PUBLIC RECORD

Dates: 18/01/2024, 04-13/03/2024

Medical Practitioner's name:	Dr Dumindu Chamikara KARANGODA
GMC reference number:	6067173
Primary medical qualification:	MB BS 2001 University of Colombo

Type of case	**Outcome on facts**	**Outcome on impairment**
New - Misconduct	Facts relevant to impairment found proved	Not Impaired

Summary of outcome

No action (warning not considered)

Tribunal:

Legally Qualified Chair	Mr Mark Scott
Lay Tribunal Member:	Ms Jo Palmiero
Medical Tribunal Member:	Dr Helen Crabtree

Tribunal Clerk:	Mr Josh Dayco 18/01/24 Mr Larry Millea 04-13/03/2024

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Ms Laura Stephenson, Counsel, instructed by Medical Protection Society
GMC Representative:	Ms Rebecca Vanstone, Counsel

Attendance of Press / Public

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

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 - 12/03/2024

Background

1. Dr Karangoda qualified as a Doctor with an MBBS in 2001 from the University of Colombo. Prior to the events which are the subject of the hearing Dr Karangoda practised in Sri Lanka, becoming a Senior House Officer (SHO) in anaesthetics in 2002. Dr Karangoda undertook a clinical attachment in anaesthetics and critical care at the Basildon University Hospital in 2004 and was subsequently appointed as an SHO. Following this, Dr Karangoda continued his training and became a consultant in anaesthetics and intensive care medicine in 2015. In addition to his NHS work, Dr Karangoda has also practised as an anaesthetist at a number of private clinics.

2. At the time of the events Dr Karangoda was practising as an anaesthetist, this included the XXX Private Hospital (“XXX Hospital”), which is part of Enhance Medical Group (“Enhance Medical”), and the XXX Clinic, where the events involving Patient A and Patient B are alleged to have occurred respectively.

3. The allegation that has led to Dr Karangoda’s hearing can be summarised as that on 19 to 20 February and on 6 July 2020, Dr Karangoda behaved inappropriately to Patients A and B respectively. It is alleged that Dr Karangoda’s actions were sexually motivated and amounted to unlawful sexual harassment.

4. The initial concerns were raised with the GMC on 7 September 2020 by Patient B via an online referral form.

The Outcome of Applications Made during the Facts Stage

5. The Tribunal granted an application made by Ms Rebecca Vanstone, counsel on behalf of the GMC, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to amend the Allegation. These changes clarified that the alleged misconduct in respect of both Patient A and Patient B was *"of a sexual nature"*. The application was not opposed by Ms Laura Stephenson, counsel, on behalf of Dr Karangoda. The Tribunal determined that it would be fair to allow the amendments and that they could be made without any injustice as the amended wording more clearly particularised the allegations against Dr Karangoda and were not opposed on his behalf.

6. The Tribunal also granted an application made by Ms Vanstone, on behalf of the GMC to allow Patient A to give her witness evidence remotely via Microsoft Teams, pursuant to Rule 34(13) of the Rules. This application was not opposed by Ms Stephenson on behalf of Dr Karangoda and the Tribunal determined that it would be fair to allow this, noting that the same approach had been agreed in respect of Patient B by MPTS Case Management prior to the commencement of the hearing.

The Allegation and the Doctor's Response

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

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

<u>Patient A</u>

1. On 19 to 20 February 2020 you were the anaesthetist for Patient A's breast augmentation procedure at the Enhance Medical Group Clinic in XXX and, whilst Patient A was recovering post-operatively, you:

   a. inappropriately asked Patient A:

      i. 'if you don't mind me asking, do you do dates?'; **To be determined**
      ii. 'are you on Adult Work?' **To be determined**

   or words to that effect; **To be determined**

b. on or before 20 February 2020, obtained Patient A's personal mobile telephone number from her medical records without her consent; **To be determined**

c. on 20 February 2020, sent one or more messages to Patient A's personal telephone number. **Admitted and found proved**

2. Your actions as set out at:

a. paragraphs 1b. and/or 1c. above were inappropriate as Patient A had been provided with a number to contact for 24-hour aftercare if required; **To be determined**

b. **paragraph 1 were sexually motivated; Amended under Rule 17(6), To be determined**

~~b.~~**c.**paragraph 1 were unlawful sexual harassment ~~related to sex~~ by virtue of Section 26**(2)** of the Equality Act 2010, in that you engaged in unwanted conduct ~~related to sex~~ **of a sexual nature** which had the purpose or effect of violating the dignity of Patient A, or creating an intimidating, hostile, degrading, humiliating or offensive environment for her. **Amended under Rule 17(6), To be determined**

<u>Patient B</u>

3. On 6 July 2020 you were the anaesthetist for Patient B's breast implant replacement procedure ('the Procedure') at the XXX Clinic and on one or more occasions you:

a. during the pre-operative assessment looked at Patient B's groin area whilst she was wearing a hospital gown; **To be determined**

b. whilst she was waking up from general anaesthetic post-operatively, you:

i. ran your hand up Patient B's thigh; **To be determined**
ii. reached inside of the hem of her underwear; **To be determined**

despite her attempting to move your hand away on one or more occasions; **To be determined**

c. asked Patient B for her personal telephone number to contact her about her progress after the Procedure; **To be determined**

d. provided Patient B with your personal mobile telephone. **Admitted and found proved**

4. Your actions as set out at:

a. paragraphs 3c. and/or 3d. above were inappropriate as you knew Patient B would be provided with a contact for appropriate aftercare; **To be determined**

b. paragraph 3 were sexually motivated; Amended under Rule 17(6), To be determined

~~b~~**c**. paragraph 3 were unlawful sexual harassment ~~related to sex~~ by virtue of Section 26**(2)** of the Equality Act 2010, in that you engaged in unwanted conduct ~~related to sex~~ **of a sexual nature** which had the purpose or effect of violating the dignity of Patient B, or creating an intimidating, hostile, degrading, humiliating or offensive environment for her. **Amended under Rule 17(6), To be determined**

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

The Admitted Facts

8. At the outset of these proceedings, through his counsel, Ms Stephenson, Dr Karangoda made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Witness Evidence

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

- Patient A, in person, who also provided written witness statements dated 24 September 2021, 10 August 2022 and 28 February 2023;
- Patient B, in person, who also provided written witness statements dated 23 May 2021, 1 December 2022 and 28 January 2023.

10. The Tribunal also received evidence on behalf of the GMC in the form of a witness statement from the following witness who was not called to give oral evidence:

- Person C, anaesthetic nurse at the XXX Clinic, dated 23 March 2021.

11. Dr Karangoda provided his own witness statement, dated 31 May 2023, and also gave oral evidence at the hearing. In addition, the Tribunal received evidence from the following witnesses on Dr Karangoda's behalf:

- Ms D, recovery nurse at the XXX Clinic, in person, who also provided a written witness statement dated 30 May 2023;
- Ms E, theatre nurse at the XXX Clinic, in person who also provided a written witness statement dated 2 June 2023.

Documentary Evidence

12. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to: messages between Patient B and the XXX Clinic dated in and around July 2020; documentation pertaining to Patient B's complaint to the XXX Clinic and the Care Quality Commission in and around September 2020; text messages between Dr Karangoda and Patient A dated 20 February 2020; notes and correspondence from Enhance Medical in relation to Patient A's complaint; a video recording taken by Patient A with a screenshot showing the time and date of the recording as 19 February 2020 at 6:55pm; and excerpts from Patient B's medical notes and records and other documentation as particularised in an agreed facts document submitted by the parties to the Tribunal on 15 January 2024.

The Tribunal's Approach

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

14. The Tribunal reminded itself that it should assess the evidence in its entirety. In terms of the extent to which it should consider the question of a witness's demeanour, the Tribunal was referred to the case of *Suddock v NMC [2015] EWHC 3612* which states:

a. "Whilst demeanour is not an irrelevant factor for a court or tribunal to take into account, the way in which the witness's evidence fits with any non-contentious evidence or agreed facts, and with contemporaneous documents, and the inherent probabilities and improbabilities of his or her account of events, as well as consistencies and inconsistencies (both internally, and with the evidence of others) are likely to be far more reliable indicators of where the truth lies. The decision-maker should therefore test the evidence against those yardsticks so far as is possible, before adding demeanour into the equation."

15. The Tribunal was mindful that it should not assess the witnesses' credibility exclusively on their demeanour when giving evidence. Their veracity should be tested by reference to objective facts, proved independently, and by reference to documents. As stated in the case of *Khan v GMC [2021] EWHC 374 (Admin)* it is open to Tribunals not to rule out the whole of a witness's evidence based on credibility; credibility can be divisible. The case of Dutta *v GMC 2020 EWCA 1974 (Admin)* provides relevant instruction that the Tribunal should make a rounded assessment of a witness's reliability rather than approaching their reliability in respect of each charge in isolation.

16. The Tribunal was also mindful that the passage of time can affect a witness's memory. So too can the effects of anaesthesia. There was no independent expert evidence before the Tribunal and it was reminded that it should not take on the role of expertise as to the effects of anaesthesia in respect of either Patient A or Patient B, instead the Tribunal should assess the relevant witnesses evidence in the manner already described. In respect of Patient B the Tribunal had excerpts from her medical notes and records and those were carefully considered and factored in.

17. In relation to witnesses generally, the Tribunal bore in mind that an honest witness can be mistaken, and a mistaken witness is not necessarily wrong about every fact.

18. The Tribunal reminded itself that it was entitled to draw proper inferences, that is common sense conclusions based on the evidence which it accepts as reliable, but it must not speculate. The Tribunal had to decide the case purely on the evidence that had been put before it. As per the case of *Sony v GMC [2015] EWCA 0364 Admin* the Tribunal should only draw an inference if it can safely exclude other possibilities.

19. The Tribunal was reminded that it should consider each head of the allegation and each subhead separately. It is, of course, open to the Tribunal to find some parts, but not others, proved. As per the case of *R v Chopra 1 Cr App R 16*, if it found that the allegation of one complainant is proved, and the Tribunal is satisfied that established a propensity on the registrant's part to engage in unwanted sexual conduct, then that propensity could be taken into account in determining whether the other complainant's allegations were proved.

20. In respect of hearsay evidence, the Tribunal had regard to the Thorneycroft principles. The Tribunal should treat such evidence with caution before deciding to place reliance on it, and in the scenario where reliance is placed on it careful consideration should be given as to what weight is placed on any such evidence.

21. The Tribunal was referred to the case of *Basson v GMC [2018] EWHC 505 (Admin).* The definition of 'sexually motivated' is as follows: *'A sexual motive means that the conduct was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship'. S*exual motivation requires a specific intent on the part of the doctor and is not the same as carelessness, recklessness, negligence or inappropriate conduct. Sexual motivation can be proved by inference or deduction from the surrounding evidence. When considering such a motivation, the Tribunal should make a deduction from all the facts and circumstances and look at the material in the round. The best evidence of sexual motivation could be the behaviour itself.

22. The Tribunal was also referred to the case of *Haris v General Medical Council [2021] EWCA Civ 763* where it was advised that sexual motivation can be inferred from a number of factors, including the location on the body where the alleged touching occurred.

23. In respect of the specific allegations referencing section 26 of the Equality Act 2010, the Tribunal noted the case of *PSA v HCPC & Yong [2021] EWHC 52 Admin*. The judgment made clear that healthcare regulators are public authorities and are bound by section 149(1)(a) of the Act. They therefore have a duty to have regard to the need to eliminate

harassment. The definition of harassment in the Act includes where someone engages in unwanted conduct related to a relevant protected characteristic or where the conduct is of a sexual nature and the conduct has the effect of violating the other person's dignity, or creating an intimidating, hostile, degrading, humiliating or offensive environment for them. In deciding whether conduct has the effect referred to above, the victim's perception must be taken into account as well as the other circumstances of the case and whether it is reasonable for the conduct to have the said effect.

24. The Tribunal reminded itself that Dr Karangoda is of good character in that he has no convictions and no previous disciplinary findings recorded against him. His good character is relevant in two ways. Firstly, he has given evidence and his good character is a positive feature which the Tribunal should take into account when considering whether it accepts his evidence. Secondly, the Tribunal should consider whether his good character makes it less likely that he acted as is now alleged against him. What weight should be given to his good character and the extent to which it assists the Tribunal in its determination is a matter to be considered in light of all the evidence. Of course, character evidence of itself does not amount to a defence to any of the particulars of the allegation.

25. The Tribunal had colleague testimonials relating to Dr Karangoda's character and these were taken into consideration in deciding what weight should be accorded to his good character. It is not evidence in that it goes directly to the allegation though it is a matter to be put into the balance when the Tribunal is evaluating all of the evidence in the case. The Tribunal was mindful that how Dr Karangoda acted in the past is not necessarily an indicator of how he acted on the occasions relevant to this case. However, if the Tribunal found that the testimonial evidence demonstrates to any significant degree what his normal behaviour is, then it may be taken into consideration when assessing whether or not he acted in the manner alleged. As emphasised in the case of *Martin v Solicitors Regulation Authority [2020] EWHC 3525 (Admin)* the significance of such evidence ought not to be overstated and should not detract from the primary focus on the evidence directly relevant to the alleged misconduct.

The Tribunal's Analysis of the Evidence and Findings

26. 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.

Patient A

27. The Tribunal first considered the evidence in respect of Patient A, including the conflicting accounts of her and Dr Karangoda and any corroborating or documentary evidence which could add weight to one version of events or the other.

28. The Tribunal noted the short video recording provided by Patient A which appeared to show her in the post-operative ward. Patient A's account according to her GMC statement of 24 September 2021 was that she had attempted to record the interaction between Dr Karangoda and herself after he asked her *"if you don't mind me asking, do you do dates?"* and *"are you on Adult Work?"*. The submissions made on behalf of Dr Karangoda were that Patient A likely accidentally recorded this short clip and retrospectively attributed this to her attempting to record the conversation. The Tribunal noted that the video placed Patient A on the post-operative ward at 6:55pm. An unidentified person in scrubs can be seen at the bottom of the room, but Patient A did not assert that this was Dr Karangoda. The Tribunal further noted that Dr Karangoda was not visible or otherwise in the video and the video therefore provided minimal assistance to the Tribunal. The GMC invited the Tribunal to view the video as lending weight to Patient A's account but owing to the extremely limited nature of the footage any such weight was equally limited. The Tribunal did not infer that the taking of the video itself was proof that a conversation with Dr Karangoda immediately preceded the recording. There were other potential reasons for the recording that could not be ruled out such as Patient A accidentally hitting record.

29. Patient A stated adamantly that the alleged events occurred immediately after she woke up from the anaesthesia, and insisted that she would not have been able to walk to the post-operative ward following her procedure. However, the medical records show entries by the recovery nurse and ward nurse that she walked there with assistance at around 17:45 to 17:47, approximately 45 minutes after leaving theatre. The defence contended that this, together with taking of analgesia and the provision of tea and biscuits at 18:15, was evidence that Patient A was awake some time prior to the video being recorded. When these matters were put to Patient A she made no concessions, denying that it was possible that she walked to the ward and also stating that it was not possible that she had been awake for some time before the video was taken. The Tribunal found Patient A's response to the questioning to be unconvincing. The entries in the medical notes were clear, contemporaneous evidence, not made by Dr Karangoda and the accuracy of which was not disputed by the GMC. In summary, the Tribunal had doubts about the accuracy of Patient A's evidence regarding the timing of the alleged incident.

30. The Tribunal heard uncontested, but not independent expert, evidence from Dr Karangoda that patients may be confused or groggy for around 10 minutes after regaining consciousness from anaesthesia. This would have passed by the time of the video given the timeline set out in the medical records and Patient A had received two doses of analgesia by this time, including Tramadol.

31. The submissions made on behalf of Dr Karangoda were that the inconsistencies in Patient A's account of the timing of the conversation between Dr Karangoda and herself were not minor and undermined her reliability as a witness. The Tribunal considered that on this issue alone it was at least possible that her timings were wrong and that her recollection was mistaken.

32. The defence invited the Tribunal to conclude that Patient A's description of the alleged comments, i.e. the language used, was a major weakness in her evidence. The Tribunal rejected this analysis and considered that whilst the exact words attributed to Dr Karangoda were not always repeated in the exact same terms, they were broadly similar, in a manner that would not be unusual in witness evidence of this nature.

33. The Tribunal next considered the inconsistent evidence of Patient A about whether a conversation occurred between a nurse and Dr Karangoda in the immediate aftermath to the alleged comments of Dr Karangoda to Patient A. In correspondence between Patient A and Enhance Medical, dated 4 July 2020, Patient A stated that:

> *"[I] tried to record it on my phone but he wouldn't say it again and all I got was the ceiling I think he new and the <u>nurse then cam back in and said what are you even doing down here and he said oh she was scared I'm checking she's okay</u> and I just looked at her and he cleared of really quick after she questioned him… [sic]"* [Tribunal emphasis added]

34. The Tribunal noted that the nurse, referred to above, was a person who could have corroborated Patient A's account but there was no independent witness evidence in relation to any such conversation. Of particular significance, there were no references within Patient A's written witness statements to the GMC about any such witness challenging Dr Karangoda. In her statement to the GMC of 24 September 2021 she detailed that a nurse walked in but did not see anything and walked straight to the sink to wash her hands. There was no reference to any conversation or challenge. In response to questions during her oral evidence Patient A initially stated that there was no conversation, before later saying in her oral

evidence "*So she she's not talking to him, she just walks in, he gets spooked and walks out.*" Patient A also said in her oral evidence that the nurse being referred to is the person who could be seen at the bottom of the video.

35. The Tribunal considered that the discrepancies and inconsistencies around the involvement of a nurse undermined the credibility of Patient A's account and raised serious questions about her reliability as a witness. According to Patient A's original account to Enhance Medical, the unidentified nurse was not only present but challenged Dr Karangoda over what they heard. Notwithstanding the potential significance of this and how memorable it would have been, as detailed above there was no reference at all to the nurse challenging Dr Karangoda in Patient A's subsequent written and oral evidence.

36. The Tribunal considered the text messages between Dr Karangoda and Patient A, which were initiated by Dr Karangoda. The content was bland, matter of fact, referred to pain management and there was an absence of any reference to the events alleged by Patient A to have preceded this. The Tribunal was mindful of the power imbalance between a doctor and a patient and was also mindful that bland messages could have served as some form of initial communication with an underlying sexual motivation. It also considered that some patients, when responding to unexpected and unsolicited texts from a doctor, may not raise concerns but might rather respond in a neutral manner. However, the Tribunal noted the timing of the texts as the day after Patient A was discharged from XXX Hospital by which stage, as detailed in her communication with Enhance Medical, she had already formed the view that she found Dr Karangoda to be *"shifty".* In her GMC statement of 24 September 2021, she described leaving XXX Hospital and telling her friend Person F *"everything that happened"* about Dr Karangoda. The Tribunal understood this to be reference to the alleged comments made by Dr Karangoda. Set against this background and having regard to all the circumstances, the Tribunal considered the blandness of the text messages was noteworthy and inconsistent with the alleged conduct having occurred the day before. Patient A's friend Person F was not called as a witness so the Tribunal had no corroborating evidence from her.

37. In respect of Dr Karangoda making telephone calls to Patient A, Patient A's evidence was inconsistent and unconvincing. In an email on 4 July 2020 she stated:

> *"… I think he's realized what he done I also received a call from an unknown number from him asked if I'm okay and do I need him to bring me anything and I hung the phone up and he hasn't contacted me again…" [sic]*

In her account to the GMC she stated that she did <u>not</u> answer any of the calls and in her written witness statement, dated 24 September 2021, stated:

> *"Around 3 – 4 days after receiving those messages, I started receiving missed calls from an unknown number. <u>I didn't answer any of the calls</u>. I wasn't receiving any calls from an unknown number before I had the procedure so I was concerned that the person calling me was Dr Karangoda, especially because I knew at that point that he had access to my mobile number."* [Tribunal emphasis added]

In her oral evidence Patient A conceded that she had presumed Dr Karangoda to have been behind the missed calls. The Tribunal was concerned that this evidence was plainly inconsistent and demonstrated a willingness on the part of Patient A to make a highly speculative, unsubstantiated and serious allegation against Dr Karangoda without any reliable basis to do so.

38. The Tribunal also noted that there was a discrepancy in Patient A's account of where Dr Karangoda was at the time of making the alleged comments. In her GMC statement of 24 September 2021 Patient A said the following:

> *"This is when Dr Karangoda entered the room from the door on the left side of the room. Dr Karangoda walked around my bed to the <u>right side</u>. He said hello and asked me how I was, and I told him I was feeling okay. <u>It was at this point</u> Dr Karangoda stepped closer to the bed and leaned closer me. He said to me, in a very quiet voice "if you don't mind me asking, do you do dates?" I was shocked. I asked him "what does that mean?" and he replied, "are you on Adult Work?" I didn't know what he meant at that point but when I went home, I googled 'Adult Work' and discovered it was a catalogue for female escorts. But when I was sat in the room with him, I could understand that what he was asking me was extremely inappropriate. I had my phone in my hand and I tried to press record so I could get proof of what he said to me. I asked him to repeat himself but as soon as I did, a nurse walked in. Dr Karangoda was standing on the <u>right side</u> of the bed, facing the door…"* [Tribunal emphasis added]

39. On multiple occasions in her oral evidence, Patient A described Dr Karangoda as being on the left side of the bed when he was said to have made the alleged comments. This discrepancy caused further doubt for the Tribunal as to the accuracy and veracity of Patient A's evidence.

40. The Tribunal was mindful that the burden of proof lies with the GMC and that the Tribunal is required to find that on the balance of probabilities one version of events is more likely. Given the absence of corroborating evidence and the cumulative discrepancies in Patient A's account, the Tribunal had significant doubt over her reliability as a witness. Whilst the timing of the conversation with Dr Karangoda could potentially have been explained by Patient A being post-surgery, further and more significant doubts arose for the Tribunal in respect of the involvement of an unidentified nurse, the evidence relating to the phone calls, and the discrepancy regarding Dr Karangoda's location in the room.

Paragraph 1(a)

41. The Tribunal noted that there was no independent contemporaneous evidence to support the Allegation and that the basis for its determination was the conflicting accounts of Patient A and Dr Karangoda.

42. The Tribunal considered the submissions of the GMC that whilst Dr Karangoda denies having visited Patient A at all in the post-operative ward, he also referred to the fact that he was keen to provide her with special treatment because she was a XXX and so it may follow that part of this special treatment would have extended to speaking with her in the post-operative ward. The only evidence before the Tribunal that placed Dr Karangoda in the post-operative ward was the accounts of Patient A and Dr Karangoda's evidence was that he did not visit her there and would have had no reason to do so unless any specific concerns about her condition had arisen.

43. Owing to the Tribunal having serious doubts about Patient A's reliability as a witness, and in the absence of any other evidence that Dr Karangoda was present and asked the questions alleged, the Tribunal determined that the GMC had not sufficiently discharged its evidential burden such that it could find that, on the balance of probabilities, these events occurred.

44. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

Paragraph 1(b)

45. The Tribunal considered that the evidence before it was again the conflicting accounts of Patient A and Dr Karangoda.

46. Dr Karangoda's version of events was that Patient A gave him her mobile number, presumably to follow her on social media. He stated that he does not usually personally contact patients after they have been discharged but that in Patient A's case she had been very anxious about the procedure and that because she was a XXX, he went out of his way to make sure that she was happy with her treatment and was comfortable.

47. Patient A's evidence was consistent throughout that at no point did she give him her number, that she had no idea how Dr Karangoda managed to get her phone number and that she did not understand why he was messaging her.

48. Whilst the Tribunal found Dr Karangoda's account of giving special treatment to Patient A to be somewhat unconvincing, it had significant concerns over the reliability of Patient A's evidence for the reasons set out above. Patient A evidently had gaps in her recall after the surgery, for example walking with help from staff.

49. Given the absence of evidence to corroborate Patient A's account and the concerns over the reliability of her recall and her evidence generally, the Tribunal determined that the GMC had not sufficiently discharged its evidential burden. The Tribunal was provided with no system access records or any other information or evidence which could demonstrate that Dr Karangoda had accessed Patient A's medical records to obtain her phone number, as set out in the Allegation.

50. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

Paragraph 2(a)

51. Having found paragraph 1(c) admitted and found proved, the Tribunal went on to consider whether Dr Karangoda's actions in sending one or more messages to Patient A's personal telephone number were inappropriate.

52. The Tribunal bore in mind that Patient A had been provided with a number to contact for 24-hour aftercare if required, and that subsequent to the text exchange she had used this number for aftercare purposes rather than contacting Dr Karangoda directly.

53. The Tribunal also noted that during his oral evidence Dr Karangoda himself stated that accepting Patient A's telephone number was *"unprofessional"* and could be *"construed as unprofessional behaviour"*. He went on to state that in using Patient A's number to contact

her the following day he *"did not protect the professional boundaries which as a professional I should have protected and I do understand that and I've learned from that and I fully appreciate it"* and that *"it was inappropriate for me to do that".*

54. The Tribunal concluded that in the circumstances, Dr Karangoda did act inappropriately as there was no clinical need for him to contact Patient A given that he was the anaesthetist for her operation and that she had been provided a number for aftercare.

55. Accordingly, the Tribunal found this paragraph of the Allegation proved in respect of paragraph 1(c).

Paragraph 2(b) & Paragraph 2(c)

56. The Tribunal considered the messages sent to Patient A by Dr Karangoda and in light of their content, and its findings in respect of the paragraphs of the Allegation set out above, determined that there was insufficient evidence to find that they were sexually motivated.

57. Similarly, the Tribunal determined that Dr Karangoda's actions in sending these messages did not constitute sexual harassment.

58. Accordingly, the Tribunal found both these sub-paragraphs of the Allegation not proved.

Patient B

59. The Tribunal considered the witness evidence in respect of Patient B, including that of Dr Karangoda, Patient B, Ms D, Ms E and Person C.

60. Patient B's first written complaint was made on 8 July 2020 in an email to the XXX Clinic and stated as follows:

> "*After the operation when I was coming round I remember not being able to move his hand from my thigh as he was moving it further closer to my knickers. I eventually managed to move his hand when I brushed him off my thigh*."

61. On 7 September 2020 Patient B made a complaint to the GMC and repeated the wording used above.

62. In a letter dated 11 September 2020, Person G, hospital manager at the XXX Clinic references Patient B's complaint as Dr Karangoda having *"touched her thigh"*.

63. The first mention in the evidence of Dr Karangoda's hand touching the hem of Patient B's underwear comes from Patient B's first statement to the GMC dated 23 May 2021:

> "*I remember being woken up by Dr Karangoda's hand going up my thigh. Dr Karangoda reached the inside of the hem of my underwear. I remember still feeling the effects of the anaesthesia, so I struggled to brush his hand off my thigh. I remember trying to move his hand away at least 3 times.*"

64. In Patient B's first supplemental statement, dated 1 December 2022, the account is as follows:

> "*I felt Dr Karangoda's hand moving in and out of the hem of the paper pants, just below my tummy and around my pubic area, for a few minutes*."

65. In her oral evidence under cross-examination Patient B said that Dr Karangoda's hand had gone through the *"leg hole of the knickers, not the top"*. She further said that she was alone with Dr Karangoda in the recovery room when the touching is alleged to have occurred.

66. The Tribunal was concerned that Patient B's account of these events had clearly evolved over time, with her first describing Dr Karangoda touching her leg and then later specifically her thigh before then referencing the pubic area. The purported duration of these events also lengthened over time, with Patient B stating that it lasted a few minutes and she tried to push Dr Karangoda's hands away several times.

67. In his statement of 31 May 2023 Dr Karangoda referenced having to *"gently restrain Patient B to stop her climbing off or climbing off the trolly [sic]"*. He added that he did not remember exactly what he did because *"…it is a second nature reaction and there is nothing unusual in a patient exhibiting this type of behaviour when first coming out of anaesthetic. I normally use my body as a physical barrier, which I would have done in Patient B's case. I would have also tried to gently turn her back onto the trolly. To do this I may have put my hand on her left or right, shoulder, hips or both to put her into a supine position. This is usual practice. I recall that I said to [Patient B] that she had to "get back on the trolley" because she*

was leaning over the trolley side." In his oral evidence, Dr Karangoda said that he would only have been in the recovery room for less than three minutes.

68. The Tribunal noted that whilst Ms D, the recovery nurse at the XXX Clinic at the time, did not produce her written witness statement for the GMC until May 2023, in her oral evidence she stated that she has some recollection of Patient B and the events of that day as she was XXX. Ms D's account was that she never left the room, did not see anything untoward occur and that in such a small room it would be impossible not to notice such behaviour as she would be right next to Patient B.

69. The Tribunal also heard oral evidence from Ms E, Theatre Nurse at the XXX Clinic. Aspects of Ms E's evidence were confusing and inconsistent, such as who was present with Patient B pre-operatively and post-operatively, and whether the complaint was raised with her/the Clinic the same day or the next. However, she was clear about Patient B having been confused coming out of theatre and specifically recalled a memorable conversation with Patient B XXX (which was erroneous). The Tribunal bore in mind that Ms E had been feeling unwell on the day of her oral evidence and that this may have contributed to the inconsistencies in her recall of events. It accepted that she was seeking to provide an honest version of events, notwithstanding the inconsistencies. The Tribunal found Ms E's evidence about Patient B's confusion to be credible.

70. The Tribunal attributed significant weight to the account of Ms D, who provided clear, consistent evidence. Ms D's evidence was that as the recovery nurse allocated to a patient, it was her responsibility to care for that patient and she would not have left the recovery room in any event. The Tribunal accepted the evidence of Ms D that she had been present throughout and had not witnessed anything untoward, and that as a registered nurse, had she done so she would have reported it.

71. In considering the likelihood that events occurred as described by Patient B, the Tribunal was mindful that for Dr Karangoda, a doctor of good character, to act in such a fashion would have been high risk and extremely audacious in a scenario where there was a nurse present and others in close proximity and coming in and out of the room.

72. In assessing the reliability of Patient B as a witness, the Tribunal had no sense that she was lying or deliberately misleading the Tribunal. Her XXX health condition was a possible explanation for the inconsistencies in her account and why her version of events may not reflect reality. XXX.

73. The Tribunal considered the GMC submissions that there are no relevant medical records for Patient B at the time of the alleged events to indicate that she was unwell at the time, but preferred the submissions made on behalf of Dr Karangoda that the absence of contemporaneous records does not mean that she was not suffering or experiencing symptoms at the time. Patient B was discharged from XXX health services prior to the date of the alleged misconduct. She had stopped attending appointments of her own accord and there were events during 2018 and 2019 which indicated that issues were present at that time even though the diagnosis of XXX was not made until some time later.

74. Overall, and accepting that Patient B genuinely believed her evidence to be true, the Tribunal concluded that she was not a reliable witness.

<u>Paragraph 3(a)</u>

75. Dr Karangoda's account is that he first met Patient B in the Pre-Operative Assessment Ward where she was accompanied by a chaperone and that this person would have stayed with Patient B during the pre-anaesthetic consultation. He states that it is possible that Patient B was already wearing a hospital gown but that he cannot recall and that he carried out all of the standard checks such assessing her BMI and demeanour prior to surgery.

76. Patient B's account was summarised in her GMC witness written statement of May 2021 where she states:

> *"I remember thinking he seemed a bit strange because he kept looking at my groin area when he was talking to me. This made me especially uncomfortable because I was only wearing a hospital gown and socks. I remember shifting my legs to make sure he couldn't see my private parts, but his eyes kept following my groin. I found the situation very shocking because there was a nurse standing right next to him when he was staring at me. I don't think the nurse could see his eye movements as she was standing next to him when he was talking to me."*

77. The Tribunal considered that Dr Karangoda's account of events was reasonable and believable. It was not satisfied that Patient B would have been able to tell that Dr Karangoda was looking specifically at her groin area during the pre-operative examination.

78. In light of this, and the Tribunal's conclusion about Patient B's reliability, the Tribunal determined that the GMC had not proven that, on the balance of probabilities, these events had occurred as set out in the Allegation and described by Patient B.

79. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

Paragraph 3(b)

80. For all the reasons set out above, the Tribunal was not satisfied that the GMC had proved that, on the balance of probabilities, these events occurred.

81. Accordingly, the Tribunal found this paragraph of the Allegation not proved.

Paragraph 3(c)

82. For the reasons set out above, the Tribunal was not satisfied that there was sufficient evidence for it to find that Dr Karangoda had asked for Patient B's telephone number, and accordingly found this paragraph of the Allegation not proved.

Paragraph 4(a)

83. Having found paragraph 3(d) admitted and found proved, the Tribunal went on to consider whether Dr Karangoda's actions in providing Patient B with his personal mobile telephone number were inappropriate.

84. The Tribunal also noted that during his oral evidence Dr Karangoda stated that he offered Patient B his phone number so that she would be able to contact him if she needed any help or advice regarding a pain management and because XXX. He stated that for these reasons he did not treat Patient B as he would have treated other patients *"which in retrospect and on reflection was not professional."*

85. The Tribunal concluded that in the circumstances, Dr Karangoda did act inappropriately. There was no clinical need for him to provide Patient B with his telephone number and there was no need for him to become involved in her follow-up care.

86. Accordingly, the Tribunal found this paragraph of the Allegation proved in respect of paragraph 3(d).

Paragraph 4(b) & Paragraph 4(c)

87. The Tribunal determined that in light of its findings in respect of paragraph 3 of the Allegation set out above, there was insufficient evidence to find that Dr Karangoda's action in providing his contact number to Patient B was sexually motivated.

88. Similarly, the Tribunal determined that Dr Karangoda's actions in this respect did not constitute sexual harassment.

89. Accordingly, the Tribunal found both these sub-paragraphs of the Allegation not proved.

The Tribunal's Overall Determination on the Facts

90. The Tribunal has determined the facts as follows:

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

Patient A

1. On 19 to 20 February 2020 you were the anaesthetist for Patient A's breast augmentation procedure at the Enhance Medical Group Clinic in XXX and, whilst Patient A was recovering post-operatively, you:

    a. inappropriately asked Patient A:

        i. 'if you don't mind me asking, do you do dates?'; **Not proved**
        ii. 'are you on Adult Work?' **Not proved**

    or words to that effect; **Not proved**

    b. on or before 20 February 2020, obtained Patient A's personal mobile telephone number from her medical records without her consent; **Not proved**

c. on 20 February 2020, sent one or more messages to Patient A's personal telephone number. **Admitted and found proved**

2. Your actions as set out at:

a. paragraphs 1b. and/or 1c. above were inappropriate as Patient A had been provided with a number to contact for 24-hour aftercare if required; **Determined and found proved in respect of paragraph 1(c)**

b. **paragraph 1 were sexually motivated; Amended under Rule 17(6), Not proved**

~~b.~~**c.**paragraph 1 were unlawful sexual harassment ~~related to sex~~ by virtue of Section 26**(2)** of the Equality Act 2010, in that you engaged in unwanted conduct ~~related to sex~~ **of a sexual nature** which had the purpose or effect of violating the dignity of Patient A, or creating an intimidating, hostile, degrading, humiliating or offensive environment for her. **Amended under Rule 17(6), Not proved**

<u>Patient B</u>

3. On 6 July 2020 you were the anaesthetist for Patient B's breast implant replacement procedure ('the Procedure') at the XXX Clinic and on one or more occasions you:

a. during the pre-operative assessment looked at Patient B's groin area whilst she was wearing a hospital gown; **Not proved**

b. whilst she was waking up from general anaesthetic post-operatively, you:

i. ran your hand up Patient B's thigh; **Not proved**
ii. reached inside of the hem of her underwear; **Not proved**

despite her attempting to move your hand away on one or more occasions; **Not proved**

c. asked Patient B for her personal telephone number to contact her about her progress after the Procedure; **Not proved**

d. provided Patient B with your personal mobile telephone. **Admitted and found proved**

4. Your actions as set out at:

a. paragraphs 3c. and/or 3d. above were inappropriate as you knew Patient B would be provided with a contact for appropriate aftercare; **Determined and found proved in relation to paragraph 3(d)**

b. paragraph 3 were sexually motivated; Amended under Rule 17(6), Not proved

~~b~~**c**. paragraph 3 were unlawful sexual harassment ~~related to sex~~ by virtue of Section 26**(2)** of the Equality Act 2010, in that you engaged in unwanted conduct ~~related to sex~~ **of a sexual nature** which had the purpose or effect of violating the dignity of Patient B, or creating an intimidating, hostile, degrading, humiliating or offensive environment for her. **Amended under Rule 17(6), Not proved**

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

Determination on Impairment - 13/03/2024

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

2. Ms Stephenson, on behalf of Dr Karangoda, invited the Tribunal to consider the issue of misconduct at this stage. She submitted that if the Tribunal finds that Dr Karangoda's actions are found to amount to misconduct, she would provide further submissions and documentary evidence with regard to whether his fitness to practise is impaired. On behalf of the GMC Ms Vanstone submitted that she did not object to this approach. This suggested approach was accepted by the Tribunal.

The Evidence

3. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

Submissions

4. As set out above, the parties provided submissions on misconduct following agreement that the Tribunal would determine and announce its findings in respect of misconduct prior to hearing submissions on impairment if required following a finding of misconduct.

On behalf of the GMC

5. On behalf of the GMC, Ms Vanstone submitted that the Tribunal would wish to look at the statutory obligations expected of a registered practitioner and any sections of Good Medical Practice (2013) ('GMP') that may have been breached by virtue of the conduct found proved, in particular paragraphs b and c of the statutory overriding objective, namely to *promote and maintain public confidence in the medical profession and promote and maintain proper professional standards and conduct for the members of the profession*.

6. Ms Vanstone submitted that there is perhaps no clear fit for an identifiable breach of GMP as is sometimes the case because the paragraphs of GMP are not rules, but factors for medical professionals to be guided by, to use their judgement so as to ensure compliance with GMP overall. She submitted that paragraphs 23 and 81 of Good Medical Practice (2024) may be of relevance, which state:

> ***23*** *You must treat patients with kindness, courtesy and respect.*
>
> ...
>
> ***81*** *You must make sure that your conduct justifies patients' trust in you and the public's trust in your profession.*

7. Ms Vanstone told the Tribunal that she did not submit that there was any specific breach of the provisions of GMP in respect of breaching professional boundaries, as it specifically refers to this in the context of a sexual relationship or sexual motivation which

was not found in this case. She submitted that despite this, the Tribunal found that Dr Karangoda's conduct was inappropriate and that there was no clinical need for text messages to be sent to Patient A. Similarly, there was no clinical need for Dr Karangoda to provide his telephone number to Patient B and no need for him to be involved in the follow up care of either patient.

8. Ms Vanstone submitted that Dr Karangoda has been practising for many years and should have been aware that such behaviour was inappropriate and that despite his acceptance of this, that inappropriate conduct was repeated on two occasions for two separate patients. She submitted that therefore, the Tribunal was invited to consider that Dr Karangoda's actions did amount to misconduct.

On behalf of Dr Karangoda

9. On behalf of Dr Karangoda, Ms Stephenson submitted that none of the allegations admitted or found proved amount to misconduct and nor do they amount to misconduct in combination.

10. She submitted that professionals make mistakes all the time in both minor and more serious ways, and that in order to make a finding of misconduct it is not just any professional misconduct which will qualify, rather that it must be a serious act or omission. She submitted that in respect of Patient A the Tribunal found that Dr Karangoda did act inappropriately as there was no clinical need for Patient A to be contacted by him. However, the Tribunal also found that the content of those text messages were *"bland, matter of fact"* and *"referred to pain management"*, and that really encapsulates what was going on here. She submitted that nothing further than it being inappropriate has been found and that Dr Karangoda accepts that his actions were unprofessional and that Patient A had an alternative, approved pathway for follow-up care.

11. Ms Stephenson submitted that in respect of Patient B, Dr Karangoda did provide her with his telephone number when there was no need for him to do so, which he accepts was unprofessional. She submitted that the circumstances, where Patient B was also XXX, do not make Dr Karangoda's actions appropriate, but that it is important context. She submitted that these actions did not come close to the level of seriousness that would be required for a finding of misconduct.

12. Ms Stephenson submitted that Dr Karangoda's actions were misjudged but did not amount to misconduct and did not fall seriously below the standards expected. She submitted that the applicable case law sets out that in some circumstances it is possible to roll up non-serious misconduct findings, but that cases of that type will be very rare and the message from the case law is clear that this should not be done routinely. She submitted that the giving of his telephone number and the sending of messages simply does not amount to a case where these non-serious findings of misconduct ought to be combined to render them serious.

The Relevant Legal Principles

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

14. In approaching the decision, 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."*

15. In that regard, the Tribunal was required to take note of the standards set out in the GMC's GMP.

16. In the case of *Remedy UK v GMC [2010] EWHC 1245 (Admin)*, it was said that:

> *"Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur*

outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession".

17. In *Cheatle v GMC [2009] EWHC 645 (Admin)* the Court made clear that misconduct must be serious rather than mere misconduct. It is generally an accepted position that the kind of serious misconduct required is such as would be described as *"misconduct that would be regarded as deplorable by fellow practitioners"*. In *Khan v. BSB [2018] EWHC 2184 (Admin)*, Warby J said that the legal authorities make plain that a person is not to be regarded as guilty of professional misconduct if they engage in behaviour that is trivial, or inconsequential, or a mere temporary lapse, or something that is otherwise excusable, or forgivable.

18. The assessment of seriousness is a matter for the Tribunal, exercising its own skilled judgement, on the facts and circumstances of the case, viewed in the light of all the evidence before it and the submissions made.

19. The Tribunal has found that Dr Karangoda acted inappropriately in respect of texting Patient A and giving his number to Patient B. The Tribunal may determine that either or both of those acts individually amount to serious misconduct. If the Tribunal concluded that neither of those acts individually amount to serious misconduct, the issue would then arise as to whether or not non-serious misconduct could collectively constitute misconduct. The Tribunal was referred to the case of *Schodlok v GMC 2015 EQCA Civ 769*. The relevant part of the judgment related to whether or not five non-serious misconduct charges, although not serious individually, amounted together to misconduct. The particular misconduct in that case related to comments made by the doctor on different occasions and other minor failures. The judgment says that the rolling-up of non-serious misconduct could happen in a very unusual case. In other words it was not ruled out but Vos LJ did specifically say "*In the normal case, I do not think that a few allegations of misconduct that are held individually not to be serious can or should be regarded collectively as serious misconduct"*. Beatson LJ agreed with that but did give what he stressed was a very preliminary view that if it is clearly charged against the doctor then a cumulating of non-serious charges could amount to serious misconduct but he added that he was envisaging a scenario with *"a large number of findings of non-serious misconduct, particularly where they are of the same or similar misconduct".*

20. The Tribunal further noted that the principles in *Schodlok* were applied in the case of *Ahmedsowida v GMC [2021] EWHC 3466 (Admin)*. In that case there were only three proven instances where the doctor had defied instructions from his superiors. Two of the instances were already found serious and the Tribunal was in effect elevating the non-serious charge to

a serious one. Kerr J opined that the Schodlok principles remained that in the normal case a few allegations of misconduct that are individually held not to be serious should not be regarded collectively as serious misconduct and that the culmination of non-serious misconduct would only arise in a very unusual case in very unusual facts. He specifically stated that the cluster of three was too small and went on to say *"there was nothing analogous to the series of minor niggling fouls in a football match, eventually cumulated to a yellow card".* He also referenced the need for the charge to be brought against the doctor on a cumulative basis.

21. The Tribunal was reminded that in the event that the misconduct was not found to be serious and the doctor's fitness to practise therefore not impaired, it remained open to the Tribunal to consider the question of imposing a warning. The Tribunal indicated to the parties that if it considered a warning may be appropriate then it would invite further submissions.

The Tribunal's Determination on Impairment

Misconduct

22. The Tribunal first considered whether the facts found proved amounted to misconduct in respect of the individual facts found proved.

Patient A

23. The Tribunal considered that Dr Karangoda's actions in respect of Patient A amounted to a single exchange of texts between them, initiated by Dr Karangoda, which spanned a period of less than half an hour.

24. The Tribunal found at the facts stage that the contents of these messages was *"bland, matter of fact"* and *"referred to pain management"*. It also found that Dr Karangoda's actions were inappropriate as there were proper pathways in place for Patient A to obtain follow-up care and it was not necessary for him to contact Patient A himself.

25. The Tribunal considered paragraphs 47 and 65 of GMP, as set out below, and also the *Maintaining boundaries (2013)* guidance.

> *47 You must treat patients as individuals and respect their dignity and privacy.*

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

26. The Tribunal determined that Dr Karangoda's actions were a departure from paragraph 47 in that he had not respected Patient A's privacy but that there were no specific departures from the *Maintaining boundaries* guidance. The Tribunal determined that paragraph 65 of GMP was not breached as it concluded that patients' and the public's trust would not be undermined by its findings of facts.

27. The Tribunal noted that there was no sexual or otherwise inappropriate content within the messages that would make the misconduct more serious, and concluded that Dr Karangoda's actions, whilst ill thought-out and a misjudgement, would not be considered *"deplorable"* by fellow practitioners. His misconduct could not be described as *"morally culpable or disgraceful"* and in the Tribunal's view it did not prejudice the reputation of the profession.

28. The Tribunal therefore determined that Dr Karangoda's actions in respect of Patient A did not amount to a serious departure from the principles of GMP and did not constitute serious misconduct.

<u>Patient B</u>

29. The Tribunal considered that in respect of Patient B, Dr Karangoda had inputted his number into her mobile phone. It concluded that this behaviour was ill-judged and misguided and that he should not have done so, despite Patient B XXX. At the time of the events Patient B was a patient of Dr Karangoda's and he should have acted accordingly.

30. As with Dr Karangoda's actions in respect of Patient A, the Tribunal concluded that this behaviour was a departure from paragraph 47 of GMP as he had not respected Patient B's privacy. The Tribunal determined that this was not a significant departure from the standards expected of a practitioner and did not amount to serious misconduct. The Tribunal again considered this misconduct to be ill thought out and a misjudgement but not conduct that would be considered *"deplorable"* by fellow practitioners nor was it conduct that could be described as *" morally culpable"* or "*disgraceful"*.

31. The Tribunal therefore determined that Dr Karangoda's actions in respect of Patient B did not amount to a serious departure from the principles of GMP and did not constitute serious misconduct.

32. In reaching this decision, the Tribunal bore in mind the overarching objective and determined that Dr Karangoda's actions did not put patient safety at risk, undermine public confidence in the profession or undermine proper professional standards for members of the profession.

33. Having determined that Dr Karangoda's action did not individually amount to serious misconduct, the Tribunal went on to consider whether cumulatively his actions amounted to serious misconduct. In doing so it bore in mind the applicable case law set out above.

34. In considering the case law of *Schodlok* and *Ahmedsowida*, the Tribunal concluded that this was not a very unusual case with unusual facts which would give rise to the accumulating of two acts of non-serious misconduct into serious misconduct.

35. The Tribunal therefore determined that Dr Karangoda's conduct did not fall so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

36. Accordingly, having concluded that there was no serious misconduct by Dr Karangoda, the Tribunal has therefore determined that his fitness to practise is not impaired.

Consideration of a warning

37. Having determined that Dr Karangoda's fitness to practise is not impaired, the Tribunal went on to consider whether to invite submissions on issuing a warning in this case. In doing so it bore in mind the *Guidance on warnings*, in particular paragraph 20, which states:

> ***20*** *The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.*
>
> > ***a*** *There has been a clear and specific breach of Good medical practice or our supplementary guidance.*

> ***b*** *The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor's fitness to practise has not been found to be impaired.*
> ***c*** *A warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely relating to a doctor's health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.*
> ***d*** *There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).*

38. The Tribunal noted that Dr Karangoda made admissions to contacting Patient A and giving his telephone number to Patient B. He also accepted in his evidence that his actions in doing so were unprofessional and inappropriate. In light of the applicable guidance on warnings, the Tribunal did not consider that the two breaches of paragraph 47 of GMP could be described as significant departures from the professional standards required from Dr Karangoda. As detailed above, the Tribunal has concluded that the misconduct would not affect public confidence or the reputation of the profession. The Tribunal further considered all the circumstances of the case and the overarching objective, and it determined that consideration of a warning was not necessary.

39. In reaching this decision the Tribunal applied the principle of proportionality, balancing the interests of the public with those of Dr Karangoda.

40. There is no interim order to be revoked.

41. That concludes the case.