PUBLIC RECORD

Dates: 19/04/2021 - 30/04/2021

Medical Practitioner's name:	Dr Adilya ABDUL RAHIM
GMC reference number:	5195856
Primary medical qualification:	MB BCh 1997 National University of Ireland

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

Summary of outcome

Erasure

Immediate order imposed

Tribunal:

Legally Qualified Chair	Ms Louise Sweet QC
Lay Tribunal Member:	Mr Philip Brown
Medical Tribunal Member:	Dr Michael Morton

Tribunal Clerk:	Mr Stuart Peachey

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Kevin McCartney, Counsel, instructed by Hempsons Solicitors
GMC Representative:	Mr Tim Grey, Counsel

Attendance of Press / Public

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

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) 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 - 28/04/2021

Background

1. In 1997, Dr Rahim qualified MBBCh from the National University of Ireland. In September 2001, she was fully registered with the General Medical Council ('GMC'). In 2009, she was awarded the Diploma of the Royal College of Obstetricians and Gynaecologists. In 2010, she was awarded the Diploma of the Faculty of Sexual and Reproductive Health.

2. At the time of the Allegation, Dr Rahim was a General Practitioner ('GP') Partner at Church View Medical Practice ('the Practice'), Kent. Patient A was a registered Patient at the Practice between 2010 and 2018.

3. The concerns in this case relate to Dr Rahim's treatment, diagnosis and records relating to two appointments on 2 and 16 January 2018 respectively. Those appointments were both with Patient A and concerned her complaint of symptoms relating to a chronic cough, shortness of breath ('SOB') a crackling feeling at the back of her throat and wheeziness.

4. In 2017, Patient A had begun to experience symptoms including a persistent cough and wheeziness. On 14 November 2017, Patient A had a consultation with Dr B, but her symptoms had not been resolved by the time she saw Dr Rahim.

5. On 31 December 2018, Patient A made her initial complaint regarding the treatment she received from Dr Rahim to the Practice. On 1 March 2019, Patient A referred Dr Rahim to the GMC via its online referral service.

Application Made During the Facts Stage

6. The Tribunal refused Mr Kevin McCartney, Counsel, on behalf of Dr Rahim's application, made pursuant to Rule 17(2)(g) of the General Medical Council (Fitness to

Practise Rules) 2004 as amended ('the Rules'). The Tribunal's determination can be found at Annex B.

The Allegation and the Doctor's Response

7. The Allegation made against Dr Rahim is as follows:

Consultation on 2 January 2018

1. On 2 January 2018 you consulted with Patient A and failed to:

a. arrange an appropriate investigation in that you did not refer Patient A for a chest x-ray;
To be determined

b. provide appropriate advice to Patient A in that you did not explain the importance of diagnosing a chronic cough;
To be determined

c. implement an appropriate management plan in that you did not make specific arrangements to review Patient A within 14 days;
To be determined

d. make an adequate record of the consultation in that you:

i. recorded 'SOB' rather than 'no SOB';
~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found proved

ii. did not record the absence of chest pain;
~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found proved

iii. did not record the absence of weight loss;
~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found proved

iv. did not record a working diagnosis;
To be determined

v. did not record safety netting advice provided.
To be determined

Consultation on 16 January 2018

2. On 16 January 2018 you consulted with Patient A and failed to:

   a. arrange appropriate investigations in that you did not obtain a:

      i. chest x-ray;
      To be determined

      ii. peak expiratory flow rate measurement;
      To be determined

      iii. spirometry;
      To be determined

   b. implement an appropriate management plan in that you did not arrange to review Patient A within 7 days;
   To be determined

   c. refer Patient A for an urgent chest x-ray for suspected lung cancer to be performed within 2 weeks;
   To be determined

   d. make an adequate record of the consultation in that you did not record:

      i. a working diagnosis;
      To be determined

      ii. a management plan;
      To be determined

      iii. the discussion regarding Patient A's chest x-ray;
      ~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found proved

      iv. information relevant to the follow up of unexplained chronic cough including:

         1. that the sinusitis and / or nose problem had not resolved;
         To be determined

2. crackling at the back of the throat;
To be determined

3. wheezing and / or chest tightness;
To be determined

4. chest pain;
To be determined

5. shortness of breath;
To be determined

6. haemoptysis.
To be determined

Amendments to medical records

3. On 7 August 2018 you made amendments, as set out in Schedule 1, to a record of the consultation with Patient A that took place on 2 January 2018.
Admitted and found proved

4. On 7 August 2018 you made amendments, as set out in Schedule 2, to a record of the consultation with Patient A that took place on 16 January 2018.
Admitted and found proved

5. When making the amendments set out at Schedule 1 on 7 August 2018, you failed to make an accurate record of the consultation on 2 January 2018 in that you recorded 'no SOB,' when patient A had reported shortness of breath.
To be determined

6. When making the amendments set out at Schedule 2 on 7 August 2018, you failed to make an accurate record of the consultation on 16 January 2018 in that you recorded 'last cxr 2016 clear review if not better with view of cxr' when this had not been discussed with Patient A.
To be determined

7. You sent a letter to Patient A dated 21 January 2019 enclosing and referring directly to the amended records referred to at paragraphs 3 and 4 and when doing so you:

   a. failed to explain that the notes had been amended;
   To be determined

   b. indicated that the amended notes could be relied upon as an accurate record of the consultations on:

i. 2 January 2018;
To be determined

ii. 16 January 2018.
To be determined

8. You knew that the amendments to the records referred to at paragraphs 3 and 4 were untrue and resulted in an inaccurate record of the consultations with Patient A on:

a. 2 January 2018;
To be determined

b. 16 January 2018.
To be determined

9. Your actions as described at paragraphs 3, 4 and 7 were dishonest by reason of paragraph 8.
To be determined

The Admitted Facts

8. At the outset of these proceedings, through her Counsel, Mr Kevin McCartney, Dr Rahim made admissions to the following Paragraphs and Sub-paragraphs of the Allegation as set out above, in accordance with Rule 17(2)(d) of the Rules:

- 1(d)(i), (ii) and (iii);
- 2(d)(iii);
- 3; and
- 4.

9. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced those Paragraphs and Sub-paragraphs of the Allegation as admitted and found proved.

10. However, following further submissions by both Mr Tim Grey, Counsel, on behalf of the GMC and Mr McCartney defending, it then became apparent to the Tribunal that those paragraphs that were admitted by Dr Rahim related to an alternative allegation that only became relevant if the GMC primary case failed on the facts. It determined all the facts of remained in dispute pursuant to Rule 17(2)(g). Notwithstanding the admissions indicated by Dr Rahim, the Tribunal therefore withdrew its announcement that Paragraphs 1(d)(i to iii) and 2(d)(iii) of the Allegation as '**Admitted and found proved**'. The Tribunal's determination can be found at Annex A.

Factual Witness Evidence

11. The Tribunal received oral evidence on behalf of the GMC from the following witnesses:

- Patient A, via Video Link; and a witness statement, dated 9 May 2019; and
- Mrs C, Church View practice manager, via Video Link; and a witness statement, dated 10 December 2019.

12. Dr Rahim provided her own witness statement, dated 12 February 2021, and also gave oral evidence.

Expert Witness Evidence

13. The Tribunal received evidence from two expert witnesses:

Dr D, (General Practitioner) instructed on behalf of the GMC:

- Expert Report, dated 24 September 2020 and oral evidence.

Dr E, (General Practitioner) instructed on behalf of Dr Rahim:

- Expert Report, dated 12 February 2021 and oral evidence

14. The Tribunal also received a joint Expert Report of areas of agreement and disagreement by both Dr D and Dr E, dated 3 April 2021.

Documentary Evidence

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

- Patient A's:
    - online referral to the GMC, dated 1 March 2019;
    - consultation notes;
    - complaint letter ('complaint letter') to the Practice, dated 31 December 2018;
    - letter, dated 28 February 2019;
- Letter of reply from Dr Rahim to complaint letter, dated 21 January 2019 ('the reply');
- The Practice audit trail, dated 8 April 2019;
- Letter from Mrs C to Patient A acknowledging her complaint against Dr Rahim, dated 16 January 2019;

- Screenshots of the Practice's management system;
- Various testimonials attesting to Dr Rahim's good character; and
- Various Continuing Professional Development ('CPD') certificates of completion by Dr Rahim.

The Tribunal's Approach

16. At this stage the Tribunal is required to determine whether the facts alleged, or any of them, have been proved.

17. The Tribunal must give separate consideration to the evidence in relation to each individual Allegation. Therefore, it does not follow from the fact that the Tribunal finds one Allegation proved, or not proved, as the case may be, that the Tribunal will reach the same conclusion in relation to any of the other allegations.

18. In considering the Allegation, the Tribunal must be satisfied that each of the elements of the Allegation have been made out before finding the particular allegation proved.

19. The GMC bring the Allegation and the burden of proving the allegations is on the GMC; there is no burden on the doctor. The fact that the doctor has chosen to give and call evidence on her own behalf does not mean that she bears any burden.

20. The standard of proof is the balance of probabilities, namely, whether is it more likely than not that the facts occurred as alleged.

21. When considering matters of dishonesty, the Tribunal took account of the principles in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67*. It bore in mind that it should first ascertain, subjectively, the actual state of Dr Rahim's knowledge or belief as to the facts and should then decide whether her conduct was honest or dishonest by applying the objective standards of ordinary decent people.

22. The Tribunal were directed that Dr Rahim is of good character with no matters adverse to her character including regulatory. It was relevant for the Tribunal in two ways: as to her propensity/otherwise to do the acts alleged and counted in her favour as to her credibility when giving evidence in this hearing.

The Tribunal's Analysis of the Evidence and Findings

23. At the outset of its consideration, the Tribunal determined to consider the Allegation in historical order rather than numerical order.

24. The Tribunal considered the evidence of Patient A with regard to each allegation separately. It bore in mind the defence submissions that she may not be a reliable historian as she appeared to be complaining of other doctors not properly following up her cough. These complaints, it was submitted, were not supported by the relevant consultation notes.

25. The Tribunal considered the evidence of Dr Rahim with regard to each allegation separately and bore in mind that the GMC submissions that she was making those amendments 7 months after the consultation when her memory regarding the consultations are likely to have deteriorated.

26. The Tribunal was of the view that the primary source of evidence was the consultation notes themselves, both the original and the amended versions.

27. There was no dispute that:

a. The consultation notes had been amended by Dr Rahim.

b. Dr Rahim had made the amendments 7 months after the consultations.

c. The amendments were made after Dr Rahim had learned of Patient A's diagnosis of cancer.

28. The Tribunal determined that the consultation notes, the manner of the admitted amendments, which aspects of the notes had been amended, any explanations for those amendments and what use those notes had been put to, if any, were relevant as to what did or did not happen at the consultations in January 2018.

29. The Tribunal therefore first made findings of fact regarding Paragraphs 5, 6 and 7 of the Allegation. It then went on to consider Paragraphs 1 and 2 of the Allegation. Finally, it made its determinations regarding Paragraphs 8 and 9 of the Allegation.

Findings

30. The Tribunal made the following findings of fact:

Paragraph 1(a) of the Allegation

31. The Tribunal considered the submissions of both parties. It considered the oral evidence of Patient A and Dr Rahim. It considered the expert evidence, where relevant. The reasons given for its findings in Paragraph 5 of the Allegation are relevant to its findings as to what happened at the consultation on 2 January 2018 and should be read as part of its determination.

32. The Tribunal found, as a fact, that based on the consultation notes, Patient A's evidence and the evidence surrounding the amendments which were made by Dr Rahim on 7 August 2018, that on the balance of probabilities it was more likely than not that Patient A had complained of SOB to Dr Rahim on 2 January 2018.

33. Patient A stated that she had also complained of an ongoing cough. There was no dispute by Dr Rahim that this complaint was made by her, and it was also recorded in the consultation note of the 2 January 2018 that Patient A had a cough which had been present *'since October'*. The presence of these two symptoms, SOB and a cough, mandated a referral for a chest x-ray under both the Medway Guidelines (accepted to be used by the Practice) and the NICE guidelines. The Tribunal noted there was little difference between the two sets of Guidelines.

34. The Tribunal also noted that both experts agreed that the referral should have either been done at this consultation, or at a future date following the consultation where both symptoms were still present. However, Dr D also opined:

> '*My opinion is that it was acceptable for Dr Rahim not to arrange investigations at the 02.01.18 consultation and to wait to assess the outcome of amoxicillin treatment. However, in this case my opinion is that Dr Rahim should have arranged a review within 1-2 weeks to plan the management of any persisting symptoms.*
>
> *If it is accepted that on 02.01.18 Dr Rahim explained the importance of diagnosing the cause of a chronic cough and made arrangements to review [Patient A] after two weeks to assess any persisting symptoms and arrange investigations as needed, then my opinion is that this represents an appropriate management plan.*
>
> *However, if it is accepted that on 02.01.18 Dr Rahim did not explain the importance of diagnosing a chronic cough and did not arrange a follow up appointment with Patient then my opinion is that this failing was seriously below the standard expected because a chronic cough may have a serious underlying cause and failure to arrange appropriate follow up placed Patient at risk of significant harm'.*

35. In all the circumstances, the Tribunal found that it was more likely than not that, on 2 January 2018, Dr Rahim consulted with Patient A and failed to arrange an appropriate investigation in that she did not refer Patient A for a chest x-ray.

36. Therefore, the Tribunal found Paragraph 1(a) of the Allegation proved.

Paragraphs 1(b) and (c) of the Allegation

37. The Tribunal considered that it was clear from the consultation note that, on 2 January 2018, Patient A complained about a chesty cough and SOB (an ongoing symptom since October 2017). There was also nothing recorded in the consultation note that any advice was given to Patient A about the importance of the diagnosing the chronic cough. It was Patient A's recollection that there was no discussion surrounding her long term cough. Her complaint letter dated 31 December 2018 stated that her complaints about all of her presenting symptoms (shortness of breath, like asthma and a cough which she had had *'for more than 6 weeks'*) were not taken seriously by Dr Rahim.

38. The Tribunal also considered Dr Rahim's explanation regarding her usual practice regarding safety netting advice where symptoms persist. She accepted that the notes focused on the potential issue of post nasal drip/ sinus problem. She stated that she would have said if the symptoms do not clear to come back. Both experts agreed that GPs do not always make a note of safety netting advice. It was also agreed evidence that a chronic cough could be a symptom of a serious underlying health condition (such as cancer). It was, therefore, reasonable to expect a GP to provide advice directed towards the importance of diagnosing this symptom. It was reasonable for a GP to implement an appropriate management plan to arrange a review Patient A in 14 days if the cough did not improve.

39. The Tribunal determined that, even if advice to come back was given but not recorded, there was no evidence before the Tribunal to support the contention that Dr Rahim had explained the importance of doing so in the context of diagnosing the chronic cough or implement any plan to review Patient A within 14 days.

40. In all the circumstances, the Tribunal was satisfied on the balance of probabilities that, on 2 January 2018, Dr Rahim consulted with Patient A and failed to:

- provide appropriate advice to Patient A in that she did not explain the importance of diagnosing a chronic cough; and
- implement an appropriate management plan in that she did not make specific arrangements to review Patient A within 14 days.

41. Therefore, the Tribunal found Paragraph 1(b) and (c) of the Allegation proved.

Paragraph 1(d) of the Allegation

42. The GMC had made clear at the outset of the proceedings that Paragraph 1(d) of the Allegation was an alternative and therefore was only to be considered in the event that Paragraphs 1(a to c) of the Allegation were found not proved. They were based on a factual version of events put forward by Dr Rahim that the GMC did not accept. If it was relevant for the Tribunal to consider them then the GMC were still critical of Dr Rahim's record keeping.

43. The Tribunal had regard to Mr Grey's written submissions on the facts (paragraph 57), where he stated:

> *'[…] It is only if Dr. Rahim's account of the appointments is accurate in a specific regard that there is a record-keeping failing of the sort charged at 1(d)(iv) and (v) and 2(d)(i) and (ii)[…]'*

44. Therefore, the Tribunal did not go on to consider Paragraph 1(d) of the Allegation.

Paragraph 2(a) of the Allegation

45. The Tribunal had regard to the evidence relevant to Paragraph 2(a)(i), (ii) and (iii) of the Allegation as a whole. The reasons the Tribunal gave explaining its determinations for Paragraph 6 of the Allegation were relevant to their determination and should be read as part of its determination.

46. The Tribunal accepted that, on 16 January 2018, Patient A returned to the surgery complaining of a continued cough, and shortness of breath. Patient A said she may not have used the phrase SOB but she did say asthma like symptoms. Dr D, the GMC expert, considered this description should have prompted further questions about shortness of breath by a reasonable GP.

47. It was also common ground that Patient A had presented with two new symptoms of *'green sputum'* and *'aching and fever'*. The Tribunal noted the consultation notes recorded that Dr Rahim did have a plan to deal with the cause of these new symptoms. There was a potential upper respiratory tract infection, for which she prescribed 7 days antibiotics.

48. Patient A's evidence was there were no discussions regarding investigations of her cough at all at this consultation. This included no discussion of a chest x-ray. Dr Rahim, in contrast, stated she clearly recalled that she discussed the potential need for further investigation. She stated she recalled that she and Patient A looked back at her notes *'together'* and saw that she had an x-ray in 2016. This had been done as Patient A was asking if it might be necessary to refer to an ENT specialist. However, Dr Rahim accepted that this was not in the contemporary consultation note. She explained this was something she specifically remembered 7 months later, when she was amending the notes. She remembered this as Patient A stood out to her as someone who normally did not consult with her and *'did not like me'*.

49. The Tribunal considered whether, on 16 January 2018, it would have been appropriate for Dr Rahim to undertake the peak expiratory flow rate measurement and spirometry. Both experts agreed that a patient presenting with the new symptoms of green sputum and aching and fever may not be well enough to undertake the tests and therefore the results could potentially be unreliable.

50. The Tribunal noted that Patient A continued to complain about her cough at this return consultation.

51. The Tribunal relied on the original consultation notes and found that there were no records of any arrangements to investigate Patient A's chronic cough. The Tribunal was of the view that it would have been important to evidence those arrangements or a management plan within the notes given this was the second consultation at which a chronic cough was presented. The importance of that is underlined by the fact that Dr Rahim, when reviewing this consultation note in August 2018, had amended it to say *'last cxr 2016 clear review if not better with view of cxr'* and evidenced her advice in the notes that Patient A should return to the Practice. There was no logical reason to not include this in the contemporaneous notes, if it was important enough to add later.

52. The Tribunal was of the view that the consultation notes had been amended to support the contention that she had a plan to arrange one or more of the appropriate investigations (as outlined in Paragraph 2(a)(i to iii) of the Allegation).

53. The Tribunal accepted that, in light of Patient A's new symptoms, as per the evidence of Dr D and that of Dr E, these investigations could be deferred to await the impact of the course of antibiotics but there must be a plan around that deferral that was discussed and agreed with Patient A.

54. Further, the Tribunal noted that Patient A did not join a new surgery until approximately 6 weeks following the consultation with Dr Rahim on 16 January 2018. Patient A did not return to the Practice and a chest x-ray was not followed up by Dr Rahim. This supported the inference that there was no plan to arrange appropriate follow up investigations.

55. The Tribunal found that it was more likely than not that there were no arrangements for appropriate investigations.

56. In all the circumstances, the Tribunal was satisfied on the balance of probabilities that, on 16 January 2018, Dr Rahim consulted with Patient A and failed to arrange appropriate investigations in that she did not obtain a:

- chest x-ray;
- peak expiratory flow rate measurement; and
- spirometry.

57. Therefore, the Tribunal found Paragraph 2(a) of the Allegation proved.

Paragraph 2(b) of the Allegation

58. Having found that there was no plan to make appropriate investigations as set out above, the Tribunal went on to consider if it was appropriate to implement a plan to review within 7 days. The Tribunal was of the view that this Paragraph of the Allegation asserted that Dr Rahim had a duty to review Patient A within 7 days and had failed to do so.

59. The Tribunal noted Dr Rahim had prescribed 7 days' worth of antibiotics to Patient A. Dr E, for the defence, gave evidence that any management plan to review should have been implemented following the completion of the antibiotics. Dr D for the GMC accepted in cross examination that this would have been reasonable and therefore an appropriate course of action, providing there was a management plan in place once the antibiotics were complete.

60. The Tribunal accepted the joint expert evidence that it was reasonable and appropriate for Dr Rahim to wait for Patient A to complete the course of antibiotics and so any review would be implemented after 7 days rather than *'within'* 7days.

61. Therefore, based on the evidence of both experts, the Tribunal found Paragraph 2(b) of the Allegation not proved.

Paragraph 2(c) of the Allegation

62. The Tribunal accepted the accuracy of the contemporary consultation note of the consultation on 16 January 2018, noting that Patient A continued to complain of a cough. It noted that Patient A's cough had been ongoing since October 2017. In her evidence, Patient A explained that on 16 January 2018, she had continued to suffer from 'asthma like symptoms'. She stated she still had SOB and a chronic cough and that she needed to be referred for investigation.

63. The Tribunal noted that both experts agreed that with Patient A's cough persisting along with shortness of breath, she should have been referred for an urgent chest x-ray.

64. The Tribunal noted that there was a requirement to refer a patient set out in both The Medway and NICE Guidelines for an urgent chest x-ray (within 14 days) for suspected lung cancer.

65. In all the circumstances, the Tribunal found that it was more likely than not that, on 16 January 2018, Dr Rahim consulted with Patient A and failed to refer her for an urgent chest x-ray for suspected lung cancer to be performed within 2 weeks.

66. Therefore, the Tribunal found Paragraph 2(c) of the Allegation proved.

Paragraph 2(d)(i) and (ii) of the Allegation

67. The Tribunal accepted the evidence of Dr Rahim, the consultation notes and the opinion of Dr E, that there was an adequate plan to deal with a working diagnosis of sinusitis. However, the Tribunal did not find that this working diagnosis and plan was adequate to deal with a chronic cough and SOB.

68. The Tribunal reminded itself that this was the second presentation of two potentially serious symptoms. Dr D also accepted that there was a working diagnosis and a plan for the *'acute symptoms'* recorded. Dr D opined that there was no working diagnosis for a chronic cough nor a plan recorded. The Tribunal agreed that the consultation note was partial. It determined the note was partial because the symptoms presented by Patient A were only partially dealt by Dr Rahim in the consultation. The consultation note was therefore inadequate with regard to those two ongoing symptoms.

69. In all the circumstances, the Tribunal found that it was more likely than not that, on 16 January 2018, Dr Rahim consulted with Patient A and failed to make an adequate record of the consultation in that she did not adequately record:

- a working diagnosis; and
- a management plan.

70. Therefore, the Tribunal found Paragraph 2(d)(i) and (ii) of the Allegation proved.

Paragraph 2(d)(iii) of the Allegation

71. In light of its previous finding the Tribunal noted Paragraph 2(d)(iii) of the Allegation was an alternative allegation and was therefore was not necessary to be considered by the Tribunal.

Paragraph 2(d)(iv) of the Allegation

72. The Tribunal considered whether there was an adequate consultation note regarding information relevant to symptoms linked to an unexplained chronic cough. Both experts agreed that whilst some of the symptoms as set out in Paragraph 2(d)(iv)(1 to 6) of the Allegation were not recorded, the only symptom they jointly criticised, as being absent, was *'SOB'*. The remainder of the symptoms were not complained of at all (chest pain) or appeared in the consultation note (sinusitis, wheezing) or were not such that either expert considered needed to be evidenced within Patient A's notes (crackling in the back of throat, haemoptysis). The Tribunal could see no reason to depart from this joint expert view.

73. Therefore, with the exception of *'SOB'*, the Tribunal found:

- Paragraph 2(d)(iv)(1)(2)(3)(4) and (6) of the Allegation not proved; and
- Paragraph 2(d)(iv)(5) of the Allegation proved.

Paragraph 5 of the Allegation

74. Schedule 1 of the Allegation states:

Consultation with Patient A on 2 January 2018

Original record	Amended record
"sob and chest feels tight"	"no sob but chest feels tight"
No reference to weight loss	"no weight loss"
No reference to chest pain	"no chest pain"

75. The Tribunal reminded itself that Dr Rahim accepted that she made the amendments set out on 7 August 2018 after learning of Patient A's diagnosis of cancer.

76. The Tribunal had regard to Patient A's evidence that stated she had complained of SOB. Her evidence before the Tribunal was consistent with the statement given to the GMC and remained consistent during cross examination. The Tribunal bore in mind that Patient A

was remembering a consultation that happened some time ago, she was looking at it as a patient who had been diagnosed with lung cancer and as a patient who had seen the original consultation notes. The Tribunal also bore in mind that Patient A had sought to criticise at least one other doctor (referred to in this determination as 'Dr B') for failing to record her complaints properly. Although there was no evidence from Dr B about the consultation before it the Tribunal noted that the GMC had received a complaint about Dr B from Patient A and closed it within 7 days. In all the circumstances, the Tribunal was cautious with regard to the weight it placed on Patient A's account and determined to not rely solely on it.

77. Patient A's memory of the consultation was, however, supported by the contemporaneous consultation note: *'sob and chest feels tight'* She stated in evidence that there had been no discussion of weight loss and there had been no discussion relating to chest pain.

78. The Tribunal also had regard to Dr Rahim's evidence. It accepted that there may have been reasons for Patient A to stand out due to Patient A refusing to consult with Dr Rahim on previous occasions. It noted Patient A was not a regular patient and not well known to Dr Rahim.

79. The Tribunal was of the view, however, that Dr Rahim's evidence lacked credibility that she would remember both consultations to the extent of the detail that was claimed 7 months' later. She would have seen many hundreds of patients and had many more consultations in that time. There was no real reason given for the details of the consultations as opposed to the patient herself to stand out, given the passage of time.

80. The Tribunal also considered that the changes admitted by Dr Rahim to the original consultation notes were significant. The Tribunal noted that there was no dispute between the expert witnesses that a patient presenting with symptoms of SOB and chronic cough should have been urgently referred for a chest x-ray. This was mandated by the Medway and NICE Guidelines.

81. Dr Rahim was aware in August 2018, when looking at the original notes, that Patient A had been diagnosed with lung cancer. The Tribunal considered that Dr Rahim must have realised that her notes of 2 January 2018 demonstrated, if they were accurate, that she should have referred Patient A for an urgent x-ray.

82. Dr Rahim gave evidence that it was a simple recording mistake that involved her missing a minus sign (minus meaning no SOB). Dr Rahim also changed the word *'and'* to *'but'* within the records. This could not be described as a minor typographical error. Dr Rahim could not explain why she made that change in August 2018 if she merely *'missed a minus'*. There was also no credible reason given by Dr Rahim to remember a conversation re weight loss and chest pain some 7 months later. Nor was there any reason to enter it into the note now (as negative symptoms). It could properly be inferred that she had these negative symptoms in mind when she reviewed the note in August 2018 as the absence of them would be important in the context of a (missed) cancer diagnosis.

83. Taking account of all the evidence before it, The Tribunal placed most reliability on the contemporaneous consultation note. It determined that it was accurate and it reflected Patient A's evidence as to the fact she had complained of SOB. The explanations as to the changes made by Dr Rahim lacked credibility for the reasons set out.

84. In all the circumstances, the Tribunal found that it was more likely than not that, when making the amendments set out at Schedule 1 on 7 August 2018, Dr Rahim failed to make an accurate record of the consultation on 2 January 2018 in that she recorded *'no SOB'*, when Patient A had reported shortness of breath.

85. Therefore, the Tribunal found Paragraph 5 of the Allegation proved.

Paragraph 6 of the Allegation

86. Schedule 2 of the Allegation states:

Consultation with Patient A on 16 January 2018

Original record	Amended record
No reference to chest x-ray	"last cxr 2016 clear review if not better with view of cxr."

87. The Tribunal reminded itself that Dr Rahim admitted that she made this amendment to the contemporaneous notes on 7 August 2018 after learning of Patient A's cancer diagnosis.

88. The Tribunal had regard to the Joint Expert Report, where they stated:

Dr D:

> *'Dr D considers that this was seriously below the standard expected because reference to [Patient A's] previous CXR in 2016, Dr Rahim's intention to*
> *review the patient if not better after one week, and to recheck the CXR are all important aspects of the management of a chronic cough with SOB. Dr D considers that failure to make an accurate record placed Patient A at risk of harm from a missed diagnosis'.*

Dr E:

> *'Dr E agrees that this failing was seriously below the standard expected if it is accepted by the Hearing that the issue was never discussed at the Consultation'.*

89. In her evidence, Patient A stated there had been no discussion at all about a chest x-ray or any investigations at the consultation of the 16 January 2018. She maintained her account in cross examination. The Tribunal noted that there was nothing in the contemporaneous note about a 2016 x-ray or review at all.

90. In her evidence, Dr Rahim stated that, in August 2018, she added *'last cxr 2016 clear review if not better with view of cxr'* as that accurately reflected part of the oral advice that she had given Patient A at the time. She stated that Patient A had asked about whether a referral to ENT might be appropriate. She recalled that they both looked at the note of the 2016 chest x-ray together. She stated she had also agreed that it might be necessary to refer to ENT if the symptoms did not improve.

91. In cross examination, Dr Rahim accepted that, in relation to the ENT referral, this was not recorded in the contemporaneous consultation notes. Dr Rahim accepted that the 2016 chest x-ray was normal and was of no value with regard to diagnosis of Patient A's cough.

92. Dr Rahim also stated that she would not necessarily say after treatment for a patient to *'come back'* rather, if there was no improvement, then *'come back'*. When asked about specific recollection of what she had said, Dr Rahim stated she had no specific recollection of what was said and *'[Patient A] is a clever lady she knows how to look after herself'. I would not need to say come back'*. This evidence was not consistent with the amended note that she had said *'review if not better with view of cxr'*.

93. The Tribunal considered that there was no reason why, if she had looked back at the 2016 notes with Patient A, she would not have made a note of it at the time especially if has informed her management plan for the cough. The Tribunal rejected the explanation that this detail was recollected 7 months later from memory. The Tribunal thought it was much more likely her awareness of this detail had come from Dr Rahim's review of Patients A's notes on the 7 August 2018.

94. The Tribunal was of the view that Dr Rahim's evidence lacked credibility when the case being put forward on behalf of her was that there was no need to note safety netting and most medical practitioners did not make a note of safety netting. It made no sense in this context to add it 7 months later.

95. In all the circumstances, the Tribunal found that it was more likely than not that, when making the amendments set out at Schedule 2 on 7 August 2018, Dr Rahim failed to make an accurate record of the consultation on 16 January 2018 in that she recorded *'last cxr 2016 clear review if not better with view of cxr'* when this had not been discussed with Patient A.

96. Therefore, the Tribunal found Paragraph 6 of the Allegation proved.

Paragraph 7(a) of the Allegation

97. The Tribunal first of all had regard to Patient A's letter of complaint to the Practice, dated 31 December 2018 (the complaint letter) and Dr Rahim's letter of response, (the response) dated 21 January 2019.

98. It was agreed evidence that the complaint letter was sent to Mrs C, the practice manager, received on 14 January 2018 and had been passed to Dr Rahim for response. It was agreed that Dr Rahim had composed the majority of the letter. Mrs C had added the last paragraph only relating to complaint appeals to the Ombudsman. It was agreed that Dr Rahim had printed 5 pages of Patient A's medical notes. The Tribunal noted that 2 of those pages had been sent with the reply along with the Medway Guidelines relating to chest referrals.

99. Within the complaint letter, Patient A set out her own memory of what occurred during the consultation and her presenting symptoms including *'shortness of breath and a barking cough that had lasted well over 3 weeks […] I explained that my shortness of breath was like asthma'*. She stated her belief that these symptoms should have been investigated and that her symptoms may been overlooked as *'I am relatively young, look healthy and a non smoker'.* She noted her symptoms met the NICE guidance for referral for a chest x-ray.

100. The Tribunal considered that it was clear on the face of Dr Rahim's letter of response that there was no explanation to say that the consultation notes had been amended. Further, Dr Rahim admitted during her evidence to the Tribunal that she had not explained in the reply to Patient A that she had made any amendments to the notes.

101. In the reply, Dr Rahim responded to the detail of the complaint letter. The reply stated *'looking back at your computer notes'*, she set out what those notes stated and specifically *'you denied that you had shortness of breath'*. This was based on the amended notes. It was agreed by Dr Rahim that there was nothing in her response to indicate she had amended the 2 January 2018 consultation records in August 2018. As stated these amended notes were also appended to the letter (the Tribunal were of the view it did not matter if they were or were not as they were quoted substantially in the reply).

102. The Tribunal was of the view that Dr Rahim's reply read as though it was based an original and therefore contemporaneous note of the consultations.

103. The Tribunal considered Dr Rahim's explanation that she was merely representing the accurate facts of the consultation based on her own memory.

104. During his evidence, Dr E for the defence opined *'if the intention was to send the records with the letter and not mention the amendment, then that would be seriously below the standards expected'*.

105. The Tribunal were of the view that where a practitioner sought to rely on a consultation note when corresponding with a Patient or anyone else, particularly about a complaint, there must be a duty on the practitioner to declare that they had made

amendments and what that amendment was, particularly where any amendment was significant. The Tribunal was of the view that the amendment to *'no SOB'* was significant. The Reply implied that Patient A's memory was at fault: *'you denied shortness of breath'*.

106. Reliance has been placed by Dr Rahim that amendments would be obvious to anyone who opened the archived records that were kept at the Practice as they are clear in the electronic audit trail. However, it would not have been apparent to Patient A, looking at Dr Rahim's letter of response, that there had been any changes to the original notes.

107. The Tribunal considered that Dr Rahim was required to be open and clear with Patient A in her reply about the fact that she had, since the consultation, amended Patient A's notes to reflect her memory.

108. In all the circumstances, the Tribunal found that it was more likely than not that Dr Rahim sent a letter to Patient A dated 21 January 2019 enclosing and referring directly to the amended records referred to at Paragraphs 3 and 4 of the Allegation, and when doing so, Dr Rahim had failed to explain that the notes had been amended.

109. Therefore, the Tribunal found Paragraph 7(a) of the Allegation proved.

Paragraph 7(b) of the Allegation

110. Having determined that there was nothing within the letter which indicated that the notes had been changed, when there ought to be, the Tribunal then considered if and how the consultation notes were relied upon by the reply. As stated the reply drafted by Dr Rahim made references to *'the computer note'*. Patient A was being invited to rely on the computer note as evidence as to what did or did not happen during the consultations of 2 and 16 January 2018 using phrases such as *'looking back at your note'* and *'according to your note'*.

111. The Tribunal was of the view that Patient A was being informed the consultation notes could be relied upon as contemporaneous notes for the 2 January 2018 and therefore by inference for the 16 January 2018.

112. In all the circumstances, the Tribunal found that it was more likely than not that, Dr Rahim sent a letter to Patient A dated 21 January 2019 enclosing and referring directly to the amended records referred to at paragraphs 3 and 4, and when doing so, Dr Rahim indicated that the amended notes could be relied upon as an accurate record of the consultations on:

- 2 January 2018; and
- 16 January 2018.

113. Therefore, the Tribunal found Paragraph 7(b) of the Allegation proved.

Paragraphs 8 and 9 of the Allegation

114. The Tribunal firstly considered separately whether Dr Rahim knew the amendments she made were untrue and resulted in an inaccurate record. It then went on to consider whether the actions described in Paragraphs 3, 4, and 7 of the Allegation were dishonest. It was of the view that these issues were so closely interconnected that the evidence for Paragraphs 8 and 9 should be looked at together.

115. The Tribunal had regard to its previous findings and all the evidence before it. By way of summary the Tribunal had, amongst other things, determined Dr Rahim had:

a. On 7 August 2018, made amendments, as set out in Schedule 1, to a record of the consultation with Patient A that took place on 2 January 2018.

b. On 7 August 2018, made amendments, as set out in Schedule 2, to a record of the consultation with Patient A that took place on 16 January 2018.

c. Made the amendments above which were an inaccurate representation of the consultations.

d. Received a complaint as to her care from Patient A.

e. Sent a detailed reply to Patient A dated 21 January 2019 enclosing and referring directly to the amended records.

f. Failed to explain that the notes had been amended when she had a duty to do so.

g. Indicated that the amended notes could be relied upon as an accurate record of the consultations on 2 January 2018 and 16 January 2018

116. When considering the issue of dishonesty, the Tribunal applied the test in *Ivey v Genting Casinos* namely:

> *'74 […] 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.'*

117. The Tribunal found that Dr Rahim knew her amendments she made on 7 August 2018 (as set out in Schedules 1 and 2 respectively) were untrue for the reasons set out below.

118. The Tribunal had regard to the evidence of Dr Rahim that these amendments were solely meant to a be personal learning exercise. She stated that no one else was meant to rely on the notes as it was part of an archived notes. She accepted that the reflection did not need to be in the consultation note at all. It was agreed the changes should have been more clearly marked.

119. The Tribunal had regard in Dr Rahim's favour that that by 7 August 2018, at the time Dr Rahim made the amendments, Patient A had not made a complaint to the Practice.

120. The Tribunal noted that it was agreed by both experts that it is not appropriate to amend patient records in the way Dr Rahim did. Further, if any amendments were to be made, they should be done clearly.

121. In his evidence, Dr D stated that keeping a separate note of the case review would be appropriate if it was a *'learning exercise'*. Further, he stated that there was no need to amend the original patient notes at all. The Tribunal noted that Dr Rahim did not give an explanation why she did not do that instead.

122. The Tribunal placed no reliance on the fact that Dr Rahim did not respond to the letter dated 28 February 2019 querying the discrepancy in the consultations notes. Although Patient A said she had sent it the letter was addressed to Mrs C. There was no evidence before the Tribunal that it was received by the Practice.

123. The Tribunal noted that, when Dr Rahim made the amendments on 7 August 2018, she was not aware that Patient A had a copy of the original, unamended notes.

124. The Tribunal was of the view that Dr Rahim would appreciate that any prospective complaint arising out of consultations for January 2018 would be dealt with by the Practice and not the new surgery and by way of reference to the archived (now amended) notes.

125. Dr Rahim had stated that there had in the past been a breakdown of the relationship between her and Patient A and for her to consult Dr Rahim was out of the norm. She gave evidence that *'she did not like me'*. The Tribunal considered whether Dr Rahim had reviewed the consultation notes and realised they reflected an inadequate consultation particularly with regard to the symptoms of chronic cough and SOB. If that were so then it was reasonable to infer, on the facts, that she may also anticipate a complaint about her failure to refer for investigations including chest x-ray. It was also reasonable to infer that she may also well have missed the importance of the symptoms as otherwise Patient A was atypical in presentation.

126. The evidence before the Tribunal was that Dr Rahim was an otherwise highly regarded GP. The Tribunal took into account and accepted evidence that any such actions by Dr Rahim would be wholly out of character. The Tribunal noted her usual clinical ability and

her usual integrity. It took into consideration the fact that actions like these were less likely given her previous demonstrable good character.

127. The Tribunal also had regard to Mrs C's evidence who stated that she did not and would not question any changes to the notes. She would have no reason to look at changes in archived or non-archived notes. Therefore, the Tribunal was of the view that only if the complaint was escalated to further investigation (for example, by her regulator) would it be likely that anyone would examine the archived electronic notes. It was only the fact Patient A had her own copy of the original consultation note that alerted her to the fact that the copies she had been sent were not the same.

128. On all the evidence, the Tribunal were compelled to the view that Dr Rahim amended the consultation notes for use to defend any anticipated criticism by Patient A of her clinical failure.

129. The Tribunal did not accept that Dr Rahim's memory of those consultations would have been as good 7 months following than at the time of the consultations. If there was any need to carry out a *'learning review'*, this could and should have been done in a separate note in her own personal records. The Tribunal considered that there was no need for Dr Rahim to amend Patient A's consultation note and any amendments that she made should have been made in a clear and obvious manner and not to give the impression that it was a true reflection of the record made contemporaneously at the consultations of 2 and 16 January 2018. The Tribunal noted that both experts were in agreement that it was inappropriate to amend the records in this way.

130. The Tribunal found that it was more likely than not that Dr Rahim knew the amendments she made to the consultation records were untrue and found Paragraph 8 (a and b) of the Allegation proved.

131. Having therefore determined that Dr Rahim had deliberately set out to amend the notes in anticipation of a potential complaint with regard to her clinical care the Tribunal determined she was subjectively dishonest.

132. Ordinary decent people would find that the amendment of the consultation notes in anticipation of a complaint was wholly inappropriate and very serious. The Tribunal therefore determined that her actions were objectively dishonest.

133. Based on all the evidence, the Tribunal was of the view that it was likely Dr Rahim was both subjectively, and objectively dishonest when she amended the notes.

134. Therefore, the Tribunal found Paragraph 9 of the Allegation, as it relates to Paragraph 8 of the Allegation, proved.

The Tribunal's Overall Determination on the Facts

135. The Tribunal has determined the facts as follows:

Consultation on 2 January 2018

1. On 2 January 2018 you consulted with Patient A and failed to:

a. arrange an appropriate investigation in that you did not refer Patient A for a chest x-ray;
Determined and found proved

b. provide appropriate advice to Patient A in that you did not explain the importance of diagnosing a chronic cough;
Determined and found proved

c. implement an appropriate management plan in that you did not make specific arrangements to review Patient A within 14 days;
Determined and found proved

d. make an adequate record of the consultation in that you:

i. recorded 'SOB' rather than 'no SOB';
~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found proved

Paragraph 1(d) of the Allegation (as part of an alternative to Paragraphs (1)(a to c) of the Allegation), was not considered by the Tribunal.

ii. did not record the absence of chest pain;
~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found proved

Paragraph 1(d) of the Allegation (as part of an alternative to Paragraphs (1)(a to c) of the Allegation), was not considered by the Tribunal.

iii. did not record the absence of weight loss;
~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found proved

Paragraph 1(d) of the Allegation (as part of an alternative to Paragraphs (1)(a to c) of the Allegation), was not considered by the Tribunal.

iv. did not record a working diagnosis;
Paragraph 1(d) of the Allegation (as part of an alternative to Paragraphs (1)(a to c) of the Allegation), was not considered by the Tribunal.

v. did not record safety netting advice provided.
Paragraph 1(d) of the Allegation (as part of an alternative to Paragraphs (1)(a to c) of the Allegation), was not considered by the Tribunal.

Consultation on 16 January 2021

2. On 16 January 2018 you consulted with Patient A and failed to:

a. arrange appropriate investigations in that you did not obtain a:

i. chest x-ray;
Determined and found proved

ii. peak expiratory flow rate measurement;
Determined and found proved

iii. spirometry;
Determined and found proved

b. implement an appropriate management plan in that you did not arrange to review Patient A within 7 days;
Determined and not proved

c. refer Patient A for an urgent chest x-ray for suspected lung cancer to be performed within 2 weeks;
Determined and found proved

d. make an adequate record of the consultation in that you did not record:

i. a working diagnosis;
Determined and found proved

ii. a management plan;
Determined and found proved

iii. the discussion regarding Patient A's chest x-ray;
~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found proved

Paragraph 2(d)(iii) of the Allegation (as an alternative to Paragraph 2(a to c) of the Allegation), was not considered by the Tribunal

iv. information relevant to the follow up of unexplained chronic cough including:

1. that the sinusitis and / or nose problem had not resolved;
Determined and not proved

2. crackling at the back of the throat;
Determined and not proved

3. wheezing and / or chest tightness;
Determined and not proved

4. chest pain;
Determined and not proved

5. shortness of breath;
Determined and found proved

6. haemoptysis.
Determined and not proved

Amendments to medical records

3. On 7 August 2018 you made amendments, as set out in Schedule 1, to a record of the consultation with Patient A that took place on 2 January 2018.
Admitted and found proved

4. On 7 August 2018 you made amendments, as set out in Schedule 2, to a record of the consultation with Patient A that took place on 16 January 2018.
Admitted and found proved

5. When making the amendments set out at Schedule 1 on 7 August 2018, you failed to make an accurate record of the consultation on 2 January 2018 in that you recorded 'no SOB,' when patient A had reported shortness of breath.
Determined and found proved

6. When making the amendments set out at Schedule 2 on 7 August 2018, you failed to make an accurate record of the consultation on 16 January 2018 in that you recorded 'last cxr 2016 clear review if not better with view of cxr' when this had not been discussed with Patient A.
Determined and found proved

7. You sent a letter to Patient A dated 21 January 2019 enclosing and referring directly to the amended records referred to at paragraphs 3 and 4 and when doing so you:

    a. failed to explain that the notes had been amended;
    Determined and found proved

    b. indicated that the amended notes could be relied upon as an accurate record of the consultations on:

        i. 2 January 2018;
        Determined and found proved

        ii. 16 January 2018.
        Determined and found proved

8. You knew that the amendments to the records referred to at paragraphs 3 and 4 were untrue and resulted in an inaccurate record of the consultations with Patient A on:

    a. 2 January 2018;
    Determined and found proved

    b. 16 January 2018.
    Determined and found proved

9. Your actions as described at paragraphs 3, 4 and 7 were dishonest by reason of paragraph 8.
Determined and found proved

Determination on Impairment - 29/04/2021

136. Having given its determination on the facts in this case, in accordance with Rule 17(2)(k) of the Rules, the Tribunal has considered whether, on the basis of the facts which it

has found proved, Dr Rahim's fitness to practise is currently impaired by reason of misconduct.

The Evidence

137. The Tribunal had regard to all of the evidence, both oral and documentary, adduced during the course of these proceedings.

Submissions

138. The following is a summary of submissions at the close of the impairment stage.

Submissions on behalf of the GMC

139. Mr Grey submitted that Dr Rahim's fitness to practise is currently impaired by reason of her misconduct. He directed the Tribunal's attention to Good Medical Practice (2013 edition) ('GMP') specifically paragraphs 11, 15, 16, 19, 21, 49, 55, 61, 65, 68, 71 when making its determination.

140. Mr Grey submitted that Dr Rahim's conduct, found by the Tribunal, is serious. He submitted that this is the sort of conduct which raises issues of moral culpability and deplorability. He stated that Dr Rahim's clinical failings were serious and, even more serious, was her amending the consultation notes and answering dishonestly a patient complaint. Mr Grey submitted that these are all of the most serious order of misconduct.

141. Mr Grey submitted that this was a course of conduct embarked upon in August 2018 which had been continued and compounded in January 2019 when Dr Rahim dishonestly responded to Patient A's complaint. Further, he submitted that Dr Rahim's failures were not easily remediable.

142. Mr Grey submitted that patients place their trust in doctors and Dr Rahim had failed to uphold that trust in her and in the medical profession.

143. Mr Grey submitted that there was a real risk of repetition in this case and so Dr Rahim represents a risk to patients by the reason of the seriousness of her misconduct. He also submitted that impairment should be found to uphold public confidence and proper professional standards in the medical profession.

Submissions on behalf of Dr Rahim

144. Mr McCartney accepted on behalf of Dr Rahim that it is inevitable the Tribunal would make a finding of current impairment as a result of its overall findings of fact.

145. Mr McCartney directed the Tribunal's attention to the testimonial evidence attesting to Dr Rahim's good character. Specifically, he submitted that the standard of care usually

provided by Dr Rahim as evidenced within the testimonials should be accepted as being very high and good. This was over a career of 20 years and is relevant to any assessment of future risk. Mr McCartney submitted that Dr Rahim is not a risk to the public. However, he submitted that he would return to this issue in his submissions on sanction.

146. Mr McCartney submitted that Dr Rahim's conduct is not beyond remediation.

The Relevant Legal Principles

147. In approaching its decision, the Tribunal was mindful of the two-stage process to be adopted: first, whether the facts, as found proved, amounted to misconduct that was serious and secondly, whether the doctor's fitness to practise is currently impaired by reason of that misconduct.

148. At both stages of the process, the Tribunal was mindful of the overarching objective of the GMC set out in section 1 of the Medical Act 1983 (as amended) which requires the Tribunal to:

a. Protect, promote and maintain the health, safety and well-being of the public,

b. Promote and maintain public confidence in the medical profession, and

c. Promote and maintain proper professional standards and conduct for members of that profession.

149. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *Grant*. In particular, the Tribunal considered whether its findings of fact showed that Dr Rahim's fitness to practise is impaired in the sense that she:

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

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

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

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

150. The Tribunal bore in mind that it must determine whether the doctor's fitness to practise is currently impaired by reason of misconduct, taking into account her conduct at the

time of the events and any other relevant factors such as any development of insight, whether the matters are remediable or have been remedied and the likelihood of repetition.

151. The Tribunal also bore in mind the observations of Mrs Justice Cox in the case of *Grant* that:

> *'in determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant Tribunal should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her 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'.*

Misconduct

152. The Tribunal noted that the parties were in agreement that the determination on the facts would lead inevitably to a finding of current impairment. None the less the Tribunal went on to consider the issues for itself.

153. In determining whether Dr Rahim's fitness to practise is currently impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amounted to misconduct.

154. The Tribunal considered the paragraphs of GMP which set out the standards that a doctor must continue to meet throughout their professional career. The Tribunal had particular regard to paragraphs 1, 15(b), 19, 21(b)(e), 55(b)(c), 61 and 65 of GMP that state:

> 1 *'Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law'.*
>
> 15(b) *'You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> *[…]*
>
> *b. promptly provide or arrange suitable advice, investigations or treatment where necessary.'*
>
> 19 *'Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards'.*
>
> 21(b)(e) *'Clinical records should include:*

[…]

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

[…]

e. who is making the record ***and when'****.*

55(b)(c) *'You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:*

[…]

b. offer an apology

c. explain fully and promptly what has happened and the likely short-term and long-term effects'.

61 *'You must respond promptly, fully and honestly to complaints and apologise when appropriate. You must not allow a patient's complaint to adversely affect the care or treatment you provide or arrange'.*

65 *'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'*

155. The Tribunal applied the above GMP guidelines to the facts in this case and considered they applied to the following Paragraphs of the Allegation:

- The entirety of the Allegation: GMP 1;
- Paragraphs 1(a to c) and 2(a to c) of the Allegation: GMP 15(b)
- Paragraphs 3 to 6 of the Allegation: GMP 55(b)(c) and 65; and
- Paragraphs 3 and 4 of the Allegation: GMP 19.

Clinical Failings

156. Dr Rahim's clinical failures in this case related to two consultations in which she missed the opportunity to refer Patient A for further investigations which included a chest x-ray, which may have revealed that she was suffering from lung cancer. Dr Rahim failed to follow the Medway and/or the NICE guidelines for referral. The Tribunal cannot say why, on the evidence before it, she failed to follow the guidelines but it notes it is agreed evidence that Patient A was otherwise atypical in her presentation in that she was: *'relatively young'* a *'non-smoker'* and otherwise healthy in her presentation. At the second consultation on 16 January 2018, Dr Rahim had focussed on Patient A's acute symptoms rather than that of the

two continuing significant symptoms (cough and shortness of breath) she was suffering from which mandated an urgent chest x-ray.

157. In all the circumstances, the Tribunal determined that Dr Rahim's clinical error in her failure to refer patient A for a chest x-ray, not following the Medway and/or NICE guidance for referrals in the context of a potential diagnosis, is misconduct which is serious.

Note taking failures and adequate record keeping

158. The Tribunal accepted both experts' opinion that Dr Rahim's original unamended consultation notes were adequate.

159. In all the circumstance and taken in isolation, the Tribunal determined that Dr Rahim's actions in this regard were not serious failings and accepted, on the whole, she was a good consultation note keeper.

Amending the consultation notes and dishonesty

160. The Tribunal found that Dr Rahim's amendment in August 2018 of the original consultation notes was inappropriate. It was of the view that without clearly detailing how and when they had been amended was also inappropriate. The Tribunal determined that it was particularly serious to use the amended consultation notes to respond to a letter of complaint received in January 2019, and to give Patient A the impression that they were the contemporaneous medical records and could be relied upon.

161. The Tribunal considered that Dr Rahim's behaviour in this regard would be considered deplorable by members of the profession and a fair minded and reasonably informed member of the public. The public rely on doctors to act with honesty and integrity. The Tribunal concluded that Dr Rahim's actions had breached a fundamental tenet of the medical profession and the highlighted sections of GMP, specifically paragraphs 1, 55 and 65, and her actions had the effect of bringing the profession into disrepute.

162. The Tribunal considered that it is a fundamental tenet of the medical profession that doctors must ensure that their conduct justifies the public's trust in the profession. This is misconduct that adversely impacts public trust.

163. In all the circumstances, the Tribunal determined that Dr Rahim's dishonest actions in this regard amounted to misconduct which was serious.

Impairment by reason of Misconduct

164. Having found that the facts found proved above amounted to misconduct, the Tribunal went on to consider whether, as a result of this, Dr Rahim's fitness to practise is currently impaired by reason of her misconduct.

165. The Tribunal determined that Dr Rahim's clinical misconduct had been such that it put Patient A at unwarranted risk of harm. Her clinical failures in conjunction with her attempts to cover up those failures has brought herself and the medical profession into disrepute. She has breached fundamental tenets of the medical profession, namely to act with honesty and integrity, and ensure her conduct justifies the public's trust in the medical profession. Therefore, the Tribunal concluded that Dr Rahim had breached all four limbs of *Grant*, as referenced in paragraph 14 above.

166. In determining whether a finding of current impairment of fitness to practise is necessary, the Tribunal looked for evidence of insight, remediation and the likelihood of repetition, bearing in mind the three elements of the overarching statutory objective. It considered that insight and remediation is important in order for a doctor to recognise areas of their practice and behaviour that require improvement, and to take appropriate and relevant steps to address them, thus reducing the likelihood of repetition.

167. The Tribunal had regard to all the evidence presented to it during the course of these proceedings. It noted that there is no evidence before it of insight or remediation. It noted the fact that Dr Rahim's mistake arose out of a matter of clinical judgment which was attempted to be covered up by an amendment of the consultation note. This was persisted with in the reply to Patient A's complaint letter and persisted with to this hearing. Therefore, the Tribunal, at this stage, could not rule out a future risk of repetition.

168. The Tribunal also noted that there is no evidence of any sort of misconduct prior to these proceedings and no evidence of repetition since the Allegation. It also had regard to the testimonial evidence produced on Dr Rahim's behalf, which attested to her good character over a 20-year career from fellow GP partners, patients and long standing friends who know her well.

169. Notwithstanding Dr Rahim's good character, Paragraph 1 of GMP makes it clear that acting with honesty and integrity is a cornerstone of the medical profession and the public expect doctors to meet this standard. A failure to act with integrity when amending consultation notes and responding to a patient's complaint is a serious breach of the standards expected of a doctor and inevitably brings the medical profession into disrepute.

170. The public expects to be able to trust doctors. The public expects doctors to act with integrity and not act against patient interests. They expect doctors dealing with their cases to adhere to the principles set out in GMP. Where doctors fail to do so in a significant way public trust in the profession is undermined and a finding of impairment of fitness to practise is required.

171. Therefore, in all the circumstances of this case, the Tribunal determined that it was necessary in order to satisfy all three limbs of the overarching objective to find that Dr Rahim's fitness to practise is currently impaired by reason of misconduct.

Determination on Sanction - 30/04/2021

1. Having determined that Dr Rahim's fitness to practise is impaired by reason of her misconduct, the Tribunal has considered what action, if any, it should take with regard to her registration, in accordance with Rule 17(2)(n) of the Rules.

The Evidence

2. The Tribunal had regard to all of the evidence, both oral and documentary, adduced during the course of these proceedings.

Submissions

3. The following is a summary of submissions at the close of the sanction stage.

Submissions on behalf of the GMC

4. Mr Grey submitted that the only appropriate and proportionate sanction in Dr Rahim's case would be one of erasure from the Medical Register. He directed the Tribunal's attention to the Sanctions Guidance (November 2020 edition) ('SG') when making its determination.

5. Mr Grey submitted that the lack of remediation, insight and any remorse is 'stark' in this case. He submitted the only evidence of remorse by Dr Rahim is the letter of response to Patient A's complaint letter of January 2019 which was the apex of her behaviour. He submitted Dr Rahim's willingness to put her own interests above that of her patient put patient safety at risk.

6. Mr Grey submitted that Dr Rahim missed a potential opportunity to diagnose Patient A with cancer at an early stage. This was a serious clinical mistake. She sought to cover up this mistake. The public expects doctors to admit their mistakes instead of covering them up. He submitted that Dr Rahim's actions were a course of conduct continuous from August 2018 to January 2019.

7. Mr Grey submitted that the dishonest conduct was so serious that it was fundamentally incompatible with continued registration.

8. Mr Grey submitted that suspension would do little to assist meeting the overarching objectives given the lack of insight, remediation and remorse.

9. Mr Grey said he made this submission with a *'heavy heart'* but it is the duty of the regulatory body to protect the public interest, which could only be served by making an order of erasure.

Submissions on behalf of Dr Rahim

10. Mr McCartney acknowledged that this is not a case where taking no action, or imposing an order of conditions would be appropriate. He accepted the choice for the Tribunal was either high end suspension or erasure.

11. Mr McCartney rehearsed the testimonial evidence which numerous peers outlined that Dr Rahim (from her old practice and her current practice):

- often goes the extra mile and is willing to undertake work with no financial reward;
- is described as a medically competent doctor and has a 'sound level of medical knowledge';
- follows protocols;
- has a high level of record keeping; and
- can be trusted with responsibilities.

12. Mr McCartney submitted the question for the Tribunal is whether there is a proportionate response which deals with maintaining public confidence in the profession and maintaining standards. He asked is it necessary to end Dr Rahim's career at this stage? Or is there a compelling public interest to retain the services for the public of a GP who is otherwise a competent doctor?

13. Mr McCartney acknowledged that there is no doubt that there has been a breach of a fundamental tenet of the profession. He requested that the Tribunal give proper weight to the testimonials assessing Dr Rahim's character and her capabilities as doctor going above what she is required to do. He submitted that the misconduct the Tribunal found does not define Dr Rahim as a doctor. He submitted the public would be better served by this otherwise good doctor being allowed to continue to practise.

The Relevant Legal Principles

14. The Tribunal took into account its earlier findings, Counsel submissions and the evidence adduced during the course of these proceedings.

15. The decision as to the appropriate sanction is a matter for this Tribunal's own independent judgment. The sanction must be proportionate and tailored to the specific circumstances of the case. In reaching its decision, the Tribunal took into account the SG and the statutory overarching objective, which includes the need to:

a. Protect, promote and maintain the health, safety and well-being of the public,

b. Promote and maintain public confidence in the medical profession, and

c. Promote and maintain proper professional standards and conduct for members of that profession.

16. The Tribunal recognised that the purpose of a sanction is not to be punitive, although it may have a punitive effect. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Rahim's interests with the public interest.

The Tribunal's Determination on Sanction

Mitigating and Aggravating Factors

Mitigating Factors

17. The Tribunal had regard to the following mitigating factors present in Dr Rahim's case:

18. Character: The Tribunal noted:

a. That Dr Rahim has had a longstanding and otherwise unblemished career prior to these events.

b. There has been no repetition since the incident.

c. Since these events Dr Rahim has been in continuous practice and she was respected for her clinical ability and usual empathy to patients.

d. Aside from these events, there have been no issues about her probity.

19. Clinical failings: The Tribunal noted:

a. Her conduct was confined to an single patient in two failed referrals which were close together in time.

b. At the second failed referral Patient A's significant symptoms had been accompanied by new acute symptoms. This complicated the appropriate diagnosis and management plan.

c. She was otherwise well regarded by her peers and patients. The Tribunal accepted that Dr Rahim, in general, is a good clinician.

d. An audit survey of patients was presented to the Tribunal analysing Dr Rahim's consultations over a 6 month period between 1 September 2020 and 28 February 2021 with patients with respiratory symptoms. In that survey there were no patients with adverse or serious outcomes, no areas of concern, her record keeping was at above the standard of GP's generally and the auditor made no recommendations for improvement. The Tribunal was of the view that this demonstrated that, since the Allegation, Dr Rahim had taken great care to ensure high standards in record keeping, clinical practice,

management and patient safety. (37 relevant records were identified directly addressing the clinical failing identified on the facts of this case.)

e. There was little likelihood of repetition. The Tribunal was of the view her clinical failings were confined to the facts of this case and were connected with the atypical presentation of Patient A. Dr Rahim had clearly worked to remedy this gap in her clinical knowledge.

20. Probity, the Tribunal noted:

a. Whilst serious, her dishonesty does not sit at the criminal end of the dishonesty spectrum.

b. Her actions started with a very serious error of judgment when she made her initial decision to amend the consultation notes and her maintaining of her stance thereafter. This was not repeated episodes of dishonesty.

c. This was not a deep seated character trait. Quite the opposite. There was extensive testimonial evidence which demonstrated that her actions were wholly out of character and a serious aberration from her normal working practice and her integrity.

d. Although the Tribunal could not rule out the risk completely, as there was no admission as to misconduct, the evidential picture suggested that repetition was unlikely.

Aggravating Factors

21. The Tribunal balanced the above mitigating factors with the aggravating factors present in Dr Rahim's case. It had regard to the following aggravating factors in the case:

22. Clinical failings: The Tribunal noted:

a. She did not listen to Patient A.

b. She missed the potential opportunity to refer Patient A when she presented at two consultations complaining about two significant symptoms.

c. She had paid little or no attention to the Practice Guidelines (Medway) nor NICE Guidelines for referral for urgent chest x-ray.

d. She had not demonstrated any insight or remediation into her clinical failings.

23. Probity, the Tribunal noted:

a. The dishonest conduct was intended to mislead Patient A as to what happened in the consultation and to mask her own clinical failings;

b. This was a persistent cover up firstly by amending the notes in August 2018 and then sending the letter incorporating the amended notes in January 2019. This fiction was maintained to this hearing.

c. There had been no evidence of insight and remediation into her dishonest conduct;

d. Her actions have a very serious impact on her own reputation but also on the wider reputation of the medical profession as a whole.

e. Her actions breached a fundamental tenet of the medical profession.

The Tribunal's Decision

24. In deciding what sanction, if any, to impose, the Tribunal reminded itself that it must consider each of the sanctions available, starting with the least restrictive, to establish which is appropriate and proportionate in this case.

No Action

25. The Tribunal first considered whether to conclude the case by taking no action. The Tribunal noted paragraphs 68 to 70 of SG.

26. The Tribunal was satisfied that there were no exceptional circumstances in Dr Rahim's case which could justify it taking no action. It determined that, given the serious nature of the Allegation, taking no action would be wholly inappropriate, inadequate and would not be in the public interest.

Conditions

27. The Tribunal then considered whether imposing an order of conditions on Dr Rahim's registration would be appropriate. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable. The Tribunal had regard to paragraphs 80, 81 and 82 of the SG.

28. The Tribunal concluded that a period of conditional registration would not be appropriate because of the seriousness of Dr Rahim's misconduct. Conditions would not sufficiently mark the gravity of the findings made by the Tribunal. It also considered that it could not formulate practicable and workable conditions that would address those findings.

29. In all the circumstances, the Tribunal concluded that imposing conditions on Dr Rahim's registration would not be sufficient to protect patients, maintain public confidence in

the medical profession or uphold proper professional standards for members of the profession.

Suspension

30. The Tribunal went on to consider whether a period of suspension would be an appropriate and proportionate sanction to impose on Dr Rahim's registration. The Tribunal noted the SG, specifically paragraphs 92 and 97(f) of the SG, which it considered relevant in this case:

> 92 *'Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession)'.*
>
> 97(f) *'Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> *[…]*
>
> *f. No evidence of repetition of similar behaviour since incident'.*

31. The Tribunal applied these guidelines to the facts found proved.

32. The Tribunal considered that Dr Rahim's misconduct was a serious breach of GMP and breached a fundamental tenet of the medical profession as to probity. Her clinical failings were serious. The fact that she had amended original consultation notes and then gone on to dishonestly rely on that amended note in her reply to Patient A's complaint letter was very serious. This is outlined in more detail in its earlier determination on impairment.

33. The Tribunal acknowledged that Dr Rahim's actions, given her longstanding and otherwise unblemished career, were wholly out of character. Further, the Tribunal noted that Dr Rahim had not repeated her actions since the Allegation.

34. The Tribunal next had regard to paragraphs 120 and 125(b)(e) of the SG which relate to cases involving dishonesty where a more serious sanction may be appropriate:

> 120 'Good medical practice states that registered doctors must be honest and trustworthy and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession'.
>
> 125(b)(e) *'Examples of dishonesty in professional practice could include:*

[…]

b. falsifying or improperly amending patient records

[…]

e. failing to take reasonable steps to make sure that statements made in formal documents are accurate'.

35. The Tribunal accepted that Dr Rahim's dishonest actions were the product of a serious episode of misjudgement arising out of consultations with one patient.

36. However, taking account the facts of this case and the relevant parts of the SG, the Tribunal concluded that Dr Rahim's actions went to the heart of patient trust. If a patient could not trust a doctor to listen to them, trust the written record of what was said during the consultation, and trust a doctor to be open and honest when things went wrong, this would lead to considerable damage to public trust and the reputation of the medical profession. The public must be able to rely on doctors to act with honesty and integrity undertaking their role as a medical professional, especially when the doctor's practice is under scrutiny as it was in this case.

37. Accordingly, the Tribunal determined that suspension would not be sufficient or proportionate to promote and maintain public confidence in the medical profession or uphold proper professional standards for members of the profession. Further, it concluded that the imposition of the maximum period of 12 months' suspension would not sufficiently meet the statutory overarching objective.

Erasure

38. In the circumstances the Tribunal determined that the only appropriate sanction in this case was one of erasure. In reaching its determination, the Tribunal had regard to paragraphs 108 and 109(a)(b)(h) of the SG, which state:

> 108 *'Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor'*.
>
> 109(a)(b)(h) *'Any of the following factors being present may indicate erasure is appropriate*
> *(this list is not exhaustive).*

a. A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor

b. A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.

[…]

h. Dishonesty, especially where persistent and/or covered up[…]'

39. The Tribunal considered and applied these paragraphs as relevant to the facts of this case. As much as the Tribunal appreciated erasure would mean the removal from the register of an otherwise good doctor, the impact of her dishonesty upon public confidence was too great to be met by a lessor sanction than erasure.

40. In conclusion, for the reasons set out earlier in this determination, the Tribunal concluded that Dr Rahim's misconduct was fundamentally incompatible with continued registration and that no lesser sanction than erasure would adequately protect patients, promote and maintain public confidence in the medical profession, and promote and maintain proper professional standards and conduct for members of that profession.

Determination on Immediate Order - 30/04/2021

1. Having determined that Dr Rahim's name be erased from the Medical Register, the Tribunal considered, in accordance with Rule 17(2)(o) of the Rules, whether her registration should be subject to an immediate order.

Submissions

2. The following is a summary of submissions made at the immediate order stage.

3. Mr Grey submitted that it would be appropriate for the Tribunal to impose an immediate order of suspension, given its findings during the course of these proceedings.

4. Mr McCartney submitted that it is not made out that an immediate order is necessary to protect members of the public, given the Tribunal's detailed reasons on sanction. However, in relation to public interest, he submitted that in any case where there has been a decision to erase it should not automatically follow that an immediate order is necessary. He reminded the Tribunal that it made specific findings to the isolated nature of the dishonesty which has been found proven in this case. He submitted that this case does not meet the test for an immediate order.

The Tribunal's Decision

5. In reaching its decision, the Tribunal has exercised its own judgment, and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public or otherwise in the public interest or is in the best interests of the practitioner. It has also borne in mind the guidance given in the relevant paragraphs of the SG relating to immediate orders.

6. The Tribunal accepted Mr McCartney's submission that, following a finding of erasure, an immediate order of suspension does not automatically follow.

7. The Tribunal determined that Dr Rahim does not present a clinical risk to patients. However, it was of the view that the Dr Rahim's misconduct was very serious. Furthermore, there had been no admission, no remorse, no insight and therefore, no remediation of Dr Rahim's misconduct.

8. Therefore, in the particular circumstances of this case, an immediate order of suspension was appropriate and necessary. It determined that this was necessary in order to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of the medical profession. Dr Rahim's misconduct was so serious it breached a fundamental tenet of the medical profession, fundamentally eroding patient trust.

9. The substantive direction for erasure will take effect 28 days from when the written notice is deemed to have been served upon Dr Rahim, unless an appeal is lodged in the interim.

10. The Interim Order currently imposed on Dr Rahim's registration will be revoked when the immediate order takes effect.

11. That concludes this case.

Confirmed
Date 30 April 2021 Ms Louise Sweet QC, Chair

ANNEX A – 19/04/2021

Tribunal Determination on Admission – 19/04/2021

1. At the outset of these proceedings, Mr Kevin McCartney, Counsel, on behalf of Dr Abdul Rahim, made the following admissions to Paragraphs 1(d)(i to iii), 2(d)(iii), 3 and 4 Allegation under Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'):

Consultation on 2 January 2018

1. On 2 January 2018 you consulted with Patient A and failed to:

[…]

d. make an adequate record of the consultation in that you:

i. recorded 'SOB' rather than 'no SOB';

ii. did not record the absence of chest pain;

iii. did not record the absence of weight loss;

[…]

Consultation on 16 January 2021

2. On 16 January 2018 you consulted with Patient A and failed to:

[…]

d. make an adequate record of the consultation in that you did not record:

[…]

iii. the discussion regarding Patient A's chest x-ray;

[…]

Amendments to medical records

3. On 7 August 2018 you made amendments, as set out in Schedule 1, to a record of the consultation with Patient A that took place on 2 January 2018.

4. On 7 August 2018 you made amendments, as set out in Schedule 2, to a record of the consultation with Patient A that took place on 16 January 2018.

2. Pursuant to Rule 17(e) of the Rules, The Tribunal announced those paragraphs and sub-paragraphs of the Allegation, as detailed above, as admitted and found proved.

Submissions

3. Following Mr Tim Grey, Counsel, on behalf of the GMC's rehearsal of the background to this case, an issue had been raised by Mr McCartney in relation to Paragraphs 1(d)(i to iii) and 2(d)(iii) of the Allegation.

4. The following is a summary of submissions made by both Counsel at this stage:

Submissions on behalf of Dr Abdul Rahim

5. Mr McCartney submitted that it was agreed that there were two different factual situations that were reflected in the Allegation and the facts admitted were an alternative to the GMC's primary case which is represented by Paragraph 1(a to c) of the Allegation and the GMC's secondary case represented by Paragraph 1(d) of the Allegation. He submitted the admissions that were made by Dr Abdul Rahim were correctly made to the Allegation based on the alternative factual scenario. He submitted that whilst the admission could not be withdrawn by Dr Abdul Rahim, the Tribunal could take the view that those admissions only become relevant if the case is found not proved in relation to Paragraphs 1(a to c) and Paragraphs 2(a to c) of the Allegation respectively. He submitted that this solves the problem as the admissions fall away.

6. Mr McCartney outlined that he is not making an application. He noted that the Tribunal had given assurance to Dr Abdul Rahim during the course of these proceedings that her indicated admissions would be noted where they became relevant in the proceedings.

7. Mr McCartney directed the Tribunal's attention to *Sloan v GMC [1970] 1 W.L.R. 1130* when making its determination. It was agreed this case demonstrated the need to draft alternative allegations carefully.

Submissions on behalf of the GMC

8. Mr Tim Grey, Counsel, acknowledged that he could see that there is a problem in the way the Allegation had been drafted. He accepted there was a lack of clarity that the allegations were based on factually alternative scenarios. He stated that he would feedback this observation to the GMC where there are 'alternatives' within an Allegation.

9. Mr Grey submitted that he is not making an application to amend the Allegation.

The Tribunal's Decision

10. The Tribunal had regard to Rule 17(2)(e) and (f) that states:

> *'17.*
>
> *[…]*
>
> *(2) The order of proceedings at the hearing before a Medical Practitioners Tribunal shall be as follows—*
>
> *[…]*
>
> *(e) where facts have been admitted, the Chair of the Medical Practitioners Tribunal **shall** announce that such facts have been found proved;*
>
> *(f) where facts remain in dispute, the representative for the GMC shall open the case for the General Council and may adduce evidence and call witnesses in support of it; […]'*

11. The Tribunal also had regard to *Sloan* and noted that if there was any cross application of this case, the Rule 7 drafting of alternative allegations must be made clear.

12. The Tribunal determined that there is an inconsistency between the admissions the practitioner wished to make and the GMC's primary case because those admissions represented an alternative factual scenario. In this respect, the Tribunal considered that the facts, in accordance with Rule 17(f) of the Rules clearly remain in dispute. However, the Tribunal was acutely aware that Dr Abdul Rahim made those admissions at the very early stages of these proceedings and would properly take those admissions into account where relevant.

13. Therefore, the Tribunal withdrew its announcement that Paragraphs 1(d)(i to iii), 2(d)(iii) of the Allegation was admitted and found proved and will now read as follows:

> *Consultation on 2 January 2018*
>
> *1. On 2 January 2018 you consulted with Patient A and failed to:*
>
> *[…]*
>
> *d. make an adequate record of the consultation in that you:*
>
> *i. recorded 'SOB' rather than 'no SOB';*
> ~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found

proved

ii. *did not record the absence of chest pain;*
~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found proved

iii. *did not record the absence of weight loss;*
~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found proved

[…]

Consultation on 16 January 2021

2. On 16 January 2018 you consulted with Patient A and failed to:

[…]

d. make an adequate record of the consultation in that you did not record:

[…]

iii. the discussion regarding Patient A's chest x-ray;
~~Admitted and found proved~~ The Tribunal withdrew its announcement that this allegation was Admitted and found proved

[…]

14. Paragraphs 1(d)(i to iii), 2(d)(iii) of the Allegation remained to be determined. Paragraph 3 and 4 of the Allegation remain as admitted and found proved.

ANNEX B – 22/04/2021

Application under Rule 17(2)(g) – 22/04/2021

1. Counsel, Mr Kevin McCartney, on behalf of Dr Abdul Rahim made an application under Rule 17(2)(g) of the General Medical Council ('GMC') ('Fitness to Practise') Rules 2004 (as amended)('the Rules').

Submissions

2. The following is a summary of submissions made by both Counsel at this stage:

Submissions on behalf of Dr Abdul Rahim

3. Mr McCartney set out that his application under Rule 17(2)(g) of the Rules was limited to Paragraph 2(a)(i to iii) of the Allegation.

4. Mr McCartney submitted that these parts of the Allegation were predicated on the opinion of Dr D, the GMC's expert witness. He reminded the Tribunal of Dr D' oral evidence during the course of these proceedings.

5. Mr McCartney reminded the Tribunal of what Dr D stated in his Expert Report:

> *'My opinion is that it was acceptable for Dr Abdul Rahim not to arrange investigations at the 02.01.18 consultation and to wait to assess the outcome of amoxicillin treatment. However, in this case my opinion is that Dr Abdul Rahim should have arranged a review within 1-2 weeks to plan the management of any persisting symptoms'.*

6. In cross-examination, in relation to 16 January 2018, Dr D accepted that there was a change in Patient A's presentation which was supportive of a diagnosis of infection. Mr McCartney conceded that Dr D was at pains to say a diagnosis of an acute infection was separate from the question of an underlying chronic condition. Dr D was asked about whether it was reasonable to deal with the acute symptoms of infection by the prescribing of erythromycin to see what the outcome was of that before returning to the question of the underlying condition. Mr McCartney submitted that Dr D accepted that it was a reasonable course with the caveat that one needed to have in mind that there was a chronic cough and the two are not mutually exclusive.

7. Mr McCartney reminded the Tribunal that at some point after the consultation, Patient A decided to change practice and the responsibility of her care went to another doctor.

8. Mr McCartney submitted that his recollection of Dr D' evidence when cross examined by the GMC was that it was reasonable for Dr Abdul Rahim to either arrange the investigations, or to arrange Patient A to take a course of antibiotics and then for her to come back to discuss the next steps.

9. Mr McCartney conceded that in relation to Paragraph 2(a) of the Allegation, on the basis of Patient A's account that if she said on 2 January 2018 that she had a shortness of breath then there was sufficient evidence that there should have been a referral made by Dr Abdul Rahim on 16 January 2018 for Patient A to undergo a chest x-ray. He submitted that this referral is distinct from an urgent chest x-ray which is clearly covered by Paragraph 2(c) of the Allegation.

10. Mr McCartney submitted that in relation to Paragraph 2(a)(i) of the Allegation, Dr D evidence was that separate investigation was required to look at an underlying condition of a chronic cough, if it persisted, after the course of antibiotics. In those circumstances, he submitted that Paragraph 2(a)(i) of the Allegation is made on a different basis than the chest x-ray in Paragraph 2(c) of the Allegation.

11. Mr McCartney submitted that in relation to Paragraph 2(a)(ii to iii) of the Allegation, Dr D' accepted that it would be reasonable to defer those investigations as they might be impeded by the acute condition namely the possibility of a respiratory infection.

12. Mr McCartney submitted the question for the Tribunal at this stage, in light of the evidence of Dr D, is that 'it was reasonable to wait to see whether the antibiotics worked because that would exclude the acute condition' and not pursue them at the 16 January 2018 consultation.

Submission on behalf of GMC

13. Mr Tim Grey, Counsel, on behalf of the GMC submitted that Paragraphs 2(a) and (b) of the Allegation hang together. He directed the Tribunal's attention to Dr D Expert Report, namely:

> '*On 16.01.18, my opinion is that Dr Abdul Rahim should either have arranged initial investigations (CXR, PEFR and spirometry) or should have arranged to see Patient A again in one week with a view to arranging investigation of any symptoms persisting after the second course of antibiotics. My opinion is that failure follow one of these management options was seriously below the standard expected because of the possibility of a serious underlying cause for Patient A symptom of chronic cough with chest tightness and shortness of breath'.*
>
> He submitted Dr D adopted and maintained the above opinion in his oral evidence during the course of these proceedings.

14. Mr Grey reminded the Tribunal of the *Galbraith* test, specifically the second limb. He stated that there is evidence that supports Paragraph 2(a) of the Allegation in its entirety and, that evidence taken at its highest could lead to a conclusion that there was a failing and that failing was material. Further, he submitted that the evidence presented in this case is not inherently weak or tenuous.

The Tribunal's Approach

15. The Tribunal has borne in mind that its role at this stage of proceedings is not to make findings of fact; it has to decide whether sufficient evidence has been adduced regarding the relevant allegation such that it could find the facts proved.

16. Rule 17(2)(g) of the Rules states:

> *'The practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld.'*

17. In reaching its decision the Tribunal heard and accepted the advice of the Legally Qualified Chair, who invited it to adopt the approach set out in the case of *Galbraith* which can be summarised as follows:

1. It must first ask itself whether there is any evidence to support the Allegation in question; if there is none, then that paragraph of the Allegation must be dismissed under Rule 17(2)(g).

2. When there is some evidence, but it is of a tenuous character, for example because of inherent weakness of vagueness or because it is inconsistent with other evidence the test to be applied is whether the evidence – taken at its highest – is such that a Tribunal, properly directed, could properly find the matter proved.

18. The question of the absence or presence of evidence and the sufficiency of the same were matters for the Tribunal. If the Tribunal finds that there is sufficient evidence, then at the end of the fact finding stage it will have to decide in the light of all the evidence before it, whether the Allegation has been found proved or not. If it did not, the Allegation would be dismissed.

The Tribunal's Decision

Paragraph (2)(a)(i) of the Allegation

19. The Tribunal noted Paragraph 2(a)(i) of the Allegation: *'On 16 January 2018 you consulted with Patient A and failed to arrange appropriate investigations in that you did not obtain a chest x-ray'*.

20. The Tribunal noted that there was no dispute that Patient A attended the Practice on 16 January 2018. It considered that there was sufficient evidence before the Tribunal from Patient A that, by 16 January 2018, she was still complaining about a cough. Further, there was also evidence from the GP records before the Tribunal, that she had been suffering from new symptoms: 'green sputum' and 'aching and feverish'.

21. The Tribunal took into consideration that Dr D substantially maintained what he had set out in his Expert Report. He also conceded that it would not be unreasonable to defer the order a chest x-ray of Patient A in light of the new symptoms. He stated there were was more than one presenting problem to be investigated. He said 'they can be done in parallel'. He

also said it was appropriate to give antibiotics to treat a respiratory infection 'and at the same time' to order chest x-ray for someone who had cough over 3 months.

22. Dr D stated, that whatever Dr Abdul Rahim did, she would need a plan to deal with the underlying problem of the cough. Further, she would also have to explain this to Patient A, as part of the management plan, and arrangements would have had to be put in place.

23. In evidence, Patient A stated that she was not offered any explanations as to how her cough was going to be dealt with and she recalled no discussion or management plan to deal with the cough.

24. The Tribunal accepted that the question of whether Dr Rahim had failed to arrange appropriate investigations pursuant to Paragraph 2(a)(i) of the Allegation was tied in with the question of whether she had arranged any management plan. Patient A's evidence was that there had been no discussion around this. This part of the evidence was disputed.

25. The Tribunal considered that, taken at its highest, there is sufficient evidence before it which could lead to a finding that there should have been either a plan put in place to arrange a chest x-ray or a chest x-ray should have been arranged at the consultation of the 16 January 2018 itself.

26. Taking account all of the above evidence, the Tribunal found that there is sufficient evidence which, if accepted, could enable a properly directed Tribunal to find the facts proved. It therefore found that in respect of this paragraph, there is a case to answer.

The Rule 17(2)(g) application is therefore not upheld in relation to Paragraph 2(a)(i) of the Allegation.

Paragraphs 2(a)(ii) and (iii) of the Allegation

27. The Tribunal noted Paragraphs 2(a)(ii) and (iii) of the Allegation respectively: *'On 16 January 2018 you consulted with Patient A and failed to arrange appropriate investigations in that you did not obtain a peak expiratory flow rate measurement; and spirometry*.

28. In his oral evidence, Dr D made concessions that it may have been appropriate to delay investigations into peak expiratory flow rate measurement and spirometry due to the presence of Patient A's new symptoms 'green sputum' and 'aching and fever'. When specifically asked whether it was appropriate to delay these two tests until the conclusion of Patient A's antibiotic plan, he agreed with the caveat that 'if at the time it is made clear and understood by the patient'.

29. In her oral evidence, Patient A stated that Dr Abdul Rahim did not discuss her cough or any plans as to how it might be dealt with and Dr Abdul Rahim's primary focus was on her respiratory infection. Patient A also stated that no arrangements for further investigations were put in place.

30. The Tribunal reminded itself this was the second consultation regarding the cough as well as Patient A presenting with new symptoms. The Tribunal accepted that it may not have been worthwhile to carry out peak flow or spirometry investigations at the consultation of the 16 January 2018 but there was sufficient evidence to suggest that is was reasonable and necessary for there to be a plan to 'arrange' those as appropriate investigations to investigate the cough pending completion of the antibiotics course.

31. The Tribunal determined, on the evidence as set out above, that there is sufficient evidence which, if accepted, could enable a properly directed Tribunal to find the facts proved. It found that in respect of this paragraph, there is a case to answer.

The Rule 17(2)(g) application is therefore not upheld in relation to Paragraph 2(a)(ii) and (iii) of the Allegation.

SCHEDULE 1

Consultation with Patient A on 2 January 2018

Original record	Amended record
“sob and chest feels tight”	“no sob but chest feels tight”
No reference to weight loss	“no weight loss”
No reference to chest pain	“no chest pain”

SCHEDULE 2

Consultation with Patient A on 16 January 2018

Original record	Amended record
No reference to chest x-ray	"last cxr 2016 clear review if not better with view of cxr."