IN THE LEEDS ADMINISTRATIVE COURT

CO/3314/2018 Aliu v GMC [2018] EWHC 3659 (Admin)
CO/3999/2018 GMC v Aliu [2018] EWHC 3660 (Admin)

Case No: CO/3314/2018 & CO/3999/2018

Courtroom No. 7

The Courthouse
1 Oxford Row
Leeds
LS1 3BG

Monday, 26th November 2018

Before:
MR JUSTICE LANE

B E T W E E N:

(1) DR ALIU

and

GENERAL MEDICAL COUNCIL

(2) GENERAL MEDICAL COUNCIL

and

DR ALIU

MS A HEARNDEN, instructed by the Solicitor, GMC, appeared on behalf of the General Medical Council
DR ALIU appeared in person

JUDGMENT
(As approved)

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MR JUSTICE LANE:

1. This is my judgment in these related claims. The first is brought by Dr Aliu against the General Medical Council, to which he has also attempted to join The Mid Yorkshire Hospitals NHS Trust. In this action Dr Aliu seeks to challenge the decision of the General Medical Council to impose on him an interim order of conditions. The GMC has subsequently, on 30 August 2018, imposed on Dr Aliu an interim suspension order and I gave permission to Dr Aliu, at the commencement of the hearing, for him to amend his claim in order to cover the interim suspension order, to which he objects. The claim is brought under section 41A of the Medical Act 1983. The GMC is responsible for the interim suspension order; not, I emphasise, the Mid Yorkshire Hospitals NHS Trust. These proceedings, accordingly, do not concern the Trust and the Trust's decision-making cannot be challenged directly in them. Indeed, the Trust quite understandably has played no part in the proceedings. The sole defendant in this claim is therefore the GMC.
2. The other application before me is brought by the GMC against Dr Aliu. In these separate, but obviously related, proceedings the GMC applies pursuant to section 41A(6) of the 1983 Act for the interim suspension order on Dr Aliu to be extended. It is currently due to expire on 29 November 2018. Originally, an extension for a period of nine months was sought, which would have taken matters to 29 August 2019. However, Ms Hearnden, who appears on behalf of the GMC, says that in all the circumstances and, in particular, bearing in mind the progress that is being made in moving towards a tribunal decision, (probably in the spring of 2019), the extension that is being sought is, in fact, for a period of seven months; that is, to 29 June 2019. Dr Aliu opposes that application including in its amended form.
3. It is plainly sensible for these two sets of proceedings to be considered together and I do so.
4. The court's approach is well-established in proceedings of this kind. Under section 41A(10), the court exercises what is known as an original jurisdiction. It is not, therefore, confined to exercising some form of statutory or judicial review. It will, however, show respect for and give weight to the decision of the Interim Orders Tribunal. It does so because that Tribunal has been entrusted, by Parliament with statutory functions in this area. It is the expert body. Accordingly, what Dr Aliu must do is to persuade me that the decision of the IOT was wrong. In deciding that question, I will give appropriate weight to the decision of the IOT.
5. It is perhaps helpful to have regard to the guidance issued by the MPTS in respect of these matters. MPTS guidance of 18 February 2016 was relevant when the original decision was taken to impose conditions upon Dr Aliu's practice. Although the guidance has subsequently been modified, it has not changed for our purposes. Under the guidance, we see that the IOT will make an order when it considers it necessary to do so for the protection of members of the public or it is otherwise desirable and in public interest to maintain public confidence and uphold proper standards of conduct and behaviour. Paragraph 22 of the guidance reminds us that it is: 'important to keep in mind that the IOT does not make findings of fact or to resolve disputes of fact'. Pausing there, that is of particular relevance in these proceedings, given that Dr Aliu is factually disputing a good deal of what I will turn to in due course.

6. Paragraph 23 states that the IOT must consider in accordance with section 41A whether to impose an interim order. It has to be satisfied:

> 'a. in all the circumstances that there may be an impairment of a doctor's fitness to practise which poses a real risk to members of the public, or may adversely affect the public interest or the interests of the practitioner; and
>
> b. after balancing the interests of the doctor and the interests of the public, that an interim order is necessary to guard against such risk, the appropriate order should be made.'

7. Paragraph 25 tells us that, in weighing up those factors, the IOT must carefully consider the proportionality of their response in dealing with the risk to the public interest, which includes patient safety and public confidence. It also includes the adverse consequences of any action on the doctor's own interests. If imposing conditions, the IOT must ensure that they are workable and enforceable; and will protect the public or if public's interests or the doctor's own interests. In reviewing interim orders, the IOT, or any tribunal chair, may consider any new information that is placed before it. That also, by extension, guides the court's approach to matters of this kind.

8. The best summation of the court's approach is, I consider, that set out by His Honour Judge Gore QC, sitting in the Administrative Court in the case of *General Medical Council v Dr Anyuam-Osigwe* [2012] EWHC 3884 (Admin):

> '12. From those expressions of principle, I come to the view that my approach must be as follows: first, I must decide whether the decision of the interim orders team was wrong. In making that decision what I have to consider is whether the material indicates that firstly the decision the team made was necessary for the protection of the public or otherwise as in the public interest, there being no suggestion here of any legitimate basis for the making of the decision in question. Secondly, in accordance with paragraph 18 of the interim orders team guidance, the team in deciding to suspend or impose conditions were entitled to have formed a view that there was an impairment of fitness to practise which posed a real risk to the members of the public and the order was necessary after balancing the interests of the doctor that is to continue in practice and earn a living and the interests of the public to guard against the risk.
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> 13. Secondly, in making that decision I exercise original powers as opposed to either appellate, or for that matter what are sometimes called public law or judicial review powers, and this calls upon me to consider all the relevant evidence and arguments. Not only those that existed or were deployed at the time of the decision of the team as indeed seems to me to be the explicit judgment in *Nicholl J v Sadler* in paragraph 12
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> 14. Thirdly, in coming to that decision I must consider what weight, if any, to attach to the decision of the team, but in doing so I must acknowledge that Parliament has entrusted that expert medical body of professionals powers to apply their own expertise and experience and their own knowledge of public expectations of the professionals they regulate and what is necessary in the public interest and I should not likely substitute my own decision unless I determine that their view was wrong.

15. Fourthly, I am entitled in coming to that judgment to have regard to all the evidence and available material. Not only that which was before the team. Indeed, both parties to these cases invite me to do so. The doctor wants me to take into account fresh evidence in the form of a witness statement and the council wish me to take into account events and developments since the team came to the decision they challenge. Therefore, there can be no dispute and I do not have regard simply to the material available to the team.'

9. The background to the present sets of proceedings is essentially as follows. On 13 April 2017, the GMC was made aware of concerns regarding Dr Aliu's performance whilst he had been working as a locum for the Trust at Pinderfields Hospital on 10 April 2017. An expert report prepared by Mr Peel and dated 7 August 2017 sets out the background and made a number of findings. These findings have diminished, perhaps, in relevance because matters have moved on, in terms of the GRC's stance, since the middle of 2017.
Nevertheless, it is relevant to have some regard to Mr Peel's report. Mr Peel is a surgeon of long-standing. Dr Aliu says that he worked with him in the past but, as I understand Dr Aliu, Mr Peel expressed ignorance of that fact. In any event, there is no suggestion, so far as I am aware, that Dr Peel's report was motivated by any bias for or against Dr Aliu. Mr Peel was asked to look at the treatment that two patients had received from Dr Aliu on 10 April, known by the letters A and B. They were not the only patients that had been treated by Dr Aliu on that day. The list is to be found in the bundle to which Dr Aliu made reference in the course of his submissions to me. They are, however, of significance because they were two patients where concern had been expressed regarding the approach of Dr Aliu.

10. Patient A was a lady who had been re-admitted to hospital following a recent discharge with the diagnosis of metastatic gastric carcinoma. She presented with constipation. It is said, although Dr Aliu disputes this, that he was keen to send Patient A home, having given her a prescription for a morphine-based drug. Patient A was said, amongst other things, to have been unhappy that Dr Aliu was on the phone much of the time he was dealing with her.

11. Patient B was a young man who presented with symptoms of diarrhoea and vomiting and some lower abdominal and right iliac fossa pain. It is said that Dr Aliu booked him to have laparoscopic appendectomy in the theatre. Again, there is some dispute about whether that occurred or not. Dr Aliu told me he had said the consultant could make that decision. The patient went home the following morning.

12. Mr Peel's report strikes me as one that is balanced in nature. A number of his findings fall in favour of Dr Aliu; for example page 327, 8.1.2.b, where Mr Peel says:

> 'In my opinion in the case of Patient A in the verbal consent and in the case of Patient B in both the verbal and written consent, … Dr Aliu's conduct does not fall below the standard of care expected of a reasonably competent locum registrar in general surgery'

13. One finds a similar finding in favour of Dr Aliu at page 329, 8.2.2, regarding the allegation that Dr Aliu was on his phone. However, importantly, significant aspects of Dr Aliu's work with Patients A and B was found by Mr Peel to fall seriously below the requisite standard. One sees that at page 330, at 8.2.4. Describing Dr Aliu's approach to an adequate treatment plan for Patient A, Mr Peel said:

> 'Since Patient A could have suffered serious harm, in my opinion, the standard of care delivered to Patient A in respect of an adequate treatment plan fell seriously below that expected of a locum registrar in general surgery. It was unsafe. Patient A would have been put at risk'

14. The point there was that sending home a patient with a prescription for a morphine-based medicine may well be unsafe if, as was the case Patient A, she was living alone. Similar serious findings occur at 8.2.5 regarding the prescription for Patient A. As I have already said, that she should be discharged home was seriously below the standard expected.
15. There is a further finding of serious failure arises at 8.3.2 at page 331 in relation to Patient B. To proceed with the steps that I have described earlier regarding Patient B, arranging theatre without informing a relevant consultant, indicated, according to Mr Peel, a level of assessment that was seriously below that expected of a reasonably competent registrar in general surgery. It put Patient B at risk of receiving inappropriate treatment. Further serious findings occur at 8.3.4 on page 332 in respect of Patient B as regards whether the surgery indicated by Dr Aliu was clinically indicated and appropriate, or whether he had adequately discussed Patient B with his colleagues.
16. Overall, at page 334, we see Mr Peel's conclusion as being that the culmination of facts indicated to him that 'Patients A and B were put at serious risk of sub-optimal and inappropriate management with potentially hazardous outcome and therefore fall seriously below the standard of care expected'.

    The interim orders team met to consider Dr Aliu's case on 30 August 2017. We see from page 389 that, on this occasion, Dr Aliu was neither present nor represented. As I have already indicated, and as we see at pages 392-393, the decision of the tribunal was to impose an interim order of conditions.

    On 15 September 2017, the GMC directed that Dr Aliu should undergo a performance assessment. It was originally scheduled to take place in March 2018 but did not, in the event, happen until 10 and 11 August 2018. This was due to factors concerning Dr Aliu. In particular, Dr Aliu was consulting with an MP and the Citizens Advice Bureau at the time and therefore the assessment did not take place when originally scheduled.

    However, the performance assessment did take place on 10 and 11 August 2018. We see this from the documentation, beginning at page 722 of the bundle. It was the unanimous opinion of the three-person assessment team that Dr Aliu's professional performance was adduced to be deficient. In answer to the question of whether Dr Aliu was fit to practise either generally or on a limited basis or at all the team said: 'Dr Aliu is not fit to practise at all'.
17. The assessment is detailed in its approach. We see at paragraph 2.3 on page 727 that, in tests of competence, Dr Aliu's knowledge test score was 36.67%, below the standard set mark of 63.77%. He also scored below the 25th centile in all of the 14 OSCE stations.
18. All this led the team, of its own volition, to conclude that Dr Aliu was not fit to practise at all.
19. Importantly, the team stated that although they assessed Dr Aliu as a junior registrar when forming their opinion, they also gave consideration to whether he could work at a more junior level. However, they found that Dr Aliu was unable correctly to fill out a discharge summary; unable to prescribe or transcribe simple drug doses; unable to perform BLS safely and effectively; unable to communicate appropriately with patients; and unable to

assess and perform basic resuscitation on an acutely unwell patient. This led the team to say as follows:

> 'The above are all competencies the team would expect of someone who has just graduated from medical school at the beginning of foundation year one and as such it is the team's opinion that Dr Aliu should not practice as a doctor. Importantly, his lack of insight into his own ability could compromise patient safety if he were practicing at any level. Dr Aliu's comprehension of basic questions, both from the assessment team and from patients, was poor and his responses were often either unrelated to the question or inadequate. The team were concerned that there was either a language or cognitive component to this lack of understanding'.

20. The report was made available in draft form to the interim orders tribunal, which met on 13 August 2018. The report has subsequently been finalised on 27 September 2018. Looking at the position as it then was, the IOT decided, following the hearing on 30 August, that the interim order of conditions should be changed to one of interim suspension.
21. That decision can be found, beginning at page 51 of the bundle. Amongst other things, it noted that part of the assessment undertaken on 10 and 11 August included the insertion of a chest drain by Dr Aliu, which was regarded as having been done in a medically unsafe – indeed, dangerous way. Dr Aliu was asked to give his reaction both to the assessment and more generally.
22. As we see at p.57, he began by reiterating the Declaration of Geneva whereby a doctor pledges himself to consecrate his life to the service of humanity. Insofar as Patients A and B were concerned, Dr Aliu said that they: 'never belonged to me, I only went there to give a helping hand and for somebody to shift his responsibility to a helper or innocent doctor is outrageous. These patients had been managed by four other doctors.'
23. Dr Aliu suggested that, in this regard, his behaviour compared favourably with that of the consultants. He considered that the performance assessment had been imposed on him by the GMC as a form of delaying tactic. Insofar as the chest drain issue was concerned, Dr Aliu said that no problem had been raised orally with him by those undertaking the assessment on the day. He then said that this aspect of the assessment was, in his view, a 'fabrication'. He prepared a case study in order to support his approach to the chest drain procedure, but it transpired after various exchanges that the document he put forward was incomplete and could bear only limited if any weight.
24. Further exchanges between the panel and Dr Aliu ensued. He reiterated that concerns regarding the chest drain had not been raised at the time. He contended that doctors work in co-operation with each other as a normal part of their lives. It seemed to the panel, as indeed it seems to me, reading the transcript, that Dr Aliu was clearly not appreciating the difference between co-operative and collaborative ways of working, on the one hand, and what is meant by working under supervision, on the other. The panel attempted to draw out that distinction, in discussion with Dr Aliu, but, it seems, without success. Dr Aliu is recorded as not accepting that being a fellow of the Royal College of Surgeons was not sufficient in order to become a consultant, despite being pressed on the matter by Professor McKenzie. Dr Aliu also considered that the GMC had apparently tapped his telephone.

This led the chair to say this:

> 'Can I be clear that as to what I understand your submission to be in response to General Medical Council's invitation to us that we vary the existing interim order of conditions, to include a condition to reflect the concern identified by the team leader

of the performance assessment. Your response is that you invite us to revoke the existing interim order of conditions'.

Dr Aliu: 'absolutely'.
Chair: 'your primary reason for that is because you submit that because you would work within the team structure, without any formal directions so far as supervision, but simply working in a team structure would provide the adequate protection to the public?'

Dr Aliu: 'absolutely'.
Chair: In the light of the concerns which have been raised then separately you say if the tribunal is to place any weight on the performance assessed as team leaders comments, and you say they are a fabrication made up, or at least they are biased or inconsistent, and that further in the light of your own training experience and the observations on document D.1 the observations of the team leader are unjustified. Is that correct? Dr Aliu: 'absolutely'.

25. All this led the tribunal to conclude that, having regard to the guidance, it was appropriate to substitute for the interim order of conditions an interim order of suspension. We see the tribunal's reasons for this beginning at page 67 of the bundle. The tribunal had regard to whether Dr Aliu's fitness to practise, if continued without restriction, would pose a real risk to members of the public which may adversely affect the public interest. The tribunal took into account the serious and wide-ranging concerns that had been raised regarding Dr Aliu's clinical performance. It noted what had been said in the recent performance assessment report.
26. While the tribunal had regard to Dr Aliu's submissions, not only did the tribunal plainly not find them persuasive; they actually raised in the tribunal's mind concern that Dr Aliu did not comprehend the effect of conditions previously imposed.
27. In the tribunal's view a reasonable and informed person would be concerned if Dr Aliu were allowed to practise without restrictions whilst the GMC investigation is ongoing. However, given Dr Aliu's attitude, it was in normal circumstances inappropriate to impose conditions.
28. This was also so because the tribunal was unable to formulate conditions of a workable specification or identify which intervention procedures might be proscribed. Conditions would have to be of sufficient breadth and meet the risk identified in the performance assessment. These would, in the tribunal's view, have been so restrictive of Dr Aliu's practice as, in effect, to amount to suspension.
29. The decision ended by refuting the assertions of Dr Aliu that elements of the performance assessment report were a fabrication.
30. Overall, the tribunal felt that Dr Aliu 'may not have insight into the practical affect of conditions imposed and that there is a material risk that he would not comply with any conditions imposed'.
31. I understand from Ms Hearnden that fitness to practise investigations are ongoing and that formal allegations, based on the performance assessment, were sent to Dr Aliu on 30 October 2018. He has 28 days to respond. The matter will then be considered by two case examiners with a view to seeing whether a formal hearing would be appropriate. If the matter is referred, then it is anticipated that a substantive tribunal hearing would be listed within four months. That would take us, bearing in mind the other procedural requirements, to mid-May 2019. Therefore, Ms Hearnden submitted that an extension which would expire on 29 June 2019 was necessary in order to protect relevant public interests and be

proportionate in all the circumstances. Those circumstances would include the fact that in Ms Hearnden's submission, there has been no material delay attributable to the GMC. I have already referred to the delay in obtaining the performance assessment which was, to a considerable extent at least, due to the actions of Dr Aliu.

32. Dr Aliu has made a number of written submissions. We identified them at the hearing and I have regard to each of them. Dr Aliu has also made extensive oral submissions and I shall do my best to summarise what he said to me.

33. Dr Aliu had worked at the hospital in question for some two years in the past. He was placed in a position, he said, where he was given a telephone which was continually ringing with calls from general practitioners, their secretaries and other departments of the hospital. He was told to give the telephone communications absolute priority, which meant priority over the patients who were waiting for him to see them.

34. Dr Aliu disputed much of the factual background regarding Patient A and Patient B. Insofar as Patient A was concerned, his view was that she should have remained in hospital, which indeed turned out to be the position. Sadly for Patient A, Dr Aliu says that she is presently in a hospice.

35. Insofar as Patient B was concerned, Dr Aliu considered that he had not usurped the function of the surgeons or of any other relevant colleague. He had had an altercation with the registrar, at the end of the shift on 10 April. He had told the registrar that Dr Aliu intended to report him. Dr Aliu contends that what has happened since is as a result of Dr Basheer pre-empting this, by making complaints to the GMC, which have resulted in Dr Aliu's current suspension.

36. Dr Aliu pointed to other patients treated by him on 10 April, as listed at page 122, including a two-and-a-half-year-old boy where, again, Dr Aliu said that his treatment had not been problematic.

37. Insofar as the performance assessment was concerned, Dr Aliu said it had been undertaken extremely hastily. He reiterated that nothing negative had been said to him by those undertaking the assessment during the time that that was happening. He reiterated that, in his view, what he had done regarding the chest drain had not been problematic. He pointed out that he was a doctor of long-standing. He doubted whether the assessment undertaken in August 2018 properly reflected his medical service to the public.

38. In response, Ms Hearnden said that the delay in this case was not an issue that could affect the court's decision. This was not only because no delay could be attributed to the fault of the GMC, but also because, at the end of the day, the correct test is based essentially on the determination of risk and, if sufficient risk exists (which Ms Hearnden said it did in the present case), then the suspension should not be lifted but should be extended to the summer of 2019.

39. As I have noted, Patients A and B were indeed not the only patients seen by Dr Aliu in April 2017. They were, as I have indicated, the two which gave rise to the greatest degree of clinical concern. Insofar as the performance assessment criticisms were concerned, Ms Hearnden said that the opportunity will be given to Dr Aliu at the forthcoming hearing to put his side of the matter.

40. Both Ms Hearnden and Dr Aliu addressed the fact that it is now the performance assessment of August 2018 which is relied on by the GMC to support its case for suspension. That is, undoubtedly, correct. I have gone into the issue of Patients A and B because it seems to me to be relevant to delve into the background for the purposes of these proceedings. Nevertheless, it is the strikingly negative unanimous verdict in the performance assessment

report that presents Dr Aliu with his difficulty in persuading the court to lift the interim order of suspension and, if that is not to be done, in seeking to persuade the court not to extend it beyond this week. The fact that the performance assessment report has now come into centre stage, as just described, is not in my view a matter of concern in these proceedings. The performance assessment is what it is.

41. Dr Aliu makes criticism of it but, as I explained to him, it is not the function of this court to make findings of fact as to whether events happened, or indeed to draw clinical conclusions from the report. What this court must do is decide whether there is currently evidence which is sufficient to ground the suspension of Dr Aliu.

42. I consider that there undoubtedly is. The report of the three person assessment team is categoric. The extent by which Dr Aliu fell short of the expected standards in terms of the tests is striking and concerning. The team looked at whether or not it would be possible to assess Dr Aliu by reference to some lower standard but concluded that, even then, he would fall short.

43. Dr Aliu has, in my view, not begun to destroy this evidential basis to the extent that would be necessary for me to give the performance assessment no or only very limited weight. Accordingly, adopting the tests that I have described earlier, one has a situation where the public interest is extremely strong. This is a doctor who has been adjudged recently not to be fit to practise at all. Dr Aliu asks, rhetorically, whether that is fair, given his long history. The simple answer is that the performance assessment represents an analysis of how good or bad a doctor is at a particular point in time. Even though Dr Aliu may have been satisfactory in the past, that past history cannot be of such weight as, for the purposes of these proceedings, materially to diminish the weight that I should place upon the performance assessment, or the weight that the IOT placed on it in August of this year.

44. The question of proportionality arises. It strikes me the IOT's conclusion that only suspension was appropriate, was manifestly correct in all the circumstances. I give that conclusion weight. I have heard nothing from Dr Aliu today that suggests that a form of supervision would be satisfactory in all the circumstances. Even if it were minded do so which (which I am not), this court cannot, as a matter of law, place Dr Aliu under conditions, if it were to lift the suspension.

45. Dr Aliu says that what has happened over the last 18 months or so has had a profound affect upon him. I do not doubt that at all. I accept that the original imposition of conditions has, in practice, precluded him from obtaining the kind of locum work that he was undertaking up to that point. Since he is currently suspended it is, of course, not possible for him to practise as a doctor. I also accept that, from a point of view of the individual doctor, the tribunal proceedings look as if they can take an inordinate amount of time. However, I do not consider that there has been any culpable delay on the GMC's part in this case and I reiterate that, even if the position were otherwise, the balancing of risk against the interests of the doctor in this case is such that the public interest must prevail.

46. It is perhaps of some, albeit limited, comfort to Dr Aliu that the suspension, which was originally sought to the end of August 2019 is now only sought until the end of June 2019. Given the circumstances, this extension is, in my view, appropriate.

47. Therefore, in the matter of the application by Dr Aliu to lift the interim order of suspension, I find in favour of the GMC. So far as concerns the GMC's application for an extension, for the reasons I have given, that application is granted, and the interim order of suspension will now last until 29 June 2019.

End of Judgment

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This transcript has been approved by the judge.