PUBLIC RECORD

Dates: 11/11/2021 - 16/11/2021
09/12/2021 – 16/12/2021

Medical Practitioner's name: Dr Amitesh VASISTHA

GMC reference number: 6143270

Primary medical qualification: MB BS 2006 University of London

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

Summary of outcome

Suspension, 12 months.
Review hearing directed

Tribunal:

Legally Qualified Chair	Mrs Julia Oakford
Lay Tribunal Member:	Mrs Debbie Hill
Medical Tribunal Member:	Dr Ann Wolton

Tribunal Clerk:	Ms Rachel Gill 11-12 November 2021 Mr Stuart Peachey 15-16 November 2021 Ms Maria Khan 9-16 December 2021

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Ms Vivienne Tanchel, Counsel, instructed by the MDDUS.
GMC Representative:	Mr Iain Simkin, 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 - 10/12/2021

Background

1. In 2004, Dr Vasistha completed a BSc in Radiological Sciences at GTK School of Medicine, Kings College London.

2. Dr Vasistha qualified with MB BS at the GTK School of Medicine, Kings College London in 2006. Prior to the events which are the subject of the hearing, Dr Vasistha worked as a salaried GP at the Grove Medical Centre between 2013 and 2014. At the time of the events Dr Vasistha was practising as a GP partner and he was the Practice lead for Prescribing and Cardiology at the Grove Medical Centre.

3. The allegation that has led to Dr Vasistha's hearing can be summarised as follows. Between January 2016 and June 2018, whilst working as a GP Partner at the Grove Medical Centre, Dr Vasistha recorded consultations in patient records where consultations had not taken place. It is alleged that at the time of recording the consultations, Dr Vasistha knew that the Practice would receive payments for achieving targets associated with the consultations.

4. It is further alleged that in June 2018, Dr Vasistha deleted one or more of the consultations from patient records in an attempt to conceal his conduct as set out above. It is alleged that Dr Vasistha's conduct was dishonest.

5. The initial concerns were raised with the NHS Counter Fraud Service by Mrs A in June 2018.

The Outcome of Applications Made during the Facts Stage

6. Ms Tanchel, on behalf of Dr Vasistha, made an application under Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to admit further evidence in the form of contemporaneous notes ('the Notes') made by Dr Vasistha in November 2018 in relation to Dr B's audit. The application was not opposed by Mr Simkin, on behalf of the GMC. The Tribunal determined that this evidence was relevant to the hearing and it was fair to admit it. Its full determination can be found in Annex A.

7. On behalf of the GMC, Mr Simkin made an application under Rule 17(6) of the Rules, to amend Schedule 1 and 2 of the Allegation by way of three deletions due to duplicate entries. Ms Tanchel, on behalf of Dr Vasistha, did not oppose the amendment. The Tribunal determined this amendment would more accurately reflect the evidence it had received and could be made without injustice. Its full determination can be found in Annex B.

8. The Tribunal refused the application of Ms Tanchel of no case to answer made pursuant to Rule 17(2)(g) of the Rules in respect of Paragraph 5(a) of the Allegation. The Tribunal's determination can be found at Annex C.

The Allegation and the Doctor's Response

9. The Allegation made against Dr Vasistha is as follows:

1. Between January 2016 and June 2018 whilst working as a GP Partner at the Grove Medical Centre ('the Practice'), you recorded one or more consultations in patient records where consultations had not taken place as set out in Schedule 1 ('the Consultations').
   Admitted and found proved

2. At the time of recording the Consultations, you knew that:

   a. the Consultations had not taken place;
   Admitted and found proved

b. the Practice would receive Quality and Outcomes Framework payments for achieving targets associated with holding the Consultations.
Admitted and found proved

3. In June 2018, you deleted one or more of the Consultations from patient records as set out at Schedule 2 ('the Deletions').
Admitted and found proved

4. When you made the Deletions, you knew the Practice would be subjected to a Post Payment Verification visit by NHS England.
Admitted and found proved

5. Your actions as set out at:

a. paragraph 1 were dishonest by reason of paragraph 2;
To be determined

b. paragraph 3 were dishonest by reason of paragraph 4.
Admitted and found proved

6. Your conduct as set out at paragraph 3 was to conceal your conduct as set out at paragraphs 1 – 2 above.
Admitted and found proved

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

The Admitted Facts

10. At the outset of these proceedings, through his Counsel, Ms Tanchel, Dr Vasistha 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;
- 2;
- 3;

- 4;
- 5(b); and
- 6

11. 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.

The Facts to be Determined

12. In light of Dr Vasistha's response to the Allegation made against him, the Tribunal is required to determine whether Dr Vasistha's recording of the Consultations in patient records when he knew that they had not taken place and that the Practice would receive Quality and Outcomes Framework payments, was dishonest.

Witness Evidence

13. The Tribunal received evidence on behalf of the GMC from the following witness:

- Dr B, Clinical Advisor, via video link; and a witness statement, undated but signed

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

- Mr C, Probity Manager, dated 4 July 2019;
- Ms A, Practice Manager, dated 23 December 2019

15. Dr Vasistha provided his own witness statement dated 24 September 2021 and also gave oral evidence at the hearing. He also provided a number of written testimonials.

Documentary Evidence

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

- Correspondence concerning the Post Payment Verification visit
- Whistle-blower recording form

- Post Payment Verification report dated 12 July 2018
- Post Payment Verification visit - email dated 16 July 2018 from Mr C to NHS England
- Record report template by Dr B following her review on 6 September 2018
- Extract from patient records exhibited by Ms A
- Details of recorded facts obtained from EMIS web clinical audit system
- Notes made by Dr Vasistha in November 2018

The Tribunal's Approach

17. At this stage the Tribunal is required to determine whether the outstanding paragraph of the allegation, namely 5(a), has been proved or not.

18. The GMC bring the Allegation and the burden of proving the allegations is on the GMC. There is no burden on the doctor.

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

20. The Tribunal was referred in particular to the following cases:

- *Byrne v GMC [2021] EWHC 2237 (Admin).* Mr Justice Morris at paragraph 22 stated:

  "The standard of proof to be applied by the Tribunal and by this Court is the civil standard of balance of probabilities. As regards the position where the allegations, or the consequences for the person concerned, are particularly serious, the Appellant referred me to Casey at §16, suggesting that there is a need for a "heightened examination of the evidence". It was common ground that the correct approach is as set out in my judgment in O v Secretary of State for Education at §66. In that case, after referring to the relevant House of Lords and Supreme Court authorities (Re B and Re S-B) (which in turn referred to Re Doherty cited in Casey), I summarised the position as follows:

  > *(1) There is only one civil standard of proof in all civil cases, and that is proof that the fact in issue more probably occurred than not.*

(2) There is no heightened civil standard of proof in particular classes of case. In particular, it is not correct that the more serious the nature of the allegation made, the higher the standard of proof required.

(3) The inherent probability or improbability of an event is a matter which can be taken into account when weighing the probabilities and in deciding whether the event occurred. Where an event is inherently improbable, it may take better evidence to persuade the judge that it has happened. This goes to the quality of evidence.

(4) However it does not follow, as a rule of law, that the more serious the allegation, the less likely it is to have occurred. So whilst the court may take account of inherent probabilities, there is no logical or necessary connection between seriousness and probability. Thus, it is not the case that "the more serious the allegation the more cogent the evidence need to prove it".

- *Soni v GMC (2015) EWHC 364*. In this case it was found that a tribunal should consider and safely exclude, other possible explanations for a doctor's conduct before drawing an inference as to dishonesty.

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 Vasistha's knowledge or belief as to the facts and should then decide whether his conduct was honest or dishonest by applying the objective standards of ordinary decent people.

The Tribunal's Analysis of the Evidence and Findings

Quality and Outcomes Framework ('QOF')

22. In 2014, after becoming a GP Partner, Dr Vasistha's level of responsibility increased, and he would have had more involvement in QOF administration. Dr Vasistha did not receive any formal training in this. Dr Vasistha's duties also included acting as the Practice prescribing and IT lead. He was in charge of updating the Practice policies and prescribing data by conducting regular audits.

23. The Tribunal had regard to Mr C's evidence relating to the Practice's QOF within his witness statement.

24. The QOF is a voluntary scheme within the General Medical Services ('GMS') contract comprising of a number of clinical indicators which requires a GMS contractor to meet certain thresholds in patient interventions.

25. The QOF contains three domains which are *'Clinical'*, *'Public health'*, and *'Public health – Additional Services'*. Each domain consists of a set of achievement measures, known as indicators, against which practices score points according to their level of achievement.

26. Mr C outlined that the 2017 to 2018 QOF measured achievement against 77 indicators; practices scored points on the basis of achievement against each indicator, up to a maximum of 559 points. The value of a QOF point in 2017 to 2018 was £171.20. At the end of the financial year, payment is made according to the contractor's achievement across the three domains.

QOF Post Payment Verification ('PPV')

27. NSH England South East's Probity Team undertakes QOF PPV visits to GP contractors and the Practice had been selected for a visit. 5% of GP contractors are randomly selected each year for PPV visits. The process involves non-clinical verification of evidence contained within patient records for 2017 to 2018 to ensure that patient records contain information to meet the respective clinical indicator's criterion.

28. Mr C was assigned to conduct the QOF PPV visit at the Practice. On 12 June 2018, a Counter Fraud Specialist at NHS England emailed Mr C outlining that Mrs A was concerned that a Partner at the Practice had been adding QOF codes to patients that had not been seen. On 12 July 2018, Mr C conducted a QOF PPV visit at the Practice.

Findings

29. The Tribunal made the following findings of fact:

Paragraph 5(a) of the Allegation

30. The Tribunal had regard to Dr Vasistha's admissions, its findings and all the evidence before it. By way of summary the Tribunal had, amongst other things, determined that:

1. Between January 2016 and June 2018 whilst working as a GP Partner at the Practice, he recorded one or more consultations in patient records where consultations had not taken place as set out in the Consultations.

2. At the time of recording the Consultations, Dr Vasistha knew that the Consultations had not taken place, and the Practice would receive Quality and Outcomes Framework payments for achieving targets associated with holding the Consultations.

3. In June 2018, Dr Vasistha deleted one or more of the Consultations from patient records as set out at the Deletions.

4. When Dr Vasistha made the Deletions, he knew the Practice would be subjected to a Post Payment Verification visit by NHS England.

5. Dr Vasistha's actions as set out in number 4 (above) was dishonest.

6. Dr Vasistha's conduct set out in number 1 – 3 (above) was to conceal his conduct.

31. 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.'*

32. The Tribunal considered Dr Vasistha's assertion in his evidence that he had not received adequate training on QOF coding. However, he also explained to the Tribunal that doctors gain experience *"on the job",* and his explanation that he was untrained did not fit with the picture of someone who knew the purpose and nature of QOF. The Tribunal also noted that Dr Vasistha had been using the coding system for quite some time as he had been at the Practice since August 2013. On the balance of probabilities, the Tribunal was of the view this ruled out the probability that Dr Vasistha was untrained.

33. The Tribunal next explored all possible reasons for Dr Vasistha's QOF coding. Primarily, there was no direct benefit to the patients registered with the Practice. In addition, as Dr Vasistha had had no contact with a third of the patients he had QOF coded, there was no reason why he would possibly code them as having had a consultation. The Tribunal found that it was more likely than not that Dr Vasistha's only purpose in coding the entries as consultations was for financial gain for the surgery.

34. The Tribunal considered Dr Vasistha's evidence in which he stated that he had deleted some entries on the system and amended others as he felt *"ashamed"* and *"embarrassed"* by his poor record keeping. The Tribunal was of the view that if Dr Vasistha had genuinely believed that he had made a mistake, and had wanted to correct the clinical records, he would have put notes on the patients' files and alerted his colleagues to the fact that the Practice had received monetary gain when it should not have done.

35. The Tribunal accepted that, whilst anyone can be *"ashamed"* and *"embarrassed"* by making professional mistakes, this did not negate its findings of Dr Vasistha's knowledge of the QOF system at the time. This was further compounded by Dr Vasistha's subsequent behaviour once he knew that his actions were going to come to light, that is the attempt to cover up his wrongdoings instead of approaching his colleagues for assistance.

36. Dr Vasistha compared himself to a junior doctor, but he had been a GP at the Practice since 2013 and became a GP Partner there in 2014, a long way from being an inexperienced doctor. The Tribunal found that as an experienced GP, Dr Vasistha would have thorough knowledge of what constitutes a consultation, how to take adequate notes, use the EMIS system, and the consequence of amending consultation notes.

37. Having therefore found that Dr Vasistha had deliberately amended the patient records knowing that the Consultations had not taken place and that the Practice would

receive QOF payments for it, the Tribunal determined that his actions were calculated and subjectively dishonest.

38. The Tribunal found that ordinary decent people would find that the recording of consultations which did not take place for monetary gain was dishonest.

39. Based on all the evidence, the Tribunal was of the view that it was likely Dr Vasistha was dishonest when he recorded the consultations.

40. Therefore, the Tribunal found Paragraph 5(a) of the Allegation, as it relates to Paragraph 2 of the Allegation, proved.

The Tribunal's Overall Determination on the Facts

41. The Tribunal has determined the facts as follows:

1. Between January 2016 and June 2018 whilst working as a GP Partner at the Grove Medical Centre ('the Practice'), you recorded one or more consultations in patient records where consultations had not taken place as set out in Schedule 1 ('the Consultations').
   Admitted and found proved

2. At the time of recording the Consultations, you knew that:

   a. the Consultations had not taken place;
      Admitted and found proved

   b. the Practice would receive Quality and Outcomes Framework payments for achieving targets associated with holding the Consultations.
      Admitted and found proved

3. In June 2018, you deleted one or more of the Consultations from patient records as set out at Schedule 2 ('the Deletions').
   Admitted and found proved

4. When you made the Deletions, you knew the Practice would be subjected to a Post Payment Verification visit by NHS England.
Admitted and found proved

5. Your actions as set out at:

   a. paragraph 1 were dishonest by reason of paragraph 2;
   Determined and found proved

   b. paragraph 3 were dishonest by reason of paragraph 4.
   Admitted and found proved

6. Your conduct as set out at paragraph 3 was to conceal your conduct as set out at paragraphs 1 – 2 above.
Admitted and found proved

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

Determination on Impairment - 14/12/2021

1. 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 Vasistha's fitness to practise is currently impaired by reason of misconduct.

The Evidence

2. The Tribunal had regard to all of the evidence, both oral and documentary, adduced during the course of these proceedings. Dr Vasistha provided a further bundle of documentation which included, but was not limited to:

- Essay 1 – 'Personal Reflective Essay and Personal Development Plan Summary'
- Essay 2 – 'Reflections on the impact of my actions on patients and maintaining public interest in the medical profession'
- Asthma Review Protocol – August 2021

- Continuing Professional Development and Reflection including clinical and practise related training
- Good practice in record keeping for GPs – 19 December 2020
- Professionalism for doctors: maintaining boundaries - 27 May 2021
- Maintaining Professional Ethics – 21-23 July 2020
- Probity & Ethics in Practice – 23 June 2021
- Professionalism for doctors: ensuring compliance with conduct requirements – 15 September 2021
- Testimonials from colleagues at the Grove Medical Centre

Submissions

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

Submissions on behalf of the GMC

4. Mr Simkin submitted that Dr Vasistha's fitness to practise is currently impaired by reason of his misconduct. He invited the Tribunal to remind itself of its own judgement at the fact-finding stage, and the reasons for its decision as outlined in its determination at that stage.

5. Mr Simkin reminded the Tribunal that it had rejected the account that Dr Vasistha had offered, in respect to the paragraph of the Allegation that he had not admitted.

6. Mr Simkin asked the Tribunal to consider whether Dr Vasistha had brought the medical profession into disrepute, breached fundamental tenets of the profession, and behaved dishonestly. Mr Simkin submitted that fellow doctors would be appalled at the fact that Dr Vasistha had recorded consultations that had not taken place and then sought to hide this fact, and they would consider Dr Vasistha's actions to be wrong and dishonest.

7. Mr Simkin submitted that whilst Dr Vasistha had provided a great amount of evidence in support of the steps he had taken to demonstrate acceptance, contrition and remediation, there was no remediation in relation to the 36 phantom entries he had made on the EMIS system.

8. Mr Simkin submitted that in spite of any remediation or lack of repetition since the index event, Dr Vasistha's misconduct was so serious that public confidence in the profession

and the upholding of standards for members of that profession would be seriously undermined if a finding of impairment was not made.

Submissions on behalf of Dr Vasistha

9. Ms Tanchel submitted that Dr Vasistha accepted his actions and dishonesty constituted serious misconduct. However, there was no issue relating to patient safety and any decision about Dr Vasistha's fitness to practise would be based on public interest alone.

10. Ms Tanchel reminded the Tribunal that the issues proven and accepted by Dr Vasistha commenced over five years ago and that the last activity was more than three years ago. As far as Dr Vasistha's practise was concerned, there had been no issue either prior to, or after, the index incident.

11. Ms Tanchel submitted that Dr Vasistha had provided a robust remediation bundle that demonstrated he was a doctor capable of remediation. He had shown acknowledgement of his failings, that he was able to address his dishonesty, and that he had dug deeply into personal and emotional resources since 2018.

12. Ms Tanchel submitted that Dr Vasistha had, at the time, denied that his entries had fallen below the standard expected of a doctor. However, he accepted the Tribunal's findings, as well as its authority and power, and did not seek to challenge this. Ms Tanchel asserted that a non-reflective doctor would not accept these findings with such humility.

13. Ms Tanchel drew the Tribunal's attention to the list of courses Dr Vasistha had completed, that related to probity and ethics. Ms Tanchel submitted that these were not undertaken as *a 'knee-jerk reaction'*, but as a journey that started in 2018 when Dr Vasistha confronted the serious issues that he had faced at the time.

14. Ms Tanchel further submitted that Dr Vasistha had assumed personal responsibility for his actions, acknowledging these and apologising to colleagues, his appraiser, his mentor, and the Performance Advisory Group (PAG), amongst others. Dr Vasistha was fully aware of the impact of his behaviour on his colleagues and the wider profession.

15. Ms Tanchel drew the Tribunal's attention to the measures Dr Vasistha had put into place to ensure that he would not be vulnerable to dishonesty again. These included ways to cope with pressure and redesigning his work-life balance.

16. Ms Tanchel submitted that the testimonials from Dr Vasistha's Partners at the Practice, written in full knowledge of the Allegations against him, highlighted that he was a humble and highly skilled doctor who was totally committed to patient care and the profession. Dr Vasistha had also provided support in the running of the Practice during the pandemic.

17. Ms Tanchel then addressed the subject of public interest, and what an objective member of public would think if no finding of impairment was to be made. Ms Tanchel submitted that they would not be shocked by this. Instead, they would acknowledge that this misconduct was serious, but that Dr Vasistha is a committed and skilled man who has deeply reflected upon his mistakes and that he has never fallen below standards expected since the incident.

18. Ms Tanchel invited the Tribunal to not find Dr Vasistha's fitness to practise impaired and instead, mark its views by way of a warning. She submitted that if the Tribunal had even a remote concern that the public would be concerned about no outcome for such a serious departure from standards to be expected from a doctor, this would be mitigated by the issuing of a warning.

19. Ms Tanchel referred the Tribunal to relevant case law which is a matter of record.

The Relevant Legal Principles

20. 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.

21. 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.

22. 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 *CHRE v NMC & Grant (2011) EWHC 927 (Admin)* ('Grant'). In particular, the Tribunal considered whether its findings of fact showed that Dr Vasistha's fitness to practise is impaired in the sense that he:

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

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

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

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

23. 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 his 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.

24. The Tribunal had regard to the principles in *Towuaghanste v The GMC [2021] EWHC 681 (Admin)*:

- If a registrant defends an allegation of primary fact by giving dishonest evidence and by deliberately seeking to mislead a tribunal then that conduct is relevant to consideration of impairment and fitness to practise in the future, However, if the registrant does no more than put the regulator to proof, then

that stance should not be held against them during the impairment and sanction stages.

- Where there is no significant gap between the findings of fact and the commencement of the impairment and sanction stages, it is unrealistic to expect a registrant who has unsuccessfully defended the fact-finding stages to demonstrate full remediation almost immediately in the impairment stage, by fully accepting in a genuinely sincere manner everything found against them.

25. The decision on impairment is a matter for the Tribunal's judgment alone. It must give reasons sufficient for the parties to understand why and how it has reached its decision.

Background

26. Between January 2016 and June 2018, Dr Vasistha had recorded 36 consultations in patients' records which had not taken place. Further, at the time of recording these consultations, Dr Vasistha had known the consultations had not taken place and that the Practice would receive monies for them. This has been found to be dishonest. In June 2018 Dr Vasistha had deleted consultations of 11 of these patients, when he knew the Practice would be subject to a Post Payment Verification visit by NHS England. This was admitted and found to be dishonest.

The Tribunal's Determination on Impairment

Misconduct

27. In determining whether Dr Vasistha's fitness to practise is currently impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amounted to misconduct. Misconduct can be found in circumstances where there have been serious departures from expected standards of conduct and behaviour, which can be identified by reference to GMP.

28. 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 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'
65 *'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession'.*

29. The Tribunal considered that Dr Vasistha's dishonest behaviour in recording consultations that did not take place, in effect for financial gain, and then subsequently deleting some of those records would be regarded as serious misconduct to a reasonably informed member of the public. The public rely on doctors to act with honesty and integrity. The Tribunal concluded that Dr Vasistha's actions had breached fundamental tenets of the medical profession including paragraphs 1 and 65.
30. 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 and included two findings of dishonesty.

31. In all the circumstances, the Tribunal found that overall, Dr Vasistha's misconduct amounted to misconduct of a high degree of seriousness.

Impairment by reason of Misconduct

32. Having found that the facts admitted and found proved amounted to misconduct which was serious, the Tribunal went on to consider whether, as a result of this, Dr Vasistha's fitness to practise is currently impaired by reason of his misconduct.

33. 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 are 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.

34. When considering Dr Vasistha's insight into his dishonesty, the Tribunal accepted that he had shown the development of insight in respect to the paragraphs of the Allegation he had admitted and that his reflective pieces and work undertaken mirrored this.

35. The Tribunal took into account the nature of the CPD courses Dr Vasistha had undertaken. These included courses on financial probity, maintaining ethics, and record

keeping. It also took into account the testimonials provided by Dr Vasistha's Partners at the Practice especially that of Dr D who wrote:

> *'I have seen firsthand the training he has undergone and continues to do so. I have also witnessed the deep regret that he has shown, and the extensive measures and processes he has undertaken over the past 2 years to learn from his mistakes. He has passed this knowledge and reflection to all of us at the practice. I hope the General Medical Council can appreciate and understand the profound changes he has made to his practice as a result of these events as much as we do.'*

36. However, the Tribunal was of the view that if Dr Vasistha's insight was fully developed, he would have demonstrated this in his evidence. Contrary to what he said in his reflective pieces, in his oral evidence Dr Vasistha sought to take attention away from his dishonesty by blaming himself for the errors which he said were underpinned by a lack of training.

37. The Tribunal concluded that Dr Vasistha had taken significant steps in addressing certain aspects of his behaviour, and had the potential to gain full insight and there was nothing to suggest he would not do so. The Tribunal had no doubt that Dr Vasistha had shown remorse.

38. The Tribunal recognised that dishonesty is a breach of a fundamental tenet of the profession. Being honest and trustworthy and acting with integrity is at the heart of medical professionalism. It considered that although in some circumstances it is possible for remediation, on the whole dishonesty is difficult to remediate. Dr Vasistha had not fully admitted his wrongdoings and the remorse shown was tainted by the fact that he claimed that some of his actions had been through error and lack of training, which the Tribunal did not accept. The Tribunal accepted that it could not expect insight for the dishonesty that Dr Vasistha had denied.

39. The Tribunal accepted Dr Vasistha's remediation in relation to the relationship between doctor and patient. Dr Vasistha accepted he had jeopardised this trust and had attended relevant courses to remedy this. He stated in his reflective piece:

> *'I have taken full ownership of my admitted dishonesty and have apologised to my peers and colleagues, whom I encounter in my various professional roles. I have been open about my dishonesty with the Practice Patient Participation Group (PPG), who*

represent the patient population of the Surgery; I made a formal apology for my deceitful behaviour at the PPG meeting on 20 October 2021.

Trust underpins the doctor-patient relationship and I will always strive to uphold my patients' trust by practising with honesty and integrity, further endorsing the trust that the public holds in the medical profession.'

40. The Tribunal noted that there had been great focus on the clinical side of remediation, but little shown in respect to the matters of financial gain in this case. Dr Vasistha stated, in his reflective piece:

'In July 2018, I explained to my partners that I had made amendments and deletions in patient records. I apologised for not being up front with them about my actions and informed them that I would take clinical and financial responsibility for any resulting consequences.'

It was clear from Dr Vasistha's statement that he accepted he had falsely made a financial gain for the Practice and was determined to remediate. However, the Tribunal noted that no evidence had been presented to show what financial reimbursement had been made.

41. The Tribunal concluded that overall, while Dr Vasistha had not demonstrated full remediation, he had taken steps towards it. This was not just through the courses undertaken and written reflections but also with the support from his Practice.

42. When assessing the risk of repetition, the Tribunal accepted the developing level of insight and remediation. It also noted that Dr Vasistha had acted dishonestly. He had recorded consultations that hadn't taken place, for financial gain, on several occasions. The Tribunal concluded that at the present time, it was unlikely that this kind of dishonesty would be repeated. However, until Dr Vasistha developed full insight into his wrongdoings, the Tribunal could not say with certainty that repetition was highly unlikely.

43. The public expects to be able to trust doctors. The public expects doctors to act with integrity and not act against patient interests. It expects 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.

44. The Tribunal, in arriving at its conclusion, took into account the large number of consultations that had been dishonestly entered by Dr Vasistha into the EMIS system for financial gain, and the subsequent deletions made by him when he knew that his actions had come to light. The Tribunal noted that if it did not make a finding of impairment, taking into consideration the gravity of the overall misconduct, it would be perverse to not think Dr Vasistha had significantly breached tenets of the overarching objective.

45. While the Tribunal accepted that no harm had been caused to patients, the second two limbs of the overarching objective were engaged and therefore Dr Vasistha's fitness to practice is impaired. The Tribunal is in no doubt that public confidence in the medical profession and the need to uphold proper standards for that profession would be adversely affected if it were not to make a finding of impairment in this case.

46. The Tribunal therefore determined that Dr Vasistha's fitness to practise is currently impaired by reason of misconduct.

Determination on Sanction - 16/12/2021

1. Having determined that Dr Vasistha's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

2. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions

3. At the outset of his submissions, Mr Simkin, on behalf of the GMC, submitted that the GMC application was that Dr Vasistha be erased from the medical register.

4. Mr Simkin reminded the Tribunal that Dr Vasistha's dishonesty ran from 6 June 2016 until 5 June 2018 and the original dishonesty involved in creating 36 *"phantom"* consultations with patients. After this, Dr Vasistha made two attempts to delete his entries in 11 of these patient records on 11 June 2018 and 16 June 2018, immediately after his actions had come to light.

5. Mr Simkin referred the Tribunal to the Sanctions Guidance (November 2020 edition) ('SG'), in particular paragraphs 109, 120, 121, 124, and 125 which state:

'109 Any of the following factors being present may indicate erasure is appropriate

h Dishonesty, especially where persistent and/or covered up

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.

121 In relation to financial and commercial dealings, paragraph 77 of Good medical practice also sets out that:

'You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.'
124 Although it may not result in direct harm to patients, dishonesty related to matters outside the doctor's clinical responsibility (eg providing false statements or fraudulent claims for monies) is particularly serious. This is because it can undermine the trust the public place in the medical profession. Health authorities should be able to trust the integrity of doctors, and where a doctor undermines that trust there is a risk to public confidence in the profession. Evidence of clinical competence cannot mitigate serious and/or persistent dishonesty.

125 Examples of dishonesty in professional practice could include:

a defrauding an employer

b falsifying or improperly amending patient records

c submitting or providing false references

d inaccurate or misleading information on a CV

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

6. Mr Simkin submitted Dr Vasistha's dishonesty was serious, persistent and sustained, with attempts made to cover it up.

7. Mr Simkin submitted that proper regard needed to be paid to the overarching objective in all the circumstances and that the GMC submissions demanded that this be a case for erasure.

8. On behalf of Dr Vasistha, Ms Tanchel submitted that it was not, in law, correct that the GMC make an application for a specific sanction and that it was a matter for submission, entirely for the Tribunal to decide.

9. Ms Tanchel submitted that while she conceded that dishonesty is serious misconduct, there were nuances and levels of seriousness. She did not seek to undermine the findings of fact made by the Tribunal or of the facts admitted by Dr Vasistha however, there was a scale of dishonesty and to approach all dishonesty with the most serious sanction would fetter the discretion of the Tribunal. The Tribunal was obliged to assess where in the framework of dishonesty Dr Vasistha's misconduct fell.

10. Ms Tanchel drew the Tribunal's attention to its observations in its Impairment determination that Dr Vasistha had made no attempts to remediate in relation to financial reimbursement. Ms Tanchel told the Tribunal that no sum had been attributed to Dr Vasistha's behaviour. In addition, the Performance Advisory Group ('PAG') met with the Practice Partners on 16 August 2018 and conceded that the level of financial gain was low but has never been identified. This, therefore, made remediation impossible in this respect.

11. Ms Tanchel submitted that taking no action would not be possible when balancing the public interest against Dr Vasistha's interests and would be neither appropriate nor proportionate. As there were no clinical concerns, a sanction of conditions would not be appropriate.

12. Ms Tanchel submitted that the most appropriate and proportionate sanction in this case was of suspension for the longest possible period of 12 months. This would demonstrate to the public how seriously this kind of misconduct is perceived.

13. Ms Tanchel added that in some cases, submissions were made that the only way to satisfy the public interest was to go for the most severe sanction and that anything less did

not mark the seriousness of the misconduct. Ms Tanchel submitted that this undermined the effect of sanctions.

14. Ms Tanchel submitted that to an objective and well informed member of the public, a suspension of 12 months that has been publicly acknowledged and published on the MPTS website is a serious sanction. It could leave a lasting impression on anyone searching for clinical care and make them aware that Dr Vasistha had fallen below the standards expected of a doctor. Even after the duration of the suspension, the information would be publicly available and affect Dr Vasistha's reputation.

15. Ms Tanchel submitted that a 12 month suspension would be the proportionate way to mark this case and satisfy members pf the public that this was adequate to protect the reputation of the profession, protect them, and to uphold the standards of the profession.

16. Ms Tanchel invited the Tribunal's to consider the mitigating and aggravating factors in this case and also that the Tribunal had given fair acknowledgement and support to some mitigating factors, such as Dr Vasistha's level of insight and remediation and his remorse, in its Impairment determination.

17. Ms Tanchel submitted that the only aggravating factor was the nature of the Allegation, namely that it was one of dishonesty. She reasoned that the Tribunal could not make a finding of dishonesty at the fact-finding stage and then *"double count"* it as an aggravating factor when considering an appropriate sanction.

18. Ms Tanchel drew the Tribunal's attention to the mitigating factors in this case. These included:

- Dr Vasistha's clinical practise and clinical commitment had at no point been called into question
- Dr Vasistha's fitness to practise had not previously been found to be impaired and he had faced no criticism from his regulator either prior to, or since, this case
- The lapse of time since the index events
- The unchallenged evidence relating to Dr Vasistha's personal life and work-related stress, and the impact it may have had on his practise
- The stage of Dr Vasistha's career that he was at
- The unchallenged evidence that Dr Vasistha was a skilled, able, and committed doctor who supported his community and fellow doctors beyond clinical care

- The quality and spread of references and testimonials provided from colleagues who were fully aware of the Allegation and continued to support Dr Vasistha
- Dr Vasistha's continued engagement throughout the investigation process with PAG, the NHS, and the GMC
- Dr Vasistha's levels of remediation, insight and remorse and the low risk of repetition as accepted by the Tribunal in its own determination

The Relevant Legal Principles

19. The legally qualified chair referred to the case of *Giele v GMC (2005) EWHC 2143 (Admin)* which states that it is the wrong approach to immediately say erasure unless there are exceptional circumstances, and the Tribunal must start with consideration of the sanctions from the bottom upwards. First it must consider taking no action, if there are exceptional circumstances. It should next consider whether conditions on the doctor's registration for up to three years would be sufficient and appropriate. Suspension up to 12 months would be the next sanction to consider and finally, only if a suspension is not considered sufficient appropriate, and the misconduct is not fundamentally compatible with continued registration as a doctor, should erasure be considered.

20. The Tribunal should consider the public interest and take into account that if the misconduct is so serious that nothing less than erasure would be considered appropriate even though a doctor may be a highly skilled practitioner, they could still be erased.

21. The Tribunal had regard to the principles of *Awan v GMC (2020) EWHC 1553 (Admin)* which stated that a Tribunal must not impose an enhanced sanction just because a doctor denies part of the Allegation.

22. The Tribunal was cognisant of the principles set out in *Bolton v The Law Society (1993) EWCA 32 (Civ),* namely the reputation of the profession is more important than the fortunes of an individual.

23. When considering sanction, the Tribunal must again have particular regard to the statutory overarching objective:

a. To protect, promote and maintain the health, safety and wellbeing of the public;
b. To promote and maintain public confidence in the medical profession; and
c. To promote and maintain proper professional standards and conduct for

members of that profession.

24. The Tribunal must apply the principle of proportionality; balancing the doctor's interests with the public interest.

25. The purpose of a sanction is not to be punitive although the sanction imposed may have a punitive effect.

26. The Tribunal must consider any relevant mitigating and aggravating factors, giving them appropriate weigh, and address them within the context of the determination.

27. In reaching its decision the Tribunal must consider the Sanctions Guidance. If the Tribunal departs from the Guidance, the relevant paragraph should be referenced, and reasons given for doing so.

28. The legally qualified chair referred to other relevant case law which is a matter of record.

The Tribunal's Determination on Sanction

29. Before considering what action, if any, to take in respect of Dr Vasistha's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

30. When considering the aggravating features, the Tribunal considered the relevant paragraphs of the SG. The Tribunal considered that the nature and seriousness of the actual Allegation spoke for itself in that it encompassed dishonesty that had been sustained and taken place over a period of time, and there had been attempts to cover it up. Although the dishonesty had been for financial gain, this had not been quantified and no claim had been made against Dr Vasistha or the Practice.

31. The Tribunal had regard to Dr Vasistha's developing insight.

32. When considering the mitigating factors of this case, the Tribunal had regard to the relevant paragraphs of the SG.

33. The Tribunal noted Dr Vasistha's developing insight and that since 2018 he had done a substantial amount of work in terms of reflection, remediation and relevant CPD courses.

34. The Tribunal took into account Dr Vasistha's previous good character and that there had been no repetition of the dishonesty since the last incident in June 2018.

35. The Tribunal had regard to the significant lapse in time of five years since the misconduct commenced and over three years since the second and final attempt to cover his wrongdoings. The Tribunal noted that Dr Vasistha has been working as a GP throughout this whole process from investigation stage to coming before the MPTS, and that as far as it was aware there were no concerns over his clinical practice or any clinical failings.

36. The Tribunal took into consideration Dr Vasistha's openness and honesty with his patients and that on 20 October 2021 he apologised in person to the Patient Participation Group ('PPG'). The PPG represents the patient population of the Practice. Dr Vasistha read out a statement to the group expressing remorse for his behaviour and apologised for his dishonesty.

37. The Tribunal accepted that Dr Vasistha had co-operated with the formal enquiry and engaged with his Regulator.

38. The Tribunal also noted that Dr Vasistha had developed protocols such as the Asthma Review Protocol dated August 2021.

39. The Tribunal acknowledged the number and quality of testimonials provided and, in particular, the recent ones from Dr Vasistha's fellow Partners at the Practice. It was clear that Dr Vasistha is regarded as a helpful, dedicated, and competent practitioner.

40. In particular, Dr D in his email dated 13 December 2021 wrote:

> *"I am the senior partner at The Grove Medical Centre, working here full time for the past 32 years, providing 9 clinical patient sessions per week. In that time I have worked with 20 salaried and GP partners, and have been involved directly in the clinical and educational supervision of over 30 GP trainees. I am told that I am now the longest serving full time GP in North West Surrey. I therefore feel that my experience and knowledge of Primary Care is as extensive as any clinician or administrator.*
>
> *In my time at the Grove Medical Centre I have worked with excellent staff. I can honestly say that in Dr Amit Vasistha I have seen a GP who is totally committed to the*

ethos of Primary Care, of being a family doctor. In the 9 years we have worked together, I have seen a degree of engagement with patients and colleagues that I haven't seen before. He is so popular with his patients and our staff. He has already developed a patient 'following', with many prepared to wait many days to ensure a consultation with him. Having observed his consulting style, he engages with his patients in a very real patient centred way. His level of clinical knowledge is impressive, as is shown by feedback I receive from patients and our GP trainees alike. In the 9 years working at The Grove he has developed into a true family doctor.

In my work with Dr Vasistha I have found him totally professional and utterly trustworthy. I have no concerns at all with regards his honesty which I know is absolute. He is at all times committed to the practice and his patients. He is always keen to learn and develop, and to pass on his knowledge to all. His skills have helped to develop both the practice and our PCN, of which he is the clinical lead, in addition to his full time clinical responsibilities. He has overseen massive changes in both and helped improve patient focused services and continues to do so."

No action

41. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Vasistha's case, the Tribunal first considered whether to take no action. The Tribunal considered that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

42. The Tribunal has determined that given the gravity of the facts found proved, and the absence of any exceptional circumstances in this case, taking no action was neither appropriate, proportionate nor in the public interest.

Conditions

43. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Vasistha's registration. The Tribunal took account of paragraph 85 of the SG which states:

'*85 Conditions should be appropriate, proportionate, workable and measurable.'*

44. The Tribunal took into consideration its findings at the impairment stage that that this was a case of dishonesty and concluded that conditions would not address the seriousness of the case at all and therefore would not be appropriate, proportionate, or workable.

Suspension

45. In considering whether to impose a period of suspension, the Tribunal had regard to paragraphs 91 and 92 which state:

> *'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> *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 (i.e., 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).'*

46. The Tribunal was able to balance the seriousness of the dishonesty with the significant amount of work Dr Vasistha had done since, in respect of remediation, reflection and insight. The Tribunal had regard to the fact that Dr Vasistha did not conceal the Allegation or investigation from his colleagues or patients. Even with the full knowledge of what he had done his colleagues and patients still looked to him for support and trusted him, going so far as to appoint Dr Vasistha as the Primary Care Network Clinical Director not only for his Practice but for others.

47. The Tribunal took into consideration paragraph 93 of the SG which states:

> *'93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions.'*

It acknowledged that Dr Vasistha had taken steps to mitigate his actions and that it found it unlikely that he would repeat his dishonesty.

48. The Tribunal also considered paragraph 97 (a), (e), (f), and (g) which state:

> *'**97** Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> ***a** A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
>
> ***e** No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> ***f** No evidence of repetition of similar behaviour since incident.*
>
> ***g** The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

49. The Tribunal took into consideration that this was potentially a case on the cusp of the maximum length of suspension, and erasure. Dr Vasistha had altered 36 patient records, deleted 11 of these records and there were two counts of dishonesty, in effect fraud, over a period of time. Balancing this with the steps taken to remediate, the developing insight, the strength of colleague testimonials and patient loyalty to a highly skilled doctor, the Tribunal recognised that a sanction of erasure would mean a loss to the medical profession and public, if Dr Vasistha were not able to practise.

50. The Tribunal was satisfied that Dr Vasistha's misconduct was so serious that significant action had to be taken to maintain public confidence in the profession and to maintain proper professional standards, whilst acknowledging that there were no patient safety issues.

51. The Tribunal was satisfied that a sanction of suspension might send the appropriate message to the profession and the wider public interest that such misconduct is unacceptable, but the Tribunal considered that having regard to the seriousness of Dr Vasistha's misconduct, it should consider erasure before determining whether suspension was sufficient.

Erasure

52. The Tribunal acknowledged that dishonesty can normally regarded as incompatible with continued registration and could justify the sanction of erasure.

53. The Tribunal took into account paragraphs 109 (a), (b), (c), (d), and (h), and 128 of the SG which state:

> *'109 Any of the following factors being present may indicate erasure is appropriate.*
>
> *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.*
> *c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients.*
> *d Abuse of position/trust.*
> *h Dishonesty, especially where persistent and/or covered up.*
>
> *128 Dishonesty, if persistent and/or covered up, is likely to result in erasure.'*

54. The Tribunal has found that in this case there had been a particularly serious departure from the principles set out in GMP as well as a deliberate and reckless disregard for them. While there had been no serious harm caused to others, Dr Vasistha had abused his position of trust.

55. The Tribunal acknowledged that the facts did point to persistent dishonesty that had been covered up but were confined to a specific area of Dr Vasistha's practice. However, the Tribunal had to consider the bigger picture painted by the mitigating factors and the passage of time. Since the time of the events, Dr Vasistha had done the complete opposite of covering up his dishonesty by being extremely open and transparent and evidence had been

put forward that attested to his change in attitude and mindset, as shown by the testimonials, training and reflections. Dr Vasistha has maintained the trust and confidence of patients and colleagues who are in full knowledge of his dishonesty.

56. The Tribunal concluded that there was a fine balance between a sanction of suspension and erasure in this case. The Tribunal, after considerable thought and deliberation, was satisfied that the balance fell slightly in favour of a suspension order. In reaching that decision, the Tribunal took into account Dr Vasistha's otherwise good character and unblemished medical career. Although Dr Vasistha had not fully developed his insight, it is found he has the potential for full insight, and it is unlikely his misconduct would be repeated. He is a highly regarded clinician. It noted the lack of repetition. Therefore, his misconduct was not fundamentally incompatible with continued registration.

57. The Tribunal was satisfied that a period of suspension was proportionate in all of the circumstances and more appropriate than erasure.

Duration of Suspension

58. The Tribunal went on to consider the length of suspension, taking into account paragraph 100 of the SG which states:

> *'100 The following factors will be relevant when determining the length of suspension:*
> *a the risk to patient safety/public protection*
> *b the seriousness of the findings and any mitigating or aggravating factors (as set out in paragraphs 24–60)*
> *c ensuring the doctor has adequate time to remediate.'*

59. The Tribunal has found that Dr Vasistha's misconduct was serious to such an extent that it just fell short of erasure. Therefore, it was necessary to consider a lengthy suspension order despite the remediation and insight in this case. In addition, it was satisfied that a shorter suspension order would not maintain public confidence or uphold proper professional standards for members of the profession.

60. Accordingly, the Tribunal concluded that a suspension of 12 months was the appropriate and proportionate sanction in this case.

Review Hearing Directed

61. The Tribunal determined to direct a review of Dr Vasistha's case. A review hearing will convene shortly before the end of the period of suspension unless an early review is sought. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Vasistha to demonstrate how he has remediated and developed insight. It therefore may assist the reviewing Tribunal if Dr Vasistha provides:

- Evidence he has kept his medical skills and knowledge up to date
- Evidence of further relevant training and CPD
- Further reflections in relation to his misconduct
- Relevant testimonials

Further, Dr Vasistha will also be able to provide any other information that he considers will assist the reviewing Tribunal.

Determination on Immediate Order - 16/12/2021

1. Having determined that Dr Vasistha's registration be suspended for a period of 12 months, the Tribunal considered, in accordance with Rule 17(2)(o) of the Rules, whether his 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 Simkin submitted that an immediate order is necessary in this case given the facts of this case. He directed the Tribunal to the SG at paragraphs 172 following when making its determination. He submitted that whilst Dr Vasishta does not pose a risk to patient safety, an immediate order is necessary to uphold public confidence in the medical profession.

4. Ms Tanchel submitted it is not necessary for an immediate order given the current COVID-19 pandemic and the requirement for doctors to be on front line. She submitted that

"the public would feel that they would rather be inoculated by a doctor who is dishonest than not at all".

5. Ms Tanchel reminded the Tribunal of the time that has lapsed since these events arose. She submitted that it is very easy to fall into the trap that the public interest can only be served if an immediate order is imposed. For the reasons set out in the Tribunal's determination on sanction, she submitted that the recognition of the hard work Dr Vasistha has done in gaining insight and specifically of relevance the fact there are already members of the public and patients who are aware of the Dr Vasistha's wrong-doing and are being treated by him.

6. Ms Tanchel reminded the Tribunal that there are no patient safety issues in this case.

The Tribunal's Decision

7. 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.

8. The Tribunal had regard to the SG and reiterated that the 12 months suspension imposed by the Tribunal marks the seriousness of Dr Vasistha's misconduct. The public interest does not require an Immediate Order of suspension; the substantive sanction is sufficient to satisfy the overarching objective. Further, as there were no patient safety risks in this case, the Tribunal determined that an immediate order is not necessary.

9. The substantive direction for suspension will take effect 28 days from when the written notice is deemed to have been served upon Dr Vasistha, unless an appeal is lodged in the interim. If Dr Vasistha does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

10. There is no interim order to revoke.

11. That concludes this case.

ANNEX A – 11/11/2021

Application under Rule 34(1) – 11/11/2021

1. On Day 1 of the hearing, Ms Tanchel, on behalf of Dr Vasistha, made an application under Rule 34(1) of the Rules to admit further evidence in the form of notes ('the Notes') made by Dr Vasistha in November 2018 in relation to Dr B's audit.

Submissions

2. Ms Tanchel submitted that there had already been a discussion between Mr Simkin and herself regarding the Notes. She submitted that the Notes are fair and relevant and can be admitted as the Notes set out Dr Vasistha's explanations and reasoning to each entry made in the Schedules of the Allegation, and furthermore they were made by Dr Vasistha contemporaneously.

3. Mr Simkin submitted that the Notes should be admitted, as it is a memory referring document that specified a number of comments and entries made by Dr B. Furthermore, he submitted that if the Notes are admitted, that it should be in advance of Dr B's oral evidence so that she may assimilate the document fully and provide her evidence accordingly.

The Tribunal's Decision

4. The Tribunal had regard to the questions of fairness and relevance, in order with Rule 34(1) of the Rules:

> 'The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'

5. In reaching its decision, the Tribunal accepted the submissions of Ms Tanchel and Mr Simkin. It noted that neither party had opposed either application.

6. The Tribunal determined that the Notes were relevant and fair, as it directly referred to the Allegation Dr Vasistha faced and considered that it would be assisted by contemporaneous Notes for future Tribunal deliberation. Therefore, the Tribunal determined to grant Ms Tanchel's application for the admission of the Notes.

ANNEX B – 12/11/2021

Application under Rule 17(6) – 12/11/2021

1. On behalf of the GMC, Mr Simkin made an application under Rule 17(6) of the Rules, to amend Schedule 1 and 2 of the Allegation by way of three deletions due to duplicate entries.

Schedule 1

NHS England records Audit		
QOF indicator	Patient identifier	Date of consultation
Asthma	16	12/3/18
Asthma	25	26/3/18

Schedule 2

NHS England records Audit		
QOF indicator	Patient identifier	Date of consultation
Asthma	25	26/3/18

2. Ms Tanchel, on behalf of Dr Vasistha, did not oppose the deletions as it was fair to do so.

Tribunal's Decision

3. The Tribunal was mindful of paragraph 17(6) of the General Medical Council's (Fitness to Practise) Rules 2004, as amended, (the Rules) which states:

> *'17(6) Where, at any time, it appears to the Medical Practitioners Tribunal that —*
>
> > *(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and*
> >
> > *(b) the amendment can be made without injustice,*
>
> *it may, after hearing the parties, amend the allegation in appropriate terms'.*

4. The Tribunal considered that this amendment would more accurately reflect the evidence it had received and could be made without injustice. Therefore, it determined to grant the application from the GMC.

ANNEX C – 12/11/2021

Application under Rule 17(2)(g) – 12/11/2021

1. On Day 2 of the hearing, following the closing of the GMC's case, Ms Tanchel, on behalf of Dr Vasistha, made an application, under Rule 17(2)(g) of the Rules which states:

> *'17(2) The order of proceedings at the hearing before a Medical Practitioners Tribunal shall be as follows —*
>
> *[…]*
>
> *(g) 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;'*

2. Ms Tanchel submitted that the GMC had failed to adduce sufficient evidence upon which the Tribunal could find Paragraph 5(a) of the Allegation proved.

Submissions

3. The following is a non-exhaustive summary of the submissions made.

Submissions on behalf of Dr Vasistha

4. Ms Tanchel drew the Tribunal's attention to the two-part test in *R v Galbraith [1981] 2 All ER 1060*. Ms Tanchel submitted that both parts are engaged, namely that no evidence has been provided to the Tribunal by the GMC and the evidence is so tenuous and vague that the GMC has failed to present sufficient evidence to support the facts alleged in Paragraph 5(a) of the Allegation. She submitted as such, the case in respect of that Paragraph 5(a) of the Allegation should be stopped.

5. Ms Tanchel submitted that Dr B's audit looked at whether the information and coding from Dr Vasistha was correct. She stated that Dr B had restrictions as to what she was identifying. She submitted that the evidence of Dr B changed over cross-examination. Dr B's original position was that she considered all the evidence however it changed once matters concerning Docman was raised, and Dr B subsequently could not remember what had been provided to her.

6. Ms Tanchel referred to the correct test for dishonesty as set out in the case of *Ivy v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] UKSC 67*, and stated that whilst Dr Vasistha accepted that it was wrong to input consultations that did not exist, she submitted that it was of particular significance that he did not intend it to be dishonest.

7. Ms Tanchel submitted that the burden of proof is on the GMC and to reverse the burden of proof to Dr Vasistha would be wrong. She submitted that the Tribunal need to make inferences on the evidence that the GMC have provided and referred to the *'Soni principle'* from *Soni v GMC [2015] EWHC 364 (Admin)* regarding the proper drawing of inferences. Considering that dishonesty is serious, there is a need for cogent evidence, and the Tribunal is required to consider the full circumstances of the case. In all the circumstances, Ms Tanchel submitted the GMC has not produced any evidence or sufficient evidence which the Tribunal can infer Dr Vasistha was dishonest, to support the allegation at Paragraphs 5(a) of the Allegation.

Submissions on behalf of the GMC

8. Mr Simkin submitted that the fact that that Paragraph 2 of the Allegation has been admitted by Dr Vasistha and found proved, provided the Tribunal with the framework to begin inferring that dishonesty had been present. This is supported by the written and oral evidence of Dr B. He also submitted that the Tribunal must also take into account the evidence of Ms A and Mr C, both of which support Dr B' findings.

9. Mr Simkin submitted that all the evidence leads to finding that there are 45 *'phantom'* appointments that were created and 15 of which were deleted after the date that Mr C had emailed the practice. He submitted that so far as the case of Galbraith was concerned, limb two has been accounted for and there is sufficient evidence available so far. He submitted that there was no reversal of the GMC's burden of proof, and it would be reasonable for the Tribunal to proceed and infer that dishonesty was committed.

The Relevant Legal Principles

11. The Tribunal had regard to the case of *Galbraith* which sets out a two-part test to follow in order to ascertain the strength of the GMC's evidence. It states (wording adapted for use in fitness to practise hearings):

> *'How then should the Tribunal approach a submission of 'no case'?*
>
> *(1) If there is no evidence that the fact alleged has been committed by the medical practitioner, there is no difficulty. The Tribunal will of course stop the case.*
>
> *(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
> *(a) Where the Tribunal comes to the conclusion that the GMC evidence, taken at its highest, is such that a properly directed Tribunal could not properly find the fact proved upon that evidence, it is the Tribunal's duty, upon a submission being made, to stop the case in relation to that alleged fact.*

(b) Where however the GMC evidence is such that its strength or weakness depends on the view to be taken of a witness' reliability, or other matters which are generally speaking within the province of the Tribunal, and where on one possible view of the facts there is evidence upon which a Tribunal could properly find the fact proved, then the Tribunal should not make a direction of no case to answer.'

10. The Legally Qualified Chair referred to the case of *Ivy and Genting*. Paragraph 74 states:

'74. These several considerations provide convincing grounds for holding that the second leg of the test propounded in Ghosh does not correctly represent the law and that directions based upon it ought no longer to be given. The test of dishonesty is as set out by Lord Nicholls in Royal Brunei Airlines Sdn Bhd v Tan and by Lord Hoffmann in Barlow Clowes: see para 62 above. 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'.

11. The Tribunal accepted the legal advice given in all respects and has approached its deliberations in line with that advice. It has had regard to the particular circumstances in this case and the further judgments brought to its attention in the legal advice given:

- *Soni v GMC [2015] EWHC 364 (Admin)* – The Tribunal needed to safely exclude as less than probable, any possible explanation for the doctor's conduct; and
- *Fish v GMC [2012] EWHC 1269 (Admin)* – Need for solid grounds of dishonesty.

12. The Legally Qualified Chair referred to the case of *Byrne v GMC [2021] EWHC 2237 (Admin)*. Mr Justice Morris at paragraph 22 stated:

'The standard of proof to be applied by the Tribunal and by this Court is the civil standard of balance of probabilities. As regards the position where the allegations, or the consequences for the person concerned, are particularly serious, the Appellant referred me to Casey at §16, suggesting that there is a need for a "heightened examination of the evidence". It was common ground that the correct approach is as set out in my judgment in O v Secretary of State for Education at §66. In that case, after referring to the relevant House of Lords and Supreme Court authorities (Re B and Re S-B) (which in turn referred to Re Doherty cited in Casey), I summarised the position as follows:

(1) There is only one civil standard of proof in all civil cases, and that is proof that the fact in issue more probably occurred than not.

(2) There is no heightened civil standard of proof in particular classes of case. In particular, it is not correct that the more serious the nature of the allegation made, the higher the standard of proof required.

(3) The inherent probability or improbability of an event is a matter which can be taken into account when weighing the probabilities and in deciding whether the event occurred. Where an event is inherently improbable, it may take better evidence to persuade the judge that it has happened. This goes to the quality of evidence.

(4) However it does not follow, as a rule of law, that the more serious the allegation, the less likely it is to have occurred. So whilst the court may take account of inherent probabilities, there is no logical or necessary connection between seriousness and probability. Thus, it is not the case that "the more serious the allegation the more cogent the evidence need to prove it".

This is the direction which could be given in due course.

The Tribunal's Decision

13. The Tribunal had regard to the relevant legal principles and considered all of the evidence that had been presented by the GMC at the close of its case. It took into account the directions it might receive if properly directed.

14. The Tribunal kept foremost in its mind that it is not making findings of fact. At this stage, the Tribunal must confine its considerations to whether there is a case to answer specifically to Paragraph 5(a) of the Allegation and to determine the sufficiency of the evidence provided to it of potential dishonesty.

15. The Tribunal considered Paragraph 5(a) of the Allegation and relied on the evidence of Dr B and her audit report that detailed the consultations that Dr Vasistha recorded but did not take place. Furthermore, it took into account the uncontested evidence from Mr C's witness statement, dated 4 July 2018, that the practice would receive payments for the consultations:

'The 2017/18 QOF measured achievement against 77 indicators; practices scored points on the basis of achievement against each indicator, up to a maximum of 559 points. The value of a QOF point in 2017/2018 was £171.20. The number of points for each domain and clinical indicator varies. For example, clinical indicator Asthma 003 is the percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using 3 RCP questions – payment stages 45-70% - points available 20. At the end of

the financial year, payment is made according to the contractor's achievement across the three domains.'

16. The Tribunal bore in mind the evidence from the GMC, and it considered that the GMC has provided sufficient evidence that there were consultations recorded that did not take place. It found that it could reasonably infer Dr Vasistha's state of mind that he knew that the consultations had not taken place at the time he recorded them. Further, he knew that Grove Practice would receive Quality and Outcome Framework payment for these consultations. It considered that ordinary decent people could at this stage regard this as dishonest.

17. The Tribunal accepted the *'Soni Principle'* but at this stage on the evidence it has received could not safely exclude other possibilities.

18. Taking all the evidence provided to it at this stage of the proceedings into account, the Tribunal determined that there was sufficient evidence in this case available that it *might* find dishonesty. The Tribunal considered it would be reasonable to infer that Dr Vasistha might have been dishonest. However, the Tribunal was mindful that it could only determine that in the future once it has received all evidence from both parties, namely the oral evidence from Dr Vasistha.

19. Accordingly, the Tribunal refused the application made on Dr Vasistha's behalf under Rule 17(2)(g) for Paragraph 5(a) Allegation not to be proceeded with any further.

The Rule 17(2)(g) application is therefore not upheld in relation to Paragraph 5(a) of the Allegation.

Schedule 1

Internal review at the Practice		
QOF indicator	Patient identifier	Date of consultation
Rheumatoid arthritis	[none]	7/5/16
Asthma	[none]	6/9/16
Asthma	[none]	16/2/17
Rheumatoid arthritis	[none]	6/6/17
Asthma	[none]	12/6/17
Asthma	[none]	11/7/17
Asthma	[none]	17/7/17
Rheumatoid arthritis	[none]	17/7/17
Asthma	[none]	27/7/17
Asthma	[none]	18/9/17

Cancer	[none]	20/09/17
Asthma	[none]	16/10/17
Asthma	[none]	30/4/18
Cancer	[none]	5/6/18
Asthma	[none]	2/5/18

NHS England Post Payment Verification report		
QOF indicator	Patient identifier(s)	Date of consultation
Asthma	6060 / 604139	22/5/17
Diabetes mellitus	8953	29/1/18
Coronary heart disease	0811 / 25813	6/2/18
Asthma	21526	2/3/18
Asthma	41450	26/3/18
Learning disabilities	6103	9/5/18

NHS England records Audit		
QOF indicator	Patient identifier	Date of consultation
Asthma	1	17/7/17
Asthma	2	6/9/16
Asthma	3	12/6/17
Asthma	4	12/3/18
Asthma	7	12/3/18
Asthma	8	12/3/18
Asthma	9	17/7/17
Asthma	10	16/10/17
Cancer	11	20/9/17
Cancer	12	5/6/18
Asthma	13	6/2/17
Rheumatoid Arthritis	14	6/6/17
~~Asthma*~~	~~16~~	~~12/3/18~~
Asthma	17	18/1/16
Smoking	18	6/6/17
Asthma	19	27/2/17
Asthma	20	2/5/18
Asthma	21	26/3/18
Asthma	22	27/7/17

Asthma	24	17/2/17
~~Asthma*~~	~~25~~	~~26/3/18~~
Asthma	26	1/6/17
Asthma	27	6/6/16
Asthma	28	11/7/17
Asthma	29	3/4/17
Asthma	30	18/7/17

*Withdrawn under Rule 17(6)

Schedule 2

Internal review at the Practice		
QOF indicator	Patient identifier	Date of consultation
Asthma	[none]	11/7/17
Asthma	[none]	17/7/17
Asthma	[none]	27/7/17
Asthma	[none]	18/9/17
Asthma	[none]	2/5/18

NHS England Post Payment Verification report		
QOF indicator	Patient identifier	Date of consultation
Asthma	21526	2/3/18
Asthma	41450	26/3/18

NHS England records Audit		
QOF indicator	Patient identifier	Date of consultation
Asthma	1	17/7/17
Asthma	20	2/5/18
Asthma	21	26/3/18
Asthma	22	27/7/17
Asthma	24	17/2/17
~~Asthma*~~	~~25~~	~~26/3/18~~
Asthma	26	1/6/17
Asthma	27	6/6/16
Asthma	28	11/7/17

*Withdrawn under Rule 17(6)