**Record of Determinations –**
**Medical Practitioners Tribunal**

# PUBLIC RECORD

**Dates**: 12/11/2018 - 16/11/2018 and 11/12/2018 - 12/12/2018 and 07/01/2019 - 08/01/2019

**Medical Practitioner's name:** Dr Hassan TWINS

**GMC reference number:** 5175180

**Primary medical qualification:** MB BS 1989 Lagos

**Type of case**
New - Misconduct

**Outcome on impairment**
Not Impaired

**Summary of outcome**
Warning

**Tribunal:**

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| Legally Qualified Chair | Miss Sally Cowen |
| Medical Tribunal Member: | Dr Damian McDermott |
| Medical Tribunal Member: | Dr Vivek Sen |

| | |
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| Tribunal Clerk: | Ms Louise Henderson<br>(12/11/2018 to 16/11/2018)<br>Dr Joshua Kirby<br>(11/12/2018 and 12/12/2018)<br>Ms Lauren Culkin<br>(12/12/2018 and 07/01/2019)<br>Miss Emma Saunders<br>(08/01/2019) |

**Attendance and Representation:**

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| Medical Practitioner: | Present and represented |
| Medical Practitioner's Representative: | Miss Bella Webb, Counsel, instructed by the Medical Defence Union |
| GMC Representative: | Mr David Temkin, Counsel<br>(12/11/2018 to 16/11/2018 and 07/01/2019 to 08/01/2019)<br>Mr Nick Walker, Counsel<br>(11/12/2018 to 12/12/2018) |

## Record of Determinations – Medical Practitioners Tribunal

**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 -** 11/11/2018

**Background**

1. Dr Twins qualified in 1989 with a Bachelor of Medicine and Surgery from the College of Medicine, University of Lagos, Nigeria. He worked in Nigeria as a Family Physician from 1992–1999 before he moved to the UK and undertook a number of roles in Paediatrics.

2. Dr Twins completed his GP vocational training in 2005 and gained his MRCGP (Membership of the Royal College of General Practitioners) in 2006, and thereafter worked as a GP throughout Sussex and Brighton and Hove.

3. The Allegation that has led this hearing surrounds concerns relating to misconduct which have arisen from Dr Twins' treatment of Patient A and Patient B. It is alleged that Dr Twins failed to carry out a number of actions which resulted in a failure to diagnose ophthalmic shingles in Patient A in 2015 when he was working at Crescent Medical Centre in East Sussex, and a failure to diagnose sepsis in Patient B in 2017 when he was working as a locum GP at Billingshurst Surgery in West Sussex.

4. The initial concerns were raised with the GMC by Patient A on 12 December 2016, in a letter which set out a number of complaints that are reflected in the Allegation. Patient B did not raise a complaint with the GMC, and declined to provide a witness statement or participate in this MPTS hearing. The allegation in respect of Patient B arose as a result of the GMC making an enquiry of Billingshurst Surgery.

**The Allegation and the Doctor's Response**

5. The Allegation made against Dr Twins is as follows:

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

Patient A

1. On 28 September 2015 you consulted with Patient A and you:

    a. failed to enquire about:

        i. eye pain; **To be determined**

        ii. eye redness; **To be determined**

        ~~iii. visual blurring;~~
        **Deleted after a successful Rule 17(2)(g) application**

        ~~iv. any family history of cardiovascular disease or hypertension;~~
        **Deleted after a successful Rule 17(2)(g) application**

    b. failed to examine Patient A's:

        i. pupillary reflexes; **To be determined**

        ii. eye movement; **To be determined**

        iii. visual acuity; **To be determined**

    c. failed to adequately consider any other causes of Patient A's eye pain; **To be determined**

    d. failed to prescribe:

        i. oral antiviral medication; **To be determined**

        ii. pain relief; **To be determined**

    e. failed to discuss Patient A's symptoms with an ophthalmology colleague; **To be determined**

    f. failed to refer Patient A to an ophthalmology colleague for review; **To be determined**

    g. inappropriately advised Patient A that a pharmacist would contact them on a daily basis; **To be determined**

h. failed to record:

i. the presence or absence of any eye symptoms as described at paragraph 1a; **To be determined**

ii. any family history of cardiovascular disease or hypertension; **To be determined**

iii. any examination of Patient A's eye as described at paragraph 1b; **To be determined**

iv. your diagnosis of Patient A's symptomatic hypertension; **To be determined**

v. your prescription of statins to Patient A; **To be determined**

vi. any discussion of Patient A's symptoms with an ophthalmology colleague. **To be determined**

2. On 2 October 2015 you consulted with Patient A and you failed to:

a. adequately engage with Patient A regarding your missed diagnosis of ophthalmic shingles during the consultation on 28 September 2015; **To be determined**

~~b. record:~~

~~i. any information shared with Patient A during the consultation;~~
**Deleted after a successful Rule 17(2)(g) application**

~~ii. any confrontation with Patient A having occurred during the consultation;~~
**Deleted after a successful Rule 17(2)(g) application**

~~iii. Patient A's blood pressure results.~~
**Deleted after a successful Rule 17(2)(g) application**

3. On 15 October 2015 you consulted with Patient A and you failed to:

a. examine Patient A's:

i. pupillary reflexes; **To be determined**

ii. eye movement; **To be determined**

iii. visual acuity; **To be determined**

b. take Patient A's blood pressure; **Admitted and found proved**

c. record:

i. any examination of Patient A's eye as described at paragraph 3a; **Admitted and found proved**

ii. Patient A's blood pressure;
**Admitted and found proved**

~~iii. any confrontation with Patient A having occurred during the consultation.~~
**Deleted after a successful Rule 17(2)(g) application**

4. On 20 October 2015 you consulted with Patient A and you failed to:

a. enquire about Patient A's eye history; **To be determined**

b. examine Patient A's eye, including:

i. pupillary reflexes; **To be determined**

ii. eye movement; **To be determined**

iii. visual acuity; **To be determined**

c. record any examination of Patient A's eye as described at paragraph 4b. **To be determined**

<u>Patient B</u>

5. On 20 January 2017 you consulted with Patient B and you failed to:

a. enquire about:

i. the presence or absence of any chest pain;

**To be determined**

ii. breathlessness;
**To be determined**

iii. whether Patient B's cough was productive of sputum or blood;
**To be determined**

iv. any other possible causes of infection;
**To be determined**

b. check Patient B's:

i. temperature; **To be determined**

ii. heart rate; **To be determined**

iii. blood pressure; **To be determined**

iv respiratory rate; **To be determined**

c. consider a diagnosis of sepsis; **To be determined**

d. adequately consider hospital admission for Patient B;
**To be determined**

e. advise Patient B:

i. to seek medical help if her condition deteriorated;
**To be determined**

ii. of any specific signs of deterioration to watch out for;
**To be determined**

f. adequately record any specific comments on Patient B's air entry to the lungs; **Admitted and found proved**

g. record:

i. Patient B's presentation to NHS 111 on 18 January 2017; **Admitted and found proved**

ii. Patient B's presentation to A&E on 18 January 2017;
**Admitted and found proved**

iii. any specific comments on Patient B's respiratory rate; **Admitted and found proved**

iv. the results of any enquiries as described at paragraph 5a; **Admitted and found proved**

v. the results of any of the checks described at paragraph 5b; **Admitted and found proved**

vi. any consideration of a hospital admission for Patient B; **To be determined**

vii. any advice to Patient B about the matters described in paragraph 5e. **Admitted and found proved**

## The Admitted Facts

6. At the outset of these proceedings, through his Counsel, Miss Webb, Dr Twins 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.

## The Outcome of Applications Prior to the Facts Stage

7. At the outset of the hearing the Tribunal granted an application by Mr Temkin, on behalf of the GMC, made pursuant to Rule 35(4) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), for the identities of Patient A and Patient B not to be revealed in public session. This application was not opposed by Miss Webb, on behalf of Dr Twins, and the Tribunal was satisfied that there would be no injustice to either party. The Tribunal therefore granted the application.

8. At the close of the GMC's case, Miss Webb, on behalf of Dr Twins, made a submission of 'no case to answer' under Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), 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*."

9. Miss Webb made the application in regard to all of the facts of the Allegation, with the exception of paragraphs and sub-paragraphs 3b, 3c(i), 3c(ii), 5f, 5g(i)-5g(v) and 5g(vii) of the Allegation, which were admitted by Dr Twins at the outset of the hearing. Full details of this application can be found at Annex A.

**The Facts to be Determined**

10. In light of the Tribunal's determination on the application under 17(2)(g) (Annex A), the Tribunal is required to make its determination on the remaining paragraphs and sub-paragraphs of the Allegation, as set out above.

**Factual Witness Evidence**

11. On behalf of the GMC, the Tribunal heard oral evidence in person from Patient A and expert evidence as detailed below.

12. Dr Twins also gave oral evidence in person at the hearing.

**Documentary Evidence**

13. The Tribunal had regard to the documentary evidence provided by the parties in the form of a joint bundle. This evidence included, but was not limited to:

- Witness statement of Patient A;
- Witness statements of Dr Twins;
- Correspondence between Patient A and the GMC;
- Correspondence between Patient A and Dr F;
- Patient A medical records;
- Employer response from Mr H, Executive Manager for Billingshurst Surgery;
- Patient B's medical records;
- Dr Twins undertakings imposed by NHS England;
- Dr Twins reflective statement prepared for NHS England;
- Dr Twins patient and colleague feedback.

**Expert Witness Evidence**

14. The Tribunal also received evidence from Dr C, an expert witness called by the GMC. Dr C provided two written Expert Reports; the first in respect of Patient A, dated 28 April 2017, and the second in respect of Patient B, dated 7 June 2017. Dr C also gave oral evidence in person. Dr C has been in practice as a GP Principal since 2003 and has experience of assessing and treating patients suffering from ophthalmic shingles and from sepsis in his own practice.

**The Tribunal's Approach**

15. In reaching its decision on the 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 Twins 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 alleged occurred.

16. The Tribunal considered all of the evidence put before it, both oral and documentary, together with the submissions made by Mr Temkin, Counsel, on behalf of the GMC, and those of Miss Webb, Counsel, on behalf of Dr Twins.

**The Tribunal's Analysis of the Evidence and Findings**

17. 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.

28 September 2015 Consultation

18. The Tribunal took account of that fact that Dr Twins had no recollection of the consultation with Patient A on 28 September 2015 ('the September consultation'), and was wholly reliant on his contemporaneous medical records and usual practice. The Tribunal also took account of the written and oral evidence of Patient A. It was sympathetic to the fact that memories fade over time and accepted there may be a degree of inaccuracy when recalling events three years later, but was concerned by the significant number of contradictions and inconsistencies in Patient A's account of the September consultation. The Tribunal does not consider Patient A to have been dishonest or malicious in his account, but considers that, due to the passage of time and the persistence of his symptoms, his recollection has become muddled.

19. The Tribunal also had regard to the medical records of 28 September 2015. In making its determination on the facts relating to the September consultation (paragraph 1), the Tribunal determined that the medical records of the September consultation, the 111 service and the Out of Hours service were, on the balance of probabilities, most likely to reflect both accurate details of the consultation and an accurate timeline of events.

Paragraph 1a(i)

20. In his written witness statement Dr Twins outlined that, following a patient reporting eye pain, it is his usual practice to ask questions about the pain and to examine the eye, which he re-affirmed in his oral evidence. The Tribunal also had regard to the medical records of the September consultation, in which Dr Twins had recorded retroocular pain in Patient A's left eye and noted a cranial nerve examination.

21. The Tribunal also heard evidence from Patient A. His written witness statement did not indicate whether eye pain was discussed at the consultation, and when Miss Webb questioned him in his oral evidence about eye pain at the September consultation, Patient A's only reply was, "searing".

22. The Tribunal considered that it could not be certain from Patient A's accounts that Dr Twins failed to enquire about eye pain. It further considered, on the balance of probabilities, that it was unlikely that Dr Twins would not follow his usual practice in this instance or that he would record details of Patient A's eye pain and his examination of the eye in the medical records if enquiries had not taken place. Taking into account all of the above, the Tribunal therefore found paragraph 1a(i) of the Allegation to be **not proved**.

Paragraph 1a(ii)

23. The Tribunal took into account the evidence of Dr C, in which he stated that doctors are required to record both positive and negative findings. The Tribunal also considered that a number of eye problems could present with fluctuating eye redness, and, as a result of its findings at paragraph 1a(i) - that Dr Twins did enquire about Patient A's eye - Dr Twins had a duty to enquire about eye redness at the September consultation, irrespective of whether Patient A was presenting with eye redness at that time.

24. In the absence of any notes in the medical records relating to eye redness, the Tribunal determined that, on the balance of probabilities, Dr Twins had not enquired about eye redness. The Tribunal therefore found paragraph 1a(ii) of the Allegation to be **proved**.

Paragraph 1b(i), 1b(ii) and 1b(iii)

25. The Tribunal was conscious of the fact that Dr Twins' duty to examine Patient A's pupillary reflexes, eye movement and visual acuity were in direct relation to how Patient A's eye presented at the September consultation. Dr Twins only had a duty to carry out these examinations in the circumstances of Patient A presenting with eye symptoms that extended beyond eye pain.

26. The Tribunal noted a number of inconsistencies in Patient A's account of his symptoms and the timeline of events relating to the September consultation. There were significant inconsistencies between his written and oral evidence, and also a number of contradictions within his oral evidence.

27. In his oral evidence, Patient A stated: he had presented with a bloodshot eye, a rash and swelling when he saw Dr Twins; he had never had a headache and would never refer to this pain as a headache; he never took painkillers; and that he had

gone to the Out of Hours service at Eastbourne District General Hospital on the evening of the same day as the September consultation with Dr Twins.

28. However, in Patient A's written witness statement he did not mention presenting with a bloodshot eye, a rash and swelling when he saw Dr Twins, and the account of his symptoms presenting on 28 September 2015 was limited to the following:

> *"Prior to my appointment with Dr Twins, I took my daughter to Covent Garden for a day out and when we went for lunch I noticed an aching pain in my left eye. The pain became worse over the day and it was very blood shot. I had also been suffering with headaches for a couple of weeks prior to this day out… On 28 September 2015, I booked an appointment at my GP surgery because the pain felt as though it was getting worse… When I got home that evening the pain in my eye seemed to get worse and my face looked as though it was getting swollen so I went to the out of hour's service at Eastbourne District General Hospital the following day."*

29. In trying to ascertain how Patient A presented at the September consultation, the Tribunal also had regard to the following records:

- Dr Twins' medical records from 28 September 2015 at approximately 14:30, in which he had documented no other eye symptoms except eye pain;

- An NHS 111 Report of Patient A's phone call on 28 September 2015 at 18:57, in which the advisor had recorded, "a new loss or disturbance of vision" and instructions to contact a Primary Care Service within two hours if symptoms persisted;

- A record from Dr I made on 29 September 2015 at 19:39 at the Out of Hours Service at Eastbourne District General Hospital, in which he noted, "swollen eye, is taking Nurofen and paracetamol… eye redness and pain, visual blurring settling now, today rash left temple".

30. The Tribunal further took into account the opinion of the GMC's expert witness, Dr C, who stated in his oral evidence that, if there were no other symptoms besides the pain in Patient A's eye, then there was not a duty to carry out the examinations detailed in paragraph 1b of the Allegation.

31. The Tribunal considered that the GMC's evidence was insufficient to prove that Patient A's symptoms of a bloodshot eye, a rash and swelling were present at the time of his consultation with Dr Twins. Furthermore, the subsequent records from the 111 service and Eastbourne Hospital supported the likelihood of these symptoms developing after Patient A's consultation with Dr Twins. The Tribunal

concluded that the GMC had failed to prove, to the required standard, that Dr Twins had a duty to examine Patient A's pupillary reflexes, eye movement and visual acuity. It was therefore unable to find that he had failed at such a duty. The Tribunal therefore found paragraphs 1b(i), 1b(ii) and 1b(iii) of the Allegation to be **not proved**.

Paragraph 1c

32. The Tribunal first considered and accepted that the word 'other' in paragraph 1c of the Allegation to mean 'other than hypertension'.

33. The Tribunal took into account the expert report of Dr C, in which he stated:

> *"If Patient A did present with eye symptoms in addition to the headache (and this is not entirely clear, see my comments under 3a above), Dr Twins would have been expected to carry out inspection of the eyes and record the visual acuity. In either case, in order to thoroughly examine the cranial nerves, which he records as NAD (no abnormality detected) Dr Twins would in addition have had to carry out inspection of the pupillary reflexes and eye movements, and check visual acuity. None of this information is explicitly recorded…"*
>
> *"…Although his diagnosis was incorrect, Dr Twins did carry out entirely appropriate initial tests and investigations based on it. He carried out an ECG at initial presentation and brought the patient back the next day for blood and urine testing. No special tests or investigations are normally required to confirm the diagnosis of shingles, which is usually made on clinical grounds."*

34. The Tribunal also took into account Dr Twins' witness statement, in which he stated that, in respect of the presentation of eye pain, he "would have been considering a number of different diagnoses including tension headache, migraine and secondary causes of a headache".

35. The Tribunal considered that any finding at paragraph 1c was in direct relation to its findings paragraph 1a of the Allegation. Having already concluded that the GMC's evidence was insufficient to prove that Patient A's symptoms extended past eye pain at the time of his consultation with Dr Twins, it followed that the Tribunal could not find that Dr Twins failed to adequately consider any other causes of Patient A's eye pain when he did not have a duty to do so. The Tribunal therefore found paragraph 1c of the Allegation to be **not proved**.

Paragraph 1d(i)

36. The Tribunal considered that any finding at paragraph 1d(i) was in direct relation to its findings paragraph 1a and 1c of the Allegation. Having already

concluded that the GMC's evidence was insufficient to prove that Patient A's symptoms extended past eye pain at the time of the September consultation, it followed that Dr Twins was not required to prescribe oral antiviral medication for the treatment of shingles when a diagnosis of shingles had not been made. The Tribunal therefore found paragraph 1d(i) of the Allegation to be **not proved**.

Paragraph 1d(ii)

37. The Tribunal heard oral evidence from Dr Twins in which he stated that it would have been his usual practice to advise OTC (over the counter) painkillers for symptomatic hypertension, owing to the fact that this was ordinarily a cheaper and more accessible option for patients, as opposed to having to pay for a prescription at a pharmacy.

38. The Tribunal further noted that Patient A had strongly asserted that he has never taken, nor would ever take, painkiller medication. The Tribunal determined that it was fair for Dr Twins to advise Patient A about painkillers, but that he did not have a duty to prescribe them, and therefore he could not be found to have failed in such a duty. The Tribunal therefore found paragraph 1d(ii) of the Allegation to be **not proved**.

Paragraphs 1e and 1f

39. The Tribunal considered that any findings at paragraphs 1e and 1f were in direct relation to its findings at paragraphs 1a and 1d of the Allegation. Having already concluded that the GMC's evidence was insufficient to prove that Patient A's symptoms extended past eye pain at the time of his consultation with Dr Twins, it followed that Dr Twins was not required to discuss Patient A with an ophthalmology colleague or refer Patient A to an ophthalmology colleague when a diagnosis of shingles had not been made. The Tribunal therefore found paragraphs 1e and 1f of the Allegation to be **not proved**.

Paragraph 1g

40. The Tribunal heard oral evidence in person from Patient A, which supported the evidence he had provided in his written witness statement, which stated:

> *"Dr Twins told me I needed to take beta blockers and statins for my symptoms so he prescribed them both to me. He advised me to go to Paydens Phamacy in Halisham to introduce myself to the pharmacist who would ring me each day to see how I was getting on with the medication. He also told me to make a follow up appointment to see him in two weeks' time."*

41. Furthermore, when questioned about the prescription of statins, Patient A admitted in his oral evidence that Dr Twins did not prescribe him statins; it had been a presumption on his part, and he never looked at the prescription.

42. The Tribunal also heard oral evidence from Dr Twins which supported the evidence that he had provided in his written witness statement, which stated:

> *"I do not believe that this is something that I would have said because I have, at no time, thought that this would be a service provided by a pharmacist and so I would not have said this."*

43. The Tribunal took into account the opinion of Dr C. Dr C emphasised the responsibility of the doctor to ensure that a patient leaves with a clear understanding of the consultation, but told the Tribunal that he thought it was highly unlikely that any reasonably competent GP would inform a patient that a pharmacist would contact them every day about their symptoms, and any belief this would happen is likely to be Patient A's misunderstanding.

44. Taking into account the above, the Tribunal determined that, on the balance of probabilities, it was unlikely that Dr Twins had explicitly advised Patient A that a pharmacist would contact him on a daily basis. The Tribunal therefore found paragraph 1g of the Allegation to be **not proved**.

**Paragraph 1h(i)**

45. The Tribunal considered that any finding at paragraph 1h(i) was in direct relation to its findings paragraph 1a(i) and 1a(ii). The Tribunal took account of the evidence of Dr C, in which he affirmed that doctors are required to record both positive and negative findings, and acknowledged that Dr Twins did enquire about and record details of Patient A's eye pain as determined at paragraph 1a(i) and set out above. However, the Tribunal has already determined that Dr Twins failed in his duty to enquire about eye redness at paragraph 1a(ii), irrespective of whether Patient A was presenting with eye redness at the time of the consultation.

46. The Tribunal concluded that if it was important for Dr Twins to enquire about eye redness, then it was important for Dr Twins to record his findings, including the absence of symptoms such as eye redness. The Tribunal therefore found paragraph 1h(i) of the Allegation to be **proved**.

**Paragraph 1h(ii)**

47. The Tribunal accepted Dr Twins' evidence that he had failed to correctly diagnose ophthalmic shingles at the September consultation and that he had incorrectly diagnosed Patient A with hypertension.

48. The Tribunal took account of the evidence of Dr C, in which he stated:

> *"There is no documentation of the presence or absence of any eye symptoms (including eye pain, redness, or visual blurring) nor was there documentation of enquiry into any personal or family history of cardiovascular disease or hypertension (which Dr Twins presumably suspected to be responsible for the symptoms). Therefore in my opinion, based on what is recorded in the notes, the history taken was not adequate."*

49. In the absence of any notes in the medical records of the September consultation relating to a family history of cardiovascular disease or hypertension, the Tribunal considered that, on the balance of probabilities, it was not likely that Dr Twins had enquired about a family history of cardiovascular disease or hypertension. The Tribunal concluded that, even if Dr Twins' diagnosis was wrong, he had a duty to record his diagnosis and all examinations that led to this diagnosis. The Tribunal therefore found paragraph 1h(ii) of the Allegation to be **proved**.

**Paragraph 1h(iii)**

50. The Tribunal has already determined that Dr Twins carried out a cranial nerve examination in relation to Patient A's eye pain, which he recorded in his medical notes. Having found paragraph 1b of the Allegation to be not proved, as examining Patient A's pupillary reflexes, eye movement and visual acuity were not clinically indicated, it therefore followed that the Tribunal found paragraph 1h(iii) of the Allegation to be **not proved**.

**Paragraph 1h (iv)**

51. The Tribunal considered paragraph 1h(iv) to be closely connected to paragraph 1h(ii) of the Allegation. The Tribunal has already determined, in its findings above, that Dr Twins had not recorded Patient A's family history of cardiovascular disease or hypertension or his diagnosis of symptomatic hypertension. Furthermore, Dr Twins accepted this in his oral evidence. It therefore followed that the Tribunal found paragraph 1h(iv) of the Allegation to be **proved**.

**Paragraph 1h(v)**

52. In his oral evidence, Dr Twins said that he had never prescribed statins to Patient A, which supported his written witness statement, in which he states:

> *"The updated QRISK2 score and information derived from these investigations would help to inform discussion about statin prophylaxis. Without this information I did not think it clinically justified to commence statins immediately. For the avoidance of doubt I did not prescribe statins on this or any occasion to this patient."*

53. Furthermore, when questioned about the prescription of statins, Patient A admitted in his oral evidence that Dr Twins did not prescribe him statins; it had been a presumption on his part, and he did not look at the prescription.

54. Taking into the account the evidence from both parties, the Tribunal concluded that the evidence was that Dr Twins did not prescribe statins to Patient A, and so it followed that Dr Twins could not have failed in a duty to record this. The Tribunal therefore found paragraph 1h(v) of the Allegation to be **not proved**.

**Paragraph 1h(vi)**

55. The Tribunal considered that paragraph 1h(vi) of the Allegation was in direct relation to its findings at paragraphs 1e and 1f of the Allegation above. As the Tribunal had determined that Dr Twins had not failed in a duty to discuss Patient A's symptoms with an ophthalmology colleague, it follows that he could not have failed a duty to record a discussion that did not take place. The Tribunal therefore found paragraph 1h(vi) of the Allegation to be **not proved**.

2 October 2015 Consultation

**Paragraph 2a**

56. During his oral evidence, Patient A strongly denied that any consultation between him and Dr Twins took place on 2 October 2015, be it in person or over the telephone. Patient A was shown the medical records of this consultation, but maintained that it did not take place and that the record had been 'made up'.

57. The Tribunal had regard to the medical records of the 2 October 2015 consultation, in which Dr Twins had documented details of Patient A's symptoms, examinations carried out, advice given and treatment plans discussed. The medical notes included: *"Shingles. RASH ERUPTED WHEN LEFT HERE A FEW DAYS AGO. Seen by OOH [Out of Hours]"*

58. The Tribunal considered it to be highly unlikely that Dr Twins had falsified detailed medical records of a consultation between him and Patient A on 2 October. It also took into account that Patient A's evidence had been inconsistent and contradictory. The Tribunal did not seek to suggest that Patient A was deliberately deceitful, but considered that he may not be able to recount this consultation accurately. The Tribunal felt that Patient A's memory and assertion of this consultation could not be relied on as to be more certain than the medical record of this appointment, and it formed the view that, on the balance of probabilities, it was likely that the consultation did take place.

59. Furthermore, the records showed that Dr Twins did discuss ophthalmic shingles with Patient A at the 2 October 2015 consultation. The Tribunal considered that it was not possible for it to determine whether Dr Twins 'adequately engaged' on the matter when the GMC's evidence was that the consultation did not happen. The Tribunal considered that the GMC had not reached the required threshold on the balance of probabilities for it to determine that Dr Twins had failed in his duty as a doctor in this instance. The Tribunal therefore found paragraph 2a of the Allegation to be **not proved**.

**Paragraph 3a(i), 3a(ii) and 3a(iii)**

60. The Tribunal heard evidence from Dr Twins relating to the consultation on 15 October 2015. Dr Twins accepted that, as a result of Patient A presenting with "no new eye symptoms" that day, he did not examine Patient A's pupillary reflexes, eye movement or visual acuity. Dr Twins accepted that he should have carried out all of these examinations as a result of Patient A's eye still feeling "strange", which was recorded in his medical notes. The Tribunal therefore found paragraph 3a(i), 3a(ii) and 3a(iii) of the Allegation to be **proved**.

<u>20 October 2015 Consultation</u>

**Paragraph 4a**

61. During his oral evidence, Patient A strongly denied that any consultation between him and Dr Twins took place on 20 October 2015, be it in person or over the telephone. Patient A was shown the medical records of this consultation, but maintained that it did not take place and that the record had been 'made up', along with the 2 October 2015 appointment. Patient A firmly declared that he only ever had contact with Dr Twins on 28 September 2015 and 15 October 2015, and that this appointment on 20 October 2015 did not happen.

62. Dr Twins stated that this consultation was a follow-up appointment relating to his diagnosis of symptomatic hypertension on 28 September 2015 and that the purpose of the consultation was to review Patient A's cardiovascular symptoms, which is why he did not enquire about Patient A's eye history.

63. The Tribunal considered it to be highly unlikely that Dr Twins had falsified detailed medical records of a consultation between him and Patient A on 20 October 2015. It also took into account the fact that Patient A's evidence was often inconsistent and contradictory. The Tribunal did not seek to suggest that Patient A was deliberately deceitful, but considered that he may not be able to recount this consultation accurately. The Tribunal concluded that Patient A's memory and assertion relating to this consultation could not be relied on as to be more certain than the medical record of this appointment, and formed the view that, on the balance of probabilities, it was likely that the consultation did take place.

64. The Tribunal was mindful of the fact that GP appointments are ordinarily limited to 10 minutes long to discuss the matters for which the appointment was made. The Tribunal accepted that the 20 October 2015 appointment was made as a follow-up appointment to the September consultation, where Dr Twins had, albeit incorrectly, made a diagnosis of symptomatic hypertension. It also took into account the fact that Dr Twins had seen Patient A five days earlier in relation to his eye symptoms. The Tribunal concluded that Dr Twins did not have a duty to enquire about Patient A's eye history at this appointment which had been made in relation to hypertension.

65. Furthermore, the Tribunal considered that it was not possible for it to determine that Dr Twins had failed in his duty to enquire about Patient A's eye history when the GMC's evidence was that the consultation did not happen. The Tribunal considered that the GMC had not reached the required threshold on the balance of probabilities for it to determine Dr Twins had failed in his duty as a doctor in this instance. The Tribunal therefore found paragraph 4a of the Allegation to be **not proved**.

**Paragraph 4b and 4c**

66. The Tribunal considered that paragraphs 4b and 4c of the Allegation were in direct relation to its findings at paragraphs 4a of the Allegation above. As the Tribunal had determined that Dr Twins had not failed in a duty to enquire about Patient A's eye symptoms, it follows that he could not have failed in a duty to examine Patient A's pupillary reflexes, eye movement or visual acuity, or to subsequently record his findings in any of these examinations.

67. Furthermore, the Tribunal considered that it was not possible for it to determine that Dr Twins had failed in his duty to examine Patient A's eye when the GMC's evidence was that the consultation did not happen. The Tribunal considered that the GMC had not reached the required threshold on the balance of probabilities for it to determine Dr Twins had failed in his duty as a doctor in this instance. The Tribunal therefore found paragraphs 4b(i), 4b(ii), 4b(iii) and 4c of the Allegation to be **not proved**.

<u>Patient B</u>

68. The Tribunal acknowledged that Patient B had not made a complaint to the GMC, had not provided a witness statement, and had declined to give any evidence at this hearing. The Tribunal took into consideration the evidence presented before it, namely Dr Twins' written and oral evidence, and the medical records of the consultation between Dr Twins and Patient B on 20 January 2017.

69. The Tribunal acknowledged Dr Twins' admissions to a number of the paragraphs of the Allegation in relation to his failure to make accurate medical records of this consultation. However, Dr Twins stated that he could not explain or understand how these failures occurred. When the matter of Patient B's deterioration was brought to his attention on 27 January 2017, Dr Twins requested an audit of all of his medical records to ensure it was an isolated incident and not a pattern of poor notes. The audit was carried out by Billingshurst Surgery and included 220 of Dr Twins' patients. The audit found that there were only deficiencies in the notes of Patient B. The Tribunal found Dr Twins to be open and honest and willing to assist the Tribunal throughout the hearing process.

**Paragraphs 5a(i), 5a(ii), 5a(iii) and 5a(iv)**

70. In relation to 5a(iv) the Tribunal considered and accepted that the word 'other' means 'other than viral infection'.

71. The Tribunal considered all of the evidence before it, which comprised of the medical records of this consultation, the expert opinion of Dr C, the results of the audit of Dr Twins' consultations at Billingshurst Surgery, and the evidence of Dr Twins.

72. The Tribunal acknowledged that, although there was a recording of "no crackles in chest", there was nothing to support the enquiry or examination of chest pain, breathlessness or a cough productive of sputum or blood in Dr Twins' medical records of the consultation with Patient B on 20 January. Dr Twins accepted that he was not sure how this had happened, but offered a possible explanation relating to the software used at the GP practice. He said that the GP had to open a template on the computer screen which related to the patient's primary complaint, and in this instance he would have opened a template for back pain. The template was not automatically saved on the patient's record, but had to be manually linked by the doctor. In the absence of the enquiries or examinations that would form his usual practice on the record, Dr Twins thought it was possible that he had linked this template, which included notes of his basic observations, to a different patient in error.

73. The Tribunal considered that Dr Twins was honest and open and did his best to assist the Tribunal in all of his evidence. However, it was mindful that he sometimes made assertions without direct recollections in relation to the consultation with Patient B, relying on his usual practice as opposed to the specific consultation itself.

74. The Tribunal had regard to the results of the audit carried out by Billingshurst Surgery, which included Dr Twins' medical records of 220 patients. It acknowledged that Patient B's record was the only one that was highlighted as being deficient, which indicated to the Tribunal that Dr Twins' note keeping was generally adequate.

It also took account of Dr C's evidence, in which he stated this it was his opinion that the absence of any recording relating to chest pain, breathlessness and a cough being productive of sputum or blood implied that these were not discussed during the consultation. The Tribunal also noted that Dr Twins' record of the consultation on 20 January 2017 contains no positive or negative record of enquiry as to other possible causes of infection.

75. Taking into account the above, the Tribunal concluded that, on the balance of probabilities, it was more likely that Dr Twins had failed to enquire about Patient B's chest pain, breathlessness, her cough productive of sputum or blood, and other possible causes of infection than he had made these enquiries but had failed to record them. The Tribunal therefore found paragraphs 5a(i), 5a(ii), 5a(iii) and 5a(iv) of the Allegation to be **proved**.

**Paragraph 5b(i)**

76. The Tribunal had sight of the A&E Discharge Summary from Worthing Hospital, where Patient B had first presented with a high temperature on 18 January 2017. At this consultation, Patient B was examined and discharged under the advice that she should see her GP if her symptoms persisted, which led her to see Dr Twins on 20 January 2017. On 22 January 2017, Patient B was admitted to hospital and diagnosed with severe sepsis and was treated in the Intensive Care Unit.

77. In Dr Twins' medical record of the consultation with Patient B, the Tribunal could not see any evidence that Dr Twins had taken her temperature. Taking into account Patient B's presenting complaint of high temperature at A&E on 18 January 2017, and the fact that Dr Twins' record shows that he was aware of a five day history of fever on 20 January 2017 and the fact that she was admitted to hospital on 22 January 2017 with sepsis, the Tribunal considered that it would be unlikely that Patient B did not have a high temperature when she saw Dr Twins on 20 January 2018.

78. In his witness statement and oral evidence, Dr Twins stated that checking the patient's temperature would have been automatic to him as part of his basic observations, but he could not account for the absence of notes to support this in the medical records. The Tribunal considered that, on the balance of probabilities, it was more likely that Dr Twins had failed to check Patient B's temperature altogether rather than observed a high temperature, but did not record it. The Tribunal therefore found paragraph 5b(i) of the Allegation to be **proved**.

**Paragraph 5b(ii), 5b(iii) and 5b(iv)**

79. There was no evidence in Dr Twins' medical records of the consultation with Patient B to support that he had checked Patient B's heart rate, blood pressure or

respiratory system. In accordance with its findings at paragraph 5b(i) above, the Tribunal determined that it was unlikely that Dr Twins would have carried out some of his basic observations, but not others. It therefore followed that if Dr Twins had not taken Patient B's temperature during the consultation then he also did not check her heart rate, blood pressure or respiratory rate. The Tribunal therefore found paragraph 5b(ii), 5b(iii) and 5b(iv) of the Allegation to be **proved**.

**Paragraph 5c**

80. There was no evidence in Dr Twins' medical records of the consultation with Patient B to support that he had considered a diagnosis of sepsis. The Tribunal considered that if Dr Twins had considered a diagnosis of sepsis then he would have checked Patient B's vital signs, which the Tribunal determined he did not do, at paragraph 5b above. It therefore followed that the Tribunal therefore found paragraph 5c of the Allegation to be **proved**.

**Paragraph 5d**

81. The Tribunal considered that there were a number of factors that would inform Dr Twins as to whether an admission to hospital was the appropriate course of action for Patient B at the consultation on 20 January 2017. The Tribunal had sight of the A&E Discharge Summary from Worthing Hospital, dated 18 January 2017, where Patient B was diagnosed with gastroenteritis and discharged under the advice that she should see her GP if her symptoms persisted. The Tribunal was mindful of the fact that Dr Twins would have seen this document and been aware that the hospital had not considered that Patient B needed to be admitted to hospital two days earlier. The Tribunal also took account of Dr Twins' oral evidence, in which he stated that the time of this consultation was flu season, which was often responsible for the symptoms Patient B presented with, such as lethargy and aches and pains.

82. The Tribunal considered that, based on its findings above, Patient B may not have presented as seriously ill, albeit with a fever, at the time of her consultation with Dr Twins. The Tribunal concluded that the GMC had not reached the required threshold on the balance of probabilities for it to determine Dr Twins had failed in his duty as a doctor in this instance. The Tribunal therefore found paragraph 5d of the Allegation to be **not proved**.

**Paragraph 5e(i) and 5e(ii)**

83. The Tribunal considered that paragraphs 5e(i) and 5e(ii) were in direct relation to its findings at paragraph 5d of the Allegation above. As the Tribunal had

already determined that Patient B may not have presented as seriously ill at the time of her consultation, albeit with a fever, it followed that Dr Twins did not have a duty to advise Patient B to seek medical help if her condition deteriorated, or of any specific signs of deterioration to watch out for.

84. The Tribunal concluded that the GMC had not reached the required threshold on the balance of probabilities for it to determine Dr Twins had failed in his duty as a doctor in this instance. The Tribunal therefore found paragraphs 5e(i) and 5e(ii) of the Allegation to be **not proved**.

**Paragraph 5g(vi)**

85. The Tribunal considered that paragraph 5g(vi) of the Allegation was in direct relation to its findings at paragraphs 5d of the Allegation above. As the Tribunal had determined that Dr Twins had not failed in a duty to adequately consider hospital admission for Patient B, it follows that he could not have failed a duty to record a consideration that did not take place. The Tribunal therefore found paragraph 5g(vi) of the Allegation to be **not proved**.

**The Tribunal's Overall Determination on the Facts**

86. The Tribunal has determined the facts as follows:

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

Patient A

1. On 28 September 2015 you consulted with Patient A and you:

    a. failed to enquire about:

        i. eye pain; **determined and found not proved**

        ii. eye redness; **determined and found proved**

        ~~iii. visual blurring;~~
        **Deleted after a successful Rule 17(2)(g) application**

        ~~iv. any family history of cardiovascular disease or hypertension;~~
        **Deleted after a successful Rule 17(2)(g) application**

    b. failed to examine Patient A's:

i. pupillary reflexes; **determined and found not proved**

ii. eye movement; **determined and found not proved**

iii. visual acuity; **determined and found not proved**

c. failed to adequately consider any other causes of Patient A's eye pain; **determined and found not proved**

d. failed to prescribe:

i. oral antiviral medication; **determined and found not proved**

ii. pain relief; **determined and found not proved**

e. failed to discuss Patient A's symptoms with an ophthalmology colleague; **determined and found not proved**

f. failed to refer Patient A to an ophthalmology colleague for review; **determined and found not proved**

g. inappropriately advised Patient A that a pharmacist would contact them on a daily basis; **determined and found not proved**

h. failed to record:

i. the presence or absence of any eye symptoms as described at paragraph 1a; **determined and found proved**

ii. any family history of cardiovascular disease or hypertension; **determined and found proved**

iii. any examination of Patient A's eye as described at paragraph 1b; **determined and found not proved**

iv. your diagnosis of Patient A's symptomatic hypertension; **determined and found proved**

v. your prescription of statins to Patient A; **determined and found not proved**

vi. any discussion of Patient A's symptoms with an ophthalmology colleague. **determined and found not proved**

2. On 2 October 2015 you consulted with Patient A and you failed to:

a. adequately engage with Patient A regarding your missed diagnosis of ophthalmic shingles during the consultation on 28 September 2015; **determined and found not proved**

~~b. record:~~

~~i. any information shared with Patient A during the consultation;~~
**Deleted after a successful Rule 17(2)(g) application**

~~ii. any confrontation with Patient A having occurred during the consultation;~~
**Deleted after a successful Rule 17(2)(g) application**

~~iii. Patient A's blood pressure results.~~
**Deleted after a successful Rule 17(2)(g) application**

3. On 15 October 2015 you consulted with Patient A and you failed to:

a. examine Patient A's:

i. pupillary reflexes; **determined and found proved**

ii. eye movement; **determined and found proved**

iii. visual acuity; **determined and found proved**

b. take Patient A's blood pressure;
**Admitted and found proved**

c. record:

i. any examination of Patient A's eye as described at paragraph 3a; **Admitted and found proved**

ii. Patient A's blood pressure;
**Admitted and found proved**

~~iii. any confrontation with Patient A having occurred during the consultation.~~
**Deleted after a successful Rule 17(2)(g) application**

4. On 20 October 2015 you consulted with Patient A and you failed to:

   a. enquire about Patient A's eye history; **determined and found not proved**

   b. examine Patient A's eye, including:

      i. pupillary reflexes; **determined and found not proved**

      ii. eye movement; **determined and found not proved**

      iii. visual acuity; **determined and found not proved**

   c. record any examination of Patient A's eye as described at paragraph 4b. **determined and found not proved**

Patient B

5. On 20 January 2017 you consulted with Patient B and you failed to:

   a. enquire about:

      i. the presence or absence of any chest pain; **determined and found proved**

      ii. breathlessness; **determined and found proved**

      iii. whether Patient B's cough was productive of sputum or blood; **determined and found proved**

      iv. any other possible causes of infection; **determined and found proved**

   b. check Patient B's:

      i. temperature; **determined and found proved**

      ii. heart rate; **determined and found proved**

      iii. blood pressure; **determined and found proved**

iv respiratory rate; **determined and found proved**

c. consider a diagnosis of sepsis; **determined and found proved**

d. adequately consider hospital admission for Patient B; **determined and found not proved**

e. advise Patient B:

i. to seek medical help if her condition deteriorated; **determined and found not proved**

ii. of any specific signs of deterioration to watch out for; **determined and found not proved**

f. adequately record any specific comments on Patient B's air entry to the lungs; **Admitted and found proved**

g. record:

i. Patient B's presentation to NHS 111 on 18 January 2017; **Admitted and found proved**

ii. Patient B's presentation to A&E on 18 January 2017; **Admitted and found proved**

iii. any specific comments on Patient B's respiratory rate; **Admitted and found proved**

iv. the results of any enquiries as described at paragraph 5a; **Admitted and found proved**

v. the results of any of the checks described at paragraph 5b; **Admitted and found proved**

vi. any consideration of a hospital admission for Patient B; **determined and found not proved**

vii. any advice to Patient B about the matters described in paragraph 5e. **Admitted and found proved**

**Determination on Impairment -** 08/01/2019

## Record of Determinations – Medical Practitioners Tribunal

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 Twins' fitness to practise is impaired by reason of misconduct.

### The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence as follows.

3. On behalf of Dr Twins the following witnesses:

- Dr D, GP and NHS appraiser, in person on 11 December 2018 and written statement dated 13 September 2018;
- Dr E, GP and NHS appraiser, via telephone link on 11 December 2018 and written statement dated 30 April 2018.
- Dr G, GP and supervisor, via telephone link on 12 December 2018 and written evidence provided in August 2018.

### Submissions

4. On behalf of the GMC, Mr Walker submitted that there is misconduct and evidence of impairment on Dr Twins' part.

5. Regarding misconduct Mr Walker submitted that there are different types of failure by Dr Twins to check, record and examine patients. Mr Walker further submitted that these failings concerned more than one patient. These acts were not isolated or a one-off incident, but spanned a period of time, one in Autumn 2015 and the other in January 2017. These failings fall short of the standards of a medical practitioner and on balance, the conduct was serious.

6. Regarding impairment, Mr Walker accepted that some acts were more serious than others but pointed out that this amounted to a serious and repeated departure as per *Roylance v GMC (No.2)* [2000] 1 AC 311 (UKPC). He submitted that whilst there has been lots of evidence of Dr Twins practice since January 2017, the Tribunal must consider whether they are satisfied that in accordance with *Azzam v GMC* [2008] EWHC 2711 (Admin), the evidence of Dr Twins' rehabilitation is outstanding. Mr Walker submitted that Dr Twins' rehabilitation was not outstanding. He acknowledged his supervision by NHSE had led to improvement but said this was not sufficient to amount to no impairment.

7. On behalf of Dr Twins, Miss Webb submitted that Dr Twins had made some mistakes, however the GMC has chosen to pursue this case as misconduct as opposed to deficient performance on Dr Twins' behalf.

8. Miss Webb re-iterated the conclusion from Dr C's expert witness evidence that there had been negligence rather than gross negligence to constitute misconduct and referred to case law including *Calhaem, R (on the application of) v GMC* [2007] EWHC 2606 (Admin) which states:

> *"A single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as "misconduct".”*

9. Miss Webb acknowledged that the allegations in relation to Patient B were more significant than Patient A, however pointed out that these events were nearly two years apart in their factual history. Principally the allegations consisted of recording issues and other relatively minor elements, some of which did not appear to hold much concern to Dr C in his evidence.

10. Miss Webb reminded the Tribunal that they are not entitled to add together non-serious misconduct, in order to feed a finding of serious misconduct (*Schodlok v GMC* [2015] EWCA Civ 769). Miss Webb acknowledged there was negligence regarding Patient B but that it was not so grave as to attract the opprobrium that is required of the test of misconduct. Furthermore, she submitted Patient B was an isolated clinical incident and that Dr Twins has been open and honest throughout.

11. Regarding impairment, Miss Webb highlighted according to GMP that a serious or persistent failure to follow guidance will put the doctor's registration at risk and the policy goes on to consider the principles of: knowledge, skills and performance. Miss Webb pointed out that Dr Twins has evidently made considerable strides to accept any deficiencies on his part and seek to remedy them and asked for the Tribunal to place considerable weight upon this.

12. Also, Miss Webb reiterated as significant in that regard, the conclusions of Dr J, the NHSE clinical reviewer, where he indicated that there was at the time of the Patient B investigation in 2017, a recommendation for further training, in relation to identifying sepsis and reflection upon the case; and that Dr J did not see any further issues regarding Dr Twins' practice. Also, before this recommendation, Dr Twins himself had already requested the audit. Dr Twins has therefore shown insight and a desire to strive for better results.

13. Miss Webb reminded the Tribunal of Dr E's oral evidence where he had nothing but praise for Dr Twins and did not consider Dr Twins required any supervision, stating that he is a very competent and able GP and would still be welcome to return to work at the practice. Miss Webb referred to a large number of references and positive testimonials from colleagues and patients on Dr Twins' behalf.

14. Miss Webb submitted that Dr Twins cannot possibly do any more than he has to exhibit his fitness to practise.

**The Relevant Legal Principles**

15. 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.

16. In approaching its decision, the Tribunal was mindful of the two stage process to be adopted: first, whether the facts as found proved amounted to misconduct and that the misconduct was serious; and then, whether the finding of that misconduct which was serious could lead to a finding of impairment.

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

18. The Tribunal also had regard to case law, such as the following of *Meadow v GMC* [2006] EWCA CIV 1390, which reads:

> *"200. As Lord Clyde noted in Roylance v General Medical Council [2000] 1 AC 311, PC, at 330F- 332E, "serious professional misconduct" is not statutorily defined and is not capable of precise description or delimitation. It may include not only misconduct by a doctor in his clinical practice, but misconduct in the exercise, or professed exercise, of his medical calling in other contexts, such as that here in the giving of expert medical evidence before a court. As Lord Clyde might have encapsulated his discussion of the matter in Roylance v Clyde, it must be linked to the practice of medicine or conduct that otherwise brings the profession into disrepute, and it must be serious. As to seriousness, Collins J, in Nandi v General Medical Council [2004] EWHC (Admin), rightly emphasised, at paragraph 31 of his judgment, the need to give it proper weight, observing that in other contexts it has been referred to as "conduct which would be regarded as deplorable by fellow practitioners".*

19. The Tribunal reminded itself of *Schodlok* where it was stated that a Tribunal (then Panel) was not open to bring findings of non-serious misconduct to feed a finding of impairment, as it states:

> *"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."*

20. The Tribunal also reminded itself of the principle of *Calhaem* which states:

*"The word "misconduct" in section 35C(2)(a) does not mean any breach of the duty owed by a doctor to his patient; it connotes a serious breach which indicates that the doctor's fitness to practise is impaired."*

**The Tribunal's Determination on Impairment**

**Patient A**

Misconduct

21. The Tribunal first considered whether Dr Twins' actions amounted to misconduct.

*Paragraph 1(a)(ii)*

22. The Tribunal bore in mind its findings, that Dr Twins had carried out his duty by enquiring about some of Patient A's eye symptoms at the 28 September 2015 consultation, but found no evidence to indicate that eye redness specifically was enquired about.

23. In light of this finding, the Tribunal considered the current edition of *Good Medical Practice* (2013) ('GMP') with regards to doctors providing medical treatment, in particular, it had regard to the following paragraph, which reads:

> *"15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> *a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient"*

24. The Tribunal determined that Dr Twins' conduct fell short of this standard of GMP and those to be reasonably expected of a doctor, such as to amount to misconduct. However taking into account the clinical presentation in this case at the time and the principles set out in *Meadow*, this was not serious misconduct.

*Paragraphs 1(h)(i), (ii) and (iv)*

25. On taking into account its findings of Dr Twins' failure to record certain aspects of Patient A's eye symptoms, family history of cardiovascular disease or hypertension, or diagnosis of Patient A's symptomatic hypertension, the Tribunal had regard to the following paragraph from the GMP, which states:

*"21 Clinical records should include:*

*a relevant clinical findings"*

26. In relation to 1(h)(i), the Tribunal took into account their findings that Dr Twins did make some record of the eye symptoms, but omitted reference to eye redness. He therefore fell short on the specific aspects as alleged. Therefore, it determined that Dr Twins' conduct breached the standards of GMP 21(a) and amounted to misconduct, but did not consider this serious misconduct.

27. In relation to 1(h)(ii), the family history of cardiovascular disease or hypertension - the Tribunal found that although there was a failure to record this, it is unlikely to have made a difference to the treatment offered at that time and although below GMP standards and therefore misconduct, it did not amount to serious misconduct.

28. In relation to 1(h)(iv), the Tribunal found Dr Twins' failure to record an explicit diagnosis of hypertension did not hamper the treatment of Patient A, but could not be considered to be seen as best practice of record keeping. On this basis it is a breach of GMP 21(a), but does not amount to serious misconduct.

*Paragraph 3(a)(i), (ii), (iii)*

29. The Tribunal noted that the purpose of the 15 October 2015 consultation was with reference to Patient A's eye only and in particular in relation to ophthalmic shingles. In that context, it considered whether Dr Twins' failure to examine Patient A's pupillary reflexes, eye movement and visual acuity amounted to misconduct.

30. The Tribunal determined that Dr Twins' conduct fell short of the standards of GMP 15(a) and those to be reasonably expected of a doctor such as to amount to misconduct. However it recognised Patient A was receiving treatment for ophthalmic shingles at the time and therefore the lack of examination was unlikely to have made a difference to this. For this reason and taking into account the principle in *Meadow*, the Tribunal did not consider this to be serious misconduct.

*Paragraph 3(b)*

31. The Tribunal considered Dr Twins' admission that he failed to take Patient A's blood pressure in the consultation of 15 October 2015, and whether this would amount to misconduct.

32. The Tribunal had regard to GMP 15a, as quoted above.

33. The Tribunal recalled from Dr C's expert witness written evidence the following:

"…*No special tests or investigations are normally required to confirm the diagnosis*

*of shingles, which is usually made on clinical grounds."*

34. It also bore in mind that as the consultation on 15 October 2015 related to ophthalmic shingles only, there was no reason why Dr Twins would specifically take Patient A's blood pressure on this occasion.

35. The Tribunal determined that Dr Twins' conduct did not fall short of the standards of conduct reasonably to be expected of a doctor and thus did not amount to misconduct.

*Paragraph 3(c)(i)*

36. The Tribunal next considered Dr Twins' admission that he failed to record any examination of Patient A's eye as described at Paragraph 3(a) of the Allegation and whether this amounted to misconduct.

37. The Tribunal had regard to the GMP 15(a) and 21(a), as quoted above.

38. The Tribunal took into account Dr Twins' admission that he failed to record any examination of Patient A's eye, as well as their finding that no eye examination did occur [as per paragraph 3(a)]. The Tribunal considered that as Dr Twins had failed in his duty to carry out the examination, he had breached GMP 21(a) by failing to record. However the Tribunal concluded that his failure to do so, in the context of *Meadow*, did not amount to serious misconduct.

*Paragraph 3(c)(ii)*

39. The Tribunal considered Dr Twins' admission of failure to record Patient A's blood pressure.

40. The Tribunal found that, in relation to paragraph 3(b) of the Allegation, Dr Twins was not under a duty to take Patient A's blood pressure as the consultation on 15 October 2015 was not in relation to hypertension. The Tribunal therefore concluded that Dr Twins' conduct did not fall short of GMP standards or those reasonably to be expected of a doctor such as to amount to misconduct.

Impairment

41. In respect of Patient A, the Tribunal determined that overall, although there have been findings of some breaches of GMP, none have been considered to be serious misconduct and therefore concluded that Dr Twins' fitness to practise was not impaired.

**Patient B**

Misconduct

*Paragraphs 5(a)(i), (ii), (iii) and (iv)*

42. The Tribunal considered its findings that at the consultation on 20 January 2017 with Patient B, Dr Twins' failed to enquire about the presence or absence of any chest pain, breathlessness, whether the patient's cough was productive of sputum or blood, or any other possible causes of infection; and whether this amounted to misconduct.

43. The Tribunal again had regard to GMP 15(a) as quoted above.

44. The Tribunal bore in mind the fact that Patient B was clearly unwell and that Dr Twins had a duty to adequately assess her. Its findings were that Dr Twins had made some enquiry as to Patient B's symptoms, which is shown by his record of Patient B *"feeling unwell in self"* and *"no crackles in chest",* but had not enquired as per the specifics outlined in this allegation.

45. Taking into account that the condition of sepsis can be serious, the Tribunal determined that Dr Twins' conduct fell short of GMP, being the standard reasonably to be expected of a doctor and therefore amounted to misconduct. The Tribunal took into account Dr C's evidence that at an early stage the signs of sepsis can be difficult to diagnose and concluded that it is not clear that Dr Twins' conduct on this occasion made a difference to the diagnosis at that time. Therefore the Tribunal concluded that his misconduct was not serious misconduct.

*Paragraphs 5(b)(i), (ii), (iii) and (iv)*

46. The Tribunal next considered whether Dr Twins' failure to check Patient B's temperature, heart rate, blood pressure and respiratory rate, amounted to misconduct.

47. Again, the Tribunal had regard to paragraph 15(a) of GMP.

48. The Tribunal took into account from Dr C's written evidence (pages 125 and 126), the following:

> *"Given the magnitude of the clinical findings two days later it is somewhat surprising that there were no abnormal signs whatsoever in the respiratory exam. A more thorough record of the examination findings would have been more reassuring in regard to the thoroughness of the examination conducted.*
>
> *In addition to the lack of documented respiratory rate, there is no record of other basic clinical observations (temperature, heart rate, blood pressure) which would be expected in addition to general inspection particularly in a patient who 'looks*

> *unwell' as Dr Twins noted to the case here. Carrying out these basic clinical observations is necessary to exclude sepsis."*

49. The Tribunal determined that Dr Twins' conduct fell below GMP and short of the standards reasonably to be expected of a doctor and further it considered that Dr Twins' *"conduct [which] would be regarded as deplorable by fellow practitioners" (Meadow)* such as to amount to serious misconduct.

*Paragraph 5(c)*

50. The Tribunal considered whether Dr Twins' failure to consider a diagnosis of sepsis amounted to misconduct.

51. The Tribunal took into account from Dr C's written evidence (page 128), the following:

> *"…Although an early diagnosis of sepsis is recognised to be difficult to make, and it is even possible that clinical signs were not evident in the chest, this is the very reason that examining these simple clinical observations is so important in raising early suspicions. …the primary concern here is not that Dr Twins did not diagnose sepsis, it is that he did not appear to look for it."*

52. The Tribunal took into account GMP 15(a) and were concerned that there was no evidence to suggest that Dr Twins had considered sepsis as would be expected of a reasonably competent GP in these circumstances and that taking into account the principle in *Meadow* this amounts to serious misconduct.

*Paragraph 5(f)*

53. The Tribunal considered Dr Twins' admission of his failure to record any specific comments on Patient B's air entry to the lungs and whether this amounted to misconduct.

54. The Tribunal acknowledged that Dr Twins had recorded such symptoms as the patient having no crackles in their chest but a cough and that Dr Twins testified he did carry out his duty of care in this capacity; however there is no record of evidence beyond this.

55. The Tribunal determined that Dr Twins' conduct breached GMP 21(a) and fell short of the standards reasonably to be expected of a doctor such as to amount to misconduct, however did not consider this to be serious misconduct.

*Paragraph 5(g)(i) & (ii)*

56. The Tribunal considered Dr Twins' admission of his failure to record Patient B's presentation to NHS 111, as well as their presentation to A&E on 18 January 2017 and whether this amounted to misconduct.

57. The Tribunal took account of the evidence on Patient B's GP surgery record that she had presented herself to NHS 111 and that she was admitted to A&E on 18 January 2017.

58. Therefore the Tribunal determined that Dr Twins' conduct was not in breach of GMP, it did not fall so short of the standards reasonably to be expected of a doctor as to amount to misconduct.

*Paragraph 5(g)(iii)*

59. The Tribunal considered Dr Twins' admission of his failure to record any specific comments on Patient B's respiratory rate and whether this amounted to misconduct.

60. The Tribunal had regard to Dr C's written statement (of page 124) which reads:

> *"… the detail recorded about the presenting symptoms is scant. In terms of the respiratory history, he does not record the presence or absence of pain in the chest or breathlessness, nor whether the cough is productive of sputum or blood. Neither does he record any systemic questioning about possible other causes of infection (apart from the respiratory system)."*

61. The Tribunal referred to its finding that Dr Twins failed to check Patient B's respiratory rate and that amounted to serious misconduct. The Tribunal concluded that Dr Twins' admission of a failure to record must also amount to misconduct, as this too falls short of GMP 21(a) and *Meadow*; and concluded this was serious misconduct.

*Paragraph 5(g)(iv)*

62. The Tribunal next considered Dr Twins' admission that he failed to record the results of any enquiries as described at *Paragraph 5(a)* and whether this amounted to misconduct.

63. The Tribunal considered the same reasoning as outlined in relation to *Paragraph 5(a)* above, and determined that Dr Twins' conduct fell below GMP 21(a) and short of the standards reasonably to be expected of a doctor but did not amount to serious misconduct.

*Paragraph 5(g)(v)*

64. The Tribunal next considered Dr Twins' admission that he failed to record the results of any of the checks described at *Paragraph 5(b)* and whether this amounted to misconduct.

65. The Tribunal considered that as the failure to carry out any of the checks at 5(b) amounted to serious misconduct, then the failure to record them must also breach GMP 21(a) and under the test in *Meadow* amounted to serious misconduct.

*Paragraph 5(g)(vii)*

66. The Tribunal considered the allegation that Dr Twins failed to record any advice to Patient B about the matters described in Paragraph 5e and whether this amounted to misconduct.

67. The Tribunal bore in mind its finding that it did not find 5(e) proved and therefore determined that Dr Twins' admission did not amount to misconduct.

Impairment

68. Having made some findings of serious misconduct, the Tribunal then went on to consider whether Dr Twins' fitness to practise was currently impaired with regards to Patient B only.

69. In doing so, the Tribunal considered that his misconduct was remediable and that Dr Twins showed he had taken steps to remedy his errors and developed considerable insight. Dr Twins demonstrated this by requesting an audit shortly after finding out Patient B's condition; his discussions with the senior partner of the practice in which he was working at the time; as well as his appraisals with Dr E and Dr D; and evidence of CPD courses. This was reflected in Dr Twins' second witness statement of 22 April 2018, where he stated:

> *"I deeply regret discounting sepsis on this occasion. The very outcome of this case has reminded me of the devastating impact that sepsis can have, but has also prompted me to undertake further learning. Immediately after the diagnosis became apparent, I sat down and undertook a Case Based Discussion with Dr K Senior Partner at the surgery and we spoke about lessons learned from the case, her previous presentation to A/E and diagnosis made there and my failure to make sure that observations taken by me were properly recorded and saved in patient notes. We wondered whether I should familiarise myself better with the clinical system used at the surgery EMIS WEB. Since then I have undertaken targeted learning and specifically have received training on EMIS. I have also reviewed PULSE Learning – Key Questions on Sepsis – 28 July 2017 and PULSE Learning Certificate –*

*Recognising and Referring Signs of Sepsis – 21 June 2017. I also prepared a Reflective Statement for NHSE… I have also discussed the case in detail with my Appraiser on 17 August 2017. In addition, I have reviewed MIMS Learning Guideline Update: Latest guidelines on sepsis on 6 January 2018, as well as Guidelines Learning Certificate Best practice in Sepsis on 14 January 2018 and Guidelines Learning Certificate NICE Guideline on Sepsis on 14 January 2018."*

70. The Tribunal also took into account the fact that there have been no other incidents/allegations since 2017 and Dr Twins has fully cooperated with both NHSE supervision and the GMC investigation. The Tribunal determined therefore from the evidence presented and the efforts Dr Twins has taken since January 2017 that the risk of repetition by Dr Twins is low.

71. The Tribunal has taken into account the overarching objective, namely to protect and promote the health, safety and wellbeing of the public; to promote and maintain public confidence in the medical profession; and to promote and maintain proper professional standards and conduct for the members of the medical profession. Notwithstanding the finding of serious misconduct in relation to a single consultation, the Tribunal took into account the large number of positive testimonials, CPD certificates, the support of his employers and appraisers, the lack of repetition, and the significant steps taken by Dr Twins to address his shortcomings.

72. The Tribunal has therefore determined that Dr Twins' fitness to practise is not currently impaired.

**Determination on Warning -** 08/01/2019

1. As the Tribunal determined that Dr Twins' fitness to practise was not impaired it considered whether, in accordance with s35D(3) of the 1983 Act, a warning was required. The Tribunal invited submissions from the parties on this point.

**GMC Submissions**

2. Mr Temkin invited the Tribunal to impose a warning in this case.

3. Mr Temkin referred to the GMC's 'Guidance on warnings' document (February 2018) ('the warnings guidance'). With reference to paragraph 11 of the warnings guidance, Mr Temkin stated that warnings provide an indication to a doctor that any given conduct or behaviour represents a departure from the standards expected of members of the profession and should not be repeated. In relation to paragraph 16 of the warnings guidance, Mr Temkin stated that a warning was appropriate in circumstances where there has been a significant departure from GMP which warranted a formal response.

4. Mr Temkin submitted that the GMC relies on the Tribunal's findings in this case, particularly in relation to Patient B.

5. Mr Temkin also referred to the principle of proportionality and that the Tribunal should take account of the aggravating and mitigating factors in this case as to whether a warning is appropriate. He reminded the Tribunal of the warning imposed on Dr Twins' registration in 2013, that Dr Twins has complied with the NHSE conditions imposed and the number of positive testimonials that are present in this case.

**Submissions on Dr Twins' behalf**

6. Miss Webb referred to paragraph 13 of the warnings guidance:

> *"Although warnings do not restrict a doctor's practice, they should nonetheless be viewed as a serious response, appropriate for those concerns that fall just below the threshold for a finding of impaired fitness to practise."*

She also raised the importance of proportionality and reminded the Tribunal, with regard to paragraph 8 of the warnings guidance, that warnings are disclosed to any person or body who brought the allegation to the attention of the GMC, the practitioner's employer, and any other enquirer. Also that a warning is published via the GMC's website on the medical register for a two-year period and disclosed to employers indefinitely on request.

7. Miss Webb submitted that, with regard to the range of mitigating factors, it would not be appropriate to impose a warning in this case. She stated that a warning does have a significant effect - it is all pervasive. Miss Webb stated that when Patient A initially wrote to the GMC he made reference to the 2013 warning. She suggested it was essentially a 'yoke' that the practitioner had around his neck. Miss Webb referred to the comments of Dr D that Dr Twins ought to be able to access different work environments where there are fewer issues; a warning would likely impair Dr Twins' ability to apply for such job posts.

8. With regard to mitigating circumstances, Miss Webb referred to the Tribunal's determination on impairment in which it stated that Dr Twins: had considerable insight; there had been no further incidents since 2017; had fully cooperated with NHSE; had a low risk of repetition; had the full support of his appraisers; and had taken significant steps to address his shortcomings.

9. Miss Webb stated that the principal concerns relate to a single consultation and there has been no repetition of the specific issues regarding the findings in relation to Patient B. She submitted that there was no public safety or confidence reason why a warning should follow in this case. Miss Webb stated that a number of

members of public had already wholeheartedly supported Dr Twins by their testimonials. She submitted that, when weighing the public interest with Dr Twins' own interests, no warning should be imposed.

10. Miss Webb reminded the Tribunal that there will be a public record of this hearing containing the findings made. She submitted that this hearing, and the process to get here, should represent deterrent enough. Miss Webb submitted that the concerns do not fall just below the threshold for a finding of impaired fitness to practise; indeed they are some considerable way below this threshold. She invited the Tribunal to take the approach that no warning is required.

**The Tribunal's Determination on Warning**

11. In reaching its decision as to whether a warning would be appropriate, the Tribunal took account of the specific circumstances of this case and had regard to the submissions provided by both parties. It had regard to the relevant guidance, including the warnings guidance.

12. The Tribunal noted that the decision whether or not to issue a warning is a matter for it alone to determine, exercising its own professional judgement. It took account of the overarching objective of the public interest and applied the principle of proportionality - weighing the interests of the public with those of Dr Twins.

13. The Tribunal has found four episodes of serious misconduct in relation to one consultation with Patient B, but which it considered did not amount to current impairment of Dr Twins' fitness to practise. It also found that there was misconduct, but which was not serious, in relation to a failure in record keeping with regard to Patient A.

14. The Tribunal was conscious of paragraph 13 of the warnings guidance, as quoted above, as to whether the concerns fell just below the threshold for a finding of impaired fitness to practise. It determined that the concerns were serious enough that they did fall just below that threshold. The Tribunal was of the view that the concerns represented a significant departure from the principles set out in GMP such as to warrant a formal response. Indeed, should there be any repetition of the conduct then the Tribunal considered that it would likely follow that there would be a finding of impaired fitness to practise.

15. The Tribunal had regard to patient safety and public confidence and determined that a doctor who failed to examine and record, as Dr Twins did with Patient B, needed some element of deterrent as well as reassuring the public that Dr Twins will continue his ongoing vigilance, as he has done since the events in 2017.

16. The Tribunal has borne in mind Miss Webb's submissions that the imposition of a warning may cause difficulty in Dr Twins obtaining a job post. Whilst the Tribunal was

conscious of this, it had to balance Dr Twins' interests with the public interest and concluded that a warning was both necessary and proportionate.

17. The Tribunal has therefore determined to impose the following warning on Dr Twins' registration:

> 'The Tribunal found that Dr Twins failed to consider, enquire or make an adequate assessment for signs of sepsis, during a consultation on 20 January 2017, and failed to record the consultation sufficiently. This falls just below the threshold for a finding of impaired fitness to practise.
>
> The Tribunal considered that a warning is a proportionate measure because this was a significant enough departure from the principles in Good medical practice to warrant a formal response and to maintain public confidence in the medical profession, which the Tribunal considered to be within the overarching objective.
>
> This conduct does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good medical practice and associated guidance. In this case, paragraphs 15(a) and 21(a) of Good medical practice are particularly relevant. These paragraphs state:
>
> 15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:
>
> > (a) adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient.
>
> 21. Clinical records should include:
>
> > (a) relevant clinical findings.
>
> Whilst this failing in itself is not so serious as to require any restriction on Dr Twins' registration, it is necessary in response to issue this formal warning.
>
> This warning will be published on the medical register in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy'.

18. There is no interim order to revoke.

19. That concludes this case.

**Confirmed**
**Date** 08 January 2019 Miss Sally Cowen, Chair

**ANNEX A -** 15/11/2018

## Application under Rule 17(2)(g)

1. At the close of the GMC's case, Miss Webb, on behalf of Dr Twins, made a submission of 'no case to answer' under Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), 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.*'

2. Miss Webb made the application in regard to all of the facts of the Allegation, with the exception of paragraphs and sub-paragraphs 3b, 3c(i), 3c(ii), 5f, 5g(i)-5g(v) and 5g(vii) of the Allegation, which were admitted by Dr Twins at the outset of the hearing.

## The Evidence

3. The Tribunal had heard oral evidence from Patient A and Dr C, an expert GP on behalf of the GMC, and had seen documentary evidence of contemporaneous medical records.

## Submissions

Submissions on behalf of Dr Twins

4. In summary, Miss Webb submitted that the GMC had insufficient evidence to support the remaining paragraphs and sub-paragraphs of the Allegation. She stated that the GMC's case was built primarily on the evidence of Patient A, whose evidence was wholly inconsistent and unreliable, and drew the Tribunal's attention to a number of contradictions between Patient A's written witness statement and his oral evidence.

5. Miss Webb submitted that the GMC had no evidence regarding Dr Twins' consultation with Patient B on 20 January 2017, except for the witness statement of Dr Twins himself and the computer-generated medical records. Patient B had not made the complaint to the GMC and had declined the opportunity to provide a witness statement or give any evidence relating to this matter.

6. Miss Webb submitted that Dr Twins had been perfectly candid in his evidence and admitted his failure to adequately record the consultation with Patient B, and he remained unclear, upset and apologetic regarding the absence of recordings on 20

January 2017, as he could remember the consultation clearly and was certain that he had carried out an adequate assessment.

7. Miss Webb highlighted a number of points made by Dr C during his oral evidence. In particular, Dr C's concern in relation to Patient A was not Dr Twins' failure to diagnose ophthalmic shingles, but a failure to carry out a full and complete examination, and that his concerns in relation to Patient B were limited to Dr Twins failure to make an accurate record of the consultation, which he stated was only a 'minor concern'.

8. Miss Webb also made detailed submissions on the legal definition of misconduct. She stated that the GMC had insufficient evidence to prove that any of the remaining paragraphs of the Allegation amounted to misconduct. She invited the Tribunal to have regard to a number of authorities that could support that Dr Twins' conduct in relation to both Patient A and Patient B did not amount to misconduct or serious misconduct.

Submissions on behalf of the GMC

9. In summary, Mr Temkin submitted, on behalf of the GMC, that he opposed the application for all the remaining paragraphs and sub-paragraphs of the Allegation to be withdrawn.

10. Mr Temkin acknowledged and accepted that Patient A's evidence was muddled and inconsistent, but invited the Tribunal to consider that he was a man doing his best in the circumstances, and should not be considered as being dishonest or misleading. Mr Temkin reminded the Tribunal that Patient A had no financial motivation relating to this hearing, and that he had not complained about a medical practitioner before.

11. Mr Temkin submitted that Miss Webb could not persuade the Tribunal on her application through any assertions made by Dr C, as he was not presented to the Tribunal as a finder of fact. Mr Temkin stated that Dr C could be relied upon to provide an expert opinion on professional conduct, such as his statement that the responsibility of communicating clear information 'lay with the sender', and if Patient A had misinterpreted details of a consultation with Dr Twins, this could demonstrate inadequate communication skills from Dr Twins.

12. Mr Temkin also made submissions on the matter of misconduct, and stated that inaccurate record keeping alone could constitute misconduct. However, Mr Temkin stressed that it would be premature for the Tribunal to make any decision relating to Miss Webb's application on misconduct prior to hearing evidence from Dr Twins, and submitted that the best evidence would come from the doctor himself.

## The Tribunal's Approach

13. The Tribunal bore in mind that, when considering the evidence at this stage of the proceedings, its role is not to make findings of fact but to apply the relevant test(s) set out in *R v Galbraith* [1981] 1 WLR 1039 as adopted to this jurisdiction. The Tribunal bore in mind that it should only uphold the application in respect of a particular sub-paragraph or paragraph where it finds that:

> 1) there is no evidence that Dr Twins acted or failed to act as alleged, and the allegation is therefore incapable of being found proved on the balance of probabilities; or
>
> 2) there is some evidence that Dr Twins may have acted or failed to act as alleged, but the evidence is insufficient for the allegation to be able to be found proved on the balance of probabilities.

14. In respect of the second limb of the test, the Tribunal bore in mind that if it were to find that there is some evidence that Dr Twins may have acted or failed to act as alleged, in order to find that the evidence is insufficient for the allegation to be able to be found proved it must be satisfied that the evidence is of a tenuous character, because of inherent weakness or vagueness, for example, or because it is inconsistent with other evidence. The Tribunal must be satisfied that the evidence, taken at its highest, is such that, if properly directed, it could not go on to find that particular allegation proved.

15. The Tribunal also reminded itself of the High Court view in the case of *Tutin V GMC [2009] EWHC 553 (Admin)*, that a view on the credibility of a witness can be taken on a particular point at this stage.

## The Tribunal's Decision

### Paragraph 1a

1. On 28 September 2015 you consulted with Patient A and you:

    a. failed to enquire about:

        i. eye pain;

        ii. eye redness;

        iii. visual blurring;

        iv. any family history of cardiovascular disease or hypertension;

16. The Tribunal first considered paragraph 1a of the Allegation. It noted that the GMC's case relied heavily on the evidence of Patient A, and that there were discrepancies and inconsistencies in his account of the consultation that took place on 28 September. Patient A stated in his oral evidence that Dr Twins did not enquire about eye pain or eye redness, despite his presenting symptoms, but asserted that visual blurring and a family history of cardiovascular disease were discussed at the consultation.

17. The Tribunal concluded that the evidence before it, taken at its highest, was that enquiries relating to 1a(iii) and 1a(iv) did take place, and it therefore acceded to the application to remove these paragraphs of the Allegation.

18. The Tribunal concluded that the evidence at its highest may show a failure to enquire about eye pain or eye redness by Dr Twins, and so paragraphs 1a(i) and 1a(ii) of the Allegation should remain.

**Paragraphs 1b – 1f**

19. The Tribunal considered that paragraphs 1b – 1f related to Dr Twins alleged failure to enquire about Patient A's eye symptoms. It therefore followed, based on its findings at paragraph 1a, that paragraphs 1b - 1f of the Allegation were also capable of proof. The Tribunal therefore determined that paragraphs 1b – 1f of the Allegation should remain.

**Paragraph 1g**

> 1. On 28 September 2015 you consulted with Patient A and you:
>
> g. inappropriately advised Patient A that a pharmacist would contact them on a daily basis;

20. The Tribunal heard evidence in person from Patient A, in which he reinforced his written account that Dr Twins advised him that a pharmacist would contact him daily. Patient A also stated that this advice was subsequently supported by his pharmacist, who offered him a daily phone call service.

21. The Tribunal acknowledged the opinion of the GMC's expert witness, Dr C, who gave evidence in person. Dr C emphasised the responsibility of the practitioner to ensure that patients leave consultations with a clear understanding of any next steps, and that any misinterpretation of information could, in part, be the result of poor communication from the doctor.

22. The Tribunal concluded that, as there remained some doubt over the communication, paragraph 1g of the Allegation was capable of proof and should remain.

**Paragraph 1h**

1. On 28 September 2015 you consulted with Patient A and you:

    h. failed to record:

        i. the presence or absence of any eye symptoms as described at paragraph 1a;

        ii. any family history of cardiovascular disease or hypertension;

        iii. any examination of Patient A's eye as described at paragraph 1b;

        iv. your diagnosis of Patient A's symptomatic hypertension;

        v. your prescription of statins to Patient A;

        vi. any discussion of Patient A's symptoms with an ophthalmology colleague.

23. The Tribunal had regard to the medical records made by Dr Twins relating to the consultation with Patient A on 28 September 2015. At this stage, the Tribunal made no judgement on whether the matters above **should** have been recorded and only considered the fact of whether they were recorded or not.

24. Firstly, the Tribunal considered that, based upon its decision for parts of paragraph 1a and paragraph 1b to remain upheld, it logically followed that paragraphs 1h(i) and 1h(iii) should also remain.

25. The Tribunal considered the remaining matters at paragraph 1h of the Allegation were not documented in the medical records, and therefore determined that paragraphs 1h(ii), 1h(iv), 1h(v) and 1h(vi) were capable of proof and should remain.

**Paragraph 2a**

2. On 2 October 2015 you consulted with Patient A and you failed to:

a. adequately engage with Patient A regarding your missed diagnosis of ophthalmic shingles during the consultation on 28 September 2015;

26. The Tribunal noted the conflict in Patient A's evidence in relation to paragraph 2 of the Allegation. During his oral evidence, Patient A strongly denied ever seeing Dr Twins in person or speaking to him on the telephone on 2 October 2015, which he maintained even when presented with medical records that documented a consultation on this day.

27. The Tribunal also noted that the medical records suggested it was possible a consultation between Dr Twins and Patient A did take place on 2 October 2015. As a result, the Tribunal determined that paragraph 2a of the Allegation was capable of proof and should therefore remain.

**Paragraph 2b**

2. On 2 October 2015 you consulted with Patient A and you failed to:

b. record:

i. any information shared with Patient A during the consultation;

ii. any confrontation with Patient A having occurred during the consultation;

iii. Patient A's blood pressure results.

28. In considering 2b(i) and 2b(iii), the Tribunal noted the medical records from 2 October 2015. At its highest, this could show that Dr Twins did share information with Patient A and noted a recorded blood pressure.

29. Patient A also gave evidence that there was not a confrontation and therefore the Tribunal concluded that the evidence at its highest did not support paragraph 2b(ii) of the Allegation.

30. The Tribunal concluded that paragraphs 2b(i), 2b(ii) and 2b(iii) were not capable of proof, and therefore determined these subparagraphs of the Allegation should be removed.

**Paragraph 3a**

3. On 15 October 2015 you consulted with Patient A and you failed to:

a. examine Patient A's:

i. pupillary reflexes;

ii. eye movement;

iii. visual acuity;

31. The Tribunal considered Patient A's assertion that Dr Twins had failed to carry out an eye examination despite his recent diagnosis of shingles in his left eye, and his related symptoms and treatment.

32. The Tribunal noted the medical records of this consultation and concluded that paragraphs 3a(i), 3a(ii) and 3a(iii) were capable of proof. The Tribunal therefore determined that these subparagraphs of the Allegation would remain.

**Paragraph 3c(iii)**

3. On 15 October 2015 you consulted with Patient A and you failed to:

c. record:

iii. any confrontation with Patient A having occurred during the consultation.

33. The Tribunal took account of Patient A's evidence of the consultation on 15 October 2015, in particular his oral evidence, in which he strongly denied there was any confrontation between himself and Dr Twins, and referred to this consultation as 'a professional conversation'. The Tribunal determined that paragraph 3c(iii) was not capable of proof and should be removed from the Allegation.

**Paragraph 4**

4. On 20 October 2015 you consulted with Patient A and you failed to:

a. enquire about Patient A's eye history;

b. examine Patient A's eye, including:

i. pupillary reflexes;

ii. eye movement;

iii. visual acuity;

c. record any examination of Patient A's eye as described at paragraph 4b.

34. In his oral evidence, Patient A denied ever seeing Dr Twins or speaking to him on the telephone on 20 October 2015, which he maintained when presented with medical records that documented a consultation on this day.

35. The medical records suggested that it was possible a consultation between Dr Twins and Patient A took place on 20 October 2015. The Tribunal concluded that paragraphs 2a, 2b(i), 2b(ii) and 2b(iii) were capable of proof and it therefore determined that these subparagraphs of the Allegation should remain.

**Paragraph 5**

5. On 20 January 2017 you consulted with Patient B and you failed to:

a. enquire about:

i. the presence or absence of any chest pain;

ii. breathlessness;

iii. whether Patient B's cough was productive of sputum or blood;

iv. any other possible causes of infection;

b. check Patient B's:

i. temperature;

ii. heart rate;

iii. blood pressure;

iv respiratory rate;

c. consider a diagnosis of sepsis;

d. adequately consider hospital admission for Patient B;

e. advise Patient B:

i. to seek medical help if her condition deteriorated;

ii. of any specific signs of deterioration to watch out for;

g. record:

vi. any consideration of a hospital admission for Patient B;

36. The Tribunal acknowledged that Patient B had not made a complaint to the GMC, had not provided a witness statement, and had declined to give any evidence at this hearing.

37. The Tribunal had regard to the medical records made by Dr Twins relating to the consultation with Patient B on 20 January 2017. At this stage, the Tribunal made no judgement on whether the matters above **should** have been done, and only considered the fact of whether they were done or not.

38. The Tribunal accepted that Dr Twins had made admissions to a number of sub-paragraphs of paragraph 5 of the Allegation, and considered that the remaining matters at paragraph 5 did not appear to be documented in the medical records. The Tribunal therefore determined that paragraphs 5a, 5b, 5c, 5d, 5e and 5g(vi) were capable of proof and should remain.