allegation and some, or all, of the following factors are present:*

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

Paragraph 30 of the Guidance states:

"Conditions are unlikely to be a proportionate response in cases where the nature of the allegations about the doctor's behaviour fall at the higher end of the spectrum of seriousness and/or suggest an underlying problem with their attitude.

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.

189. The Tribunal reminded itself of the Guidance on sanction in dishonesty cases. The Guidance indicates that the proportionate sanction in response to an allegation of dishonesty will depend on the extent of the doctor's behaviour and the impact it is assessed to have on the three parts of public protection. Where the level of current and ongoing risk to public protection is medium or high, this will require consideration of suspension or erasure. It noted considering the factors in paragraph 28 that Dr Benjamin has demonstrated a good level of insight and has taken meaningful steps towards remediation. Although conditions might indirectly address certain issues in the case such as record-keeping and patient safety, the Tribunal did not consider those to be the central remaining concerns as far as the level of risk to public protection was concerned. It determined that imposing conditions was not an appropriate and proportionate response considering the seriousness of the allegation involving the dishonesty in this case and the Tribunal's findings both at the fact-finding and impairment stage.

190. The Tribunal determined that, given the seriousness of the dishonest behaviour linked to Dr Benjamin's professional practice and the importance of maintaining public confidence and promoting high standards within the medical profession, conditions would not be an appropriate or proportionate response to the seriousness of Dr Benjamin's misconduct. They would be insufficient to protect the public and maintain confidence in the profession.

Suspension

191. The Tribunal then went on to consider whether imposing a period of suspension on Dr Benjamin's registration would be appropriate and proportionate. It had regard to the following paragraphs of the Guidance:

'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:*

- 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.*

192. The Tribunal considered the further oral evidence of Dr Benjamin provided at this stage and was mindful of the relevant Guidance when taking this into consideration:

'66. The following matters are not relevant to the assessment of current and ongoing risk to public protection which will have informed the medical practitioners tribunals (MPT's) decision on impairment, but can be considered at this stage when deciding what sanction is proportionate:

- a. evidence about the impact that taking a specific type of action may have on patients or members of the public, or the doctor themselves, and/or*
- b. references and testimonials about the doctor's character.*

67. Where the MPT considers it is appropriate to take such evidence into account, they must explain the weight given to it and the impact this has had on their decision on sanction. This will include justifying any departure from a sanctions banding, if one is available for the specific case type.'

193. The Tribunal acknowledged that dishonesty in any form is serious, although there are different degrees of dishonesty. The Tribunal took into account that at the impairment stage it had identified that Dr Benjamin *"had demonstrated that he did not have a deep-seated attitudinal issue with honesty and probity."* It noted that Dr Benjamin's actions occurred during a very difficult period in his personal life, which he has since taken steps to address and reflect on. Further, the Tribunal acknowledged that Dr Benjamin has significant insight and has expressed sincere remorse for his actions.

194. The Tribunal took into consideration the testimonials provided in support of Dr Benjamin. The testimonials all indicated that Dr Benjamin is a capable and highly regarded doctor. The Tribunal noted that prior to these proceedings there had been no similar concerns regarding Dr Benjamin's conduct and there have been none since. The Tribunal is required to explain the weight given to testimonials and the impact this has had on its decision on sanction. In this case, the Tribunal has given some weight to the testimonials

when reaching its decision at the Impairment stage but they have had limited impact on the decision on sanction.

195. The Tribunal reminded itself that the objective of imposing a period of suspension would be to manage the current and ongoing risk to public protection with the ultimate aim of Dr Benjamin being able to return to unrestricted practice in the future.

196. The Tribunal determined that a sanction of suspension is appropriate to mark the seriousness of the misconduct, and that it is also proportionate when considering the current and ongoing level of risk to public confidence and upholding professional standards. This was a case involving dishonesty arising from Dr Benjamin's professional practice.

197. The Tribunal then went on to consider whether erasure was proportionate in this case as required by the Guidance. It had regard to paragraphs 55 and 57 of the relevant section of the 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.'

198. Although the conduct in this case 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 Dr Benjamin's level of insight and his ongoing remediation. Further, it was satisfied that it was possible for Dr Benjamin to remediate his conduct and address the concerns of the Tribunal. Consequently, the Tribunal did not find that Dr Benjamin's conduct was fundamentally incompatible with continued registration. The Tribunal was satisfied that professional standards could be 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 Benjamin to continue to hold his registration despite the seriousness of the facts found proven and the Tribunal's assessment of current and ongoing risk to public protection.

199. The Tribunal was referred to *General Medical Council & v Gilbert & the Professional Standards Authority [2026] EWCA Civ 53*. In that case it was decided that *when assessing seriousness, there is a distinction between conduct capable of imperilling patient safety, and conduct which actually imperils patient safety. That distinction is not an artificial one and could rationally make a difference when deciding what sanction is necessary and proportionate for the protection of the public and maintenance of professional standards; Paragraph 109 of the Sanctions Guidance should not be approached as a "score sheet" against which the tribunal should place ticks or crosses and then count up the number of ticks; the decision should be based on an evaluation of the overall gravity of the matter. The substance of the conduct matters far more than any labels.*

200. The Tribunal noted in this case that Dr Benjamin's actions had risked harm to patient safety but there was no actual harm to patient safety as outlined by the Tribunal at the impairment stage.

201. The Tribunal went on to consider the length of time a suspension should be imposed for. The Tribunal referred to the Guidance which sets out relevant factors to be considered when deciding on the length of a period of suspension.

202. 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.

203. If the Tribunal decides to direct a suspension, the following factors will be relevant in determining the length of suspension:

- a. the assessment of the level of current and ongoing risk to public protection posed by the doctor Section 35D(2)(b) of the Medical Act 1983 (as amended)*
- 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.*

204. The Tribunal determined factors c and d above not relevant in this case. It reminded itself of its assessment of the level of current and ongoing risk to public protection posed by the doctor, Section 35D(2)(b) of the Medical Act 1983 (as amended) and the reasons for assessing suspension as being the proportionate response.

205. It reminded itself of Paragraph 47 of the Guidance which states: *“A short suspension may be appropriate in cases where: the doctor’s behaviour fell at the higher end of the spectrum of seriousness; there was evidence of relevant context and/or evidence of insight and remediation that decreased the level of current and ongoing risk to public protection such that there are no outstanding patient safety considerations; and suspension is being imposed on public confidence grounds and/or to maintain professional standards. It might also be appropriate in relation to a very small number of clinical cases where a doctor’s performance was such that although unlikely to recur, the nature of the allegation was so serious as to undermine the public’s trust in the profession”.*

206. The Tribunal considered the circumstances of the case, the actions that Dr Benjamin had taken along with his insight, remediation and testimonials. It was mindful of the following paragraphs:

’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.

98. When deciding on sanction, the medical practitioners tribunal (MPT) should consider the sanctions banding for dishonesty cases in Part C of Section 3: MPT hearings.

99. In dishonesty cases, evidence about the impact of a specific type of restrictive action and references and testimonials will have limited, if any, relevance to the medical practitioners tribunals (MPT's) decision about what sanction is appropriate.'

207. The Tribunal reminded itself of the suggested range of suspension within the medium level of risk sanctions banding for dishonesty cases of three to nine months. It concluded there was no reason to depart from the sanctions banding. It was satisfied that a short period of suspension would be sufficient in this case, taking into account the seriousness of Dr Benjamin's conduct, but also acknowledging his sincere remorse, genuine insight into his conduct and the remediation he has completed. The Tribunal was satisfied that Dr Benjamin was unlikely to repeat his conduct in the future.

208. The Tribunal considered the additional evidence provided by Dr Benjamin about the impact that suspension will have on him and on his family. The Tribunal reminded itself of Paragraphs 66 and 67 of the Guidance. The Tribunal also reminded itself of the case of Bolton v Law Society, that the interest of the profession outweighs the interests of any individual. The Tribunal acknowledged that a period of suspension would have some impact on Dr Benjamin and his family but was of the view that this is outweighed by the need to uphold professional standards and maintain public confidence in the profession.

209. The Tribunal concluded that in the circumstances a period of suspension for three months was the appropriate and proportionate response and the least restrictive action that would meet the aims of public protection. The Tribunal determined that this period acknowledges Dr Benjamin's genuine insight and the work he has done to remediate his conduct, whilst also marking the unacceptable nature of his actions.

210. The Tribunal reminded itself of paragraph 133 of its previous determination at the Impairment stage which reads: *'This was a case where Dr Benjamin had written false records relating to patient consultations. It had the effect of undermining collaborative working if other medical professionals had placed reliance on those records. There was a risk of harm, but there was limited harm that arose in this case due to the actions of the two patients who raised concerns about the records at a very early stage.'*

211. The Tribunal also reminded itself that it had determined that there was a low risk of repetition and that Dr Benjamin had shown a good level of insight and had made significant and meaningful efforts to remediate.

212. In the circumstances, the Tribunal determined that it is not necessary to direct a review hearing in Dr Benjamin's case.

Determination on Immediate Order - 29/09/2026

213. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

214. Having determined that a three-month suspension is to be imposed, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Benjamin's registration should be subject to an immediate order.

Submissions on behalf of the GMC

215. On behalf of the GMC, Ms Ferrario submitted that the GMC did not ask for an immediate order as there have been no interim conditions in this case and the doctor has continued working without issue over the course of these proceedings. She maintained that the Tribunal may impose an immediate order if they wish to do so.

Submissions on behalf of the Doctor

216. On behalf of Dr Benjamin, Mr Irwin submitted that the Tribunal ought not to impose an immediate order. He directed the Tribunal's attention to paragraphs 78 and 83 from the *Guidance for MPTS Tribunals* ('Guidance' henceforth)

78. A sanction imposed by an MPT only takes effect at the end of the 28-day appeal period. Therefore, where the MPT imposes a sanction, it must consider if an immediate order is needed and/or if any action is required in respect of any existing interim order that may be in place.

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

217. Mr Irwin highlighted that the GMC has not asked for an immediate order and further submitted that the lack of an immediate order would give Dr Benjamin the opportunity to get his professional commitments and household finances in order.

218. Mr Irwin reminded the Tribunal that no interim order has been deemed necessary in the past, and the doctor has worked without issue for the last two years. The misconduct found has been limited to a period of 10 days in November 2024.

The Tribunal's Determination

219. The Tribunal referred to the relevant section of the Guidance, including:

'79 *The MPT may impose an immediate order where it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. Where the MPT has imposed a sanction of conditions, it may impose an immediate order of conditions. Where the MPT has imposed a sanction of suspension or erasure, it may impose an immediate order of suspension.*

80 *In the context of an immediate order, the best interests of the doctor includes avoiding putting them in a position where they may come under pressure from patients and/or may repeat the behaviour or poor performance giving rise to the allegation, particularly where this may also put the doctor at risk of committing a criminal offence. It may also include where the doctor's ability to practise safely and effectively may be impacted by an ongoing health condition.*

81 *When deciding if an immediate order is needed, the MPT should balance these considerations against the other interests of the doctor, which may be to return to work pending the outcome of any appeal, and against the wider public interest which may require an immediate order is put in place.*

- 82 *Representations are sometimes made by the doctor that no immediate order should be imposed by the MPT on the basis the doctor needs time to make alternative arrangements for the care of their patients before a sanction of suspension or erasure takes effect. Whilst the issue of how much weight to attach to representations made by the parties is a matter for the MPT, this argument is unlikely to be persuasive. This is because the doctor will have been aware of the date of the hearing for some time, and consequently of the risk of a sanction being imposed. The doctor will therefore have already had reasonable time to plan for the care of patients before the hearing, should the need arise. Additionally, the GMC also notifies the doctor's employers or, in the case of general practitioners, the relevant body, of the date of the hearing. They themselves have a duty to make sure that appropriate arrangements are in place for the care of the doctor's patients should an immediate order be imposed.*
- 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.'*

220. The Tribunal considered the seriousness of the allegation and the level of current and ongoing risk to public protection. The Tribunal also directed itself to the factors set out in paragraph 84 of the guidance.

221. The Tribunal considered that Dr Benjamin has been working safely for the past two years and does not pose a current and ongoing risk to public safety. The Tribunal had determined at Impairment and Sanction stage that there were no remaining concerns in relation to patient safety and that the risk of repetition was low. The Tribunal determined the risk to public protection to be medium. They remained mindful of the fact that an immediate order had not been requested by the GMC considering the nature of the allegation and its seriousness.

222.The Tribunal reminded itself that it's rationale behind imposing sanction was largely grounded in the need to maintain professional standards and public confidence rather than a risk to patient safety. The Tribunal did not find that an immediate order was necessary to maintain public confidence.

223.Hence, the Tribunal determined not to impose an immediate order.

224.This means that Dr Benjamin's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal. If Dr Benjamin does lodge an appeal, he will remain free to practise unrestricted until the outcome of any appeal is known.