Members of the public expect medical doctors to be honest in both their public and private life. The public still holds doctors in high regard, with the majority of doctors being given due respect for their contributions to the welfare of society.

The General Medical Council (GMC) – the regulator of doctors – will take action against those doctors who do not conduct themselves with the utmost probity, integrity, and honesty. Doctors who admit or are found guilty of dishonest conduct will almost certainly be found to have committed professional misconduct. Those doctors whose fitness to practise is also found to be impaired [at an Medical Practitioners Tribunal Service (MPTS) professional conduct hearing], as a consequence of their failing to uphold professional standards – because of their dishonest conduct – might also face the prospect of a long period of suspension, or even erasure from the register.

Indeed, a doctor who has been dishonest is at significant risk of erasure. In the case of Nicholas-Pillai v GMC [2009] EWHC 1048 per Mitting J, it was stated (para 27), that:

“In cases of actual proven dishonesty, the balance ordinarily can be expected to fall down on the side of maintaining
It is essential as a consequence of this risk that a doctor facing an allegation of dishonesty does not mislead the GMC, when making an oral or written response. A doctor must undertake appropriate remediation, show insight, and present good quality evidence, among other things, if they are to seek to reduce the risk of erasure.

Dishonesty can take many forms. Some examples might include: a doctor lying in their CV to give it greater weight in a job application round, by exaggerating claims or making them up altogether; a doctor taking monies from a patient without authority, for personal use; a doctor engaging in business arrangements that have benefitted them, through subterfuge and misdirection; theft of drugs from a ward for personal use or to sell on to others; a doctor telling lies when being investigated, by a Trust or the GMC, concerning allegations of professional or workplace misconduct.

A doctor who is convicted of a criminal offence (or has otherwise committed misconduct) will also face GMC / MPTS fitness to practise proceedings, and risk being suspended or struck off, as a consequence of their criminal conviction. There is additionally an obligation on doctors to promptly inform the GMC, and those doctors who fail to do so may also face a misconduct charge for such a failure.

What is Dishonesty in Regulatory Law?

See GMC v Krishnan [2017] EWHC 2892 (Admin) which holds that Ivey judgment, below, is good law in professional conduct tribunals. The case did not provide any guidance as to how the case of Ivey should be applied in GMC regulatory cases.
**NEW JUDGMENT ON DISHONESTY** *Ivey (Appellant) v Genting Casinos (UK) Ltd t/a Crockfords (Respondent) [2017] UKSC 67*, on appeal from [2016] EWCA Civ 1093.

Lord Hughes adopted the test applied by Lord Hoffman in *Barlow Clowse* and held, [at para 74] that:

“...the second leg of the test propounded in Ghosh does not correctly represent the law and...directions based upon it ought no longer to be given. The test of dishonesty is as set out by Lord Nicholls in *Royal Brunei Airlines Sdn Bhd v Tan* and by Lord Hoffman in *Barlow Clowse*.

When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual’s knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. **There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.**

In short, the legal test for dishonesty is “whether by ordinary standards the defendant’s mental state would be characterised as dishonest”, applying the above test.

The second limb in *Ghosh*, below, should no longer be given.

The more significant the acts of dishonesty the greater the risk of suspension or erasure will be. A twelve month suspension could cause considerable financial difficulties for a doctor but a suspension would be likely to be catastrophic.
Doctors do fall into error, with genuine reasons or mitigation for their dishonest conduct, which, if explained carefully to the GMC, can lead to a good outcome for the doctor. Explaining the history of events in a clear and well-evidenced manner, showing insight, and taking steps in remediation, can all potentially help a doctor to achieve an outcome that falls short of erasure.

In January 2018, the case examiners in a Rule 8 Decision Letter stated that the two part legal test that they were applying was as follows:-

“When considering dishonesty allegations, case law has suggested that we must consider:

(a) subjectively, the doctor’s knowledge or genuine belief as to the relevant facts and;

(b) in light of the doctor’s knowledge or belief, whether the doctor’s conduct was objectively dishonest by the standards or ordinary honest people.”

See also the case law towards the end of this article, but bear in mind that many of them were pre-Ivey and so applied the law as it stood at the time.

Deliberate Dishonesty

With the evolution of the case law on dishonesty in regulatory proceedings, it is clear that there is a distinction to be made (which could affect findings of fact, misconduct and impairment, and which may in turn affect sanction) between deliberate and unintentional dishonesty. The concept of ‘deliberate dishonesty’ is referred to obiter by the Court of Appeal in the case of Sanusi v The General Medical Council [2019] EWCA Civ 1172 (July 2019) at paras 86 and 91. Therefore, doctors who have not been deliberately dishonest will need to challenge that implied element contained within the allegation.
Impairment in Cases of Dishonesty

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

1. Dishonesty encompasses a very wide range of different facts and circumstances. Any instance of it is likely to impair a professional person’s fitness to practise: R (Hassan) v General Optical Council [2013] EWHC 1887 per Leggatt J at paragraph [39].


3. A finding of impairment does not necessarily follow upon a finding of dishonesty. If misconduct is established, the tribunal must consider as a separate and discrete exercise whether the practitioner’s fitness to practise has been impaired: PSA v GMC and Uppal [2015] EWHC 1304 at paragraph [27].

4. However, it will be an unusual case where dishonesty is not found to impair fitness to practise: PSA v Health and Care Professions Council & Ghaffar [2014] EWHC 2723 per Carr J at
paragraphs [45] and [46].

5. The attitude of a practitioner to the allegations made and any admissions of responsibility for the misconduct will be taken into account as relevant factors in determining whether or not fitness to practise has been impaired: *Nicholas-Pillai v GMC [2009] EWHC 1048* per Mitting J at paragraph [18].

6. The overarching concern is the public interest in protecting the public and maintaining confidence in the practitioner and medical profession when considering whether the misconduct in question impairs fitness to practise: *Yeong v GMC [2009] EWHC 1923* per Sales J at paragraphs [50] and [51]; *Nicholas-Pillai* (above) at paragraph [27]:

“In cases of actual proven dishonesty, the balance ordinarily can be expected to fall down on the side of maintaining public confidence in the profession by a severe sanction against the practitioner concerned. Indeed, that sanction will often and perfectly properly be the sanction of erasure, even in the case of a one-off instance of dishonesty.”

(August 2017)

**Warnings in Dishonesty Cases**

Where a doctor’s fitness to practise (at a fitness to practise hearing) is found to be not currently impaired, the tribunal may all the same impose a warning. A warning sits on a doctor’s registration for a period of two years and will be visible to anyone who looks up the doctor’s registration online, on the GMC’s website.

The supervising courts have given guidance about the need to impose a warning in cases of established dishonesty. This is to uphold public confidence in the profession and uphold the standards of the profession more generally: *Professional Standards Authority for Health And Social Care v The General
The below guidance is due to be revised in light of the decision in the above case, so it should be read with the Ivey judgment in mind.

What is dishonesty in regulatory law? This question is not easy to answer because the case law keeps changing. For many years the criminal law on dishonesty has been applied. Our guidance therefore starts with the criminal law definition and moves on through other case law. However, various High Court judges have held different views about how dishonesty should be assessed in regulatory proceedings. And until the Court of Appeal rules on the matter we will have to see how the regulators seek to approach matters. In the case of Kirschner v General Dental Council [2015] EWHC 1377 (June 2015) the appeal judge held that there should be “one test for dishonesty in all civil proceedings, whatever their nature”. The suggested test to be adopted was that applied in the case of Barlow Clowes (full citation below), the test to be applied in all healthcare regulatory proceedings. More on this case below.

Criminal Law

The leading criminal law judgment that sets out the legal test for dishonesty is the case of R v Dr Ghosh – a criminal case. [The full citation being R v Ghosh [1982] EWCA Crim 2, [1982] 3 WLR 110, [1982] EWCA Crim 2, [1982] QB 1053, [1982] 2 All ER 689] The case also has relevance to proceedings in other jurisdictions, including GMC fitness to practise processes. [View the Full Law Report.]

Dr Ghosh was convicted of dishonesty at criminal trial by jury. The jury had found the doctor guilty of four counts of
dishonesty. The appeal court (in R v Ghosh) summarised the findings of the jury, as follows:

“The effect of the jury’s verdict was as follows: as to count 1, that the appellant had falsely represented that he had carried out a surgical operation and had intended dishonestly to obtain money thereby; that as to count 2 he had falsely pretended that an operation had been carried out under the National Health Service; that as to count 3 he had falsely pretended that money was due to an anaesthetist; and as to count 4 that he had obtained money by falsely pretending that an operation had been carried out on a fee-paying basis when in fact it had been conducted under the terms of the National Health Service.”

Dr Ghosh appealed to the Court of Appeal (Criminal Division). He argued at the appeal that the presiding trial judge had not given a fair direction to the jury on the test to be applied by the jury when considering whether Dr Ghosh had been dishonest. Dr Ghosh lost the appeal. The Court of Appeal held that there had been no error of law or direction and, by way of clarification, laid down the following test, which has since become known as the “Ghosh Test”.

The Ghosh Test requires two questions to be answered in the affirmative, before a person (a defendant in criminal proceedings, or a doctor in GMC / MPTS proceedings) can be found to have committed a dishonest act. The two questions are also known as the objective assessment and the subjective assessment of dishonesty.

The Lord Chief Justice, Lord Lane, stated, in the case of R v Ghosh:

“In determining whether the prosecution has proved that the defendant was acting dishonestly, a jury must first of all decide whether according to the ordinary standards of reasonable and honest people what was done was dishonest. If
it was not dishonest by those standards, that is the end of the matter and the prosecution fails.” [This is the objective assessment.]

“If it was dishonest by those standards, then the jury must consider whether the defendant himself must have realised that what he was doing was by those standards dishonest. In most cases, where the actions are obviously dishonest by ordinary standards, there will be no doubt about it. It will be obvious that the defendant himself knew that he was acting dishonestly. It is dishonest for a defendant to act in a way which he knows ordinary people consider to be dishonest, even if he asserts or genuinely believes that he is morally justified in acting as he did.” [This is the subjective assessment.]

Regulatory Law (inc. GMC/MPTS Law)

A further modification of this legal test may be necessary in some cases, as per Hussain v GMC (2014), below. It may be necessary to apply the standards of the profession, rather than people generally, when assessing whether a doctor has been dishonest. However, some lawyers doubt the validity of this approach and this is not always the approach adopted.

Nevertheless, in the appeal case of Professional Standards Authority for Health and Social Care v Health and Care Profession Council, Elizabeth Abosede David [2014] EWHC 4657 (Admin) the High Court assumed that the test for dishonesty in regulatory proceedings is a modified Ghosh test:

Applying the balance of probabilities test to the evidence, a panel must find that the acts or omissions of the doctor were dishonest by the standards of reasonable and honest doctors AND that the doctor in fact realised that the acts and omissions were dishonest by the standards of reasonable and honest doctors.

So let us apply the Ghosh test to a notional scenario, to
illustrate how the Ghosh test is applied to an allegation of shoplifting (theft):

A doctor visits a DVD shop and browses for a while, then decides he wants a particular DVD but decides he is going to snaffle it, without paying for it. He quickly and discreetly hides the DVD in the inside of his jacket and then rapidly strolls out of the store, setting off the alarm. The store detectives arrest him. Applying the objective test, a person who intends to take something without paying for it would be committing a dishonest act by ordinary standards of reasonably honest people. Applying the subjective test, the doctor had intended to steal the DVD, and so had dishonest intent. The tribunal would look at the CCTV footage, to infer that the doctor had dishonest intent by observing the doctor’s behaviour, and observing that the doctor hid the DVD inside his jacket, before walking out immediately, without paying.

Contrast that scenario with the scenario where a doctor goes into a DVD shop with the intention of buying a DVD at the shop till. He browses the shelves for a while and selects a DVD to purchase. Then his mobile phone rings and he answers. He then has a conversation with the person on the end of the phone and walks up and down this aisles with his DVD in one hand, while using his phone with the other. He then absent mindedly walks out of the shop without paying. The alarm is triggered and the store detectives apprehend him. Objectively, by ordinary standards of honesty, someone who takes a DVD without paying would be considered to be dishonest. However, when we apply the subjective test, it is clear that the doctor had every intention to pay, but he was distracted by his phone call and forgot about the DVD. He would therefore not have the subjective intent to steal, and so would not be guilty on the subjective level of a dishonest intent, and so he would not be guilty of a dishonest act. The tribunal or court determining
the issues would have to hear the testimony of the doctor and look at the store video, noting that the doctor was distracted by a phone call and took no steps to conceal the DVD when he walked out of the store. [/box]

In applying the test in by ordinary standards of reasonably honest people, we would substitute by ordinary standards of reasonably honest ‘people’ with the word ‘doctors’.

In a second example, let us look at a doctor who dishonestly prescribes medication:

[box title="Dishonesty in Prescribing, by way of further illustration" color="#B8B8B8"]A doctor who is working away from his home country has run out of medication to treat his long-term severe allergy to cats. He is unable to prescribe the drug for himself under the drug company protocol and the GMC’s Good Medical Practice, so the doctor asks a lay colleague to pretend to be a patient so that he can order the drugs for his own use. The colleague completes the documentation and the doctor then signs it off as the prescribing doctor. The drugs are then obtained in the colleague’s name for use by the doctor. By ordinary standards of honesty (by ordinary standards of reasonably honest doctors), such conduct would be dishonest from an objective perspective. [/box]

If we were to apply the approach in Kirschner v GDC, (see above citation (June 2015)) we would be moving away from the test set out in the above case law and adopt the test in Barlow Clowes International Ltd v Eurotrust International Ltd [2005] UKPC 37, so not using the Ghosh test. However, the appeal judge in Kirschner applied the Ghosh/Twinsectra approach to the case he was deciding, holding that it was for a higher court (or Parliament) to determine the correct test. Hussain (referred to above) therefore remains good law, as does the case of David (also referred to above).
The test:

“The tribunal should first determine whether on the balance of probabilities, a defendant acted dishonestly by the standards of ordinary and honest members of that profession; and, if it finds that he or she did so, must go on to determine whether it is more likely than not that the defendant realised that what he or she was doing was by those standards, dishonest.”

Another case that reaffirms the above approach is Dowson v The General Medical Council EWHC 3379 (Admin). (November 2015)

An appeal court in the case of Irvine v The General Medical Council [2017] EWHC 2038 (Admin) was comfortable that the tribunal had applied the Ghosh test correctly in a case of alleged dishonesty. (August 2017)

[See also the case of Twinsectra Ltd v Yardley [2002] UKHL 12, which is also applied in regulatory cases.]

In Enemuwe v Nursing And Midwifery Council [2015] EWHC 2081 (Admin) the court held that a tribunal must not rely on decisions of employment level disciplinary bodies and the like when determining factual matters (at paras 37-38 and 79) (July 2015).

Also, in the case of Lavis v Nursing and Midwifery Council [2014] EWHC 4083 (Admin) – it was opined that the regulators of healthcare professionals must look at other explanations for the conduct complained of, before arriving at the conclusion that a practitioner has been dishonest, as alternative explanations may be extant, such as innocent or negligent mistake per Uddin (December 2014).

In Nduka v General Medical Council [2017] EWHC 1396 (Admin) – the appeal court was of the view that the Gosh test was correct, when modified to take account of the standard of proof in civil cases. (June 2017)
Any tribunal (for example the GMC/MPTS, or criminal courts) tasked with determining whether a doctor has been dishonest must form its view from all of the evidence. In the case of the removal from the store of the the DVD, the tribunal would look at the oral testimony of witnesses including the store detectives and the doctor, documentary evidence, CCTV footage. In the case of the prescribing of drugs illustration, the tribunal would look at the reasons the doctor had prescribed for another. If the colleague were to confess that the prescribed drugs were not for her, an inference could be drawn that the doctor had prescribed them in a manner that was dishonest. The totality of the evidence would be considered.

At any hearing, the credibility of the doctor may be doubted and the version of events the doctor advances might be rejected. A doctor is entitled to call evidence of previous good character at the facts stage: Donkin v Law Society [2007] EWHC 414 (Admin), and Wisson v HCPC (April 2013).

In the criminal courts an allegation of dishonesty is tested against the criminal standard of proof. The magistrates or jury must be satisfied beyond reasonable doubt (also known as satisfied so that you are sure). Contrast that with civil cases, such as the GMC / MPTS tribunals, where the evidence is tested to the civil standard: the balance of probabilities (or which version of events is more probable). In both criminal cases and GMC cases, it is for the person or authority bringing the allegation to prove its case against the defendant or doctor. The civil standard, being a lower threshold, means that there is a greater chance of being found guilty of a dishonest act in GMC / MPTS proceedings, than in the criminal courts.

The GMC, when charging a doctor with dishonest conduct, will send copies to the doctor of the documentary evidence and exhibits obtained during the GMC’s investigation, along with formal allegations in the form of charges. In the illustration
above, concerning the prescribing of drugs, the GMC charges might read as follows:

1. That being a registered medical practitioner, on 27 April 2013, you:

(a) prescribed a drug, namely Cattalergen 4
(b) to a colleague, namely Mrs KY
(c) who was not your patient
(d) when the drugs were obtained for your own use,
and in doing so, your actions were:
(e) misleading
(f) dishonest

And by reason of your misconduct your fitness to practise is impaired.

Below, we shall examine the types of dishonesty cases that go before the GMC / MPTS that have been appealed to the High Court, along with the sanctions that are imposed on doctors who are found guilty of dishonesty.

At the Rule 7 stage (of the GMC investigation), the GMC Case Examiners approach allegations of dishonesty with reference to the GMC’s polices. For more details of the GMC’s policy on the disposal of cases at the Rule 7 stage, visit our GMC Investigations page.

It is also important to take note of the GMC’s Indicative Sanctions Guidance, which aims to ensure consistency of disposal between panels at the FTP stage of proceedings. The guidance describes the different types and degrees of dishonesty that may lead to particular sanctions. Visit our GMC Publications page for more details.
Remember, it is dishonesty at the time of the act or omission that is the test, not a retrospective test applying hindsight.

Examples of Cases of Dishonesty – contained in High Court Appeals

In the case of Dr Atkinson v General Medical Council (GMC) [2009] EWHC 3636 (Admin) the doctor had been found guilty of some 22 incidents (on 12 occasions) of dishonesty over a period of approximately five years of practice as a doctor. She appealed the GMC Fitness to Practise (FTP) panel’s decision (to direct that her name be erased from the medical register), arguing that the decision to erase was disproportionate. The High Court upheld the decision of the GMC FTP panel, finding no error of approach (November 2009).

In the case of Dr Moneim v General Medical Council (GMC) [2011] EWHC 327 (Admin) the doctor (a GP) had been found guilty of altering a number of computerised patient records, after complaints had been brought to his attention by GP partners. He appealed the findings of fact and a suspension of twelve months. While the appeal court found that the GMC FTP panel had made some minor errors in its determinations, the majority of findings were sound, and the twelve month suspension from practice was proportionate (February 2011).

In Dr Karwal v General Medical Council (GMC) [2011] EWHC 826 (Admin) the doctor had been found guilty of three acts of dishonesty and was suspended for 12 months. At the end of that period of suspension, there was a Review Hearing. The GMC FTP Review panel remained concerned about the doctor’s failure to accept the original FTP panel’s findings, or show insight into the wrongfullness of her conduct. The FTP Review panel further suspended the doctor. The appeal court determined that the various GMC panels had come to appropriate decisions, and that
the sanction of consecutive suspensions was proportionate, in the circumstances of the case. By the time of the appeal the doctor had been suspended, cumulatively, for some 2 years and 9 months (April 2011).

In Dr Uddin v General Medical Council (GMC) [2012] EWHC 2669 (Admin) the appeal court overturned 5 findings of dishonesty by a fitness to practise panel. The court suggested that panels must take care when approaching the issue of dishonesty on the balance of probabilities and that the panel had shown a lack of understanding of the approach that should have been taken (July 2012).

In Fabiyi v Nursing and Midwifery Council [2012] EWHC 1441 (Admin) the High Court overturned decisions made by the Conduct and Competence Committee in relation to its findings of dishonesty. It was held that the Legal Assessor had given the wrong direction in relation to the Ghosh test, by failing to follow the standard directions laid down by the Crown Court Compendium (formerly the Crown Court Bench Book). The legal assessor had failed to advise the panel to make its findings of fact before considering whether the acts were dishonest. Case remitted back to the NMC. (June 2012)

In Fish v The General Medical Council (GMC) (2012) EWHC 1269 (Admin) the appeal court overturned a (GMC)/MPTS FTP panel’s findings that a doctor had been dishonest. (May 2012)

In Bhatnagar v The General Medical Council [2013] EWHC 3412 (Admin) the appeal court upheld the GMC/MPTS IOT Panel’s original order imposing an interim suspension of a doctor who faced allegations of dishonesty. (November 2013)
In *Brew v The General Medical Council [2014] EWHC 2927* the appeal court declined to overturn an erasure order. The court stated that: ‘It is possible to argue that this case could qualify on its facts for either suspension or erasure applying the considerations set out in the Indicative Sanctions document. Which side of the line it falls is a matter of judgment for the tribunal concerned having considered all the facts and their experience of applying professional standards to those facts.’ (September 2014)

In *Hussain v GMC [2014] EWCA Civ 2246* a doctor, who had been erased from the register, appealed to the Court of Appeal from a judgment in the High Court that had upheld a decision of the MPTS at a first instance appeal. The Court of Appeal reaffirmed the legal test for determining dishonesty in GMC cases. One of the appeal judges emphasised the need to look at the mischief alleged by the the standards of honesty within the profession, rather than people generally:

Longmore LJ opined (at Para 51) that: ‘I would only add that I am a little troubled about the Ghosh direction given by the legal assessor in this case. It would have been standard in a criminal case. But this was a professional disciplinary hearing and it seems to me that in future it would be right and proper for the first part of the direction to be adapted to read that the panel should decide “whether according to the standard of reasonable and honest doctors [not people] what was done was dishonest”. There may be a not unimportant difference between the two as shown by the decision of the judge in this very case.’

*  

Also of note is Bean LJ’s, at para 40, comments that, ‘Grief caused by bereavement is not a defence to a charge of dishonesty. It may be mitigation, but that is a different point’ (November 2014)

In *Soni v General Medical Council (no 2) [2015] EWHC 364* the appeal
court overturned a MPTS FTP panel’s finding of dishonesty. The tribunal had found dishonesty proved. The appeal judge (Holroyde J) overturned the tribunal’s decision, opining as follows (para 67):

“The Panel was wrong to do so, because a finding against Mr Soni of a failing of administration, even of negligent administration, does not without more justify a finding of dishonesty.

What was needed was evidence from which it could safely be inferred that the explanation for the failing probably lay in dishonesty on the part of Mr Soni rather than in oversight or confusion or even a lack of concern for ensuring that the Trust was made aware that a fee was due to it from a private patient. There was in my judgment no direct evidence, and no basis for a safe inference, that Mr Soni charged the patients for hospital facilities and retained those sums for himself; and no basis on which the Panel could reasonably reject the alternative explanations of innocent oversight or administrative confusion which were clearly raised by Ms L’s evidence as to the deficiencies of the system.”

At para 68:

“For those reasons I conclude that the Panel made a wrong determination against Mr Soni. It was wrong to reject the submission of no case to answer, and wrong to find that dishonesty was proved. With all respect to the Panel, I am afraid it must have confused grounds for suspicion with evidence sufficient to prove, on the balance of probabilities, a serious allegation against a professional man.”

Also, at para 69: “I also conclude that no future Panel could be in any different position if the case were remitted. Any future Panel, before it could infer dishonesty, would have to consider whether the evidence showed other possible explanations, and if so whether it could safely conclude that
those other explanations were less probable than deliberate dishonesty. In my judgment, the first question can only be answered in the affirmative, and the second question can only be answered in the negative. The evidence adduced against Mr Soni by the GMC was insufficient, and always would be insufficient, for any Panel reasonably to answer those two questions in any other way. Ms L’s evidence makes it impossible to conclude that there was no realistic prospect of innocent error, oversight or administrative confusion on the part of Mr Soni and/or his secretary. The evidence as a whole makes it impossible to conclude that the probable reason for the Trust’s having no record of the five private patients was that Mr Soni had been deliberately dishonest.” (February 2015)

In Arfan Dad v A Decision of the General Dental Council [2010] ScotCS_CSIH_75 the Scottish court of appeal held that a dentist who had denied that he had dishonestly withheld from his regulator information about past convictions would not be successful in his appeal against erasure. (August 2010) The case has ramifications for doctors who do the same.

In Irvine v The General Medical Council [2017] EWHC 2038 (Admin) an appeal court upheld an erasure order where a doctor had practised medicine for five years, while knowing that he did not have professional indemnity insurance.

In Nduka v General Medical Council [2017] EWHC 1396 (Admin) – the appeal court declined to overturn findings of dishonesty. The following test was approved (at para 63):

i) whether, on the balance of probabilities, the Appellant acted dishonestly by the standards of reasonable and honest doctors; and if so;
ii) whether, on the balance of probabilities, the Appellant realised that what he was doing was, by those standards, dishonest.

(June 2017)

In *Naheed v GMC [2011] EWHC 702 (Admin)* at [21] Parker J. held that: Acts of dishonesty “which compromise the integrity of job applications are acts which undermine something fundamental to the system of medicine“. (February 2011)

**Sanction:**

Suspension is considered a “merciful” or lenient sanction for a doctor’s dishonesty – *Nicholas-Pillai v GMC [2009] EWHC 1048 (Admin)* [at para 27]). (May 2009)

In *Peckitt v General Dental Council [2016] EWHC 1803 (Admin)* – the appeal court dismissed Professor Peckitt’s appeal, upholding disciplinary findings of dishonest conduct.

The judgment also examined the concept to *Nelsonian Dishonesty* – the conscious decision not to look for something, knowing that one will find something wrong so forcing one to act, (as covered in *Twinsectra [para 46 to 49]*). (April 2016)

(Other cases will be added in due course)

Doctors should take care when responding to allegations to ensure that their reply is not ambiguous, and has been properly thought through. Doctors are advised to take legal advice before responding to GMC allegations and, ideally, should be legally represented at any hearings, in order to protect their interests.

**Pleading Guilty / Making Admissions of Dishonesty**
Doctors who have been dishonest may fear the consequences of admitting to the GMC what they have done. However, it should be noted that those doctors who cover up their past dishonesty are more likely to be erased from the register in comparison to those who came clean at the first opportunity. The GMC's/MPTS's Indicative Sanctions Guidance makes it clear that doctors who lie over time are more likely to face erasure (be 'struck off') from the register. By way of example, paragraph 122 of the MPTS's Sanctions Guidance (July 2016) holds that: 'Dishonesty, if persistent and or covered up, is likely to result in erasure'.

Admitting dishonesty obviously needs to be done with care and precision, and doctors are advised to take legal advice before making admissions to GMC charges.

**In Conclusion:**- Regrettably, there are a number of doctors in practice in UK who are dishonest, duplicitous, or disingenuous in much that they do, both in clinical practice and in their business transactions or personal dealings with others. Such doctors are out to make personal gains at considerable cost to their patients and colleagues. Thankfully the real rogues are few in number but the GMC has an imperative based on public policy considerations to identify them, discipline them, and throw them out of the profession.

In one example, a physician who was also an academic was found to have built much of his career on fraudulent studies that he wrote about in academic journals to further his career. The GMC brought almost 70 allegations of misconduct against him, many of them alleging **dishonesty**, which demonstrated that his whole career was based on deceit. He was struck off. Such an extreme case is rare indeed but such doctors are out there and the GMC will expend a lot of time and resources to justly deal with them. The GMC will also bring charges against doctors who have been dishonest in more modest ways. Even relatively 'low level' dishonesty, in comparison to the preceding illustration, can lead to GMC regulatory proceedings. Doctors
who are dishonest risk being suspended, pending investigation, and a minimum of suspension at a fitness to practise hearing, if their cases reach that stage. There is a provision to issue a doctor with a warning for dishonest conduct in certain circumstances, but such occasions have been relatively rare. Though that may change in light of the case of PSA v GMC v Uppal (2015) EWHC 1304, in which it was held that a finding of impairment is not inevitable in cases of dishonesty.

Doctors Defence Service provides assistance to doctors who face allegations of dishonesty in GMC legal proceedings.

For legal advice or representation in GMC proceedings, contact Doctors Defence Service in strict confidence on: 0800 10 88 739

(Doctors Defence Service)

See also our GMC / MPTS Regulatory Case Law Digests

If you are a doctor who is facing GMC / MPTS proceedings that include allegations of dishonesty, call Doctors Defence Service in confidence on: 0800 10 88 739