Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 12/11/2018 - 23/11/2018

Medical Practitioner's name: Dr Andrew Hilton

GMC reference number: 3476062

Primary medical qualification: MB BS 1991 University of London

Type of case
New - Misconduct

Outcome on impairment
Not Impaired

Summary of outcome
No warning

Tribunal:

Legally Qualified Chair	Ms Angela Black
Lay Tribunal Member:	Mr Darren Shenton
Medical Tribunal Member:	Dr Alan Shepherd

Tribunal Clerk:	Mr Sewa Singh

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Andrew Hurst, Counsel, instructed by DWF Solicitors
GMC Representative:	Mrs Chloe Fordham, 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 - 21/11/2018

Background

1. Mr Hilton qualified with MBBS in 1991 from the University College Hospital (University of London). Following pre-registration, he began specialist training in orthopaedic and spinal surgery. Mr Hilton obtained a FRCS in trauma and orthopaedic surgery in 2004. This was followed with a year's fellowship in spinal surgery at the Royal National Orthopaedic Hospital before taking up a substantive consultant post at Dorset County Hospital in 2005. Mr Hilton also undertakes private work at the BMI Winterbourne Hospital in Dorchester and the BMI Harbour Hospital ('the Hospital') in Dorset. Mr Hilton has been on the GMC's specialist register for trauma and orthopaedic surgery since 2005. All of his work involves managing patients with spinal conditions.

2. In March 2014, Mr Hilton performed a L2/3 fusion procedure on a private patient ('Patient A') at the Hospital. He did not recognise either intra- or post- operatively that the right L2 screw ('the Screw') was out of place, and as a consequence, did not discuss this with Patient A until Patient A made a formal written complaint on 19 July 2016.

3. Patient A had self-referred to the Hospital in July 2013 where he presented with low back pain. He consulted Mr Hilton who initially diagnosed a simple muscle strain and referred Patient A for physiotherapy. Mr Hilton also arranged for him to undergo an x-ray and a MRI scan. At the next review consultation on 24 July 2013, Mr Hilton noted some facet joint degeneration at L4/5 and L5/S1. It was agreed with Patient A that a 'watch and wait' approach would be adopted to see if Patient A's symptoms settled. At the next review in September 2013, Patient A presented with ongoing back pain and Mr Hilton noted, on examination, that Patient A's back was tender over the lower facets at L4/5 and L5/S1 levels. Mr Hilton administered facet joint injections to Patient A at these levels on 11 September 2013 and referred him for follow-up physiotherapy, with a review in six weeks. This took place on 25 October 2013. However, on 11 December 2013, Patient A re-presented with recurrent symptoms and Mr Hilton repeated the facet joint injections on 18 December 2013. Patient A attended a follow-up appointment on 21 January 2014.

4. Patient A re-presented on 19 March 2014 saying that he had been well but then his back pain returned despite his compliance with physiotherapy treatment. Mr Hilton arranged for Patient A to undergo x-rays and noted that flexion/extension x-rays demonstrated a retrolisthesis at L2/3, and that on examination Patient A was tender at this level. Mr Hilton explained the risks and benefits associated with surgery and Patient A agreed to undergo spinal fusion. Mr Hilton told Patient A that there was a 70% chance that his pain could be reduced by 50% or more. This procedure was carried out on 26 March 2014. Patient A was discharged from the Hospital on 28 March 2014. Patient A

was reviewed in out-patients by Mr Hilton on 16 April 2014 and 19 September 2014 before being discharged from Mr Hilton's care following final review on 20 March 2015.

5. Patient A's treatment was being funded by Aviva. Patient A was experiencing further back spasms and pain following discharge by Mr Hilton and therefore rang Aviva who arranged a consultation with Mr B. An MRI scan was taken. Patient A was seen by Mr B on 19 April 2016 and he was referred for a CT and bone scan. At a consultation with Mr B on 1 June 2016 Patient A was shown the scan results and told the screw was not in the bone. Revision surgery was proposed but delayed due to Patient A's holiday commitments.

6. In the meantime, on 19 July 2016 Patient A wrote a letter of complaint to Mr Hilton. He asked for explanations from Mr Hilton as to why the screw was incorrectly positioned and there had been a failure of fusion elsewhere. He asked how this had gone unnoticed.

7. Having received no response from Mr Hilton, Patient A wrote to BMI on 19 August 2016 enclosing his letter of complaint to Mr Hilton. He also sent a reminder letter to Mr Hilton on 19 August 2016.

8. Mr Hilton responded by (dictated but unsigned) letter of 25 August 2016. He accepted the screw "may not be in full contact with bone". He offered to meet Patient A to talk about his "grievances".

9. On 27 September 2016 Mr B carried out revision surgery.

10. On 3 October 2016 Patient A emailed the Quality and Risk Manager at the hospital reiterating his complaint about the spinal fusion by Mr Hilton.

11. A meeting took place on 2 November 2016 with Patient A and his wife, Mr Hilton, the BMI Quality and Risk Manager and two other members of hospital staff, including a notetaker. At that meeting Mr Hilton said he had known about the misplaced screw post-operatively; he had not wanted to worry Patient A and that he had adopted a watch and wait approach.

12. Towards the end of that meeting Patient A asked for financial compensation from Mr Hilton. Mr Hilton asked him to email him about this which Patient A did. Mr Hilton did not respond.

13. Initial concerns were raised with the GMC by Patient A in an email dated 26 November 2016.

The Allegation and the Doctor's Response

14. The Allegation made against Mr Hilton is as follows:

1. On 26 March 2014 you performed a L2/3 fusion procedure ('the Procedure') on Patient A.
Admitted and Found Proved

2. Between 26 March and 29 March 2014, following the Procedure you:

a. failed to adequately review Patient A's imaging, in that you failed to recognise that the right L2 screw ('the Screw') was out of place;
To be determined

b. deliberately failed to advise Patient A that the Screw was misaligned;
To be determined

c. failed to record that you had recognised that the Screw was out of place.
To be determined

3. Between 16 April 2014 and 20 March 2015 you consulted with Patient A and you:

a. failed to adequately review Patient A's post-operative imaging, in that you failed to recognise that the Screw was out of place;
To be determined

b. deliberately failed to advise Patient A that the Screw was misaligned;
To be determined

c. failed to record that you had recognised that the Screw was out of place;
To be determined

d. failed to request a CT scan to confirm the position of the screw.
To be determined

4. On 14 May 2014 you consulted with Patient A and you recorded that Patient A's x-ray was satisfactory.
Admitted and Found Proved

5. On 19 September 2014 you consulted with Patient A and you recorded Patient A's x-ray as demonstrating a good position of implants.
Admitted and Found Proved

6. On 20 March 2015 you consulted with Patient A and you:

   a. recorded Patient A's x-ray as demonstrating a good position of implants;
   Admitted and Found Proved

   b. inappropriately dismissed Patient A's symptoms including:

      i. back pain;
      To be determined

      ii. discomfort;
      To be determined

   c. failed to act upon Patient A's increased level of pain, in that you failed to revisit Patient A's x-rays;
   To be determined

   d. failed to record Patient A's symptoms accurately.
   To be determined

7. During a meeting with Patient A at Harbour Hospital on 2 November 2016, you said that you were aware, post-operatively, that one screw was lateral but did not wish to worry Patient A and had therefore adopted a watch and wait decision, or words to that effect, and that statement was:

   a. untrue;
   To be determined

   b. you knew it to be untrue.
   To be determined

8. The information which you entered into Patient A's records as referred to in paragraphs 4, 5 and 6a:

   a. was untrue;
   To be determined

   b. you knew to be untrue.
   To be determined

9. Your actions as described at paragraphs 2b, 2c, 3b, 3c, 4, 5, 6a, 7 and 8 were dishonest.
To be determined

The Admitted Facts

15. On 13 November 2018 (day two) of the proceedings and through his counsel, Mr Andrew Hurst, Mr Hilton admitted paragraphs 1, 4, 5 and 6(a) of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

16. In light of Mr Hilton's response to the Allegation made against him, the Tribunal was required to determine the outstanding paragraphs of the Allegation and whether Mr Hilton's actions, as found proved, were dishonest.

Factual Witness Evidence

17. The Tribunal received, on behalf of the GMC, a written statement from Patient A and heard his oral evidence. It also received three reports and oral evidence from Mr C, expert witness for the GMC.

18. The Tribunal received the report and oral evidence of Miss D, expert witness for Mr Hilton.

19. Mr Hilton provided his own witness statement, undated, and also gave oral evidence at the hearing.

Documentary Evidence

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

- Patient A's initial complaint to the Hospital;
- Patient A's SPECT-CT scans and X-rays;
- Copy of private clinical notes made by Mr Hilton;
- Copy of Patient A's medical records provided by the Hospital;
- Patient A's medical records provided by Bournemouth Nuffield Hospital;
- Patient A's GP records;
- A chain of email correspondence between Patient A and the Hospital;
- Mr C's initial report dated 21 July 2017 and his supplementary reports dated 2 October 2017 and 18 May 2018;
- Miss D's report dated 8 November 2018.

The Tribunal's Approach

21. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Mr Hilton does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

22. In paragraphs 2, 3, 6c and 6d of the GMC allegation, it is alleged that Mr Hilton failed to provide good clinical care owing to his actions. The Tribunal adopted a two-step approach to its deliberations on those allegations. First, it determined whether or not the alleged action had occurred as a matter of fact. In the event it found that the alleged action had occurred, it went on to decide whether there was a requirement upon Mr Hilton to undertake the action.

23. It is alleged that Mr Hilton's actions in relation to paragraphs 2b, 2c, 3b, 3c, 4, 5, 6a, 7 and 8 were dishonest. The Tribunal adopted the test for determining dishonesty which is set out in the case of *Ivey (Appellant) v Genting Casinos (UK) Ltd t/a Crockfords (Respondent) [2017] UKSC 67*, which states:

> '1. 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.
>
> 2. 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.'

24. The Tribunal heard oral evidence from Patient A, Mr C, Miss F and Mr Hilton. The Tribunal found, with regard to each witness, as follows:

> Patient A: The Tribunal found Patient A to be an intelligent and knowledgeable individual who fully understood what he was told by Mr Hilton about the spinal fusion procedure and its anticipated outcome. He has significant knowledge of litigation and complaints processes as a result of his former role as an Insurance Broker.
>
> The Tribunal found Patient A to be a confident witness who answered questions in an assertive manner. However, he was sometimes guarded in his answers and evasive. His account of what took place during the consultations with Mr Hilton was not balanced. Patient A was reluctant to make concessions. For example, he

did not initially accept that Mr Hilton had informed him of the percentage rate of success of this type of procedure. This was despite his having no concerns in his witness statement about Mr Hilton's consultation note which refers specifically to Mr Hilton having informed him of the prospects of success. Patient A was not open-minded and his evidence was tainted by the outcome of the revision surgery by Dr B. Patient A appeared to attribute continuing symptoms principally to the procedure carried out by Mr Hilton, whereas the x-ray reports and physiotherapy notes refer to his having a degenerative spine. During his evidence, Patient A told the Tribunal that if Mr Hilton had paid him the compensation he sought, he would not have reported Mr Hilton to the GMC.

Mr Hilton: The Tribunal found Mr Hilton to be a credible and reliable witness. His account of events was consistent throughout. He accepted that he had made a mistake in that the Screw was misaligned and not in the pedicle. The Tribunal considered Mr Hilton was straightforward in his evidence to the Tribunal. His account of what took place during the consultations with Patient A is largely consistent with other clinical records such as physiotherapy notes and GP records. Mr Hilton presented as someone who had been open with Patient A. By way of example, during the post-operative consultation on 28 March 2014, Mr Hilton, at the request of Patient A, took a photo of Patient A's x-ray with Patient A's son's mobile phone.

25. The Tribunal heard from two expert witnesses. It found Mr C to be a credible and competent witness. He answered questions clearly and concisely and demonstrated considerable and impressive experience in the field of spinal surgery. Mr C made concessions at times, for example, he accepted that a misaligned pedicle screw is a known risk in this type of procedure. However, the Tribunal considered that, in oral evidence, Mr C appeared to have assessed Mr Hilton's overall clinical performance against a 'gold standard' in the NHS. This was set against a background of a large NHS unit in which regular Multi-Disciplinary Team (MDT) meetings take place (albeit he accepted that these were not in place at the date of the spinal fusion in March 2014). Mr Hilton, however, undertook the procedure in a private hospital.

26. The Tribunal found Miss D to be a competent and experienced spinal surgeon. However, she delivered her evidence in a somewhat haphazard style and was reluctant to concede any issue, despite Mr Hilton having already made concessions on some aspects. The Tribunal considered Miss D's report, nonetheless, to be well-structured, comprehensive and helpful.

The Tribunal's Analysis of the Evidence and Findings

27. The Tribunal considered the facts in dispute in regards to each paragraph of the Allegation.

Paragraph 1

1. On 26 March 2014 you performed a L2/3 fusion procedure ('the Procedure') on Patient A.
Admitted and Found Proved

Paragraph 2

2. Between 26 March and 29 March 2014, following the Procedure you:

a. failed to adequately review Patient A's imaging, in that you failed to recognise that the right L2 screw ('the Screw') was out of place;
Found Proved

28. In his evidence to the Tribunal, Mr Hilton accepted that he did not review all Patient A's imaging post-operatively and did not recognise that the Screw was not in the position intended, despite potentially being alerted to this by the x-rays. Mr Hilton told the Tribunal it was not until he checked the x-rays and reports upon receipt of Patient A's letter of complaint on 19 July 2016 that he recognised that the Screw was not in the pedicle, as intended. Mr Hilton explained his usual practice when performing this type of procedure. He told the Tribunal that he had been confident, at the time of surgery, the Screw was in the position intended. However, he said that, when looking at the images post-operatively, he focussed on the lateral view and not the AP view. The experts asserted and Mr Hilton accepted this constituted an incomplete review.

29. The Tribunal had regard to Mr Hilton's undated written statement. At paragraphs 13 – 14, he stated:

'13 Patient A's surgery was uneventful, and as I was placing the screws, I felt the expected resistance, which indicated to me good positioning of all the screws in the bone. In accordance with my usual practice, I took intra-operative and post-operative AP and lateral x-rays, which at the time I reviewed and believed demonstrated satisfactory positioning of the screws. Had I believed at the time that the screws were not correctly positioned, I would have re-positioned them at the time of surgery, which would not have been a difficult thing to do.'

'14 I reviewed Patient A at the end of my operating list and reassured him that the surgery had gone well, which I believed it had. As a very experienced spinal surgeon, I have a great deal of skill and experience in reviewing x-rays, CT and MRI scans on a daily basis. I perform spinal fusion surgery regularly.'

30. Throughout his evidence, Mr Hilton maintained that he was not aware that the Screw was out of place. He said that if he had been aware that the Screw was out of place at the time of the procedure, he would have repositioned it. If he had become aware of it post operatively, he would have adopted a 'watch and wait' approach. Mr Hilton told the Tribunal that his routine practice was not to review all the x-ray images when undertaking consultations with his patients post-operatively. This was because he relied on his impression during surgery, intra-operative imaging, his assessment of the patient's symptoms over time, and the patient's own reporting.

31. In his evidence to the Tribunal, Mr Hilton conceded that he should have reviewed all images carefully, rather than concentrating on the lateral view. He agreed it was never acceptable to view on one plane. He also conceded that he did not view all x-rays and radiology reports post-operatively.

32. Mr Hilton and the two experts agreed that misalignment of the Screw is a known risk in this type of procedure. It was incumbent on the surgeon to review all images.

33. The Tribunal therefore found paragraph 2a of the Allegation proved.

> b. deliberately failed to advise Patient A that the Screw was misaligned;
> **Found Not Proved**

34. The Tribunal accepted Mr Hilton's evidence that he had not noted the Screw was misaligned. It noted that, at the consultation on 28 March 2014, at the request of Patient A, Mr Hilton took a photograph of Patient A's post-operative x-ray, on Patient A's son's mobile phone. Mr Hilton now accepts that this image clearly showed the Screw to be misaligned. Had Mr Hilton known at the time the Screw was misaligned, it is unlikely he would have photographed the x-ray for Patient A if he were seeking to withhold adverse information from him.

35. In any event, this paragraph is an allegation in the alternative. Mr Hilton did not know the Screw was misaligned. He was not therefore required to tell Patient A about it.

36. It therefore found paragraph 2(b) not proved.

> c. failed to record that you had recognised that the Screw was out of place.
> **Found Not Proved**

37. The Tribunal has already determined that Mr Hilton did not recognise that the Screw was out of place. There was therefore no requirement for him to record this. The Tribunal therefore found paragraph 2(c) of the Allegation not proved.

Paragraph 3

3. Between 16 April 2014 and 20 March 2015 you consulted with Patient A and you:

a. failed to adequately review Patient A's post-operative imaging, in that you failed to recognise that the Screw was out of place;
Found Proved

38. The Tribunal has already found, and Mr Hilton has conceded, that he failed to review all Patient A's imaging. He failed to recognise the Screw was out of place when Patient A was an in-patient during 26 – 28 March 2014. He accepted the AP x-ray image showed the Screw to be outside the pedicle.

39. The Tribunal had regard to the report of Dr E, Consultant Radiologist, dated 14 May 2014, detailing his examination of Patient A's x-ray on 14 May 2014. Dr E stated:

'…There has been a posterior instrumental fusion at the L2/3 level. There has been no change in the appearances in comparison with previous imaging of 28/03/14. The right superior screw lies slightly more laterally than the remainder.'

40. The Tribunal also had regard to the report of Dr F, Consultant Radiologist, dated 19 September 2014, detailing his examination of Patient A on 19 September 2014. Dr F stated:

'Comparison made with previous radiographs of the lower thoracic and lumbar spine dated 28/3/14. 14/5/14.

Bilateral pendicular screws are present at the L2 and L3. The right sided L2 screw does not appear to be sited within the pedicle. The other screws are satisfactorily positioned. There are posterior interconnecting lordotic rods. Stable alignment at the fused level.'

41. Mr Hilton told the Tribunal that his practice at the time was, at a follow-up consultation, not to review all the patient's x-ray images. He said that he used to write a short summary on the top of the patient's file detailing the procedure which the patient had undergone and their progress to date. He told the Tribunal that he has changed his practice since these events. His working practice was also to rely on

the consultant radiologists with whom he worked closely to alert him to any concerns arising from the x-rays, before Mr Hilton received their written report.

42. Mr Hilton was asked, during cross examination, whether he had reviewed all images and reports. He said words to the effect that *'I am saying I can't remember reading them. If I had read them [the reports] then I would have revisited the x-rays'.* Mr Hilton told the Tribunal that he could not recall whether he had read the reports of Dr E and Dr F. He went on to say that he focussed on the lateral x-ray images during follow-up and that, had he looked at the AP view images, he would have recognised that the Screw was not in the pedicle. He told the Tribunal that he focussed on other factors such as the 'danger zone' i.e. that the Screw was not penetrating the foramen or the spinal canal.

43. Taking all the evidence into account, the Tribunal decided that by the time of the September 2014 review consultation with Patient A, and particularly in light of the reports of Dr E and Dr F dated 14 May 2014 and 19 September 2014 respectively, Mr Hilton should have recognised that the Screw was not in the pedicle and was misaligned. His review of post-operative imaging was not adequate.

44. The Tribunal therefore found paragraph 3(a) of the Allegation proved.

> b. deliberately failed to advise Patient A that the Screw was misaligned;
> **Found Not Proved**
>
> c. failed to record that you had recognised that the Screw was out of place;
> **Found Not Proved**
>
> d. failed to request a CT scan to confirm the position of the screw.
> **Found Not Proved**

45. The Tribunal has already found that Mr Hilton failed to recognise the Screw was out of place. The Tribunal therefore considered 3(b) to 3(d) together.

46. In his evidence, Mr Hilton told the Tribunal, and the Tribunal accepted his evidence, that because he did not know the Screw was out of place, he had no reason to request a CT scan to confirm its position.

47. The Tribunal has determined that Mr Hilton did not know that the Screw was misaligned. It also determined that Mr Hilton could not therefore record that he had recognised that the Screw was out of place; nor was there reason for him to request a CT scan to confirm the position of the screw. The Tribunal found paragraph 3(b) to 3(d) of the Allegation not proved.

Paragraph 4

4. On 14 May 2014 you consulted with Patient A and you recorded that Patient A's x-ray was satisfactory.
Admitted and Found Proved

Paragraph 5

5. On 19 September 2014 you consulted with Patient A and you recorded Patient A's x-ray as demonstrating a good position of implants.
Admitted and Found Proved

Paragraph 6

6. On 20 March 2015 you consulted with Patient A and you:

a. recorded Patient A's x-ray as demonstrating a good position of implants;
Admitted and Found Proved

b. inappropriately dismissed Patient A's symptoms including:

i. back pain;

ii. discomfort;

48. In paragraph 29 of his witness statement dated 15 May 2018, Patient A stated:

'…In my opinion the x-ray does not show a good position of implants and AH did not make an accurate note of the problems I was having during and after playing golf and in general. I remember the meeting well. I told him that I had managed a couple of rounds of nine hole golf on holiday but, every time I played I would have an adverse reaction. I also mentioned the flare ups and spasms I kept getting but, he attributed these symptoms to wear and tear. I was quite upset after this appointment because AH made me think the problems I was still experiencing were in my head. His assessment of my present condition was significantly minimised and contradict the notes taken by [H] 8 days previously. I was discharged from his care at this appointment.'

49. The Tribunal had regard to Mr Hilton's clinical notes made during the consultation with Patient A on 20 March 2015. Mr Hilton stated:

> *'**Present situation**: I reviewed [Patient A] today who describes significant improvement in his pain since surgery. He describes occasional twinges but overall he states that he is significantly better and manages every day activities well. He is playing golf.*
>
> ***X-ray**: X-ray demonstrates a good position of implants.*
>
> ***Plan**: I have reassured Patient A today and encouraged him to continue mobilising. I have discharged from care with an SOS appointment should he require it.'*

50. During his evidence at cross examination, Patient A conceded, albeit reluctantly, that his symptoms on the date of discharge had reduced considerably as against those in the months immediately before the surgery.

51. The Tribunal took into account the contemporaneous records of Patient A's physiotherapist. It noted the following entries:

> On 19 January 2015:
>
> *'back been V.good went on holiday*
> *Been swimming…'*
>
> On 9 April 2015:
>
> *'Joined gym/swim 4x week*
> *Playing 9 holes golf regularly*
> *No probs.'*

52. The GP records of 27 January 2015 refer to a 'flare up' in December 2014 and his 'managing to go to driving range' at the date of that appointment.

53. The physiotherapist's entry on 9 April 2015 is discordant with paragraph 29 of Patient A's statement in which Patient A states *'I told him that I had managed a couple of rounds of nine hole golf …*'.

54. Mr Hilton told the Tribunal that at no point did he tell Patient A that his back would be perfect following the surgery. The Tribunal was of the view that the records of Patient A's other treating clinicians accorded with the notes of Mr Hilton that Patient A was making good progress. In reference to Mr Hilton's comment 'I have reassured [Patient A] today …', the Tribunal considered this demonstrated that Mr Hilton had not dismissed Patient A's concerns but had addressed them. Further, when Mr Hilton discharged Patient A, he gave him an SOS appointment so that if Patient A had any further difficulties or issues, he could consult Mr Hilton without the need for a referral by his GP.

55. In all the circumstances, the Tribunal determined that Mr Hilton did not inappropriately dismiss Patient A's symptoms including his back pain or discomfort.

56. It therefore found paragraph 6(b) of the Allegation not proved.

> c. failed to act upon Patient A's increased level of pain, in that you failed to revisit Patient A's x-rays;

57. The Tribunal has already found that Mr Hilton did not dismiss Patient A symptoms including his back pain or discomfort. He was not told about an increase level of pain. Therefore, it cannot find that Mr Hilton failed to act upon Patient A's increased level of pain by not revisiting Patient A's x-rays.

58. The evidence before the Tribunal, which includes Patient A's GP records, the physiotherapists reports, and Mr Hilton's clinical notes indicate that Patient A's pain was gradually reducing and his symptoms were getting better day by day. Mr Hilton's oral evidence was that Patient A's recovery was at a slower rate than he had anticipated. The Tribunal noted an entry in the physiotherapists' records on 12 March 2015 which states *'Pain improving but variable, ..'* This is consistent with an improving picture and in line with the anticipated outcome of the spinal fusion.

59. It therefore found paragraph 6(c) of the Allegation not proved.

> d. failed to record Patient A's symptoms accurately.

60. Having taken into account Mr Hilton's clinical notes, the Tribunal determined that his clinical notes accorded largely with the records made by Patient A's GP and his physiotherapist about Patient A's symptoms. The overall description of symptoms is consistent. It was satisfied, therefore, that Mr Hilton recorded Patient A's symptoms accurately.

61. The Tribunal found paragraph 6(d) of the Allegation not proved.

Paragraph *7*

> 7. During a meeting with Patient A at Harbour Hospital on 2 November 2016, you said that you were aware, post-operatively, that one screw was lateral but did not wish to worry Patient A and had therefore adopted a watch and wait decision, or words to that effect, and that statement was:
>
> a. untrue;
>
> b. you knew it to be untrue.

62. During cross examination, Mr Hilton accepted that he had referred at this meeting to knowing that the Screw was lateral prior to the letter of complaint, that he had not wanted to worry Patient A, and that he had therefore adopted a 'watch and wait' approach. Mr Hilton said he had an angry patient sitting in front of him, the patient had described the Screw as having missed the bone entirely, he had made an analogy with a shelf being fixed to a wall and that shelf falling off the wall. Mr Hilton described being confused about the information he was receiving from Patient A which was in conflict with his professional experience and confidence at the time of surgery. He had also checked the physiotherapy records on the morning of 2 November 2016, the physiotherapist had gone through the records with him and described Patient A as 'worried well'. Mr Hilton had also noted references to left sided pain rather that right sided pain. He described having 'all this going on in my head' and he described thinking 'foolishly' that the best way to describe this to Patient A, causing him least distress, was to try to explain what fusion surgery was about, and that a misplaced Screw was not a failed operation.

63. In so doing, Mr Hilton told Patient A that he had known the Screw was out of place, when in fact he only knew about this after receipt of Patient A's complaint. He did not want to get into a dispute with Patient A about the position of the Screw and therefore took Patient A's version at face value, despite the fact he had not seen the CT scan commissioned by Dr B. This was despite his belief that the Screw could not have been in soft tissue but was in bone.

64. Mr Hilton also accepted that the notes of the meeting on 2 November 2016 were largely accurate. These notes support the alleged facts.

65. In summary, the Tribunal finds Mr Hilton deliberately told Patient A that he knew earlier the Screw was out of place both to avoid a dispute about the position of the Screw and to enable him to have a meaningful discussion with Patient A about spinal fusion.

66. In all the circumstances, the Tribunal determined that Mr Hilton's alleged comments at the meeting were untrue and he knew them to be untrue.

67. It therefore found paragraph 7(a) and 7(b) of the Allegation proved.

Paragraph 8

8. The information which you entered into Patient A's records as referred to in paragraphs 4, 5 and 6a:

a. was untrue;

b. you knew to be untrue.

68. Mr Hilton has already admitted paragraphs 4, 5 and 6a of the Allegation. The Tribunal has accepted his evidence that he did not appreciate that the Screw was misaligned and that he believed the x-ray to be satisfactory and the implants to be in a good position. These are Mr Hilton's notes of the Patient's history and his clinical impression at the time. To that extent, they are true because they reflect Mr Hilton's understanding of the clinical position at the time, albeit that understanding was wrong.

69. The Tribunal therefore found paragraphs 8(a) and 8(b) of the Allegation not proved.

Paragraph 9

> 9. Your actions as described at paragraphs 2b, 2c, 3b, 3c, 4, 5, 6a, 7 and 8 were dishonest.

In relation to paragraphs 4, 5 and 6a

70. Mr Hilton has already accepted that he did not look at all of Patient A's x-ray images and x-ray reports. He said that if he had done so, and recognised the Screw was misaligned, he would have taken appropriate steps to correct it. He believed at the time that his records were accurate. The Tribunal noted that Patient A was a private patient and that any revision treatment would be chargeable. The Tribunal was of the view that Mr Hilton had no motive to be dishonest to Patient A in the way alleged.

71. The Tribunal concluded that the evidence before it was insufficient to make a finding of dishonesty. Mr Hilton's records arose from inadequate analysis rather than dishonesty. It therefore found paragraph 9 in relation to paragraphs 4, 5 and 6a not proved.

In relation to paragraph 7

72. Mr Hilton had received a letter of complaint from Patient A. Patient A had sent a letter of reminder a month later because Mr Hilton had not responded promptly. In that reminder letter Patient A threatened Mr Hilton with a complaint to the GMC if he did not respond within fourteen days. Mr Hilton had been told by the Physiotherapy team, whom he had consulted about Patient A's progress, that Patient A was known to them as "worried well". Mr Hilton explained this as 'meaning he was in and out with problems'. Mr Hilton had also consulted his own clinical records and x-rays and noted the misplacement of the pedicle screw during the procedure in March 2014. He had noted Patient A's progress up to and at the date of discharge in March 2015, over a year earlier. Not unreasonably, Mr Hilton believed that the operation had gone well, notwithstanding his failure to identify the pedicle screw was not in the pedicle: his notes showed a positive picture, as did those of the

physiotherapists who had treated Patient A. There were no adverse consequences as a result of the screw not being in the pedicle so far as he knew from his records. On the contrary as was his routine at the time, on discharge he had given Patient A an SOS appointment to enable him to bypass the usual procedure of referral by his GP if he had any concerns arising from his surgery. The patient had not taken advantage of that appointment. With all this in mind, Mr Hilton reasonably believed that Patient A had suffered no adverse consequences as a result of his failure to identify that the screw was not in the pedicle.

73. In his detailed written response of 25 August 2016 to Patient A's complaint, Mr Hilton asked Patient A for permission to see the CT scans which had been taken in connection with the treatment he had received from Mr B. This would have enabled Mr Hilton to establish the location of the pedicle screw and its impact on Patient A. Nonetheless despite the absence of that information, he told Patient A that he accepted "the screw may not be in full contact with bone". Thus he made an immediate admission in the face of Patient A's complaint. He had no legal advice at this stage and could not have known whether any adverse consequences had occurred for Patient A as a result of this misplacement. Furthermore, he had not received Patient A's permission to view the CT scans; he did not have a full picture of the current situation. Thus he was making an admission without knowing the consequences of that admission for himself and his practice. This suggests he was attempting to be open and transparent with Patient A to some degree. That said, he also stated at bullet point four in that letter that he had previously been aware that there may have been misplacement but had felt it did not require any further investigation. That statement was not true.

74. Mr Hilton went into the meeting in November 2016 knowing the patient was angry and upset by the treatment he had received from him. His intention was to apologise to Patient A, explain spinal fusion, and that a misplaced screw did not mean failed surgery. He also wanted to reassure the patient that, even if the issue had been identified earlier, the outcome would have been no different. Not unreasonably, given his own records of patient A's progress, Mr Hilton did not consider Patient A's account of the screw being in the psoas muscle could be accurate. He was confident that Patient A's account was not correct but chose to take it "at face value" in order to avoid confrontation with the patient: his objective was to apologise to Patient A for failing to identify during and after surgery that the screw was not in the right place, as planned, and to reassure Patient A that his failure had not led to an adverse outcome for Patient A. He believed, not unreasonably given the clinical records, including the physio notes, that the intended outcome of the treatment, namely a 70% percent chance of a 50% improvement of his symptoms, had been achieved.

75. The Tribunal finds that Mr Hilton's decision to accept Patient A's version of clinical events as the starting point for their discussion on 2 November 2016 was extremely unwise. It informed the basis of the discussion. Mr Hilton exacerbated the situation by conveying the impression that he had treated Patient A in a certain way,

as if he had known about the misplacement at the time: that he had taken the positive decision to watch and wait when he had taken no such decision.

76. The Tribunal is satisfied that Mr Hilton had no malicious intention to deceive Patient A, merely to create a positive environment in which he could apologise to Patient A for his error and reassure him that there had been no adverse outcome resulting from that error. However, Mr Hilton knowingly misrepresented the facts in two ways: he told Patient A he had known earlier than was the case about his failure to identify the misplaced screw and that he had taken a positive decision to watch and wait, having identified that misplacement and not wanting Patient A to worry about it. This was a misrepresentation of the facts as he knew them to be and a repetition of the assertions he had made in similar vein in his letter to Patient A of 25 August 2016.

77. The Tribunal has therefore turned to the issue of whether ordinary decent people would consider Mr Hilton acted dishonestly. As was said in **Ivey**, "Truthfulness is indeed one characteristic of honesty, and untruthfulness is often a powerful indicator of dishonesty". Mr Hilton did not tell the truth to Patient A.

78. Mr Hilton impressed the Tribunal as a man with considerable emotional intelligence. The evidence does not suggest he is a man who puts his professional reputation above the care and well-being of his patients. Rather, his actions were driven by his desire to put matters right for the patient and to reassure him. The Tribunal is satisfied he was not motivated to avoid litigation or to avoid payment of financial compensation: he knew that could not be avoided because of the tone of Patient A's correspondence to date: he had threatened to report Mr Hilton to the GMC for failure to respond to earlier correspondence. Despite this, it was Mr Hilton who proposed a meeting with Patient A. This was a conciliatory approach and consistent with his actions in the meeting which subsequently took place. It is wholly understandable that Mr Hilton sought to minimise areas of disagreement between them in such circumstances given his objective of apologising again to Patient A (as he had already in his letter of 25 August 2016). It would have been clear to Mr Hilton that this matter would not be resolved as a result of anything he did at that meeting: the patient had been consulting Mr B by the stage of his initial complaint and was already seeking financial recompense before the meeting in November 2016.

79. Mr Hilton told the Tribunal he had deliberately told Patient A he knew the screw was out of place because of all the available information in front of him; he had spoken to the physiotherapist who had described the patient as "worried well", he had had a 'good feel' when he put the screw in during surgery, the patient had made good progress. He told the Tribunal Patient A was angry at the meeting and "what [he] had wanted to try and explain, which [he] should never have done, was … if [he] had known this was out of place, the process he would have taken would have been probably to watch and wait". He accepts he conveyed the impression that

that was what he had actually decided to do at the time. When asked why he had created a false impression deliberately, he referred to Patient A as being an angry man and his not wanting to dispute the position of the screw although he knew it had to be in bone. He agreed, in retrospect, under cross-examination, that this was not what he should have done; he wanted to apologise and "make it as easy as possible" for Patient A to understand spinal fusion and that a misplaced screw was not a failure of surgery. Mr Hilton denied being flustered; he said he had been confused by the information in front of him.

80. Mr Hilton had a duty to be candid with Patient A in that meeting. This is not a case where Patient A was relying on what Mr Hilton told him; indeed he had made it plain that he was seeking compensation from him; he had threatened to report Mr Hilton to the GMC. Patient A made it clear he no longer considered Mr Hilton to be treating him. This was a doctor-patient relationship which had broken down and would not be recovered. Patient A was receiving medical treatment by this time from Mr B. Thus the information given by Mr Hilton to Patient A was not material to any future relationship between them as patient and doctor. Patient A had made it clear he would pursue litigation if he had to and that he would refer the matter to the GMC if Mr Hilton did not pay him.

81. The Tribunal considers Patient A's manner of dealing with Mr Hilton to be unattractive. Nonetheless this does not justify Mr Hilton's conduct (albeit lacking in malicious intention to deceive) at the meeting on 2 November. The Tribunal is satisfied that an ordinary decent and fully informed member of the public would have considerable sympathy for Mr Hilton in his dealings with Patient A at the meeting in November 2016. He was faced with a situation where he had not been provided with access to crucial medical records which would have enabled him to make an informed decision about where he had gone wrong with patient A's treatment; he was being conditionally threatened with referral to his regulator and with an action in negligence. Patient A was angry and upset and the meeting was, in the words of Mr Hilton, "heated" at times and "a bit strained".

82. The Tribunal appreciates that materiality and reliance are not pre-requisites to establishing dishonesty, particularly where there is a general obligation to be candid, as was the case here. Mr Hilton has not acted dishonestly previously; he has no adverse history with the GMC. He is a man of good character and a credible witness who has given wholly reliable evidence about his perception of the situation with Patient A. He has not sought to excuse the manner in which he dealt with Patient A's complaint. He sought to do his best for Patient A when he realised he had missed a misplaced pedicle screw and was unable to explain to himself or anyone else how he had done so, despite being aware it was a known risk.

83. The information given by Mr Hilton to Patient A was not true and Mr Hilton knew it was not true. He did not maliciously intend to deceive Patient A. His intention was to lay the basis for creating a dialogue between himself and Patient A such that he could apologise to Patient A for failing to identity the screw had been

misplaced and to reassure Patient A that the outcome of his surgery had not been adversely affected by his failure. By doing so Patient A was misled. That said, this is not a case of patient A being unable to make an informed choice about his treatment; nor is it a case of his not being fully informed about possible courses of action or his making a decision which he would not otherwise have made. He was by this stage being treated by Mr B.

84. Solid grounds are required for a finding of dishonesty. The Tribunal is satisfied that a reasonable and well-informed member of the public would have considerable sympathy for Mr Hilton in his dealings with Patient A. However, all doctors have to deal with patients in difficult circumstances. Mr Hilton had a duty of candour; he would be expected by a member of the public to be open and transparent about the treatment he had given Patient A. Mr Hilton was not truthful in circumstances where he had a duty to act with integrity and honesty. Ordinary decent members of the public would consider his assertions and inferences in that meeting to be dishonest because they were not truthful and Mr Hilton knew it.

85. The Tribunal therefore found paragraph 9 in relation to paragraph 7 proved.

The Tribunal's Overall Determination on the Facts

86. The Tribunal has determined the facts as follows:

Paragraph 1

1. On 26 March 2014 you performed a L2/3 fusion procedure ('the Procedure') on Patient A.
Admitted and Found Proved

Paragraph 2

2. Between 26 March and 29 March 2014, following the Procedure you:

a. failed to adequately review Patient A's imaging, in that you failed to recognise that the right L2 screw ('the Screw') was out of place;
Found Proved

b. deliberately failed to advise Patient A that the Screw was misaligned;
Found Not Proved

c. failed to record that you had recognised that the Screw was out of place.

Found Not Proved

Paragraph 3

3. Between 16 April 2014 and 20 March 2015 you consulted with Patient A and you:

a. failed to adequately review Patient A's post-operative imaging, in that you failed to recognise that the Screw was out of place;
Found Proved

b. deliberately failed to advise Patient A that the Screw was misaligned;
Found Not Proved

c. failed to record that you had recognised that the Screw was out of place;
Found Not Proved

d. failed to request a CT scan to confirm the position of the screw.
Found Not Proved

Paragraph 4

4. On 14 May 2014 you consulted with Patient A and you recorded that Patient A's x-ray was satisfactory.
Admitted and Found Proved

Paragraph 5

5. On 19 September 2014 you consulted with Patient A and you recorded Patient A's x-ray as demonstrating a good position of implants.
Admitted and Found Proved

Paragraph 6

6. On 20 March 2015 you consulted with Patient A and you:

a. recorded Patient A's x-ray as demonstrating a good position of implants;
Admitted and Found Proved

b. inappropriately dismissed Patient A's symptoms including:

i. back pain;
Found Not Proved

ii. discomfort;
Found Not Proved

c. failed to act upon Patient A's increased level of pain, in that you failed to revisit Patient A's x-rays;
Found Not Proved

d. failed to record Patient A's symptoms accurately.
Found Not Proved

Paragraph 7

7. During a meeting with Patient A at Harbour Hospital on 2 November 2016, you said that you were aware, post-operatively, that one screw was lateral but did not wish to worry Patient A and had therefore adopted a watch and wait decision, or words to that effect, and that statement was:

a. untrue;
Found Proved

b. you knew it to be untrue.
Found Proved

Paragraph 8

8. The information which you entered into Patient A's records as referred to in paragraphs 4, 5 and 6a:

a. was untrue;
Found Not Proved

b. you knew to be untrue.
Found Not Proved

Paragraph 9

9. Your actions as described at paragraphs 2b, 2c, 3b, 3c, 4, 5, 6a, 7 and 8 were dishonest.

Found Not Proved in relation to paragraphs 2b, 2c, 3b, 3c, 4, 5, 6a and 8
Found Proved in relation to paragraph 7

Determination on Impairment - 22/11/2018

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Mr Hilton's fitness to practise is impaired by reason of misconduct.

The Evidence

2. The Tribunal has taken into account all the oral and written evidence received during the facts stage of the hearing.

3. Mr Hilton provided a bundle of documents which included:

- his undated reflective statement;
- a report from his Appraiser, Dr G, dated 9 January 2013;
- his Appraisals dated 23 January 2014, 9 April 2015, 23 June 2016, 23 March 2017 and 26 December 2017;
- his personal report dated 9 January 2014 for the purpose of revalidation;
- Colleague Feedback Report – 29 October 2018;
- Patient Feedback Reports – 25 October 2017 and 30 October 2018;
- Testimonials from Mr Hilton's clinical colleagues attesting to his clinical practice and good character.

Submissions

<u>For the GMC</u>

4. On behalf of the GMC, Ms Chloe Fordham, Counsel, submitted that Mr Hilton's fitness to practise is impaired. She referred to the Tribunal's finding of dishonesty in relation to paragraph 7 of the Allegation and acknowledged that the Tribunal's other findings did not amount to misconduct. Ms Fordham referred the Tribunal to relevant authority and to paragraph 55 of Good Medical Practice ('*GMP*') (2013 version) as being engaged in this case. She submitted that this is essentially case where the doctor had failed in his duty of candour. Ms Fordham said that Mr Hilton's conduct, which involved being dishonest to a patient in a clinical setting breached a fundamental tenet of the profession.

5. In relation to remediation, Ms Fordham submitted that Mr Hilton only acted upon the false information given to Patient A after Patient A had submitted his letter of complaint (19 July 2016) and the subsequent GMC investigation.

6. In relation to insight, Ms Fordham acknowledged that, from the bundle provided by Mr Hilton, it is clear that he recognises what he did was not right. However, it was not of a minor nature. His actions would have left a negative impression on Patient A causing him stress. Ms Fordham submitted that his dishonesty compounded the mistakes he had made in not recognising the problem at an earlier stage.

7. She invited the Tribunal to find Mr Hilton's fitness to practise is currently impaired.

For Mr Hilton

8. Mr Hurst submitted that there was no misconduct and Mr Hilton's fitness to practise is not impaired. He referred the Tribunal to relevant authority. He said that a finding of dishonesty did not automatically lead to a finding of impairment. He added that this case involved one single episode relating to one patient. Mr Hurst submitted that Mr Hilton's actions were not motivated for any financial or personal gain or to save his reputation.

9. Mr Hurst referred the Tribunal to its determination on facts. He told the Tribunal it needed to consider the context in which Mr Hilton had acted dishonestly. He said that Mr Hilton arranged to meet with Patient A so that he could reassure Patient A and to apologise to Patient A. Mr Hurst said that Mr Hilton acted in the best interests of Patient A and his actions were without malicious intent but rather 'foolish' and 'unwise'.

10. Mr Hurst said that recognition of the seriousness of the conduct was the first step to remediation and said that Mr Hilton has remediated. He drew the Tribunal's attention to Mr Hilton's reflective statement which had been personally prepared before the outcome of Stage 1 was known. Mr Hurst said that Mr Hilton has amended his practice so that he now looks at all x-ray images during and following surgery.

11. Mr Hurst submitted that Mr Hilton has demonstrated insight into his actions. From the point at which he became aware the screw was not in the position intended and throughout these proceedings, Mr Hilton has repeatedly apologised to Patient A for the standard of care he gave him. Mr Hurst referred the Tribunal to Mr Hilton's reflective statement and highlighted the courses he has attended, and is yet to attend, to address the concerns raised.

12. Mr Hurst also referred the Tribunal to Mr Hilton's appraisals which demonstrated that he met the required standards of care to his patients. Mr Hurst drew the Tribunal's attention to the testimonials received from Mr Hilton's clinical colleagues attesting to his clinical work and good character, and to positive patient feedback forms. He said that this demonstrated that Mr Hilton is highly regarded and that he takes the care of his patients seriously.

13. Mr Hurst told the Tribunal that Mr Hilton has no previous history with the GMC and there are no concerns about his clinical practice. In all the circumstances, Mr Hurst submitted that a reasonable and informed observer would consider that there was no malign motive in Mr Hilton's actions. He invited the Tribunal to find Mr Hilton's fitness to practise not impaired.

The Relevant Legal Principles

14. The Tribunal reminded itself that, at this stage of the proceedings, there is no burden or standard of proof and the decision on impairment is a matter for the Tribunal's judgement alone.

15. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct, and then secondly whether that misconduct led to a finding of impairment.

16. The Tribunal must determine whether Mr Hilton's fitness to practise is impaired today, taking into account his conduct at the time of these events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

17. The Tribunal was mindful of the statutory overarching objective which is:

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.

18. The Tribunal considered that (b) and (c) are engaged in this case.

19. Misconduct is conduct which falls seriously below what is expected of a medical practitioner. There is no legal definition for the word "serious" and the word should be given its ordinary meaning.

20. If the Tribunal were to find misconduct (as defined above) in relation to the findings, it would be appropriate to consider any other findings which do not amount to misconduct when considering the question of impairment.

The Tribunal's Determination on Impairment

Misconduct

21. The Tribunal first determined whether Mr Hilton's actions amount to misconduct.

22. The Tribunal has noted Mr Hilton's admissions at the outset of these proceedings in relation to the factual elements of the Allegation. It has taken into account its finding that between 26 March 2014 and 28 March 2014; and between 16 April 2014 and 20 March 2015, Mr Hilton failed to adequately review Patient A's imaging and to recognise the Screw was out of place. Ms Fordham has acknowledged that these findings do not amount to misconduct. The Tribunal agrees with this and finds that to be the case.

23. The Tribunal had regard to paragraphs 1, 55, 65 and 68 of GMP (2013 version):

> "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,1 are honest and trustworthy, and act with integrity and within the law.
>
> 55. 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:
>
> a. put matters right (if that is possible)
> b. offer an apology
> c. explain fully and promptly what has happened …..
>
> 65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.
>
> 68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate."

24. In relation to dishonesty, The Tribunal adopted its findings as set out in its facts determination. It was mindful that the matters found proved took place in a clinical setting albeit Mr Hilton was not treating Patient A at the time.

25. The Tribunal found that, at the meeting on 2 November 2016, Mr Hilton knowingly misrepresented the facts in two ways: he told Patient A he had known earlier than was the case about his failure to identify the misplaced screw and that he had taken a positive decision to watch and wait, having identified that misplacement and not wanting Patient A to worry about it. This was a misrepresentation of the facts as he knew them to be and a repetition of the assertions he had made in similar vein in his letter to Patient A of 25 August 2016.

26. The Tribunal determined that his statements to Patient A at that meeting were not true and he knew them to be untrue. He therefore acted dishonestly. The Tribunal considered that fellow professionals would view Mr Hilton's actions as wholly inappropriate, despite the difficult circumstances of the meeting and the conflicting information presented to him.

27. The Tribunal considered whether ordinary decent people would consider Mr Hilton acted dishonestly. As was said in Ivey, "Truthfulness is indeed one characteristic of honesty, and untruthfulness is often a powerful indicator of dishonesty". Mr Hilton did not tell the truth to Patient A.

28. Misrepresenting to a former patient the treatment he had provided, when questioned about errors in that treatment, is clearly in breach of the standards expected of the medical profession, as set out in GMP. The dishonesty occurred in a clinic context, albeit Patient A was no longer a patient of Mr Hilton.

29. In all the circumstances, the Tribunal decided that Mr Hilton's actions fell far short of the standards of conduct reasonably to be expected of a doctor. The Tribunal concluded that Mr Hilton's actions amounted to misconduct.

Impairment by reason of misconduct

30. The Tribunal went on to consider whether Mr Hilton's fitness to practise is impaired by reason of the misconduct it has found. In making its decision, the Tribunal bore in mind that the purpose of fitness to practise proceedings is not to punish a doctor for past wrongdoing but to maintain proper standards in the profession and to protect the public. The Tribunal must look forward not back but, in order to determine whether a doctor is fit to practise without restriction today, it must take into account the way in which a doctor has acted, or failed to act, in the past.

31. The issue of impairment is one for the Tribunal to determine exercising its own judgment. The Tribunal has taken into account the public interest which includes the need to protect patients and the public, to maintain public confidence in the profession, and to declare and uphold proper standards of conduct and behaviour. It considered that the second and third limbs are engaged in this case.

32. The Tribunal had regard to paragraph 76 of the judgment in the case of CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin), in which Mrs Justice Cox provided a helpful approach to the determination of impairment:

> 'Do our findings of fact in respect of the doctor's misconduct…show that his/her fitness to practise is impaired in the sense that s/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.'

33. The Tribunal took into account the circumstances in which Mr Hilton acted as he did (paragraphs 72 to 75 of its determination on facts). It adopts here its findings of fact as regards the meeting of 2 November 2016. In summary, Mr Hilton went into that meeting knowing the patient was angry and upset by the treatment he had received from him. Mr Hilton's intention was to apologise to Patient A, explain spinal fusion, and that a misplaced screw did not mean failed surgery. He also wanted to reassure the patient that, even if the issue had been identified earlier, the outcome would have been no different. Mr Hilton did not consider Patient A's account of the screw being in the psoas muscle could be accurate. He was confident that Patient A's account was not correct but chose to take it "at face value", in order to avoid confrontation with the patient: his objective was to apologise to Patient A for failing to identify during and after surgery that the screw was not in the right place, as planned, and to reassure Patient A that his failure had not led to an adverse outcome for Patient A. He believed, not unreasonably given the clinical records, including the physio notes, that the intended outcome of the treatment, namely a 70% percent chance of a 50% improvement of his symptoms, had been achieved.

34. The Tribunal considered whether Mr Hilton's conduct was capable of being remediated, has been remediated, and the likelihood of its repetition. In so doing, it considered whether there was evidence of Mr Hilton's insight into his conduct and any steps taken by him to remediate it.

35. The Tribunal had regard to Mr Hilton's reflective statement. In this he explained changes he had introduced into his practice. Whilst the Tribunal has noted the content of Mr Hilton's reflective statement, and accepts it as an accurate account of all he has done to address the issues arising from the Allegation (irrespective of the Tribunal's findings of facts) it gave little weight to the statement given that the crux of the issue here was the second and third public interest limbs. That said, it accepts Mr Hilton has reflected fully on the issues raised in the Allegation.

36. The Tribunal had regard to the wide ranging and excellent testimonials from Mr Hilton's clinical colleagues. They speak very highly of his clinical work and of his good character even in the knowledge of the dishonesty allegation he faced in these proceedings. Mr Hilton's colleagues confirm that Mr Hilton takes the care of his patients seriously. The Tribunal has taken into account Mr Hilton's Appraisals,

including feedback from patients, all of which are exemplary. However, the Tribunal gave less weight to these given the public interest concerns here.

37. The Tribunal noted that Mr Hilton has practised medicine for many years and has no previous history with the GMC. He has a long unblemished career. There is no evidence before the Tribunal that he has ever behaved in a similar way prior to these events. Nor has the Tribunal been provided with any evidence that he has repeated the misconduct since November 2016.

38. The Tribunal considered that taking all of the evidence into account, Mr Hilton has taken effective steps to remedy the failings in his clinical practice and insofar as he is able, the failing in his duty of candour. It took into account that these events occurred in 2016 and the evidence before the Tribunal demonstrated that Mr Hilton has been working safely.

39. The Tribunal has taken into account that this was a single episode of dishonesty. There is no evidence before the Tribunal that Patient A came to any harm but it finds he was distressed, very concerned and worried to hear about the misplaced screw, particularly so long after the event.

40. The Tribunal then went on to consider whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment was not made.

41. This is the crux of this determination on impairment. The central issue is the public interest in the promotion and maintenance of public confidence in the medical profession and the promotion and maintenance of proper professional standards and conduct in that profession.

42. This was an isolated incident at a meeting with Patient A on 2 November 2016, over two years ago. The Tribunal bore in mind the particular circumstances in which the dishonest conduct occurred: this was a difficult meeting between a former patient and a conscientious doctor who knew he had made a mistake and wanted to explain his actions to the patient in such a way as to minimise worry and concern for Patient A. In so doing he lost sight of the need to be open and transparent. Instead he chose to minimise areas of dispute to enable the discussion to focus on the patient's concerns about the outcome of the surgery and his future health.

43. Mr Hilton admitted at an early stage that he had not been straight with Patient A. Even in his Rule 7 response of 16 January 2016 to the draft allegations, his solicitors stated on his behalf that he "confused the situation by saying in the meeting with Patient A on 2 November 2016 that he was aware post operatively that one screw was lateral". This was in response to draft allegations which did not include an allegation of dishonesty at that meeting. Thus Mr Hilton was, in his

dealings with his regulator, open and transparent, at the earliest opportunity, about what he had done.

44. Similarly in his witness statement, at the fact finding stage, Mr Hilton admitted he "told [Patient A] he knew the screw was misplaced". Again he had been open and transparent about misrepresenting the facts to Patient A at that meeting.

45. The Tribunal recognises that Mr Hilton did not make formal admissions to the allegation of dishonesty at the meeting; nor did he formally admit that the comments asserted in the allegation were "untrue". The Tribunal is somewhat perplexed by this, given his continued and consistent admissions, but relies in any event on Mr Hilton's own statements and correspondence with the GMC which make it clear that he, at no time, shied away from admitting what he said to Patient A.

46. The Tribunal does not criticise Mr Hilton for failing to make a formal admission of dishonesty in these proceedings as regards his conduct at the meeting: his evidence was sufficient to make a finding at the first stage of the Ivey test; it was not unreasonable for him to leave it to the Tribunal to make findings as to the background and circumstances of the meeting and whether an ordinary decent member of the public would find his actions to be dishonest.

47. In summary, save for his dishonesty with regard to the timing of his knowledge of the screw being out of the pedicle and his implication he had taken a watch and wait approach, Mr Hilton has been open and transparent about all other aspects of Patient A's treatment. He has, for example, told colleagues, his peer group and his employer.

48. This is not a case where Mr Hilton acted out of malice, for reputational reasons or profit. His testimonials refer to his exceptional regard for the welfare and well-being of his patients. To that extent they are consistent with his approach to the meeting with Patient A. This is a doctor who puts the best interests of his patients above all else (even to the consternation of others, judging by some of the appraisals he has received).

49. Mr Hilton's dishonesty at the meeting on 2 November 2016 was an aberration. Dishonesty is not a pervading trait in this case. There was no adverse motivation for it, only a positive one.

50. The Tribunal accepts the GMC submission that Mr Hilton's dishonesty compounded his earlier mistakes. However, they were only the springboard for his dishonesty. There was no attempt to cover up his mistakes.

51. The Tribunal acknowledges that insight and remediation are principally relevant to the first limb of the overarching objective. That limb is of less concern here. There is no risk to patients as a result of Mr Hilton's misconduct. Furthermore,

while the Tribunal is confident that there is no risk of repetition, this is of secondary importance when considering the second and third limbs of the overarching objective.

52. Dishonesty is a breach of a fundamental tenet of the profession. Being honest and trustworthy and acting with integrity are at the heart of medical professionalism.

53. The Tribunal took into account that doctors occupy a position of privilege and trust. They are expected to act in a manner which maintains public confidence in them and in the medical profession and to uphold proper standards of conduct. Mr Hilton's conduct was dishonest. The Tribunal concluded that his conduct brought the profession into disrepute and breached a fundamental tenet of the medical profession.

54. The Tribunal recognises that these proceedings alone are not sufficient to meet the requirement of maintaining public confidence in the profession and the regulator or standards in the profession.

55. This is a very unusual case. The dishonesty occurred in the context of Mr Hilton attempting to do his best for Patient A. He was trying to help Patient A understand the context of his mistake and the impact of it. There was no financial or reputational motivation for the dishonest conduct. He apologised profusely; he was trying to help Patient A understand that no harm had come from the misplaced screw and that, even if he had recognised it earlier, the treatment would have been no different. He knew he was misrepresenting the facts but he did in the belief that it was for the good of Patient A and to help him understand.

56. A fully informed member of the public, including within medical profession, would have considerable sympathy for Mr Hilton who was faced with a difficult meeting. He was required to explain a complex topic (spinal fusion) and his objective was to reassure the patient. The manner in which he chose to do so, by adopting the patient's version of events to minimise areas of dispute, was foolish and led to his dishonesty.

57. The issue of impairment is finely balanced. The balance is just in favour of Mr Hilton being fit to practise. The Tribunal is satisfied that because of the lack of incentive to be dishonest other than the perceived best interests of the patient, that public confidence in the profession would not be undermined by a finding that Mr Hilton's fitness to practise is not impaired. Similarly, the promotion and maintenance of proper professional standards and conduct in the profession would not be undermined by such a finding. A fully informed member of the public would take into account the context of the dishonesty, including Mr Hilton's positive motivation, and consider the circumstances to be exceptional. This is one of those rare cases where a finding of impairment of fitness to practise is not warranted. This is not a case where patients' and the public's trust in Mr Hilton and the medical

profession generally would be undermined by not finding his fitness to practise to be impaired.

58. The Tribunal has determined that Mr Hilton's fitness to practise is not impaired by reason of his misconduct, pursuant to Section 35C(2)(a) of The Medical Act 1983 as amended.

Determination on Warning - 23/11/2018

1. Having determined that Mr Hilton's fitness to practise is not impaired, the Tribunal has now considered whether to issue a warning on his registration.

Submissions

2. Ms Fordham submitted a warning is appropriate. She took the Tribunal through the relevant paragraphs of the Sanctions Guidance (SG) and the document entitled 'GMC Guidance on warnings' (the Guidance) (February 2018 version). She submitted a warning was necessary in order to uphold public confidence in the medical profession and proper standards for members of that profession. Ms Fordham referred the Tribunal to its previous finding that Mr Hilton's actions were in breach of the standards expected of the medical profession and fell short of the standards of conduct reasonably expected of a doctor.

3. Mr Hurst reminded the Tribunal of its powers when considering the imposition of a warning. He said that this was an unusual and unique case. Mr Hilton's actions were not motivated for any financial or personal gain or any other malign motive, but rather unwise and foolish. Mr Hurst submitted that a reasonable and well-informed member of the public would not feel there are any concerns to warrant a warning.

4. Mr Hurst told the Tribunal that Mr Hilton appreciates his responsibility and has amended his clinical practice in the light of these events. He said there is no risk of Mr Hilton repeating his misconduct. He told the Tribunal Mr Hilton undertakes a great deal of private work and the imposition of a warning would have an impact on Mr Hilton's ability to secure such work. Further, Mr Hurst added that a warning would impact adversely on Mr Hilton's income in the private sector.

The Tribunal's Approach

5. In making its decision as to whether a warning would be appropriate in the circumstances of Mr Hilton's case, the Tribunal has had regard to both SG and the Guidance.

6. Throughout its deliberations the Tribunal has applied the principle of proportionality, weighing the public interest with Mr Hilton's interests. It has also adopted its findings on fact and impairment where relevant.

The Tribunal's Decision

7. The Tribunal recognises that warnings allow the Tribunal to indicate to a doctor that his misconduct represents a departure from the standards expected of members of the profession and should not be repeated. It is a formal response from the Tribunal in the interests of maintaining good professional standards and public confidence in doctors.

8. Mr Hilton has, from the outset of his dealings with his regulator, been contrite and remorseful. He has been open and transparent about what he told Patient A at the meeting on 2 November 2016. The Tribunal has made a finding of misconduct in relation to his dishonesty. It is confident he will not repeat it.

9. The Tribunal acknowledges a formal response may nonetheless be necessary as a result of Mr Hilton's dishonesty in his dealings with Patient A.

10. It notes a warning allows the GMC to identify any repetition of the particular conduct and take appropriate action. However, as has been stated at the impairment stage, it is confident that Mr Hilton will not repeat his dishonesty.

11. A warning is a serious response and appropriate for those concerns, as here, which fall just below the threshold for a finding of impaired fitness to practise. Thus the Tribunal has taken the view that its starting point is that a warning is appropriate.

12. There is no requirement for a deterrent in this case. A warning would be required if it were necessary to remind Mr Hilton that his conduct fell significantly below the standard expected and that a repetition would be likely to result in a finding of impaired fitness to practise. Mr Hilton is a conscientious and caring doctor; he does not need such a reminder. While the Tribunal recognises the need to mark the fact his conduct fell seriously below the standards expected of him, there is no prospect of repetition of his dishonesty.

13. The Tribunal acknowledges warnings may also have the effect of highlighting to the wider profession that certain conduct or behaviour is unacceptable. It adopts its earlier findings with regard to the overarching objective, particularly the maintenance and promotion of confidence in the profession and the maintenance and promotion of standards within it. There is a finding of misconduct in this case.

14. The Tribunal recognises that a warning is appropriate when there has been a significant departure from GMP, as in this case. As indicated above, and for this reason also, the Tribunal's starting point is that a warning is appropriate. However, it

also takes into account a warning is not mandatory in such circumstances: it is appropriate to take into account the merits of this case.

15. The Tribunal has considered the various factors identified in the guidance on warnings. There has been a clear and specific breach of GMP, as identified in the Tribunal's findings on impairment. The dishonesty is sufficiently serious that, if there were a repetition, it would result in a finding of impaired fitness to practise. The Tribunal bears in mind its findings on impairment as regards the impact on patient care, public confidence in the profession and the reputation of the profession. It considers there is no need to record formally the particular concerns because additional action will not be required: there will be no repetition.

16. The Tribunal acknowledges there is a presumption that the GMC should take some action when the allegations concern dishonesty (paragraph 24 of the guidance refers). However, it considers that this paragraph relates to the investigation stage, rather than to proceedings before the Tribunal. In any event, even if it were to apply to the Tribunal, the mere existence of a presumption is not, alone, sufficient to require the issue of a warning. This case should be considered in the round.

17. The Tribunal has applied the principle of proportionality. It has had regard to the guidance in Bolton v Law Society [1994] 1 WLR 512, [1993] EWCA Civ 32.

18. As regards mitigating and aggravating factors, the Tribunal finds as follows.

- Mr Hilton apologised to Patient A at the outset of his dealings with him, having received the letter of complaint of 19 July 2016. He reiterated that apology many times, including in these proceedings (notwithstanding the existence of ongoing litigation for the recovery of damages resulting from alleged clinical negligence);
- Mr Hilton has a long and unblemished record (apart from this misconduct) and there is no adverse history from the date of the incident to today's date;
- The incident was an isolated one; there has been no repetition and there will be no repetition. This was an aberration;
- There are no indicators that the misconduct will be repeated;
- Mr Hilton has changed his practice; he has attended relevant courses and training. He has fully reflected;
- There are exemplary wide-ranging testimonials and references which are relevant and informed. Mr Hilton is held in high regard by his peers and patients;
- The context of the dishonesty was a difficult meeting with a former patient who had made a complaint and who had made it clear he was seeking financial compensation and if he did not receive it he would report Mr Hilton to his regulator;

- Mr Hilton's motive (albeit misguided) was to act in the perceived best interests of the patient;
- While the dishonesty occurred in a clinical context, Patient A was no longer Mr Hilton's patient. He was not cooperating with Mr Hilton (e.g. he did not give permission for Mr Hilton to see his CT scans);
- The dishonesty was not exculpatory.

19. The Tribunal accepts there would be some impact on Mr Hilton's earnings in the private sector if a warning were issued but gives this no weight. Similarly, it accepts he would resign from various official organisations if a warning were issued but it considers that he would consider doing this in any event given the finding of misconduct. It gives this no weight therefore.

20. It is an aggravating factor that the dishonesty occurred in a clinical context (albeit in dealings with a former patient).

21. The Tribunal has taken into account the likely content of a warning if one were issued (referring to the guidance and Template A).

22. As in the case of impairment, the decision whether to issue a warning is finely balanced. However, taking the relevant factors in the round and noting the exceptional circumstances of this case and the lack of adverse motive, the Tribunal considers that while a warning would be appropriate in this case, particularly given the significant breach of GMP and the need to promote and maintain confidence and standards in the profession, it is not necessary or proportionate, given the wide-ranging mitigating factors and the particular circumstances in which the dishonesty occurred.

23. The Tribunal has therefore decided not to issue a warning.

24. That concludes this case.

Confirmed
Date 23 November 2018 Ms Angela Black, Chair