PUBLIC RECORD

Dr James has lodged an appeal against decisions of this Tribunal. He remains free to practise unrestricted while the appeal is considered.

Dates: 16/10/23 – 31/10/23; 08/07/2024 - 18/07/2024

Medical Practitioner's name:	Dr David JAMES
GMC reference number:	3124509
Primary medical qualification:	MB BS 1986 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, 3 months

Tribunal:

Legally Qualified Chair	Mr Ian Comfort
Medical Tribunal Member	Dr John Moriarty
Medical Tribunal Member	Dr Nagarajah Theva

Tribunal Clerk:	Ms Ciara Fogarty 16/10/23 - 23/10/23 Ms Kanwal Rizvi – 24/10/23 Mr Joel Taylor-Garratt 25/10/23 - 31/10/23 Ms Fiona Johnston 08/07/24 - 18/07/2024

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Ms Vivienne Tanchel , Counsel, instructed by Weightmans
GMC Representative:	Ms Elizabeth Dudley-Jones, 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 - 15/07/2024

Background

1. Dr James is a registered consultant anaesthetist. He qualified in 1986 from the University of London. At the time of the alleged events, Dr James was working at St Thomas' Hospital, part of Guy's and St Thomas' Hospitals Trust ('the Trust') in London.

2. The allegation that has led to Dr James' hearing can be summarised as that on 9 August 2019, whilst providing anaesthetic care to Patient A, Dr James slapped Patient A on one or more occasions and said to him '*stop messing around you fucker'*, or words to that effect. Towards the end of the procedure, Dr James administered medication to Patient A intending to cause retrograde amnesia. After the operation, Dr James said to Operating Department Practitioner ("ODP") Mr D, '*you're not going to say anything are you'*, or words to that effect, with the intention of preventing his actions being reported.

3. Patient A, a male, attended on 9 August 2019 for surgery to have his gallbladder removed. The previous month he had pancreatitis, an infection secondary to gallstones. Patient A's surgery was scheduled for 12:30 but due to the unavailability of an anaesthetist, was delayed by over two hours. On the day of his surgery, Patient A was assessed by Ms C, consultant surgeon. During the assessment, Patient A explained that he did not like needles. This information was relayed to Dr James and other colleagues in the operating theatre. Patient A was then taken into the operating theatre. When cannulation failed a decision was made by Dr James to use a gaseous induction. Whilst this was being attempted it is alleged that Dr James slapped Patient A.

4. When Patient A's surgery had finished, Mr D who had been checking on other theatre listings returned to theatre 5, where Patient A was in the postoperative bed. It is alleged that Dr James said to Mr D words to the effect '*you're not going to say anything are you?*' to which Mr D did not respond. Later that day, Mr D reported the incident to Ms E, who asked Mr D to write a statement and told him that she would escalate the matter to the matron.

5. When Patient A later started to wake up, he was very agitated and, it is alleged, appeared to be in pain. It is alleged that Dr James went to the anaesthetic room and came back and administered midazolam to Patient A. Dr B then allegedly asked Dr James what dose he had given to Patient A. It is alleged that Dr James then went to the anaesthetic room to check the vial and returned stating he had accidentally given Patient A a 10mg dose instead of a 5mg dose. Dr James then administered flumazenil to Patient A to reverse the effect of the midazolam.

6. Ms C next saw Patient A on 10 August 2019 when Patient A was to be discharged. During their conversation, Patient A informed Ms C that he was slapped by Dr James and that he just wanted to go home.

7. The matter was subsequently investigated by the police and led to a criminal trial at which Dr James entered a not guilty plea. He was found guilty of assault by the Magistrates' Court and following an appeal to the Crown Court his conviction was not upheld.

The Outcome of Applications Made

8. The Tribunal partially granted an application made on behalf of the General Medical Council (the 'GMC'), pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), whether to consider redactions to documents, resolve issues with the defence bundle and decide on admissibility of testimonials and the content. The Tribunal's full decision on the application is included at Annex A.

9. At the close of the GMC's case, Ms Tanchel, on behalf of Dr James, made an application pursuant to Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004, as amended ('the Rules') that there was no case to answer. The Tribunal's full decision on the application is included at Annex B.

The Allegation and the Doctor's Response

10. The Allegation made against Dr James is as follows:

That being registered under the Medical Act 1983 (as amended):

1. On 9 August 2019, whilst providing anaesthetic care ('the Procedure') to Patient A you:

a. slapped Patient A on one or more occasion;
To be determined

b. ~~said 'stop messing around you fucker', or words to that effect.~~
Withdrawn following Rule 17(2)(g) application

2. Towards the end of the Procedure, as Patient A emerged from anaesthesia, he became agitated and/or aggressive and you:

a. administered midazolam instead of opiate analgesia;
To be determined

b. administered 10mg of midazolam.
To be determined

3. The use of midazolam in preference to the use of opiate analgesia as described in paragraph 2a was not clinically indicated.
To be determined

4. The 10mg dose of midazolam as described in paragraph 2b was:

a. excessive; To be determined

b. not clinically indicated. To be determined

5. ~~Your actions at paragraph 2b were intended to cause Patient A retrograde amnesia.~~ Withdrawn following Rule 17(2)(g) application

6. After the operation you said to Mr B 'you're not going to say anything are you', or words to that effect. To be determined

7. ~~Your actions between paragraphs 2 and 6 were an attempt to prevent your actions at paragraph 1 being reported.~~ Withdrawn in relation to paragraphs 2-5 following Rule 17(2)(g) application.

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

Witness Evidence

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

- Patient A, in person
- Dr B, anaesthetic registrar, by video link
- Mr D, Operations Department Practitioner, by video link
- Ms E, nursing sister, in person
- Ms C, consultant surgeon, in person

12. Dr James provided a witness statement, his statement to the police and gave oral evidence at the hearing.

Expert Witness Evidence

13. The Tribunal also received evidence from Dr F and Professor I, both consultant anaesthetists, who provided individual expert reports and a joint expert report. They also gave oral evidence at the hearing to assist the Tribunal in understanding Dr James conduct in respect of certain alleged incidents.

Documentary Evidence

14. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to statements, emails, transcripts of police interviews, the anaesthetic record, expert reports and testimonials.

The Tribunal's Approach

15. 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. Dr James does not need to prove anything.

16. When addressing issues of fact, the Tribunal had regard to the case of *Roomi v GMC (2009) EWHC 2188*. Mr Justice Collins noted that:

> *'.....the practitioner faces an allegation which is contained in the notice and no other allegation unless that notice is amended in accordance with rule 17(3)*

17. 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. When considering the standard required to prove an allegation, the Tribunal should have regard to

the case of *Byrne v General Medical Council [2021] EWHC 2237 (Admin) (10 August 2021)* which states:

> *"A serious allegation requires careful analysis of the evidence taking account of inherent probabilities or improbabilities of an event happening. However there is no different standard of proof or especially cogent type of evidence required."*

18. The LQC reminded the Tribunal that it is entitled to draw proper inferences from the evidence, but it must not speculate. It should not *confuse grounds for suspicion with evidence sufficient to prove, on the balance of probabilities, a serious allegation against a doctor.* It should only draw an inference if it can safely exclude other possibilities as confirmed in *Sony v GMC (2015) EWAC 0364 Admin.*

19. The Legally Qualified Chair also referred the Tribunal to the cases of *Dutta v GMC (2020) EWHC 1974 (Admin)* and *Khan v The General Medical Council [2021] EWHC 374 (Admin)* which set out some useful reminders of how evidence should be evaluated by tribunals when considering the facts -and, in particular, the caution to be applied when considering the confidence and demeanour of a witness.

- In any approach to the factfinding stage care must be taken to avoid considering each part of the evidence in isolation. The tribunal should consider the reliability of the evidence as a global picture and not in isolation.
- Witness evidence is one part of the evidence. Objective evidence, for example contemporaneous documents, should be considered first.
- We believe memories to be more faithful than they are. Two common errors are to suppose (1) that the stronger and more vivid the recollection, the more likely it is to be accurate; (2) the more confident another person is in their recollection, the more likely it is to be accurate.
- The confident delivery and demeanour of a witness' evidence is not a reliable guide to whether it is the truth.
- Tribunals should not assess a witness's credibility exclusively on their demeanour when giving evidence.
- Tribunals should consider all of the evidence before them before coming to a conclusion about a witness's credibility. This could include conflicts in evidence with another witness, denials of the allegations and reasons why they could not be true.
- It is open to Tribunals not to rule out the whole of a witness's evidence based on credibility; credibility can be divisible.

20. The Tribunal was mindful of the case of *Byrne v General Medical Council [2021] EWHC 2237 (Admin)* which confirmed that the best evidence on which to base fact finding will always be objective matters shown by contemporaneous documentation. The court went on

to observe, however, that this is not always required and may not always be available. In such circumstances, "*substantial reliance may be properly placed on the oral evidence of a complainant, including in preference to that of a respondent*". It was stated that: "*… in a case where the complainant provides an oral account, and there is a flat denial from the other person concerned, and little or no independent evidence, it is commonplace for there to be inconsistency and confusion in some of the detail. Nevertheless, the task of the court … is to consider whether the core allegations are true.*

21. Studies have demonstrated that memory can be contaminated by erroneous information that people are exposed to after they witness an event. A person's evidence is *'contaminated*' if the evidence is false or misleading in any respect, or is different from what it would otherwise have been, and the evidence arises:

- as a result of an agreement or understanding between that person and one or more others, or
- as a result of the person being aware of anything alleged by one or more other persons whose evidence may be, or has been, given in the proceedings.

22. The Tribunal also accepted the advice of the Legally Qualified Chair that it was for the Tribunal to consider the reliability of any evidence that they conclude is contaminated and should consider whether to disregard it.

23. The Tribunal was informed that Dr James has no previous convictions or disciplinary findings. The Tribunal reminded itself that Dr James's good character was a matter it was entitled to take into account where his credibility was called into question, when considering whether it is more likely than not that he was telling the truth and whether he was likely to have behaved in the manner alleged.

The Tribunal's Analysis of the Evidence and Findings

24. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Paragraph 1a of the Allegation

25. The Tribunal considered whether, on 9 August 2019, whilst providing anaesthetic care to Patient A, Dr James, on one or more occasions, slapped Patient A. In determining this paragraph, the Tribunal reminded itself of the evidence of Patient A, Ms C, Mr D and Dr B, all of whom were present at the time. In particular it has considered the initial reports of these witnesses, mindful that over time evidence can be influenced by other matters.

26. Patient A recalls being slapped '*up to three times*' by Dr James. The Tribunal took into account that Patient A was being administered drugs to make him unconscious and could have been mistaken about being slapped or for how many times. The Tribunal had determined earlier that Patient A had no reason to fabricate the story about Dr James.

27. Ms C who conducted the operation was present in the operating theatre at the time although she did not witness Dr James slapping Patient A. She says she was at her computer and her mind was focussed on preparing for the operation. She saw Patient A the next day. She says that Patient A spontaneously volunteered words to the effect of "I got a slap" from Dr James.

28. Mr D says that he was standing next to Dr James and Patient A. He initially said that he saw Dr James slap the patient's face. While Mr D did not report the matter straight away, he did inform a work colleague Ms E about the incident later that day. In later statements Mr D said that Dr James slapped Patient A three times.

29. Dr B did not see Dr James slap Patient A. She says that she heard a loud slap sound. She says that she mouthed "did he just slap him" to Mr D and that he mouthed back "yeah" and nodded.

30. Dr James denies slapping Patient A. He says "*I did not slap the Patient A. However, I accept that this may have been how my actions were perceived as I attempted to keep his head still and the mask in position….*"

31. The Tribunal considered the environment in which the slap is alleged to have taken place.

32. In his initial written report of this matter, Mr D says:

> *'The situation was now hectic. The patient was large and becoming agitated, flailing his arms around. The consultant anaesthetist was trying to maintain the airway. The situation was tense, and force was being used to maintain airway. The consultant in this commotion slapped the patient's face and using a raised voice tone used an expletive expression something like 'stop fucking around.' I was in confusion and disbelief regarding the situation as so much had changed since I came back into the room'.*

33. Dr James also describes a fast-moving situation:

> *'Although Patient A was not fully anaesthetized by this point- insofar as he was not yet ready for surgery, he was no longer fully conscious and entering deeper anaesthesia. By that point it is vital to maintain oxygenation through the face mask to avoid hypoxia (with the risk of brain damage or death} and to deepen the anaesthesia. Airway compromise is also a real risk, particularly in an obese patient which*

potentially further worsens hypoxia and agitation. Doing nothing was therefore not an option- either the mask had to be held in situ with a good seal to ensure a continued supply of oxygen and anaesthetic drugs, or the procedure abandoned altogether, which I concluded at that point was the riskier option.

In the anaesthetic room the patient would be on a trolley with sides to prevent a patient rolling off during the induction of anaesthesia. The operating table had no sides and I was concerned that the patient might roll off the table and sustain injury. There was also a risk of compromise to his airway. I therefore acted quickly and in Patient A's best interests by restraining him to prevent him sustaining harm or injury. I held his head in position and kept the mask in place- which was difficult without assistance, given Patient A's size, strength, and level of agitation.'

34. In his evidence Dr F says

"This can be an extremely taxing situation to manage as it becomes increasingly difficult to keep the facemask in place to administer further anaesthesia. Without the ability to deepen anaesthesia, the patient may remain in the excitatory phase, obstructing their airway in the process and becoming hypoxic. On occasions this may result in a potentially life-threatening situation and a medical emergency…In this instance the patient was obese and anxious. These factors would have made obtaining intravenous access more difficult than otherwise might have been the case. Obesity can also make airway management much more difficult and unquestionably adds to the complexity and risk of gaseous induction of anaesthesia.

35. The Tribunal was mindful that this incident took place in a hectic environment with a potentially life-threatening situation and a medical emergency where Dr James' focus was on Patient A's well-being. However, there were three witnesses that say Dr James slapped Patient A at least once and, despite some differences, their evidence was reliable. The Tribunal was satisfied that it was more likely that not that Dr James did slap Patient A.

36. Accordingly, the Tribunal determined and found paragraph 1a of the Allegation proved.

Paragraph 2a and 2b of the Allegation

37. The Tribunal considered whether, towards the end of the procedure, as Patient A emerged from anaesthesia, Dr James administered midazolam instead of opiate analgesia and administered 10mg of midazolam. The Tribunal noted that it is the GMC's case that Dr James directly administered the drug to Patient A.

38. The Tribunal noted that there was a factual dispute about who directly administered midazolam to Patient A.

39. Dr James's says that he asked his assistant, Ms G to fetch 5mg of midazolam from the controlled drug cupboard. He says that he did not directly administer the midazolam but cannot recall who did. He says that he instructed an assistant to administer a 5mg dose.

40. Dr B says that she saw Dr James go to the anaesthetic room. He came back and gave Patient A an injection. She said that she asked him what this was, and that he said that it was midazolam. She said that when she questioned Dr James on the dose, he had given he went to the anaesthetic room to check the vial. She said that Dr James said he had accidently given a 10mg dose rather than a 5mg dose. He then administered flumazenil to reverse the effect of midazolam.

41. The Tribunal noted that Dr James stated that the midazolam was already available when Patient A was on the post operative bed. Dr B in her witness statement accepted that the midazolam would have been signed out in advance of the operation.

> *'Midazolam is a controlled drug, as is morphine and fentanyl, so would have been signed out of the controlled drugs cupboard by the ODP in advance of the operation. Non-controlled drugs such flumazenil are freely available for use in the theatre and are stored in the anaesthetic room'*.

42. On that basis the Tribunal concluded that it was more likely than not the midazolam was readily available, and that Dr B had been mistaken. She had assumed Dr James had gone to get the drug when he left the room, However, there was not any evidence that Dr James had access to the controlled drugs cabinet to get the midazolam.

43. The Tribunal also concluded that Dr B could have mistaken the administration of midazolam with the administration of flumazenil or saline. Therefore, the Tribunal accepted Dr James' version of events that he prescribed midazolam and directed someone else to administer it.

44. Notwithstanding who administered the midazolam the Tribunal considered whether midazolam was administered instead of opiate analgesia. The Tribunal took into account the expert opinions of Professor I and Dr F.

45. Professor I's opinion was:

> *'…the administration of an opioid to a patient who remains intubated and who is agitated during emergence is generally unhelpful.*
> *…*
> *the analgesia administered to [Patient A] during the anaesthetic would have been expected to provide adequate (but perhaps not optimal) pain relief. Consequently, I believe that the administration of opioid to treat his emergence agitation would not have made a useful contribution'.*

46. Dr F's opinion was:

> "*Post-operative agitation is not uncommon after surgery. There may be situations in which the administration of a small dose of midazolam is indicated in these circumstances. In most cases, however, post-operative agitation is primarily the result of either pain or urinary retention, and the vast majority of anaesthetists would administer further analgesia in the first instance whilst excluding the latter by clinical examination..*
> *In this case, whilst it is entirely possible that it might have been appropriate to administer midazolam if agitation persisted, it should only have been administered after more analgesia had been given. In my view to have given midazolam as a first line treatment to an agitated patient who may well have been in pain, in preference to opiate analgesia, was clinically incorrect…*
> *If pain had been excluded as a cause for agitation, it might have been reasonable to administer midazolam 2mg as an initial dose."*

47. Dr James says

> *'I do not agree that opioids would have been a better choice in those circumstances. Opioids used for pain management were of secondary importance in these circumstances. I would never consider the use opioids in a semi-conscious, morbidly obese patient with a compromised airway to be a safe undertaking; indeed that could rapidly worsen the outcome for the patient. Opioids suppress respiratory effort ie the rate and depth of breathing, which is exactly what this patient didn't need given his breathing was already severely compromised. Opiods given at doses to reduce " pain" are not reliable sedatives.'*

48. Dr F's opinion is based on a presumption that Patient A was in pain. However, Professor I says that in Patient A's case:

> "*I believe that the emergence agitation was almost certainly not caused predominantly by pain; he had several risk factors for emergence agitation… consequently, I am of the opinion that re-sedation was the appropriate management in this potentially dangerous situation."*

49. The Tribunal was satisfied that there was a body of opinion, articulated by Professor I and Dr James, that in relation to the circumstances of Patient A there was not a preference in using opiate analgesia instead of midazolam.

50. Accordingly, the Tribunal found paragraphs 2a and 2b not proved.

<u>Paragraph 3 of the Allegation</u>

51. Paragraph 3 of the Allegation is found not proved due to the Tribunal's findings at paragraph 2a.

Paragraph 4a and 4b of the Allegation

52. The Tribunal considered whether the 10mg dose of midazolam was excessive and not clinically indicated.

53. Dr James and both experts agreed that administering a 10mg dose of midazolam as described in paragraph 2b was excessive.

54. Therefore the Tribunal find paragraph 4a and 4b proved; however, it noted that the Tribunal has found that it was not Dr James who directly administered the midazolam as set out in paragraph 2b.

Paragraph 6 of the Allegation

55. The Tribunal considered whether after the operation Dr James said to Mr D '*you're not going to say anything are you*'. Dr James says that he has no recollection of making any such comment.

56. The Tribunal also took into account the written evidence of Mr D provided for the GMC. He said: *'I walked around foot (sic) of the patient's bed and Dr James said to me 'You're not going to say anything are you.'*

57. In his earliest account to the Trust and his later statement to the police, Mr D uses different wording. He says: *'I was back in theatre 5 again and Dr James asked me ; "Are you going to say anything*?"

58. Dr B gives a different variation on the words used:

> *'Just before waking the patient up Dr James asked [Mr D] in front of everyone in theatre, "You're not going to tell on me are you? You're not going to say anything about this are you?" which [Mr D] ignored and did not respond.'*

59. The Tribunal noted that Mr D gave different accounts of what Dr James allegedly said. It also noted that Dr B's recollection varied from Mr D.

60. The Tribunal considered that the words '*are you going to say anything*?' have a very different interpretation and effect than the words '*you're not going to say anything are you*?'. The first could be seen as a straightforward question; the second as a possible attempt to influence a person's actions.

61. Given its findings that the words 'are you going to say anything?' do not have the same effect as the words in the Allegation, the Tribunal did not find it more likely than not that words in the Allegation or words with a similar effect were used by Dr James, the Tribunal found paragraph 6 of the allegation not proved.

Paragraph 7 of the Allegation

62. Paragraph 7 of the Allegation is found not proved due to the Tribunal's findings at paragraph 6.

The Tribunal's Overall Determination on the Facts

63. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

1. On 9 August 2019, whilst providing anaesthetic care ('the Procedure') to Patient A you:

a. slapped Patient A on one or more occasion; Found proved

b. ~~said 'stop messing around you fucker', or words to that effect.~~ Withdrawn following Rule 17(2)(g) application

2. Towards the end of the Procedure, as Patient A emerged from anaesthesia, he became agitated and/or aggressive and you:

a. administered midazolam instead of opiate analgesia; Found not proved

b. administered 10mg of midazolam. Found not proved

3. The use of midazolam in preference to the use of opiate analgesia as described in paragraph 2a was not clinically indicated. Found not proved

4. The 10mg dose of midazolam as described in paragraph 2b was:

a. excessive; Found proved

b. not clinically indicated. Found not proved

5. ~~Your actions at paragraph 2b were intended to cause Patient A retrograde amnesia.~~ Withdrawn following Rule 17(2)(g) application

6. After the operation you said to Mr B 'you're not going to say anything are you', or words to that effect. Found not proved

7. ~~Your actions between paragraphs 2 and 6 were an attempt to prevent your actions at paragraph 1 being reported.~~ Withdrawn in relation to paragraphs 2-5 following Rule 17(2)(g) application. Not proved in relation to paragraph 6.

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 - 17/07/2024

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether Dr James' fitness to practise is impaired by reason of misconduct.

The Evidence

2. The Tribunal has taken into account all the findings of fact and the evidence it considered in reaching its earlier findings.

Submissions

On behalf of the GMC

3. Ms Dudley-Jones, Counsel, submitted that the facts found proved in this case amount to serious misconduct and that Dr James' fitness to practise is impaired by reason of that misconduct. She referred the Tribunal to the relevant case law in *R (on the application of Calhaem) v. General Medical Council [2007] EWHC 2606 (Admin); Roylance (no 2) v GMC [2000] AC 311; Cheatle v GMC [2009] EWHC 645 (Admin); Council for Healthcare Regulatory Excellence v NMC, Grant [2011] EWHC 927;* and *Yeong v The General Medical Council [2010] 1 WLR 548.* She also referred the Tribunal to the relevant paragraphs in good medical practice ('GMP').

4. She submitted that the Tribunal should take a 2-stage approach. She submitted that the Tribunal should consider misconduct and then current impairment. She set out the factors which may assist the Tribunal in determining if there was serious misconduct.

5. Ms Dudley-Jones submitted that the Tribunal has found that the incident took place in a hectic environment with a potentially life-threatening situation and a medical emergency where Dr James' focus was on Patient A's wellbeing. However, the Tribunal has found that there were three witnesses to Dr James slapping Patient A.

6. Ms Dudley-Jones referred the Tribunal to the expert reports and took the Tribunal through the witness statements of Dr B, Patient A and Mr D. She submitted that the impact of assaulting the patient caused shock at the scene to Mr D and Dr B as well as the patient. She said that Patient A verbally reacted to Dr James after having been struck.

7. Ms Dudley-Jones took the Tribunal through the relevant dates of the various Trust, criminal and regulatory hearings that had taken place in relation to this matter. She submitted that in the circumstances there had been no delay occasioned by the GMC in bringing these proceedings.

8. She submitted that, given the proven allegation, Dr James' actions can be properly categorised as deliberate behaviour towards Patient A who had his own vulnerabilities due to his weight, anxieties and needle phobia. She submitted that Dr James' actions demonstrate a number of clear and serious breaches of GMP. She submitted that Dr James' actions in assaulting Patient A have plainly put Patient A at risk of harm, albeit no actual harm was caused to him. She submitted that Dr James' actions seriously undermine public confidence in the profession and have breached one of the fundamental tenets of the profession.

9. Ms Dudley-Jones submitted that the Tribunal has seen his testimonials and will be able to evaluate him and judge his response to the allegations, which he has denied. She said that remediation and insight thereafter are matters for the Tribunal to judge accordingly. She submitted that there is no evidence before the Tribunal that Dr James has remedied or attempted to remedy his misconduct. Therefore, can the Tribunal be satisfied his misconduct will not be repeated were he to find himself in a similar situation in the future?

10. She submitted that Dr James' misconduct is so serious that a finding of impairment of fitness to practise is justified. She submitted that the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.

<u>On behalf of Dr James</u>

11. Ms Tanchel said that Doctor James has read the determination on facts and accepts that slapping a patient would amount to misconduct; as has always been his position. She said that the Tribunal has found that Dr James slapped Patient A at least once.

12. She said that Dr James appeared at Croydon Magistrates Court on the 17 October 2022. He was found guilty of common assault and the District Judge dealt with this by way of a conditional discharge. She said that the conviction was appealed to the Inner London Crown Court, where an application of no case to answer was successful and the conviction not upheld.

13. Ms Tanchel submitted that the approach to impairment is more nuanced than that to misconduct. She said that Dr James does not accept that his practice is currently impaired.

14. She submitted that when considering impairment, the Tribunal will of course consider the three limbs of the overarching objective. With regard to patient safety, the likelihood of Dr James behaving in this way again was improbable. Ms Tanchel referred the Tribunal to the numerous testimonials which attest to Dr James good character and clinical skills. She submitted that Dr James is a doctor of some 30 years practice without prior complaint, and 25 years practice at the time of these events. She submitted that these testimonials are not written by people who only have a casual knowledge of him, they have known him for decades and have worked alongside him.

15. She submitted that this operation, although very challenging, would not have been the first very challenging operation undertaken by Doctor James. She said that it has been claimed that Dr James was frustrated and in a hurry because the list was overrunning. She said that the Tribunal has not found this a proven fact. She said the incident is a classic example of an isolated incident and out of character sequence of events.

16. She submitted that every testimonial writer would not be shocked and dismayed if Dr James was not to be found impaired on a public interest basis. In fact, each and every one of them attests to the fact that they would happily work with him again.

17. She submitted that the doctor's current fitness to practise must be gauged partly by his past conduct or performance and must also be judged by reference to how he is likely to behave or perform in the future. She said Dr James will not find himself in this position again on the evidence which the Tribunal has seen.

18. Ms Tanchel referred the Tribunal to several cases which considered the issue of a rejected defence. These included *Misra v GMC* [2003] UKPC 7; *Nicholas-Pillai v GMC* [2009] EWHC 1048 (Admin); *GMC v Awan* [2020] EWHC 1553 (Admin); *Sayer v GOsC* [2021] EWHC 370 (Admin); *Towuaghantse v GMC* [2021] EWHC 681 (Admin); and *Sawati v General Medical Council* [2022] EWHC 283 (Admin). She submitted that Dr James does not accept the allegation and he does not need to go on a course to understand that slapping a patient is not appropriate and therefore it is simply box ticking by going on courses. She submitted that

Dr James was entitled to defend the allegations against him and that this should not be a reason for concluding that he does not have insight. She submitted that Dr James denying the offence should not automatically lead to a conclusion of current impairment and it is wrong to equate maintenance of innocence with lack of insight. She said that a finding of misconduct does not ineluctably lead to impairment. There is no evidence of attitudinal or deep seated problems.

19. She submitted that the Tribunal is left with considering the reputation of the profession. She submitted that a member of the public fully informed of all of the circumstances of this matter would not be shocked if Dr James was found not impaired, five years after the event. She submitted that there would be no reputational risk to the profession if in the circumstances of this case a finding of impairment was not made.

The Relevant Legal Principles

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

21. In approaching the decision, the Tribunal adopted a two-stage approach: first do the proven facts amount to a category of impairment under section 35C of the Medical Act 1983 and if so is Dr James' fitness to practise currently impaired.

22. The Tribunal noted the provisions of section 35C of the Medical Act 1983 which provides that a person's fitness to practise may be regarded as impaired by reason of misconduct.

23. The Tribunal reminded itself that it must determine whether Dr James' fitness to practise is impaired today, taking into account his conduct and actions at the time of the events and any relevant factors since then such as any expressions of remorse or insight, whether the matters are remediable, whether they have been remedied and any likelihood of repetition.

24. The Tribunal had regard to the case of *Roylance v General Medical Council (No.2) [2000]1 AC 311 (UKPC)* which states:

> *'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [medical] practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word professional which links*

the misconduct to the profession [of medicine]. Secondly, the misconduct is qualified by the word serious. It is not any professional misconduct which would qualify. The professional misconduct must be serious.'

25. The Tribunal reminded itself that in determining whether the proven facts establish misconduct it should consider whether Dr James has breached any of the relevant provisions of Good Medical Practice, the extent of any such breach and the circumstances or context in which the breach occurred.

26. In order to determine whether Dr James' fitness to practise is impaired as of today, the Tribunal took into account his conduct and actions at the time of the events and any relevant factors since then, such as any expressions of remorse or insight, whether the matters are remediable, whether they have been remedied and any likelihood of repetition.

27. In dealing with insight, the Tribunal directed itself to the case of *GMC v Awan [2020] EWHC 1553 (Admin)* which considered whether, if a person disputes the misconduct allegations and continues to do so even after a finding of gross misconduct, can the misconduct hearing conclude that the person lacks insight and remorse. This case concluded that such a conclusion should not be reached automatically although a continued denial of the findings may be a relevant factor. Also, in the case of Sayer v GOC 2021 it was stated that the maintenance of innocence is not to be equated with lack of insight.

28. The LQC referred the Tribunal to the cases that Ms Tanchel had highlighted relating to how it should consider a rejected defence. In addition to *Sawati*, from which Ms Tanchel had referenced a number of paragraphs, he drew the Tribunal's attention to the following cases:

Towuaghantse v General Medical Council (Rev 2) [2021] EWHC 681 (Admin)

"In my judgment a distinction should be drawn between a defence of an allegation of primary concrete fact and a defence of a proposed evaluation (or exercise of discretion) deriving from primary concrete facts. The former is a binary yes/no question. The latter requires a nuanced analysis by the decision-maker with a strong subjective component. If a registrant defends an allegation of primary concrete fact by giving dishonest evidence and by deliberately seeking to mislead the tribunal then that forensic conduct would certainly say something about impairment and fitness to practise in the future. But if, at the other end of the scale, the registrant does no more than put the GMC to proof then I cannot see how that stance could be held against him in the impairment and sanctions phases."

General Medical Council v Awan [2020] EWHC 1553 (Admin)

> *"I think that it is too much to expect of an accused member of a profession who has doughtily defended an allegation on the ground that he did not do it suddenly to undergo a Damascene conversion in the impairment phase following a factual finding that he did do it. Indeed, it seems to me that to expect this of a registrant would be seriously to compromise his right of appeal against the factual findings and add very little, if anything, to the principal allegations of culpability to be determined.*

Ahmedsowida v GMC [2021] EWHC 3466 (Admin)

> *"I do not think the principle is sophisticated or complicated. It is just ordinary due process. Contesting the charges, even robustly, should not be treated of itself as evidence of lack of insight; something more must be shown. A finding that blatant lies were told to the tribunal is one possibility. A long hiatus between the fact finding, and impairment and sanction stages may be a contributing feature."*

29. 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 and Paula Grant [2011] EWHC 297 Admin*. In particular, the Tribunal considered whether its findings of fact showed that Dr James' 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. …*

30. The LQC advised the Tribunal that it should bear in mind the guidance in Grant (above) at paragraphs 71 and 74, that:

> *'it is essential when deciding whether fitness to practise is impaired, not to lose sight of fundamental considerations […] namely the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession'*
>
> *…*

'the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public…..but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

31. The Tribunal considered whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of current impairment were not made. Throughout its deliberations, the Tribunal has been mindful of its responsibility to uphold the overarching objective as set out in the Medical Act 1983 (as amended). That objective is the protection of the public and involves the pursuit of the following:

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

The Tribunal's Determination on Impairment

Misconduct

32. The Tribunal first considered whether the facts found proved amounted to misconduct that was serious.

33. The Tribunal had regard to its determination at the fact-finding stage.

34. The Tribunal noted that Dr James and both the experts agreed that slapping a patient was unacceptable and would amount to misconduct that was serious.

35. The Tribunal reminded itself of the standards set out in Paragraphs 2, 46 and 65 of GMP that:

2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

46 You must be polite and considerate.

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

36. Taking into account all of the above, the Tribunal determined that Dr James' actions in slapping Patient A was misconduct that was serious.

Impairment by reason of misconduct

37. Having found misconduct, the Tribunal went on to consider whether Dr James' fitness to practise is currently impaired by reason of that misconduct. Throughout its deliberations, the Tribunal had regard to the statutory overarching objective and the legal principles set out above.

Insight, remediation and risk of repetition:

38. The Tribunal considered insight, remediation and the risk of repetition.

39. When dealing with insight and remediation, the Tribunal directed its mind to the evidence and submissions made by the GMC and on behalf of Dr James. The Tribunal also considered whether the misconduct in question is remediable and whether it has been remediated.

40. The Tribunal acknowledged that it is always difficult for a doctor to demonstrate insight or remediation when they have put forward a robust defence to an allegation and also where there is no gap between the fact finding and impairment stages of a hearing. The Tribunal was cautious not to consider Dr James' defence as an impairment to his demonstrating insight. In this case, the Tribunal noted that Dr James has always accepted that slapping a patient is wrong. In all of the circumstances the Tribunal considered that Dr James has demonstrated such insight as he can into the impact of a doctor striking a patient.

41. The Tribunal has been provided with many testimonials which to attest to Dr James' good character and clinical practice. The Tribunal accepts that his misconduct was out of character. It found that the slap was a single, isolated incident. As such, the Tribunal considered the risk of repetition to be very low. The Tribunal has borne in mind that there were no prior disciplinary matters and there has been no repetition since the events of 2019 and his appearance in court in 2022. The Tribunal considered it unlikely that he would repeat his behaviour were he in a similar situation again.

Public Interest

42. The Tribunal agrees with Ms Tanchel that the key issue for this Tribunal in considering impairment in this matter is the public interest in upholding standards and maintaining confidence in the profession. It is accepted by all that slapping a patient is unacceptable. This matter is aggravated by the fact that at the time this was a particularly vulnerable patient.

43. The Tribunal is in no doubt that both the medical profession and the wider public would find Dr James' conduct towards Patient A to be a matter of serious concern.

44. Having considered the public interest in the case, the Tribunal concluded that, in all the circumstances, and despite the passage of time a finding of impairment was required to promote and maintain public confidence in the medical profession, and to uphold proper professional standards and conduct for members of that profession.

45. The Tribunal determined that proper professional standards would not be upheld and public confidence in the medical profession would be undermined if a finding of impairment were not made.

46. Accordingly, the Tribunal determined that Dr James' fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 18/07/2024

1. Having determined that Dr James' 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

On behalf of the GMC

3. Prior to making any submissions, Ms Dudley-Jones informed the Tribunal that on 23 December 2020, following a disciplinary hearing, Dr James was dismissed by the Trust and has not worked since.

4. Ms Dudley-Jones reminded the Tribunal that the decision on sanction is a matter for it alone, exercising its own judgment. She reminded the Tribunal that when determining the appropriate sanction, it needed to impose the least restrictive sanction to protect the public. She referred the Tribunal to the relevant paragraphs of the Sanctions Guidance (November 2020 edition) ('the SG'), the relevant case law and its findings on impairment.

5. Ms Dudley-Jones submitted that the appropriate and proportionate sanction in this case was erasure.

6. She submitted that Dr James is not a junior doctor, he is a very experienced consultant and anaesthetist, and ought to have been well able to deal with the situation that presented itself on the 9th of August. She said there has been a lapse of time since the incident. However, the Tribunal may feel that this is as a consequence of Trust and criminal proceedings, his appeal, and thereafter these proceedings.

7. She submitted that the aggravating factor in this case is the disparaging comment regarding the patient's weight made immediately before assaulting him. She said that the Tribunal has identified in its determination at paragraph 42 that the slapping of Patient A was aggravated by the fact that at the time this was a particularly vulnerable patient.

8. She submitted that Dr James' misconduct was a serious departure from GMP. She said that slapping a patient is plainly unacceptable. She submitted that Dr James' actions were a deliberate disregard for the principles set out in GMP. They plainly involved the loss of his temper in that he slapped a particularly vulnerable patient whilst on the operating table who was about to undergo an operative procedure and it is an abuse of a position of trust.

9. She submitted that this is not a case where serious harm has been done, but the doctor risked harming his patient by his actions. She said that the Tribunal might consider that the doctor did not act in a patient's best interest and failed to provide an acceptable level of care, falling well below expected professional standards, taking into consideration both expert's views.

<u>On behalf of Dr James</u>

10. Ms Tanchel said that the Tribunal had decided impairment on public interest grounds only. She said that the facts of this case are unusual, and this makes the Tribunal's task difficult. She submitted that the Tribunal has found this incident happened in a challenging and fast-moving environment and that Dr James' focus was on Patient A's well-being. She

submitted that this was not a random assault on a patient in a corridor but did not seek to undermine the fact that slapping a patient is serious.

11. She submitted that there is a spectrum of seriousness and the Tribunal needs to decide where Dr James misconduct falls in considering what would serve the public interest in deciding Sanction. With regards to the mitigating factors, she submitted that Dr James is a doctor of good character; there are no previous findings by any professional tribunal. She said that it would be wrong to consider Dr James' dismissal by the Trust as an aggravating factor.

12. She said at the time of events this was a difficult operation for all involved who had to deal with a complex patient in an environment where resources were stretched.

13. She submitted that the GMC was making an attempt to shoehorn rather unusual circumstances into the '*aggravating features*' in the SG. She submitted that discrimination does not apply. There is no evidence before the Tribunal that Dr James singled out this patient because of his personal characteristics.

14. With regards to remediation, she reminded the Tribunal of its findings on impairment, which clearly set out why remediation in this case has limited scope. She invited the Tribunal to discard any notion that the public interest is not served by anything less than erasure, because this doctor has not remediated.

15. She also referred the Tribunal to the positive testimonials and pointed out that, although she accepted that the testimonials were written in advance before the findings of fact, they are extraordinary, and his colleagues hold him in high regard.

16. Ms Tanchel submitted that the appropriate sanction in this case is a period of suspension. This would maintain public confidence and maintain proper standards of conduct.

17. Ms Tanchel referred the Tribunal to the following two cases:

Wallace v Secretary of State for Education [2017] EWHC 109:

'The criticism begins with the principle set out in Bolton v Law Society [1994] 1 WLR 512 that because professional disciplinary proceedings are concerned primarily with the public interest in maintaining professional standards and the reputation of the profession rather than punishment, personal mitigation generally has a lesser effect or weight than would otherwise be the case. However, the public interest in retaining a person who is able to make a valuable contribution to a profession, can be a factor

carrying substantial weight against prohibiting him or her from working in that profession'

Bijl v General Medical Council, 2001 WL 1135145 (2001)

'The Committee was rightly concerned with public confidence in the profession and its procedures for dealing with doctors who lapse from professional standards. But this should not be carried to the extent of feeling it necessary to sacrifice the career of an otherwise competent and useful doctor who presents no danger to the public in order to satisfy a demand for blame and punishment.'

18. She submitted that Dr James will never find himself in this position again. She submitted that Dr James still has a large amount to contribute to the profession and erasing him from the register when he presents no public safety issue, would be a loss to the public. She stated that erasing Dr James's name from the register was not appropriate or proportionate.

The Tribunal's Determination on Sanction

19. The Tribunal reminded itself that the decision as to the appropriate sanction to impose, if any, was a matter for it alone, exercising its own judgement. In reaching its decision on sanction, the Tribunal had regard to the SG, its findings on misconduct and impairment and the submissions made by Ms Dudley-Jones and Ms Tanchel. It bore in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it recognised that any sanction imposed may have a punitive effect. It reminded itself that in deciding what sanction, if any, to impose, it should start with the least restrictive.

20. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr James' interests with the public interest. It considered and had regard to the overarching objective, which includes the protection of the public, the maintenance of public confidence in the profession, and the promotion and maintenance of proper professional standards and conduct for members of the profession.

Aggravating and Mitigating Factors

21. The Tribunal had already concluded that slapping a patient was a very serious matter. Before considering what action, if any, to take in respect of Dr James' registration, the Tribunal identified what it considered to be the aggravating and mitigating factors in this case.

22. The Tribunal identified the following aggravating factors:

- At the time the patient was vulnerable by virtue of his anxiety, and his position on the operation table while being anesthetised;

23. Having identified aggravating factors in this case, the Tribunal identified the mitigating factors to be:

- This incident took place in a hectic environment with a potentially life-threatening situation and a medical emergency;
- Dr James has no adverse regulatory history;
- This was an isolated incident and out of character, as attested to by his testimonials;

24. The Tribunal determined that Dr James' insight is neither a mitigating nor an aggravating factor. It recognised that Dr James has denied this matter throughout but he has always acknowledged that he said striking a patient is unacceptable and amounts to misconduct.

25. The Tribunal did not consider the lapse of time to be significant mitigation in this case. There had been a number of different hearings before different bodies before this matter could be considered by this Tribunal. The Tribunal accepted that this matter had been dealt with in a timely manner by the GMC given these circumstances. In addition, the Tribunal did not consider that during the 5 years that have passed since this incident there has been anything to indicate that this should mitigate the misconduct.

26. The Tribunal balanced the aggravating and mitigating factors throughout its deliberations and went on to consider each sanction in order of ascending severity, starting with the least restrictive.

No Action

27. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

28. The Tribunal determined that there were no exceptional circumstances in Dr James's case which would justify it taking no action. It considered that given the seriousness of the

misconduct and its findings of impaired fitness to practise, taking no action would not be sufficient, proportionate, or in the public interest.

Conditions

29. The Tribunal next considered whether to impose conditions on Dr James's registration. The Tribunal took note that any conditions would need to be appropriate, proportionate, workable and measurable. The Tribunal determined that no measurable or workable conditions could be formulated in this case. Further, the Tribunal did not consider that a period of conditional registration would be sufficient to mark the seriousness of the misconduct found and would not satisfy the overarching objective, public interest or uphold public confidence in the profession.

Suspension

30. In giving weight to the aggravating and mitigating factors previously identified, the Tribunal was satisfied that action must be taken to mark the seriousness of the misconduct and to maintain public confidence in the profession. The Tribunal considered whether it should impose a period of suspension on Dr James' registration. The Tribunal had regard to paragraphs 91, 92, 93 and 97(a), (e), (f) and (g) of the SG which provide:

> *'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 (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*
>
> *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.*
> ...

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, e.g. 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.'*

31. The Tribunal was in no doubt that Dr James' misconduct was sufficiently serious that significant action is required to meet the needs of the overarching objective and, specifically, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of the profession. The Tribunal considered that a message must be sent to the medical profession and the public that Dr James' behaviour was entirely unacceptable.

32. The Tribunal considered that Dr James' misconduct involving an act of slapping a vulnerable patient, who was on an operating table receiving anaesthetic was very serious and significantly departed from GMP. However, it took into account the fact that this was an isolated, out of character incident over a lengthy career during which Dr James has not come to the attention of his regulator. The Tribunal considered whether Dr James had deliberately or recklessly disregarded GMP. Although it has found that the slap itself was deliberate it could not conclude on the evidence available that this meant that Dr James' had a deliberate or reckless disregard for GMP. The Tribunal considered that not every falling short of the standards implies a deliberate or reckless disregard for GMP.

33. The Tribunal recognised that a sanction of suspension does have a deterrent effect and can be used to send a signal to Dr James, the profession, and the public about what is regarded as behaviour unbefitting a registered doctor. It also acknowledged that suspension is an appropriate response to misconduct which is sufficiently serious that action is required in order to maintain public confidence in the profession, but which falls short of being fundamentally incompatible with continued registration.

34. Taking all of the evidence, submissions and its own earlier conclusions into account, the Tribunal determined that a period of suspension would be an appropriate and proportionate sanction balancing Dr James interests with those of the public. Additionally, it would have the deterrent effect of sending a signal to Dr James, the profession and the public that his misconduct was unbefitting of a registered doctor.

Erasure

35. While the Tribunal considered a period of suspension would satisfy the overarching objective, it went on to consider the sanction of erasure, as submitted by the GMC. The Tribunal considered paragraph 108 of the SG:

> *108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.*

36. Having balanced the aggravating and mitigating factors and considered all the circumstances of this case, the Tribunal did not find Dr James' conduct fundamentally incompatible with continued registration. The Tribunal considered that to erase Dr James' name from the register would be disproportionate and that erasure was not the least restrictive sanction to protect the public interest and would deprive the public of an otherwise competent and well-regarded doctor.

Length of Suspension

37. Having determined that a period of suspension was the appropriate and proportionate sanction, the Tribunal went on to determine the length of the suspension. In doing so, it had regard to paragraph 100 of 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…*

c ensuring the doctor has adequate time to remediate.'

38. The Tribunal had regard to the need to mark the seriousness of Dr James' misconduct and to declare and uphold proper standards of behaviour. It had regard to the fact there was no risk of harm to patients as well as the aggravating and mitigating factors in this case. Having taken all these matters into account the Tribunal determined to impose a three-month period of suspension on Dr James's registration. The Tribunal considered that suspension for a period of three months would be sufficient to send a signal to Dr James, the wider profession and the public about conduct which is regarded as unbefitting a registered doctor. It considered that a period of suspension of any greater length would be unnecessary and punitive.

Review

39. The Tribunal considered whether to direct a review hearing. It bore in mind the guidance at paragraph 164 of the SG which advises that:

> *'164 In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. However, in most cases where a period of suspension is imposed, and in all cases where conditions have been imposed, the tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions or further conditions. A review hearing is therefore likely to be necessary, so that the tribunal can consider whether the doctor has shown all of the following (by producing objective evidence): a they fully appreciate the gravity of the offence b they have not reoffended c they have maintained their skills and knowledge d patients will not be placed at risk by resumption of practice or by the imposition of conditional registration'*

40. The Tribunal was satisfied that a review hearing was not necessary in this case as it concluded that the public interest would be met upon the expiration of the suspension without the need for a review given the unlikely risk of repetition. The Tribunal took the view that a review hearing would serve no useful purpose and it considered that Dr James would be safe to return to unrestricted practice at the end of the period of suspension.

Determination on Immediate Order - 18/07/2024

1. Having directed that Dr James' registration be suspended for three months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr James' registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Ms Dudley-Jones submitted that it was necessary in this case to make an immediate order in light of the Tribunals findings. She submitted that an immediate order is in the public interest and to protect public confidence in the profession.

3. On behalf of Dr James, Ms Tanchel submitted that an immediate order is neither necessary nor desirable in the public interest. She said that Dr James represents no risk whatsoever to any patient or any member of the public.

The Tribunal's Determination

4. The Tribunal has taken into account the relevant paragraphs of the SG which state:

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor….'*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect*.

5. The Tribunal determined that the events leading to this sanction occurred 5 years ago, the Tribunal does not think the public would be concerned if Dr James were able to return to unrestricted practice pending the substantive sanction of suspension coming into effect. The Tribunal concluded it is not necessary to impose an immediate order to protect members of the public, it is not in the public interest, and it is not in the best interests of the doctor.

6. This means that Dr James' registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served unless he lodges an appeal. If Dr James does lodge an appeal, he will remain free to practise unrestricted until the outcome of any appeal is known.

7. The interim order is hereby revoked.

8. That concludes the case.

Annex A – 18/07/24

Application on the admission of evidence pursuant to Rule 34(1)

1. On 16 October 2023, in the preliminary stage of the hearing, Ms Elizabeth Dudley-Jones, Counsel for the GMC, provided a skeleton argument to the GMC. The preliminary matters before the Tribunal consisted of; application for redactions within GMC documentation, issues with the defence bundle, admissibility of testimonials and their content pursuant to Rule 34(1).

2. On behalf of Dr James, Ms Vivienne Tanchel, Counsel, also provided a skeleton argument to the Tribunal. Ms Tanchel proposed potential redactions to evidence. The skeleton argument was a response to the GMC's skeleton argument. Ms Tanchel opposed various submissions made the GMC.

Submissions

Dr B's evidence

3. Ms Dudley-Jones submitted there are four proposed redactions where the GMC seek a ruling by the Tribunal as to their admissibility. Ms Dudley-Jones opposed Ms Tanchel's submission that a partial redaction to Dr B's evidence be applied. Ms Dudley-Jones submitted that Dr B's evidence remain in its entirety, as the witness is commenting on the administration of midazolam and how common the use of it was in her experience. Dr B is an anaesthetist and is a witness of fact. Ms Dudley-Jones submitted that Dr B is not giving opinion evidence about the propriety or otherwise of drug administration nor is she usurping the GMC expert. She submitted that Dr B is giving evidence of her experience. She submitted that it is the GMC's case that Dr James sedated upon emergence and Dr B stated that that is unusual.

4. She submitted that Dr B is an anaesthetist and a primary witness to Dr James administering midazolam, states that is usual to give analgesia in her experience and this mirrors the GMC's expert's view.

5. Ms Tanchel submitted a proposal that the GMC redact part of Dr B's witness statement. Ms Dudley-Jones said that the GMC disagrees with this proposed redaction and maintain it should remain in in its entirety - as the witness is commenting on the administration of midazolam and how common this was in 'her experience'. Dr B is an anaesthetist and is also a witness of fact. She is not giving opinion evidence about the propriety or otherwise of drug administration nor is she usurping the GMC expert. Dr B is giving her evidence of her experience that "*we don't often have to give other drugs to sedate someone upon emergence".* The GMC's case is that Dr James sedated upon emergence which this witness herself says in her experience, is unusual. She states that in her experience she has not seen anyone else give sedation in that situation. She states that "*It is common to give more analgesia if required but not sedation".* Therefore, Dr B an anaesthetist and a primary witness to Dr James administering midazolam, states it is usual to give analgesia on emergence but not sedation (midazolam) which not only is unusual in her experience, but it is precisely the GMC's case and also mirrors the GMC's expert's view.

6. Ms Tanchel submitted that Dr B is a witness of fact in this case and is called by the GMC. Ms Tanchel submitted that Dr B's role is not one of an expert witness. She submitted that Dr B is plainly not independent, neither has she been asked to confirm that her evidence is objective and that she has the correct skill and expertise to offer opinion.

7. Ms Tanchel submitted that Dr B's witness statement as set out above is Dr B giving her opinion. She submitted that opinion evidence is hearsay and is only admissible when the following steps are complied with;

> 1 *'Expert evidence presented to the court should be seen to be the independent product of an expert uninfluenced as to form or content by the exigencies of litigation.*
> 2 *An expert witness should provide independent assistance to the court by way of objective unbiased opinion in relation to matters within his/her expertise and should not assume the role of the advocate.*
> 3 *An expert witness should state the facts or assumptions on which his/her opinion is based. He should not omit to consider material facts which detract from his concluded opinions.'*

8. Ms Tanchel submitted that, if Dr B's opinion evidence is admissible then the evidence of the GMC expert on this issue is outside the requirement of fairness in Rule 34(1) as calling 2 experts on the same issue would be prejudicial to Dr James.

<u>Mr D's evidence</u>

9. In relation to Mr D's evidence, Ms Tanchel proposed a redaction in relation to the following question and answer:

'was it excessive. Yes',

10. Ms Tanchel submitted that Mr D's opinion of the same is irrelevant and usurps the function of the Tribunal. She submitted that the remainder of the assertions made by the GMC in respect of this challenge to the admissibility are not understood as the "excessive" nature or otherwise of purported physical contact between Dr James and the Patient is not a matter of expertise.

11. Ms Dudley-Jones submitted that the GMC opposes this proposed redaction. She submitted that the GMC maintain that this witness is able to comment on whether they felt something to be excessive and their evidence is directly relevant to the matter in issue namely whether Dr James did slap the patient. It is not about whether this is a witness of fact giving opinion evidence. She submitted that Mr D is a witness of fact and was present at the time of the alleged slaps.

12. In relation to Mr D's initial account, Ms Tanchel proposed a further redaction in relation to the following question and answer:

> *'what do you think he meant by what he said. I think he was worried that I would report it. I think he didn't want me to report it'.*

13. Ms Tanchel submitted this proposed redaction derives from Mr D's interview with the Trust. She submitted that inferences are solely a matter for the Tribunal.

14. Ms Dudley-Jones objected to this proposed redaction and submitted that, in the interest of fairness, the question '*what do you think he meant by what he said*' be redacted. She submitted that it is accepted that the witness cannot give evidence or an opinion on what was in Dr James' mind. She submitted that this witness is permitted to state what their interpretation of the facts was, namely that they thought he was worried that they would report it and that they thought that Dr James didn't want them to report it.

15. In relation to Mr D's initial account, Ms Tanchel proposed the redaction of the following sentence, 'he can lose his temper'. Ms Tanchel submitted that this sentence is wrong in law as none of the testimonial witnesses relied upon by the defence assert that Dr James has never lost his temper and rebuttal evidence is only admissible once the initial evidence is heard and not pre-emptively.

16. Ms Dudley-Jones objected to this proposed redaction and submitted that bad character can be and is admissible.

<u>Expert Report</u>

17. The GMC submitted that it has requested that Dr F re-draft a sentence identified by the Defence in his first report.

Defence Bundle

18. In relation to the defence bundle, Ms Dudley-Jones submitted that there are a number issues with the defence bundle, namely duplicate testimonials and undated documents. Ms Dudley-Jones submitted there is a supplemental statement in the defence bundle from Ms G but the GMC submit that defence are not calling any witnesses. Therefore, the GMC object to the supplemental witness statement from a witness who may not be called to give evidence remaining in the bundle.

19. The GMC propose a redaction to Ms G's statement (redact from "*I am also aware…punching them*") and submitted that this witness is not an expert, and this evidence traverses into potential hallucinogenic effects of anaesthesia and she is suggesting or hypothesising that Patient A may have hallucinated and this is plainly inadmissible and should be redacted if the witness is to be called.

20. In response Ms Tanchel submitted that the GMC's objection is noteworthy. She submitted that the GMC expose the untenable approach adopted by the GMC in these proceedings and the request for the redaction fails to explain how the alleged "expert" evidence objected to in the statement of Ms G is distinguishable from the expert evidence relied upon by them in the statements of their witnesses of fact.

The Relevant Legal Principles

21. The Tribunal had regard to Rule 34(1) (as set out below) of the Rules and accepted the Legally Qualified Chair's advice.

> *Rule 34*
>
> *(1)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.*

22. The Tribunal was mindful that Rule 34(1) of the Rules gives it a broad discretion to admit evidence if it is fair and relevant to do so. It reminded itself that it must consider fairness from all perspectives and consider the overarching objective.

The Tribunal's Decision

23. The Tribunal had regard to both preliminary skeleton arguments and submissions made by both counsel. The Tribunal had regard to Rule 34(1) of the Rules.

24. At this stage in proceedings the Tribunal was mindful to distinguish between admissibility and weight and the Tribunal must only consider admissibility. In considering fairness, the Tribunal was conscious that it was important to consider not only any prejudice

to Dr James by the admission of the evidence but also the public interest, and balance this with fairness to Dr James when reaching its decision.

25. The Tribunal considered the proposed redaction of Dr B's evidence in relation to the following sentence,

> *'but in my experience we don't often have to give other drugs to sedate someone upon emergence. I haven't seen anyone else give sedation in that situation. It is common to give more analgesia if required but not sedation'.*

26. The Tribunal noted that Dr B was in the operating theatre at the time, they considered it fair, relevant and within Dr B's own expertise to comment on. Accordingly, the Tribunal opposed the proposed redaction in relation to this statement.

27. In relation to Ms Tanchel's proposed redaction of the question and answer in regard to Dr B, the Tribunal considered it to be a leading question and determined it should not be admitted. Accordingly, the Tribunal granted the proposed redaction.

28. The Tribunal considered Tanchel's proposed redaction in relation to Mr D', *'was it excessive. Yes'*. The Tribunal considered it to be evidence by a non expert witness. The Tribunal considered this to be admissible evidence. The Tribunal opposed the proposed redaction in relation to this statement.

29. The Tribunal considered the proposed redaction by Ms Tanchel in relation to the following question and answer,' *what do you think he meant by what he said. I think he was worried that I would report it. I think he didn't want me to report it'.* The Tribunal considered this to be speculative and do not consider it a factual matter. Accordingly, the Tribunal granted the proposed redaction.

30. The Tribunal considered the proposed redaction by Ms Tanchel in relation to the following statement 'he can lose his temper'. The Tribunal considered this propensity and determined that if required a good character direction should be given at the factual stage. Accordingly, the Tribunal determined that this statement should not be redacted.

31. In relation to the admissibility of Dr F's report the Tribunal considered the case *of Sawati v General Medical Council [2022] EWHC 283 (Admin).* The Tribunal considered that weight can be given by the Tribunal. The Tribunal determined the report is admissible.

32. In relation to Ms G's statement, the Tribunal noted the GMC's objections. The Tribunal determined that if Ms G is available to give evidence the statement can be admitted and introduced as a testimonial.

Annex B – 31/10/2023

Application of no case to answer

1. At the close of the GMC's case, Ms Tanchel, on behalf of Dr James, made an application pursuant to Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004, as amended ('the Rules') that there was no case to answer. Her application was in relation to the entirety of the Allegation and she invited the Tribunal to determine that the GMC had adduced insufficient evidence upon which it could properly find each paragraph proved.

Submissions on behalf of Dr James

2. Ms Tanchel reminded the Tribunal that the test at this stage was whether or not a properly directed Tribunal could properly find the Allegation proven or if the evidence is, on the whole, unsatisfactory as set out in the case of *Regina v. Galbraith 73 Cr App R. 124 (CA)*:

> *'How then should the judge approach a submission of "no case"? (1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge 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 judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.(b) Where, however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury, and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury'*

3. Ms Tanchel reminded the Tribunal that the burden of proof rests with the GMC and the standard is the civil standard, namely that of the balance of probabilities. She also referred the Tribunal to the case of *Basson v GMC [2018] EWHC 505*, which set out that a doctor's state of mind is a fact that the Tribunal must determine like any other but that it must be determined by inference and not direct evidence.

4. Ms Tanchel submitted that the evidence of the GMC's witnesses of fact had been contaminated and, as such, could not be relied upon. She submitted that the witnesses,

including Dr B, Mr D and Ms C had discussed the incident prior to making any sort of witness statement or raising a complaint. Ms Tanchel did not contend that the witnesses had deliberately conspired but did submit that, on their own evidence, the witnesses has spoken to each other about the case. She said that even honest witnesses can be mistaken and reject the notion that their memories have been interfered with by speaking to others. Ms Tanchel said that Mr D had given evidence that they had *'unanimously decided to report the incident'*, which was stark evidence of the witness evidence being contaminated.

5. Ms Tanchel submitted that the evidence of Dr B was inconsistent both between her own accounts and when compared to that of other witnesses. She submitted that Dr B's first record of the incident came 19 days later, after she had spoken to Mr D about it. Ms Tanchel said that various details of Dr B's account had changed between statements such as initially reporting a 'hit', which later became a 'slap'. Dr B also said in her statement to the Trust that Patient A had a partially obstructed airway on waking, whereas in her statement to the GMC she said that he lost his airway at a later stage. Ms Tanchel also said that Dr B's account of who was present at what stage was inconsistent with that of other witnesses.

6. Ms Tanchel submitted that the chronology and accounts of Dr B, Mr D and Ms C were all different and there was no evidence for a Tribunal to begin to decide which of these accounts was accurate. Ms Tanchel said that the evidence for the chronology of events was inherently undermined by the witnesses failure to accurately identify what happened. She said that this was not a case where credibility was a matter for the later stages of the hearing as the witness accounts undermined each other and meant that it was not possible for them to all be reliable.

7. Ms Tanchel said that there was a discrepancy between Dr B's and Mr D's account of when Ms C came over to assist with Patient A and also how many times Dr James was alleged to have slapped him. Ms Tanchel also reminded the Tribunal that there were no physical marks or bruising on Patient A despite the alleged slap being loud enough to hear over a busy theatre filled with people. Further, Ms Tanchel submitted that, in her oral evidence, Ms C said she did not remember if Patient A had told her that it was the anaesthetist who had slapped him or had just said *'he slapped me'*. She also reminded the Tribunal that it had not seen any of the relevant patient records and that Patient A had never complained of any pain and did not claim to have been slapped by Dr James until the day after the procedure.

8. Ms Tanchel submitted that there was no evidence that the comment '*stop messing around you fucker'* was directed at Patient A or that those were the exact words spoken.

She said that 'words to that effect' was a key issue in this case as it could mean the difference between a comment said to the air in the heat of the moment and one directed at a patient.

9. Turning to the evidence of Dr F, Ms Tanchel said that the primary submission was that his evidence was inadmissible and should be wholly disregarded. She said that, if the Tribunal did not agree with her on that, it should give little weight to his evidence. Ms Tanchel submitted that Dr F's evidence was inadmissible because he had failed to comply with the requirements of an expert witness.

10. Ms Tanchel said that expert witnesses are required to be independent and objective, that they are, in essence, giving hearsay evidence and their obligation is to the Tribunal, not the party that called them. She submitted that Dr F had failed to remain objective and had trespassed into judging facts.

11. Ms Tanchel submitted that expert witnesses must clearly identify where they rely upon the opinions of others and where those opinions have come from, which, she said, Dr F had failed to do. Instead, she submitted, he had relied upon his own experience, relied on unidentified colleagues' opinions and not sought out further research when faced with issues that he was unaware of; for example, the historic use of midazolam as a co-induction agent.

12. Ms Tanchel submitted that Dr F had failed in his duty as an expert witness to seek out documents that had not been supplied to him when he learned of their existence. She also said that Dr F did not give due consideration to Dr James' chronology, which he received after writing his initial report. Ms Tanchel said that this was evidenced by the fact that he had agreed with her during his evidence that, if Dr James' account was correct, then administering midazolam was not inappropriate.

13. Ms Tanchel submitted that Dr F's expertise and knowledge had been undermined by his conduct at the hearing. She said that he had repeatedly avoided answering questions as asked, had claimed that questions were irrelevant, which is a matter for the Tribunal, and had made judgements of fact in his evidence. Ms Tanchel also questioned the credentials of an expert witness who, having produced hundreds of expert reports and with years of medicolegal experience, would enter a hearing room alone and reman there for several minutes without realising the impropriety of that action.

14. In summary, Ms Tanchel submitted that the evidence of the witnesses of fact was compromised or, at best, inconsistent and so could not be relied upon. She also submitted that Dr F's evidence should be disregarded or, failing that, be given little

weight. She told the Tribunal that it should first consider this application as it related to paragraph 1 of the Allegation because other paragraphs were necessarily tied to this one. If the Tribunal agreed that there was no case to answer in the case of paragraph 1 of the Allegation then that would necessarily mean that paragraphs 5 and 7 would also need to be withdrawn. She also highlighted the distinction between administering and prescribing, how that related to paragraph 2 of the Allegation and that a single drug error would not support a finding of misconduct.

15. Finally, Ms Tanchel submitted that there was no evidence to say what Dr James may have been referring to in his comment as set out in paragraph 6 of the Allegation and, even if there were sufficient factual evidence, this could not support a finding of misconduct.

16. Ms Tanchel referred the Tribunal to the cases of *Soni v GMC (2015) EWAC 0364 Admin* and *McLennan v General Medical Council [2020] CSIH 12*, and submitted that the Tribunal is entitled to draw proper inferences from the evidence, but it must not speculate. It should only draw an inference if it can safely exclude other possibilities.

Submissions on behalf of the GMC

17. On behalf of the GMC, Ms Dudley-Jones agreed that the proper test for the Tribunal at this stage was that set out in *Galbraith*. She also referred the Tribunal to the case of *R v Shippey [1988] Crim LR 767,* which she said set out the principle that, when considering the evidence adduced by the GMC, the Tribunal should be mindful to not throw out the plums and leave behind only the duff. She submitted that this was a case that did have ample evidence for the Tribunal to consider the entirety of the Allegation.

18. Regarding paragraph 1 of the allegation, Ms Dudley-Jones reminded the Tribunal that it had before it evidence from Dr B, Mr D and Ms C. She said that Mr D's evidence was that he had seen Dr James slap Patient A and told Patient A to *'stop fucking about'*. Dr B's evidence was that she had heard the slap and, upon seeing a look of shock on Mr D's face, mouthed to ask him if Dr James had slapped the patient, to which Mr D answered yes. Ms C's evidence was that, although she had not seen or heard the slap, Patient A had told her on the following day that he had been slapped by the anaesthetist.

19. Ms Dudley-Jones submitted that these three witnesses were all reliable and had given credible evidence, which was sufficient for a properly directed Tribunal to find paragraph 1 of the Allegation proved. She said that any variation in the words used by Dr James was covered by the phrase 'or words to that effect' in the Allegation. Ms Dudley-Jones said that Dr B's reliability was not undermined by virtue of her not making a note on the

operation record or by waiting to report the incident. She said that Dr B was a bright, measured and thoughtful young woman who had been distressed by what she had witnessed. Ms Dudley-Jones also reminded the Tribunal that it was Dr B's first day and the prospect of immediately having to report a senior colleague was very stressful and she wanted the support of Mr D in this. Ms Dudley-Jones also submitted that there was no significance in the word 'hit' becoming 'slap' in witness statements as they were synonymous.

20. Turning to Ms Tanchel's submission that the GMC witnesses' evidence was contaminated because they had spoken to each other, Ms Dudley-Jones submitted that the fact that Dr B's and Mr D's accounts differed was evidence that they had not colluded. She said that Dr B had been nervous about reporting Dr James and had wanted to speak to Mr D first, as he was the only other witness to the events. Ms Dudley-Jones submitted that, when they met in the reception area, the conversation between Dr B and Mr D was not about the details of the event or their report, but was merely about whether they should make a report and, if so, how best to do that. Ms Dudley-Jones submitted that this was not evidence of their accounts being contaminated, nor was the fact that Dr B had spoken to her husband. Indeed, Ms Dudley-Jones submitted that Ms Tanchel was being purely speculative when suggesting that Dr B's husband had influenced her. Ms Dudley-Jones conceded that it was not until 19 days after events that Dr B and Mr D committed anything to writing, but that this was not evidence of collusion.

21. Ms Dudley-Jones submitted that the account of Dr B, plus the anaesthetic drug record, was sufficient evidence for the Tribunal to find that Dr James had administered midazolam. Ms Dudley-Jones urged caution with Ms Tanchel's assessment of Dr F's evidence on this point as the Tribunal had not yet heard Dr James' evidence and it was only if his account were true that Dr F had agreed with the administration of midazolam.

22. Ms Dudley-Jones submitted that Dr F's evidence should be given due consideration by the Tribunal as he was an expert witness who had endured robust cross examination, properly understood the *Bolam* test and gave an appropriate opinion. She said that Dr F should not be criticised for his mistake of entering the hearing room alone as he had been candid about what had happened and gave a plausible explanation. Ms Dudley-Jones submitted that Dr F's evidence was fair and reasonable and had not unduly strayed into commenting on facts, he had merely used questions as part of his particular turns of phrase.

The Tribunal's approach

23. This application is made under Rule 17(2)(g), which states:

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

24. The Tribunal reminded itself that, at this stage, its purpose was not to make findings of fact but to determine whether sufficient evidence, taken at its highest, had been presented by the GMC such that a Tribunal, correctly directed as to the law, could properly find the relevant paragraphs proved to the civil standard.

25. The Tribunal considered the submissions of both parties. It also took account of all of the evidence presented to date, both oral and documentary, in reaching its decision.

26. The Tribunal had particular regard to the principles in *Galbraith* with respect to submissions of no case to answer and had in mind the comments made in *R Tutin v General Medical Council [2009] EWHC 553 Admin* and *R(Sharaf) v GMC [2013] EWHC3332 (Admin*) in respect of applying those principles to regulatory proceedings; proceedings where the Tribunal necessarily acts as both judge and jury and the standard of proof is civil rather than criminal.

27. In response to Ms Tanchel's submission regarding the admissibility of Dr F's evidence, the Legally Qualified Chair advised the Tribunal that Rule 34 provides that the Tribunal may admit any evidence it considers fair and relevant to the case before it, whether or not such evidence would be admissible in a court of law. Dr F is not a witness of fact, he is an expert witness who is able to give his opinion to assist the Tribunal. It is for the Tribunal to decide the weight that it gives to any evidence taking account of a range of factors and circumstances.

28. The Legally Qualified Chair referred the Tribunal to paragraph 68 of *Soni v The General Medical Council [2015] EWHC 364 (Admin) (25 February 2015)* where it was said that the Panel "*confused grounds for suspicion with evidence sufficient to prove, on the balance of probabilities, a serious allegation against a professional man."* He advised the Tribunal to bear this in mind when drawing inferences from any of the evidence that had been adduced by the GMC.

29. The Tribunal also gave consideration to the case of *Byrne v General Medical Council [2021] EWHC 2237 (Admin)*. It is commonplace for there to be inconsistencies and confusion about certain details of evidence. The task of the Tribunal is to determine if

the allegations are true or, at this stage of proceedings, whether there is sufficient evidence that they could be found proved.

30. The Legally Qualified Chair advised the Tribunal that *Dutta v GMC (2020) EWHC 1974 (Admin); Khan v The General Medical Council [2021] EWHC 374 (Admin)* and *Byrne* all assist in how evidence should be assessed: the Tribunal should consider the reliability of the evidence as a global picture and not in isolation; witness evidence is one part of the evidence - objective evidence, for example contemporaneous documents, should be considered first; caution should be applied when considering a witness' demeanour and confidence; it is not the case that the more confident a witness the more likely that their evidence is true; reliability of a witness is more important than their credibility and credibility can be divisible.

31. The Tribunal also had regard to the test in *Bolam v Friern Hospital Management Committee [1957] 1 WLR 582*, which says that no doctor can be guilty of negligence *'if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art'*

The Tribunal's determination

32. The Tribunal began by setting out the evidence before it, which included but was not limited to:

- Patient A's oral evidence, witness statement, Ms C's account that Patient A reported the slap to her within 24 hours. Patient A's evidence goes to the slap and coarse language alleged to have been used towards him.
- Ms C's oral evidence, witness statement, report to the Trust and police interview. This evidence goes to what Patient A said the day after events and the general use of language in theatre, but nothing directly to the slap or midazolam. The Tribunal reminded itself that the absence of evidence is not evidence of absence.
- Dr B's oral evidence, witness statements, email sent 19 days after events, trust interview, police interview and court transcript. This evidence goes to the slap, language, midazolam and the words Dr James spoke to Mr D.
- Mr D's oral evidence, witness statement, trust interview, email on or around 19 August, police statement and court transcript. This evidence goes to the slap, language and words spoken by Dr James to Mr D.
- Ms E's oral evidence and witness statement. This evidence goes to the slap and language but the Tribunal reminded itself that this was not direct evidence and was based only on what Ms E was told by Mr D. It also reminded itself that Ms E's first account was made significantly after events and may be vulnerable to contamination.

- Dr F's expert report, joint report and oral evidence. The Tribunal reminded itself that Dr F is not a witness of fact but an expert giving their opinion.
- Limited documentary evidence in the form of the anaesthetic drug record.

33. First, the Tribunal considered the admissibility of Dr F's evidence. The Tribunal noted that this evidence had already been admitted as part of the bundle and considered that it would need to be satisfied that Dr F's evidence was neither fair nor relevant before disregarding it. The Tribunal considered that Dr F was an expert witness whose evidence was plainly relevant to the case. It considered that it had seen no reason that Dr F's evidence should be thrown out wholesale and if the issue was credibility then, as set out in the legal advice, that was divisible. The Tribunal determined that Dr F's evidence should remain. It would be for the Tribunal to assess how much weight this evidence should be given once it had been assessed against other evidence, including that of the Defence's expert witness.

34. The Tribunal then considered the issue of witness contamination and collaboration. The Tribunal noted that Patient A had no prior relationship with Ms C and had seen nothing to indicate he had any motive to fabricate the allegations against Dr James. The Tribunal reminded itself that neither Dr B nor Mr D made any contemporaneous records of the events, neither did they immediately report Dr James. However, the Tribunal did note that Mr D had informally reported the events to Ms E on the same day. The Tribunal considered that Ms Tanchel's claim was that Dr B and Mr D met in the reception area and discussed what they would include in their report. The Tribunal noted that the content of Dr B's and Mr D's complaint emails included differing accounts.

35. The Tribunal was unable to exclude completely the possibility that Dr B and Mr D had some brief discussion in the reception area about whether Dr James had struck Patient A. However, it did not consider that this contaminated their evidence to the extent that it was unreliable or unhelpful. The Tribunal accepted that there may be some risk over time that they shared details of the event but considered that this brief conversation was primarily about their decision to report something that they believed each had witnessed. The Tribunal accepted Mr D's claim that he had not made an official report at this point, despite having spoken to Ms E, informally, on the day. The Tribunal considered that this conversation was two colleagues sharing their concern about 'putting their heads above the parapet' to raise the issue and the only collusion was agreement that they would make a report, not any of the details of that report.

36. The Tribunal was mindful that Dr B was new to the department and wanted to speak with Mr D about the events but was satisfied that this conversation was about whether to make a report and to whom. The Tribunal considered that these were two

professional who had witnessed something that they say shocked them and had already had an interchange during the event. The Tribunal considered that the risk of contamination here was minimal and does not impact the credibility of either Dr B or Mr D.

37. The Tribunal considered that it would be speculative to try and determine what Dr B's husband had said and whether this had changed her account. It considered that it was normal for a person to talk about stressful events and considered that Dr B's account had remained consistent over time, as had that of Mr D, with the exception of a change in detail about what specific language Dr James used with Patient A.

38. The Tribunal considered that there was more risk of Ms E's evidence being contaminated as she made her statement sometime later. However, the Tribunal considered that Ms E evidence was chiefly to corroborate that of Mr D, whose account was, in the main, consistent. Therefore, the Tribunal determined that it the GMC witness evidence was not contaminated and should stand.

39. Having determined that the evidence of the GMC witnesses should stand, the Tribunal went on to consider if that evidence was sufficient for a reasonable Tribunal, properly directed, to potentially find the facts proved.

40. The Tribunal first considered paragraph 1(a) of the Allegation – the slap. The Tribunal reminded itself that the evidence for this occurring came from Patient A's account of the event, Dr B's evidence that she heard a slap and Mr D' evidence that he saw it. The Tribunal also noted that there was second hand evidence from Ms E and Ms C who were informed of the slap by Mr D and Patient A respectively.

41. The Tribunal considered it immaterial whether the word 'hit' or 'slap' was used in witness statements as they were used synonymously. The Tribunal also noted that Patient A had reported the slap to Ms C the next day. The Tribunal considered that there were three witnesses to the slap, which, despite some differences in details, was sufficient that a Tribunal could find the facts proved on this matter. The Tribunal considered that Ms C's evidence did not alter this opinion as her evidence that she did not witness the slap was not evidence that it did not happen. Therefore, the Tribunal determined not to withdraw this paragraph of the Allegation.

42. The Tribunal then moved on to consider paragraph 1(b) of the Allegation – the abrasive language used by Dr James to Patient A. The Tribunal considered that the evidence of the words used in the Allegation comes from Mr D and Ms E, who was only able to say what Mr D had told her. The Tribunal noted that Dr B gave evidence that a different form

of words was used than that in the Allegation and Patient A varied in his account. Only Mr D gave evidence on the language being as drafted in the Allegation and this had changed from his original statement and trust interview.

43. The Tribunal considered that the phrase as drafted in the Allegation – *'stop messing around you fucker'* – was not capable of being proved by the evidence before it. The only direct evidence came from Mr D, whose evidence varied about what the specific words used were. The Tribunal considered the phrase in the Allegation 'or words to that effect'. The alternative form of words that had been put forward by the GMC was *'stop fucking around.'*

44. The Tribunal considered that for the phrase 'or words to that effect' to be able to be proved, the alternative words must be comparable to the original phrase in both intent and effect. It considered a key aspect in determining this to be the expletive in this phrase. The Tribunal considered that it was clear from the various accounts that, whatever words were used, they were directed at Patient A. The Tribunal also noted that there was a variety of evidence that Patient A was wriggling around and making it difficult for the team to administer anaesthetics.

45. The Tribunal considered the two phrases that had been suggested. It considered that the expletive in the phrase as drafted in the Allegation was clearly a pejorative directed at Patient A. However, as stated above, the Tribunal did not consider the evidence available to be sufficient to prove that this phrase was used. The Tribunal considered that the expletive in the alternative phrase, whilst improper language, could reasonably be substituted for a more benign word such as 'messing', meaning that the expletive was a broader expression of frustration rather than an insult directed specifically at Patient A.

46. The Tribunal considered there to be a material difference between the two phrases that had been suggested and that it was being asked to substitute in words to fit the Allegation. It considered that the evidence before it was not capable of proving that the alternative phrase had the same effect as the phrase drafted in the Allegation and therefore determined to withdraw this paragraph of the Allegation.

47. The Tribunal then moved on to consider paragraphs 2, 3 and 4 of the Allegation together as they all relate to the factual aspects of the administration of midazolam.

48. The Tribunal noted that the documentary evidence of the anaesthetic record showed that midazolam was administered to Patient A. The Tribunal also reminded itself of Dr B's evidence that she had seen Dr James injecting something into the IV, had asked what it was and been told by Dr James that it was midazolam.

49. The Tribunal considered that the Allegation implied that opiate analgesia should have been administered instead of midazolam. It recalled the evidence of Dr F, who said that pain is the most common cause of distress during emergence from anaesthesia, in which case opiate analgesia should be administered. The Tribunal recalled Dr B's evidence that she thought Patient A was in pain which, if accurate, would mean that opiate analgesia should have been administered.

50. The Tribunal also recalled Dr F's evidence that midazolam was not clinically indicated in the situation and that 10mg was an excessive dose. It determined that Dr B's account was plausible and, in conjunction with the expert evidence, was sufficient that a Tribunal could find the facts proved. It therefore determined not to withdraw paragraphs 2, 3 and 4 of the Allegation.

51. The Tribunal then considered paragraph 5 of the Allegation and considered that it was being asked to draw an inference about Dr James' motivation. It reminded itself of paragraph 68 of *Soni*.

52. The Tribunal reminded itself of Dr F's evidence that, whilst it was plausible, there was poor evidence that a high dose of midazolam had the effect of causing retrograde amnesia. The Tribunal noted that a low likelihood of success did not necessarily mean that this was not Dr James' motivation.

53. The Tribunal looked at where this suggestion had originated and considered that it came from speculation on the part of Dr B, who later conceded that her understanding of the effect of midazolam was wrong. The Tribunal considered that the evidence that Dr James' motivation was malign was very dubious and it was being asked to speculate. It considered that, taken at its highest, the GMC's evidence was only grounds for suspicion and determined that the evidence was not capable of proving the Allegation. Therefore, it determined to withdraw paragraph 5 of the Allegation.

54. Turning to paragraph 6 of the Allegation, the Tribunal reminded itself that the evidence for this came from the accounts of Dr B and Mr D. As set out above, the Tribunal considered these to both be reliable witnesses and so determined that the evidence of two witnesses was sufficient and that a Tribunal could find the Allegation proved.

55. Moving on the paragraph 7 of the Allegation, the Tribunal could see that, having withdrawn paragraph 5, this paragraph had no relevance to paragraphs 2, 3 and 4 and so determined to withdraw it in relation to those paragraphs. In regard to paragraph 6 of the Allegation, the Tribunal considered that, if paragraph 6 were found proved, it would

therefore be capable of proving this paragraph as it related to paragraph 6. Therefore, the Tribunal determined to not withdraw this paragraph of the Allegation in relation to paragraph 6.

56. In summary, the Tribunal determined to withdraw paragraphs 1(b) and 5 of the Allegation as well as paragraph 7, where it related to paragraphs 2, 3 and 5.