PUBLIC RECORD

Dates: 21/11/2022 - 01/12/2022

Medical Practitioner's name:	Dr Jibu VARGHESE
GMC reference number:	5207018
Primary medical qualification:	MB BS 1994 Bangalore

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

Summary of outcome

Suspension, 2 months.
Review hearing directed

Tribunal:

Legally Qualified Chair	Mr Colin Chapman
Lay Tribunal Member:	Dr Matthew Fiander
Medical Tribunal Member:	Dr Jeffrey Phillips

Tribunal Clerk:	Mr Mark Hibbert

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Richard Smith, Counsel, instructed by MDDUS
GMC Representative:	Ms Ceri Widdett, Counsel

Attendance of Press / Public

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

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 28/11/2022

Background

1. Dr Varghese qualified in 1994 with MB BS from Bangalore University, India. He obtained a Diploma in Dermatology and Genitourinary Medicine in 1997, a Diploma in Dermatological Sciences in 2000 and an MSc in Dermatology in 2001. He gained MRCP in 2005, MRCP Dermatology in 2010 and FRCP in 2017.

2. At the time of the Allegation Dr Varghese had been a Consultant Dermatologist at Yeovil District Hospital since March 2017 and undertook private work at BMI Winterbourne Hospital and Nuffield Hospital Taunton.

3. The allegation that has led to Dr Varghese's hearing can be summarised as follows. Patient A attended an appointment with Dr Varghese on 21 November 2018 following a referral by her GP. Dr Varghese diagnosed a Morphoeic Basal Cell Carcinoma ('BCC') on her forehead. On 6 March 2019 Dr Varghese performed a Mohs procedure on Patient A at Salisbury District Hospital, where he worked one day a week to use the Mohs facilities there.

4. Patient A was unhappy with the size of the excision made to her forehead to remove the BCC. She expressed her concerns on the day of the procedure and subsequently made a complaint to the Hospital. Patient A received copies of her clinical notes including consent form. She noticed that the words 'LARGE Excision' had been added to the consent form where details of potential risks were listed, which did not appear on the carbonated copy she had been given and which she claimed had not been discussed with her.

5. It is alleged that Dr Varghese amended the hospital copy of the consent form after Patient A had signed it, knowing that he had not discussed this particular risk with Patient A and knowing that the amendment was not included on the copy given to her. It is alleged that in doing so, Dr Varghese acted dishonestly.

6. Patient A reported the matter to the GMC on 18 March 2020.

The Outcome of Applications Made during the Facts Stage

7. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that an amendment be made to the Allegation to properly reflect the wording on the consent form. The Tribunal's full decision on the application is included at Annex A.

8. The Tribunal granted Dr Varghese's application, made pursuant to Rule 34(1) of the Rules, to admit testimonial evidence at Stage 1 of the hearing. The Tribunal's full decision on the application is included at Annex B.

The Allegation and the Doctor's Response

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

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

1. On 6 March 2019, you performed a Mohs procedure on Patient A. **Admitted and found proved.**

2. You retrospectively amended the hospital copy of the consent form 'Patient agreement to investigation or treatment' dated 6 March 2019 ('the Consent Form') to include 'LARGE EXCISION' under the section 'Any significant, unavoidable or frequently occurring risks, or risks patient thinks important'. **Amended under Rule 17(6). Admitted and found proved.**

3. You knew that:

    a. the amendment to the Consent Form referred to in paragraph 2 was not included on Patient A's copy of the Consent Form; **To be determined.**

    b. you had not discussed the amendments you made to the Consent Form with Patient A at the time the Consent Form was signed by Patient A. **To be determined.**

4. Your actions as described at paragraph 2 were dishonest by reason of paragraph 3. **To be determined.**

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

The Admitted Facts

10. At the outset of these proceedings, through his counsel, Mr Smith, Dr Varghese made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Witness Evidence

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

    - Patient A, via video link. Witness statements dated 6 May 2021 and 20 April 2022;
    - Mrs B, via video link. Witness statement dated 1 April 2022.

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

    - Dr C, Dr Varghese's Responsible Officer, dated 18 March 2022.

13. Dr Varghese provided his own witness statement, dated 4 November 2022, and gave oral evidence at the hearing.

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

    - Mrs D, Laboratory Manager in Histopathology at Salisbury District Hospital, dated 27 July 2022;
    - Ms E, Locum Mohs Biomedical Scientist, dated 5 August 2022.

Expert Witness Evidence

15. The Tribunal also received evidence from Dr H, expert witness for the GMC. Dr H provided an expert report dated 21 October 2022 and gave evidence, via video link, at the hearing. Dr H is a Consultant Dermatologist and Mohs Surgeon at NHS Tayside. Dr H was instructed to give his opinion on the procedure undertaken and the care provided to

Patient A. He was also asked to comment on the obtaining of consent from Patient A and the appropriateness of retrospectively amending a signed consent form.

Documentary Evidence

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

- Patient A's GMC online complaint form, dated 18 March 2020;
- Mohs information leaflet given to Patient A;
- Hospital and patient copies of the consent form, dated 6 March 2019;
- Various clinical notes made by Dr Varghese, dated 21 November 2018 and 6 March 2019;
- Photographs taken by Patient A of her wound and the subsequent scar;
- Dr Varghese's response to the initial hospital complaint;
- WHO surgical checklist, dated 6 March 2019;
- Referral letter sent By Dr Varghese for his surgical list at Salisbury, dated 22 November 2018;
- Letter sent by Dr Varghese to Patient A's GP following her initial consultation, dated 22 November 2018;
- Histopathology report, dated 17 April 2019;
- Bundle of testimonials from colleagues, patients and friends.

The Tribunal's Approach

17. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC. Dr Varghese does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred. The standard is not higher for more serious allegations but the Tribunal must look more critically and anxiously at the facts. It must take into account, to the extent it considers appropriate, that the more serious the allegation, the less likely it is that the event occurred, and the stronger the evidence should be before it concludes that the allegation is established on the balance of probabilities.

18. The Tribunal must consider all of the evidence before it and make its findings based upon it. It must not speculate but can draw reasonable inferences from the evidence.

19. The Tribunal shall form its own judgement of the witness evidence and make an assessment of its reliability and credibility and decide what weight to attach to it.

20. The expert witness evidence should be seen in its proper perspective as part of the evidence as a whole and is there to assist the Tribunal. The Tribunal is entitled to take expert opinions into account but does not have to accept them. It remains a matter for the Tribunal to consider what weight, if any, it attaches to it.

21. In considering the alleged dishonesty, the Tribunal had regard to the case of *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords) [2017] UKSC 67* which stated that:

> *'74 …When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

22. The Tribunal reminded itself that Dr Varghese has no previous adverse criminal or regulatory findings against him and has also seen evidence of good character in the form of testimonials. The Tribunal bore in mind that good character is relevant in two ways. First, it supports the credibility of Dr Varghese's evidence. Second, it may be taken into account when considering his propensity to act in the way that has been alleged. However, good character itself is not a defence and it remains a matter for the Tribunal to determine the importance of it and attach appropriate weight to it.

The Tribunal's Analysis of the Evidence and Findings

23. 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.

24. The Tribunal reminded itself that Dr Varghese admitted retrospectively amending Patient A's consent form to include the words 'LARGE Excision'. Therefore, it remained a matter for the Tribunal to decide whether this risk had been discussed with Patient A, whether

Dr Varghese knew the amendment was not included on Patient A's copy, and whether he acted dishonestly.

25. In determining the contested paragraphs of the Allegation, the Tribunal decided to approach the evidence by looking at the documentary records before considering the evidence given by the witnesses.

26. The Tribunal reminded itself that Dr Varghese's first consultation with Patient A was on 21 November 2018 and that they next met when he performed the Mohs procedure on 6 March 2019.

21 November 2018 – Consultation

27. The Tribunal noted the documents relating to this consultation. There was a clinical note with two diagrams of a face, a copy of the information leaflet given to Patient A and two letters which were sent after the consultation; one referring Patient A for Mohs surgery at Salisbury and one to her GP.

28. The Tribunal considered the diagrams and writing in the clinical record. The purpose of the diagrams was contested. Patient A said that she was sitting opposite Dr Varghese, could not see what was being drawn, and was not shown the diagrams. Dr Varghese's account was that he drew them to explain the procedure to Patient A.

29. The Tribunal was of the opinion that these were fairly basic diagrams. There was no indication of scale or written explanation of possible size of the tissue to be removed during the Mohs procedure. The Tribunal considered that the note did not refer to a large excision or words to that effect.

30. Dr Varghese explained that the upper diagram was used to explain the cutting out of the BCC lesion with a small margin of healthy tissue around it, as shown by two concentric circles. The oblique line, he said, was to indicate a 'primary closure' of the wound by suturing. He explained in oral evidence that in order to close a circular wound, more tissue must be taken either side to create an ellipse, allowing the two sides to be brought together neatly without any bulges or 'dog ears'. However, the Tribunal noted that this elliptical wound shape was not drawn in the diagram, nor was it referred to in the notes.

31. Dr Varghese told the Tribunal that the lower diagram and note beside it were to demonstrate the possibility of using a bilateral advancement flap ('flap closure') to close the wound if it was too big to perform an elliptical closure. The content of any discussion with Patient A is not recorded.

32. The Tribunal considered the information written in the two letters by Dr Varghese on 22 November 2018. In both letters he confirmed the diagnosis of morphoeic BCC. In the letter to Patient A's GP, he confirmed that he discussed two possible procedures; a *'surgical excision or excision by a Mohs procedure'*. However, whilst the letter confirms that these options were discussed with Patient A, it does not record that the risk of 'large excision' was discussed, or indeed any other risks. The referral letter to Salisbury also did not contain any record of having discussed risks but did record that Patient A was directed to the website of the British Academy of Dermatology for further information.

33. The Tribunal next turned to the information leaflet on Mohs procedures, which was given to Patient A at this consultation. The Tribunal noted that it was in almost identical terms to the information produced by the British Academy of Dermatology.

34. Having reviewed the leaflet, the Tribunal noted that it did not unequivocally detail the risk of a large excision during a Mohs procedure. Whilst it did state: *'Sometimes the tumour can be much larger than is visible at first on the surface of the skin'*, it did not go on to say that this would lead to a large excision being required.

35. Patient A said in her statement that she understood a Mohs procedure to *'involve removing thin layers of the growth a bit at a time in stages'*. She also highlighted that part of the leaflet where it states: *'the skin cancer is removed a thin layer at a time with a small margin of healthy skin… The advantage of removing the skin layer by layer in this way is that as little healthy skin around the skin cancer is removed, which keeps the wound as small as possible.'*

36. In his oral evidence, the expert witness, Dr H, stated that the information leaflet was misleading if read alone and with no accompanying explanation by a clinician. The Tribunal agreed.

37. In his statement Dr Varghese said that he provided Patient A with the leaflet and had discussed the potential risks with her, including the risk of a large excision. He

maintained this in his oral evidence, and in the response he provided to the Hospital after the initial complaint from Patient A.

38. In considering the evidence relating to this consultation, the Tribunal bore in mind that Dr Varghese was a Mohs surgeon who was considering a routine straightforward procedure. Dr Varghese was experienced in Mohs surgery and the Tribunal noted his good character and unblemished record.

39. Dr Varghese was consistent throughout his evidence that Patient A would not require a large excision and that, in his opinion, she did not receive one. The Tribunal accepted Dr H's opinion that the resultant procedure was not a large excision from a medical perspective.

40. The Tribunal noted that the leaflet detailed three possible options after the tumour is removed depending on the size of the excision: a smaller wound is left to heal naturally; a larger wound is closed with stitches; or, the wound may require repair by a plastic surgeon. If the latter method is required, the leaflet states that this would usually be planned in advance. In Patient A's case, there was no plan made for this, suggesting that it was not anticipated that this would be the outcome. The Tribunal reminded itself that Dr Varghese's evidence was that the surgery on Patient A would not involve a large excision.

41. Considering all of the evidence relating to this initial consultation, the Tribunal took the view that some discussion did take place between Patient A and Dr Varghese about the size of the excision, wound closure and the cosmetic result of the options available to remove the BCC. The Tribunal considered it likely that Patient A would have wanted to know the likely outcome.

42. The Tribunal considered that any discussion as to the size of the wound would have been focussed on minimising the amount of healthy tissue removed rather than how large the excision would be. This is one of the benefits of the Mohs procedure over non-Mohs surgery. The Tribunal decided that this was consistent with Patient A's evidence about her expectations following the consultation and subsequently, on the day of the surgery.

43. In summary, the Tribunal was satisfied that on 21 November 2018, Dr Varghese did discuss the two procedure options available (surgical excision or Mohs) and two possible ways to close Patient A's wound (elliptical primary closure or bilateral advancement flap).

However, the Tribunal was satisfied on the balance of probabilities that the risk of a large excision was not discussed at this consultation as claimed by Dr Varghese in his evidence.

6 March 2019 Pre- Surgery

44. The Tribunal noted that there were two relevant clinical documents completed on 6 March 2019, prior to the Mohs procedure taking place: the consent form; and the 'sign in' part of the WHO surgical checklist.

45. The sequence of events on the day was uncontested. Patient A arrived and was taken into the operating room by a nurse. Dr Varghese went through the consent form which was signed by Patient A and the procedure then began.

46. The Tribunal considered that prior to the surgery, Dr Varghese's mindset was that he would be undertaking a routine Mohs procedure which was unlikely to involve a large excision. In Patient A's mind she was expecting a Mohs procedure which she understood *'would involve removing thin layers of the growth a bit at a time in stages and examining it under a microscope to study it. I understood that the reason it would be in stages as to aim to minimise the size of the excision and the subsequent scarring.'*

47. In her oral evidence, Patient A stated that Dr Varghese 'read out' the risks to her before she signed the consent form. She was clear that the risk of a large excision was not mentioned at this point. The Tribunal preferred Patient A's evidence to that of Dr Varghese in this respect. Dr Varghese was undertaking a routine Mohs procedure in which he did not expect a large excision. Patient A's expectations were that layers would be removed and that no large excision was anticipated.

48. The Tribunal considered that prior to the surgery neither Patient A nor Dr Varghese anticipated a large excision.

49. The Tribunal therefore considered that it was unlikely that there was a discussion about the risk of a large excision at the time the consent form was signed before the procedure. It considered it likely that the risks which were discussed at that time were the ones documented on the copy that was handed to Patient A. These did not include the risk of a large excision. The Tribunal considered that otherwise Patient A would not have been so shocked when she looked at the surgical wound following the procedure.

Patient A's evidence about this was corroborated by Mrs B and was, in the view of the Tribunal, consistent and credible.

50. The Tribunal did not find it credible that Dr Varghese had discussed the risk of large excision when he had not written it on the form along with the other risks which he had documented. His evidence was that he added it later for completeness as it had been discussed before the procedure. The Tribunal was of the opinion that if it was so important to document it retrospectively, if indeed it had been discussed, then Dr Varghese would have written it at the same time as he documented the other risks he mentioned to Patient A, before she signed the consent form.

51. The Tribunal was satisfied on the balance of probabilities that it was more likely than not that the risk of a large excision was not discussed prior to the consent form being signed by Patient A on 6 March 2019.

52. The Tribunal therefore determined that paragraph 3b of the Allegation was proved.

<u>The consent form</u>

53. The Tribunal heard evidence that there was a hospital copy of the consent form which was retained by the hospital ('the hospital copy') and a carbonated copy which was handed to the patient ('the patient copy'). It was not disputed that the amendment does not appear on the patient copy of the consent form.

54. Patient A's evidence suggested that she was handed her patient copy before the procedure started. Dr Varghese could not recall when Patient A was given a copy. He suggested that it must have been given to Patient A at some point by a nurse as he did not do so himself and this was the usual practice. His evidence was that he was unaware as to whether the patient copy had been removed from under the hospital copy when he made the retrospective amendment.

55. Dr Varghese's evidence was that the amendment was made to reflect accurately the discussion he had had with Patient A when the consent form was completed. The Tribunal has already decided that it was unlikely that a large excision was discussed at that time and has not accepted Dr Varghese's evidence in this respect.

56. The Tribunal therefore considered it likely that any discussion about a large excision came about after Patient A had seen the size of the wound to her forehead and expressed her distress and dissatisfaction. It considered that the retrospective amendment to the consent form was made following that discussion. It considered it likely that this discussion was the point at which Dr Varghese realised that a large excision had not been discussed earlier in the day and that this risk had not formed part of the consent process.

57. The Tribunal considered Dr Varghese's evidence about the amendment carefully. He said, *'I have no specific recollection of adding the words 'large excision' to the consent form'*. The Tribunal did not consider this evidence credible in the light of his acceptance that he knew the importance of good record keeping and that this was the first time he had ever altered a consent form in this way.

58. The Tribunal also considered Dr Varghese's oral evidence to be vague and inconsistent when explaining the amendment. For example, in cross-examination, he said the amendment was *'Added this afternoon after my conversation with the patient initially about the procedure'* which was inconsistent with having no recollection. It was also at odds with his belief that he was never dealing with a large excision.

59. Dr Varghese went on to say that he may have made the amendment because there had been an audit which identified incomplete consent forms and which had led to him to implement a practise of always checking the documentation to ensure it was completed to the appropriate standard. He told the Tribunal that he had never before found an omission on a consent form which required amendment. This was inconsistent with his earlier explanation and something that he had not mentioned before. The Tribunal considered this explanation to be incredible.

60. Alternatively, Dr Varghese suggested that the amendment was made when he was 'in a state'. He explained that he was under pressure because he was having a difficult day. He told the Tribunal that his usual journey of an hour and a quarter had taken him one and a half hours, he had calls about other patients, and he had another patient that day requiring a more complex procedure. The Tribunal was of the opinion that if he was under the pressure he claimed, it would have been unlikely for Dr Varghese to have taken the time to routinely check through his documentation for any omissions.

61. The Tribunal therefore did not find credible Dr Varghese's evidence about why the amendment was made and the circumstances in which it was made. It found that it was much more likely that Dr Varghese added the comment to the consent form because of the reaction of Patient A.

62. The Tribunal did not find Dr Varghese's explanation, that he had not noticed that the patient copy was detached when he made the amendment to be credible. It considered that, if his explanation that the amendment was made to be thorough, then he would have made sure that it was included on Patient A's copy of the form whilst she was still at the hospital.

63. The Tribunal took the view that Dr Varghese would have been aware that adding the comment retrospectively to Patient A's copy, with her knowledge, would have been likely to inflame the situation and cause further anger and distress to her. It was therefore satisfied on balance, that it was more likely that he added the comment, aware that Patient A already had her copy and that his amendment was only to the hospital copy.

64. The Tribunal therefore determined that paragraph 3a of the Allegation was proved.

Dishonesty

65. The Tribunal reminded itself of the two-part test for dishonesty as set out in the case of *Ivey.*

66. The Tribunal, having determined 3a and 3b as proved, was satisfied that Dr Varghese knew that the amendment to the consent form was not included on Patient A's copy, and that he had not discussed either the fact or the substance of the amendment with Patient A either before she signed the consent form or at any stage of his dealings with Patient A that day.

67. The Tribunal found that the Mohs procedure performed by Dr Varghese involved an excision of a size that Patient A had not expected, and which came as a shock to her. She was distressed at what she perceived to be a large excision. She needed calming down and had to be taken to a quiet room with Mrs B and a nurse so that she could express her concerns privately and so that Dr Varghese could explain what had occurred.

68. The Tribunal considered Dr Varghese's evidence about the reasons he was *'in a state'* when he made the amendment. The Tribunal considered his explanation implausible and rejected it.

69. The Tribunal determined that Dr Varghese's state of mind at the time he amended the form resulted from Patient A's anger and distress about the size of the excision, and his knowledge that he had not discussed a large excision with her and that he had not obtained her informed consent.

70. In these circumstances, the Tribunal considered that Dr Varghese's motive for amending the form was to give the false impression in the hospital records that informed consent had been obtained for a procedure which carried the risk of a large excision, in anticipation of a possible complaint. The Tribunal concluded that when Dr Varghese amended the form, he knew that he was giving the false impression that he had discussed the risk of a large excision as part of the consent procedure with Patient A.

71. The Tribunal determined that this would, in the opinion of ordinary decent people, be considered dishonest.

72. The Tribunal therefore determined that paragraph 4 of the Allegation was proved.

The Tribunal's Overall Determination on the Facts

73. The Tribunal has determined the facts as follows:

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

1. On 6 March 2019, you performed a Mohs procedure on Patient A. **Admitted and found proved.**

2. You retrospectively amended the hospital copy of the consent form 'Patient agreement to investigation or treatment' dated 6 March 2019 ('the Consent Form') to include 'LARGE EXCISION' under the section 'Any significant, unavoidable or frequently occurring risks, or risks patient thinks important'. **Amended under Rule 17(6). Admitted and found proved.**

3. You knew that:

    a. the amendment to the Consent Form referred to in paragraph 2 was not included on Patient A's copy of the Consent Form; **Determined and found proved.**

b. you had not discussed the amendments you made to the Consent Form with Patient A at the time the Consent Form was signed by Patient A. **Determined and found proved.**

4. Your actions as described at paragraph 2 were dishonest by reason of paragraph 3. **Determined and found proved.**

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

Determination on Impairment - 30/11/2022

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

The Evidence

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

76. Dr Varghese provided his own witness statement dated 28 November 2022.

77. The Tribunal also received the following documents:

- A reflective statement written by Dr Varghese;
- Various CPD certificates;
- Dr Varghese's appraisal output 2022;
- Letter from Dr F, Consultant Dermatologist and Clinical Lead for Dermatology, Yeovil District Hospital, dated 24 November 2022;
- Letter from Ms G, Executive Director, The Winterbourne Hospital, dated 28 November 2022;
- Additional testimonials;
- TopDoctors patient feedback;
- Thank you cards from patients.

Submissions

On behalf of the GMC

78. Ms Widdett provided the Tribunal with a written skeleton submission and made oral submissions.

79. Ms Widdett reminded the Tribunal of the two-stage process it ought to take when considering impairment, as set out in the case of *Cheatle v General Medical Council [2009] EWHC 645 (Admin).*

80. Ms Widdett drew the Tribunal's attention to the case of *Roylance v. The General Medical Council (Medical Act 1983) [1999] UKPC 16*, which stated:

> *'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will qualify. The professional misconduct must be serious.'*

81. Ms Widdett drew the Tribunal's attention to the case of *Nandi v General Medical Council [2004] EWHC 2317 (Admin),* which described misconduct as:

> *'…a failing short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be "serious". The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.'*

82. Ms Widdett invited the Tribunal to consider the following cases in relation to dishonesty:

- *GMC v Dr Nwachuku [2017] EWHC 2085 (Admin);*
- *PSA v GMC & Igwilo [2016] EWHC 524;*
- *Patel v GMC Privy Council Appeal No.48 of 2002;*
- *PSA v GMC and Hilton [2019] EWHC 1638 (Admin).*

83. Ms Widdett reminded the Tribunal of the case of *General Medical Council v Meadow [2006] EWCA Civ 1390*, which stated:

> *'The [Tribunal] looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past.'*

84. Ms Widdett reminded the Tribunal of the test for impairment in The Fifth Shipman Report, cited in *CHRE v NMC and P Grant [2011] EWHC 927 (Admin),* which asks:

> *'(a) Whether the registrant has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;*
> *(b) Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;*
> *(c) Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.*
> *(d) Whether the registrant has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

85. Ms Widdett submitted that the Tribunal should consider the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin),* which states:

> *'It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated'.*

86. Ms Widdett submitted that the Tribunal should consider the case of *Sawati v GMC [2022] EWHC 283 (Admin*) in which Mrs Justice Collins Rice discussed four principles relevant to a rejected defence and findings as to lack of insight: the nature of the allegation; whether the doctor denied primary or secondary facts; the presence of any other evidence of a lack of insight; and the nature and quality of the rejected defence.

87. Ms Widdett submitted that a finding of dishonesty lies at the top end in the spectrum of gravity of misconduct and that there were no exceptional circumstances in this case. She

stated that falsifying a consent form seriously undermined trust and confidence in the profession. She reminded the Tribunal that the evidence of the expert witness, Dr H, was that in doing so, Dr Varghese's conduct fell seriously below the standard of care expected of him.

88. Ms Widdett submitted that Dr Varghese's action breached the following principles of *Good medical practice* ('GMP'):

> *'65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> *[…]*
>
> *68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.*
>
> *[…]*
>
> *71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading:*
>
> > *(a) You must take reasonable steps to check the information is correct.*
> > *(b) You must not deliberately leave out relevant information.*
>
> *72. You must be honest and trustworthy when giving evidence to courts or tribunals. You must make sure that any evidence you give or documents you write or sign are not false or misleading:*
>
> > *(a) You must take reasonable steps to check the information.*
> > *(b) You must not deliberately leave out relevant information'*

89. Ms Widdett submitted that Dr Varghese's misconduct was serious and that his actions would be considered deplorable by fellow practitioners.

90. Ms Widdett submitted that the GMC accept that Dr Varghese's actions did not put Patient A at unwarranted risk of harm, and that the first limb in the test for impairment is not engaged in this case.

91. Ms Widdett reminded the Tribunal of its findings on the facts in relation to Dr Varghese's motivation. She submitted that Dr Varghese's rejected defence is relevant to his current lack of insight. She stated that whilst his dishonesty was secondary dishonesty, Dr Varghese has dishonestly denied primary facts and there is no other evidence of insight. She submitted that the nature and quality of Dr Varghese's defence was such that Dr Varghese told a blatant lie involving Patient A.

92. Ms Widdett submitted that Dr Varghese has brought the profession into disrepute, has breached fundamental tenets of the profession and has acted dishonestly. She submitted that his lack of insight means he is likely to act in the same way in the future

93. Ms Widdett submitted that dishonesty is not easy to remediate. She noted that Dr Varghese had not attended a probity course, not written a reflective statement of what led to his dishonesty, and not apologised for his dishonesty or accepted that he should have behaved differently.

94. Ms Widdett submitted that Dr Varghese continued to present a risk to proper professional standards and public confidence in the medical profession.

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

95. Mr Smith submitted that whilst he makes submissions on behalf of Dr Varghese, the Tribunal should not interpret them as the doctor's views unless otherwise stated.

96. Mr Smith reminded the Tribunal that Dr Varghese admitted retrospectively amending the consent form. He stated that the expert, Dr H, gave his opinion that this fell seriously below the expected standards, and that his did not seek to convince the Tribunal otherwise.

97. Mr Smith submitted that dishonesty self evidently amounts to misconduct which cannot be excused and is a serious and grave matter.

98. Mr Smith submitted that, whilst serious, this case was not the most serious example of dishonesty and that the Tribunal may acknowledge that there are more serious examples of misconduct involving fraud or sexual offences.

99. Mr Smith noted that Ms Widdett referred to 'falsifying the consent form' which suggested the form itself was false. He submitted that this was not the case and urged the Tribunal to avoid exaggerating the gravity of the facts.

100. Mr Smith stated that this was an isolated incident and not a course of conduct in an otherwise unblemished career.

101. Mr Smith drew the Tribunal's attention to the documents submitted at this stage and the testimonials previously submitted. He submitted that the testimonials all demonstrate that the misconduct was entirely out of character for Dr Varghese.

102. Mr Smith invited the Tribunal to bear in mind its finding about Dr Varghese's motivation for amending the form, namely the anticipation of a possible complaint. He pointed out that when a complaint was made, Dr Varghese had not sought to draw attention to the amended consent form as a means of answering the complaint.

103. Mr Smith noted that this was not dishonesty which resulted in any financial gain or avoidance of financial loss to Dr Varghese as any claim would have been against the NHS.

104. Mr Smith reminded the Tribunal that the event took place over three years ago. Mr Smith invited the Tribunal to consider the seriousness of the dishonesty in its proper context based on the facts, and to conclude that it was not the most serious example.

105. Mr Smith submitted that a finding of impairment doesn't necessarily follow a finding of misconduct. The Tribunal must consider other factors such as remediation and the doctor's previous record.

106. Mr Smith submitted that dishonesty does not always require a finding of impairment and noted the case of *Hilton* as previously referenced by Ms Widdett. In that case, he submitted, the Tribunal found dishonesty but determined that the doctor was not impaired on the basis of it being an isolated incident in an otherwise unblemished career.

107. Similarly, Mr Smith drew the Tribunal's attention to the case of *PSA v GMC and Uppal [2015] EWHC 1304 (Admin).* In this case the dishonesty found did not result in a finding of impairment, again due to it being considered that the doctor's actions amounted to a one-off lapse in judgement. The Tribunal found that the public interest could be satisfied by a finding of misconduct.

108. Mr Smith submitted that a finding of impairment is not necessarily the next step. In both of the cases noted, the High Court ruled that the doctors should have received a warning. The ability to issue a warning is only available if no finding of impairment is made.

109. Mr Smith submitted that Dr Varghese's actions are remediable, have been remedied and will not occur again. This was truly a one-off incident. Dr Varghese does not have a propensity to act in this way. It was entirely out of character. He has a previously unblemished career. He does not pose a risk to patients.

110. Mr Smith drew the Tribunal's attention to the letters and testimonials submitted, and some in particular, for example those from Dr F and Ms G which demonstrate the demand for the service he provides. He submitted that this evidence demonstrates that Dr Varghese is highly valued by his patients and his employers.

111. Mr Smith submitted that Dr Varghese has reflected upon what is the only significant complaint made against him. He has taken steps to ensure there will be no repetition. Addressing the point made by Ms Widdett, he stated that Dr Varghese had not provided reflections on dishonesty as he does not accept he acted dishonestly. Mr Smith urged the Tribunal not to hold this against Dr Varghese as he was properly entitled to defend the allegation of dishonesty against him.

112. Mr Smith highlighted the various courses that Dr Varghese has completed on record keeping, consent, and complaints. He has also attended a one-to-one training course on ethics which covered fundamental principles of truth and honesty. He submitted that Dr Varghese had examined his conduct with regard to probity and ethics, albeit in the context of a doctor that did not, and does not, accept that he was dishonest.

113. Mr Smith drew the Tribunal's attention to the case of *Grant* as set out above. He noted paragraph 74 of the judgment which states:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

114. Mr Smith submitted that proper professional standards and public confidence would not be undermined if a finding of impairment were not made.

115. Mr Smith reminded the Tribunal that Dr Varghese had admitted the primary factual allegation but that he maintained that his usual practice is to warn of the risk of a large excision. He stated that it would be wrong to consider his evidence as a lie since he had based his evidence on his usual practice. Whilst the Tribunal had rejected this, his evidence was not a lie.

116. Mr Smith submitted that the GMC are relying on the rejected defence as an aggravating factor and as demonstrating a lack of insight. Mr Smith drew the Tribunal's attention to the cases of *Towuaghantse v General Medical Council (Rev 2) [2021] EWHC 681 (Admin)* and *General Medical Council v Awan [2020] EWHC 1553 (Admin)* where this approach was stated to be unfair.

117. Mr Smith submitted that in this case, Dr Varghese was putting the GMC to proof rather than defending the allegation on a dishonest basis.

118. Mr Smith noted the case of *Sawati* as submitted by the GMC. He reminded the Tribunal of the actual text of the judgement at paragraph 109 which states:

'In short, before a Tribunal can be sure of making fair use of a rejected defence to aggravate sanctions imposed on a doctor, it needs to remind itself of Lord Hoffmann's starting place that doctors are properly and fairly entitled to defend themselves, and may then find it helpful to think about four things:

(i) how far state of mind or dishonesty was a primary rather than second-order allegation to begin with (noting the dangers of charging traps) – or not an allegation at all,

(ii) what if anything the doctor was positively denying other than their own dishonesty or state of knowledge;

(iii) how far 'lack of insight' is evidenced by anything other than the rejected defence and

(iv) the nature and quality of the defence, identifying clearly any respect in which it was itself a deception, a lie or a counter-allegation of others' dishonesty.'

119. Mr Smith submitted that the GMC accepted that this was a case of secondary dishonesty. He stated that Dr Varghese denied the matters in paragraph 3 of the Allegation, based on his own standard practice and genuine recollection, albeit the Tribunal had rejected it on the balance of probabilities.

120. Mr Smith submitted that there was no evidence of a lack of insight and again reminded the Tribunal of the isolated nature of this incident. He stated that Dr Varghese had reflected and remediated. He submitted that Dr Varghese was an otherwise unimpeachable practitioner who had never received any similar complaints and who would never repeat these actions.

121. In summary, Mr Smith submitted that it is accepted that the matters found proved do amount to misconduct but that the rejected defence should not be held against Dr Varghese. Dr Varghese's fitness to practise is not impaired. The need uphold proper professional standards and public confidence would not be undermined with a finding of no impairment.

The Relevant Legal Principles

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

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

124. The Tribunal must determine whether Dr Varghese's fitness to practise is impaired today, taking into account his 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.

125. The Tribunal reminded itself that dishonesty can be difficult to remediate and that it would be an unusual case in which a finding of dishonesty did not lead to a finding of impaired fitness to practise. The Tribunal reminded itself that in dishonesty cases it is particularly important to give appropriate consideration and weight to the second and third limbs of the over-arching objective.

126. The Tribunal considered the submissions made and the legal authorities provided by the parties regarding the matter of rejected defence and insight.

The Tribunal's Determination on Impairment

127. The Tribunal reminded itself that the primary fact in this case is that Dr Varghese retrospectively added 'LARGE Excision' to Patient A's consent form, and that he admitted this from the outset.

128. Dr Varghese denied that he had not discussed this risk with Patient A and denied knowing that the amendment was not included on her copy of the consent form. The Tribunal rejected this and determined that it was more likely that he had not discussed the risk and knew that he was only amending the hospital copy of the consent form.

129. The Tribunal noted the submission by the GMC regarding the breaches of principles set out in GMP. The Tribunal accepted that its finding of dishonesty represented a breach of paragraphs 65, 68 and 71 as set out above. However, it was required to consider whether or not Dr Varghese's evidence amounted to a lie, and therefore a breach of paragraph 72.

130. The Tribunal noted the submission by Mr Smith, that Dr Varghese's defence was that he had put the GMC to proof and that his evidence was based on his recollection of events and his normal practice rather than being a false or misleading account.

131. The Tribunal considered that during his evidence, Dr Varghese had not, at any point, sought to blame Patient A or say that she was lying.

132. The Tribunal considered that Dr Varghese's defence was an alternative explanation of what occurred, largely based on his standard practice. Although, the Tribunal had found his explanations to be incredible, it accepted that this was not the same as being deceitful or telling an out and out lie. It therefore did not consider that the principle set out at paragraph 72 of GMP had been breached.

133. Having considered the submissions and the relevant principles in the legal authorities, particularly the four principles set out by Mrs Justice Collins Rice in *Sawati*, the Tribunal accepted that Dr Varghese was entitled to defend himself against the allegation.

134. The Tribunal considered the questions posed by Mrs Justice Collins Rice at paragraph 108 of her judgement:

> '*Was it a blatant and manufactured lie, a genuine act of dishonesty, deceit or misconduct in its own right? Did it wrongly implicate and blame others, or brand witnesses giving a different account as deluded or liars? Or was it just a failed attempt to tell the story in a better light than eventually proved warranted?*'

135. The Tribunal considered Dr Varghese's defence to be more appropriately categorised as a failed attempt to tell his story in a better light than eventually proved warranted.

136. The Tribunal therefore determined that no weight should be attached to Dr Varghese's denial of dishonesty in these proceedings when considering his insight.

Misconduct

137. The Tribunal noted that the expert, Dr H, was of the opinion that Dr Varghese's actions in retrospectively amending Patient A's consent form fell seriously below the standards expected of a competent consultant dermatologist. Mr Smith accepted this and did not seek to suggest otherwise.

138. The Tribunal found no reason to disagree with the opinion of the expert and determined therefore that Dr Varghese's actions in this respect amounted to serious professional misconduct.

139. The Tribunal considered the submissions made in regard to dishonesty. It noted that Mr Smith accepted that dishonesty was misconduct which was 'serious and grave'.

140. The Tribunal reminded itself of its determination on the facts and the likely motive it found for Dr Varghese's actions. It noted the submission by Mr Smith that Dr Varghese did not, in any event, come to rely on the amended consent form when the complaint was made.

141. However, the Tribunal took the view that, based on its findings at the facts stage, Dr Varghese knew that the amendment was not on Patient A's copy of the form and was dishonest in this regard. This meant that he was able to rely on the amended hospital copy in the knowledge that the amendment had been made and that if those dealing with any complaint were to look at the document, it would falsely show that the risk of a large excision had been discussed.

142. The Tribunal accepted that there was no financial benefit arising from Dr Varghese's dishonesty, However, it was of the view that, if Patient A had not compared the patient copy with the hospital copy, Dr Varghese would have continued to benefit from the dishonest amendment. This was because it would have meant that any complaint made by Patient A would have been considered on the basis that she had consented to the risk of a large excision when this was not the case. It was only because Patient A, after making her complaint, was able to compare her own copy of the consent form with the hospital copy that the dishonest conduct was identified.

143. The Tribunal therefore took the view that there was no requirement for Dr Varghese to have expressly relied upon the amendment to have benefitted from it. The Tribunal considered that this is an aspect of his misconduct about which Dr Varghese has shown no, or little, insight, and it took this into account in considering impairment.

144. The Tribunal concluded that Dr Varghese's dishonesty fell far short of the standards reasonably to be expected of a doctor so as to amount to serious professional misconduct.

Impairment

145. The Tribunal having found that the facts found proved amounted to serious professional misconduct, went on to consider whether, as a result, Dr Varghese's fitness to practise is currently impaired.

146. The Tribunal had regard to the considerations set out in the case of *Cohen* as to whether the actions were remediable, had been remedied and the likelihood of repetition.

147. The Tribunal acknowledged that dishonesty is difficult, although not impossible, to remediate.

148. The Tribunal noted the evidence of remediation submitted by Dr Varghese. It considered that the steps taken to remediate are of themselves positive, particularly regarding paragraph 2 of the Allegation regarding the amendment to the consent form.

149. The Tribunal had regard to Dr Varghese's reflective statement and noted the courses he has attended. In particular it noted that he has undertaken coursework targeted at consent, good practice in recordkeeping and in handling complaints from patients and that he has undertaken a bespoke one-to-one ethics course. The Tribunal was satisfied that this is likely to have had a positive impact on the risk of repetition.

150. The Tribunal considered that Dr Varghese has demonstrated insight with regard to amending the consent form, having noted the remediation undertaken and the several changes he has made to his practice to minimise the risk of the same thing happening again.

151. The Tribunal was of the view that Dr Varghese has demonstrated sufficient insight for it to conclude that the likelihood of him inappropriately amending a consent form again in the future is low.

152. However, the Tribunal was of the view that Dr Varghese has not demonstrated sufficient insight into his dishonesty.

153. The Tribunal noted that Dr Varghese continues to maintain that he did not act dishonestly. It took the view that, in his reflective statement, he acknowledged that the retrospective addition led to his probity being called into question and expressed regret in making the amendment. However, the Tribunal could find no evidence to suggest that

he understands why such actions might be considered dishonest by others, nor why they have ultimately led to a finding of dishonesty against him.

154. The Tribunal accepted the submission by Mr Smith that this issue was an isolated one in an otherwise unblemished career and that Dr Varghese's probity has never been called into question before or since.

155. However, the Tribunal concluded that Dr Varghese continues to lack insight into why his actions were dishonest.

156. Considering the test set out in *Grant*, the Tribunal determined that Dr Varghese has brought the medical profession into disrepute, has breached one of the fundamental tenets of the medical profession, and that he has acted dishonestly.

157. The Tribunal could not be satisfied that, if faced with a similar situation when he is under pressure, Dr Varghese would not resort to being dishonest. It therefore determined that there remains a risk of repetition.

158. The Tribunal determined that a finding of impairment is required to uphold proper standards and maintain public confidence in the profession.

159. The Tribunal determined that Dr Varghese's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 01/12/2022

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

The Evidence

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

Submissions

On behalf of the GMC

162. Ms Widdett reminded the Tribunal that in reaching a decision on sanction, it should have regard to the Sanctions Guidance ('SG'). She noted that the Tribunal had determined that Dr Varghese's misconduct undermined public confidence in the medical profession and did not uphold proper professional standards and conduct.

163. Ms Widdett reminded the Tribunal that it had found Dr Varghese's actions to have breached the principles set out in paragraphs 65, 68 and 71 of *Good medical practice* ('GMP'). She drew the Tribunal's attention to the fact that falsifying or improperly amending patient records was an example of dishonesty set out in the SG.

164. Ms Widdett stated that the Tribunal must consider and balance any mitigating factors against the central aim of sanctions.

165. Ms Widdett stated that the Tribunal had already determined that Dr Varghese had not shown insight into why his actions were dishonest. In addition, she submitted that he had not accepted he should have behaved differently, had not apologised at an early stage before the hearing, and had not demonstrated timely development of insight into his dishonesty.

166. In terms of mitigating factors, Ms Widdett accepted that Dr Varghese is of previous good character and that there was a significant lapse of time of three and a half years since the incident occurred.

167. Turning to aggravating factors, Ms Widdett submitted that the SG stated the importance of considering a lack of insight when determining sanctions. She submitted that Dr Varghese's lack of insight into why his actions were dishonest is an aggravating factor. Furthermore, he had not apologised for his mistakes and his remediation was undertaken shortly before this hearing.

168. Ms Widdett submitted that there are no exceptional circumstances to justify taking no action and that conditional registration would not be appropriate or workable given Dr Varghese's lack of insight.

169. Ms Widdett submitted that an order of suspension would be an appropriate response in that it would have a deterrent effect and would send a signal to Dr Varghese, the profession and the public about what is considered behaviour unbefitting of a doctor.

170. Ms Widdett submitted that suspension would be an appropriate response and that any sanction lower would be insufficient to maintain public confidence in the profession.

171. Ms Widdett submitted that, in determining the length of any suspension, the Tribunal should ensure Dr Varghese has sufficient time to develop insight into his dishonesty.

172. Ms Widdett drew the Tribunal's attention to paragraph 97g of the SW which states that a Tribunal must be satisfied that a doctor has insight and does not pose a significant risk of repeating the behaviour. She stated that the Tribunal would need to address this matter if it determines that suspension is an appropriate sanction.

On behalf of Dr Varghese

173. Mr Smith reminded the Tribunal that its purpose is to promote the public interest objectives namely the promotion and maintenance of public confidence in the medical profession and upholding proper professional standards. He pointed out that there have been no concerns about patient safety in this case.

174. Mr Smith stated that the Tribunal should bear in mind the negative impact on the public of any sanction it imposes. He submitted that removing Dr Varghese from practice for any length of time would result in increased waiting times for treatment of skin cancer for patients in East Somerset and Dorset.

175. Mr Smith stated that the NHS was in a very difficult situation following the pandemic, especially in rural and semi-rural areas where there are fewer doctors.

176. Mr Smith acknowledged that this was a case where the Tribunal were unlikely not to take any action and that imposing conditions would not address the type of impairment found.

177. Mr Smith stated that the next more serious sanction was suspension. He submitted that the Tribunal need not go any further.

178. Mr Smith reminded the Tribunal of the need for proportionality. He noted that the SG mentions the need to balance the interests of the doctor with the interests of the public. He stated that this rather oversimplifies matters as these interests pull in opposite directions. He submitted there is a public interest in a doctor not being prevented from practising.

179. Mr Smith submitted that the Tribunal should also take into account the effect of suspension on Dr Varghese. It will have a financial detriment since he will not be able to work. XXX.

180. Mr Smith submitted that Dr Varghese does have insight and has addressed ways in which he can avoid patients not properly understanding the outcome of the consent process. He has demonstrated that he understands the need for better record keeping and that the retrospective amending of a consent form is not acceptable.

181. Mr Smith reminded the Tribunal of what Mr Justice Mostyn said in the case of *Towuaghantse v General Medical Council (Rev 2) [2021] EWHC 681 (Admin)* at paragraph 63:, '*In my judgment, it is not procedurally fair for a registrant to face the risk of enhanced sanctions by virtue of having robustly defended allegations made against him before the MPT or before another court.*'

182. Mr Smith reminded the Tribunal that Dr Varghese's defence should not count against him. It had already determined that he had not told blatant lies.

183. Mr Smith submitted that it was wrong for the GMC to say that Dr Varghese had not apologised to Patient A. He drew the Tribunal's attention to the doctor's first witness statement at paragraph 59 where he had expressed an apology.

184. Mr Smith acknowledged that the Tribunal had found there to be a risk of repetition but that the risk of inappropriately amending a consent form was low. He reminded the Tribunal that there had never before been any concerns about Dr Varghese's honesty and that the testimonials show this to be completely out of character. He reminded the Tribunal this this was a single, isolated incident in an otherwise unblemished career.

185. Mr Smith submitted that the evidence showed a high level of patient satisfaction with Dr Varghese's work. He also pointed out that the incident was three and a half years ago with no repetition.

186. Mr Smith stated that the only aggravating feature suggested by the GMC was lack of insight which should not be considered if based solely on the rejected defence.

187. Mr Smith submitted that the deterrent effect of a suspension did not require a lengthy period being imposed. The mere fact of a suspension, taken with the Tribunal's finding of misconduct, would be enough to send the necessary signal regarding this behaviour. He submitted that Dr Varghese did not require any form of remediation or rehabilitation.

188. Mr Smith submitted that it would be wrong to assume that after reflecting further, Dr Varghese would have a 'Damascene conversion' and suddenly admit to lying. He stated that there was no need for Dr Varghese to do that in order to satisfy a Tribunal that there was no need for further sanction. He submitted that any suspension imposed should send the required signal without requiring Dr Varghese to change his beliefs.

189. Mr Smith drew the Tribunal's attention to the SG where it sets out relevant factors to consider when determining the length of suspension to impose. He submitted that a suspension of one month would be a proportionate response to the Tribunal's findings.

190. Mr Smith stated that there was no requirement for a review since there were no concerns about Dr Varghese's current practice. A review, he submitted would be a pointless use of resources and money.

191. Mr Smith submitted that whilst some dishonesty cases justify a sanction of erasure there are factors which mean this is not such a case: the isolated nature of the dishonesty; Dr Varghese's unblemished career; the lack of financial benefit; and no patient harm.

The Tribunal's Approach

192. The Tribunal reminded itself that the submissions made were only to assist in its decision making. It was not bound by them and the decision on what sanction, if any, to impose was one for it to determine.

193. There is no burden or standard of proof at this stage. The decision as to sanction is a matter for the Tribunal exercising its independent judgement.

194. The Tribunal had regard to the current version of the SG including the guidance on the approach it should take and the sanctions available to it.

195. The Tribunal noted that the main purpose of imposing a sanction is to protect the public. Its purpose is not to punish, although it may have a punitive effect. When imposing a sanction, it must be proportionate and the Tribunal must impose the least restrictive sanction necessary.

The Tribunal's Determination on Sanction

Aggravating and Mitigating Factors

196. In approaching its decision on sanction, the Tribunal first considered whether there were any aggravating factors. It had regard to the examples given in the SG. The Tribunal did not find any aggravating factors in this case.

197. The Tribunal noted the submission by the GMC that Dr Varghese's lack of insight into his dishonesty was aggravating. It also had regard to the response by Mr Smith and the guidance provided in the legal authorities which were submitted at the impairment stage regarding rejected defences.

198. The Tribunal acknowledged Dr Varghese's right to defend the allegation of dishonesty. It therefore did not consider any lack of insight regarding dishonesty in doing so to be an aggravating factor. However, the Tribunal considered Dr Varghese's lack of insight as to his dishonesty to be a significant feature of this case.

199. The Tribunal gave consideration to the examples of mitigating factors set out in paragraph 25 the SG. The Tribunal found the following factors which it considered to be mitigating:

- *'Evidence that the doctor understands the problem and has insight, and of their attempts to address or remediate it. This could include the doctor admitting facts relating to the case, apologising to the patient, making efforts to prevent behaviour recurring…'.* The Tribunal acknowledged that Dr Varghese had shown insight into his actions in retrospectively amending the consent form. It also considered that he had fully remediated this aspect of his misconduct through the reflection and targeted learning he has

undertaken. It also noted that he has expressed regret and apologised for retrospectively amending the consent form.

- *'Lapse of time since an incident occurred'.* The Tribunal noted that the incident involving Patient A occurred more than three years ago.

- *'Evidence that the doctor is adhering to important principles of good practice (ie keeping up to date, working within their area of competence), and of the doctor's character and previous history…'.* The Tribunal acknowledged Dr Varghese's previously unblemished record, the testimonials he has provided, and that there has been no repetition of the misconduct.

- The Tribunal noted that the testimonials and references speak highly of Dr Varghese and demonstrate that he is clearly well thought of by patients, colleagues and friends.

No action

200. The Tribunal was mindful that taking no action was only appropriate where there were exceptional circumstances to justify it doing so. The Tribunal did not consider there to be exceptional circumstances in this case.

Conditions

201. The Tribunal noted that conditions are particularly relevant when addressing deficiencies in performance or knowledge of the English language. They are less likely to be appropriate in addressing findings of misconduct, particularly when dishonesty is involved. The Tribunal took the view that it would not be possible to formulate workable conditions to adequately address the dishonesty that has been found proved, nor would it be a proportionate response in addressing the public interest factors in this case.

Suspension

202. The Tribunal noted that both parties were in agreement that suspension would be an appropriate and proportionate response in this case. It reminded itself of the relevant paragraphs of the SG.

203. The Tribunal noted the SG at paragraph 91: *'Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor…'.* The Tribunal took the view that in a case such as this, where there are no patient safety concerns, but where a sanction was required to uphold proper standards and maintain public confidence in the profession, a period of suspension may be an appropriate response.

204. It considered the guidance at paragraph 92: *'…A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration…'*. The Tribunal gave consideration to the fact that whilst dishonesty is a serious matter, this was an isolated, single occurrence of dishonesty in an otherwise unblemished career. It was satisfied that Dr Varghese's dishonesty was not of sufficient seriousness to be considered as fundamentally incompatible with continued registration.

205. The Tribunal had regard to paragraph 97 of the SG which sets out factors that, where present, may indicate that suspension is an appropriate response. The Tribunal identified the following to be relevant in this case:

> *'a) A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors*
>
> *[…]*
>
> *e) No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> *f) No evidence of repetition of similar behaviour since incident*.'

206. The Tribunal considered that 97e was relevant as Dr Varghese had demonstrated that he had remediated his misconduct regarding paragraph 2 of the Allegation.

207. The Tribunal noted that the SG states that *'Dishonesty, especially where persistent and/or covered up'* may indicate erasure as being the appropriate sanction. However, the Tribunal decided that the dishonesty in this case was neither persistent nor covered up. The Tribunal considered that the other indicators in the SG pointing towards erasure were not satisfied in this case.

208. Having considered these factors, the Tribunal considered Dr Varghese's misconduct to be serious enough to justify imposing a period of suspension.

209. Further, the Tribunal was satisfied that a period of suspension was the appropriate and proportionate response in this case, taking into account both Dr Varghese's interests and the public interest.

210. In determining the length of suspension the Tribunal had regard to the SG, the submissions made by parties and to its own findings.

211. The Tribunal took into account that Dr Varghese has already fully remediated the misconduct at paragraph 2 of the Allegation.

212. The Tribunal took into account the evidence from Dr Varghese's current employers that his service is required to help meet the demand for his speciality, and the impact on patients of Dr Varghese being unable to practise. It weighed this factor in the balance along with the seriousness of its findings, the need to properly address the misconduct and to satisfy the public interest limbs of the overarching objective.

213. The Tribunal took the view that, given its findings that Dr Varghese has not yet gained insight into his dishonest conduct, that he needs time to be able to reflect further and demonstrate that he understands the importance of honesty and probity required of medical professionals and why dishonesty can undermine confidence in the profession.

214. Considering all of the factors together, the Tribunal determined that suspension for a period two months would be an appropriate and proportionate response to the misconduct found.

215. The Tribunal determined that two months was an appropriate and proportionate period to send a signal to Dr Varghese, the profession and the wider public that his actions were unacceptable and should never be repeated. It would adequately satisfy the public interest limbs of the overarching objective.

216. The Tribunal was of the view that, having identified a risk of repetition and a lack of full insight into why he had been found to be dishonest, Dr Varghese's suspension should be subject to a review.

217. The Tribunal noted that Dr Varghese has very recently completed a bespoke ethics course. The Tribunal considered that the period before the review is likely to be sufficient to enable Dr Varghese to reflect on the Tribunal's findings of dishonesty.

218. The Tribunal therefore determined to direct a review of Dr Varghese's case. A review hearing will convene shortly before the end of the period of suspension.

219. The Tribunal makes it clear that at the review hearing, the onus will be on Dr Varghese to demonstrate that he has developed insight into why his actions were considered dishonest. It is entirely a matter for Dr Varghese as to how he does this, but it may assist the reviewing Tribunal if Dr Varghese were to provide:

- A statement reflecting on the Tribunal's findings on dishonesty. This may include the potential impact on patients and public confidence in the medical profession.

- Any other information or evidence which Dr Varghese considers may assist.

Determination on Immediate Order - 01/12/2022

220. Having determined that Dr Varghese's registration should be suspended for two months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order of suspension.

Submissions

221. On behalf of the GMC, Ms Widdett submitted that there is no need for an immediate order in this case but that it is a matter for the Tribunal. She referred the Tribunal to the relevant paragraphs in the SG. Ms Widdett accepted that there were no patient safety concerns in this case.

222. On behalf of Dr Varghese, Mr Smith agreed with the submission made by Ms Widdett and submitted that an immediate order was not necessary in this case.

Relevant Legal Principles

223. The Tribunal's attention was drawn to paragraphs 172 and 173 of the SG which state:

> *'172. The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173. An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.'*

The Tribunal's Decision

224. The Tribunal noted that both parties were in agreement that an immediate order was not required. The Tribunal accepted that there are no patient safety concerns and that an immediate order in the wider public interest was not required.

225. The Tribunal was satisfied that it was not in the public interest, nor in Dr Varghese's best interests to impose an immediate order.

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

227. There is no interim order to revoke.

ANNEX A – 28/11/2022
Application to amend the Allegation under Rule 17(6)

228. At the outset of the hearing, the Tribunal raised a matter regarding paragraph 2 of the Allegation.

229. In the Allegation, paragraph 2 referred to a section on the patient consent form called 'Significant, unavoidable or frequently occurring risks, or risks patient thinks important'. However, the Tribunal noted that the section on the form itself was titled 'Any significant, unavoidable or frequently occurring risks, or risks patient thinks important'.

230. On behalf of the GMC, Ms Widdett, made an application pursuant to Rule 17(6) to amend the Allegation accordingly.

231. On behalf of Dr Varghese, Mr Smith submitted that the amendment was not opposed.

232. The Tribunal reminded itself that it may amend the Allegation in accordance with Rule 17(6) and that it should consider whether doing so would cause any injustice to Dr Varghese.

233. Having looked at the evidence and considering that the application to amend the Allegation was not opposed by Dr Varghese, the Tribunal took the view that the amendment could be made fairly to properly reflect the documentation.

234. Paragraph 2 of the Allegation therefore is amended to the following:

2. You retrospectively amended the hospital copy of the consent form 'Patient agreement to investigation or treatment' dated 6 March 2019 ('the Consent Form') to include 'LARGE EXCISION' under the section 'Any significant, unavoidable or frequently occurring risks, or risks patient thinks important'.

ANNEX B – 28/11/2022
Application to admit further evidence under Rule 34(1)

235. At the outset of the hearing, Mr Smith made an application on behalf of Dr Varghese that good character evidence in the form of testimonials be admitted at Stage 1 of proceedings, pursuant to Rule 34(1) of the Rules.

Submissions

236. Mr Smith provided submissions to the Tribunal in writing and made oral representations at the hearing.

237. Mr Smith submitted that testimonial evidence of Dr Varghese's good character is relevant and particularly pertinent in a case such as this where dishonesty is alleged by the GMC. He submitted that it is well established in case law that it should be admitted.

238. Mr Smith referred to the cases of *Donkin v Law Society [2007] EWHC 414 (Admin), Bryant v Law Society [2007] EWHC 3043 (Admin), Wisson v Health Professionals Council [2013] EWHC 1036 (Admin)* and *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*. He submitted that these authorities demonstrated the approach that should be taken to evidence of good character in dishonesty cases.

239. Mr Smith, noted the recent example of *Khan v General Medical Council [2021] EWHC 374 (Admin)* in which reliance was placed on *Wisson* and *Donkin* in confirming the relevance of good character especially where credibility was in issue.

240. Mr Smith submitted that it was surprising, in light of the authorities and its usual practice, that the GMC opposed the inclusion of testimonial evidence at Stage 1 in this case.

241. Mr Smith invited the Tribunal to admit the good character evidence as it is relevant to the issues to be considered and fair to do so. He submitted that not doing so would amount to a serious procedural error which would amount to an error of law.

242. On behalf of the GMP, Ms Widdett submitted that it did not dispute that Dr Varghese is of good character as he had no previous criminal or regulatory findings against him. Ms

Widdett accepted that good character can be a relevant factor for the Tribunal to consider in determining the issues at the facts stage.

243. However, Ms Widdett submitted that the testimonial evidence itself is not relevant at this stage in the light of the GMC's acceptance that Dr Varghese is of good character. She submitted that the Tribunal can take good character into account in accordance with the case law without seeing the detail contained in the testimonials as they add no value. The doctor, she submitted, either has good character or he does not. If he does, then he is entitled to a good character direction and there is no need for the testimonial evidence to be admitted at this stage as it is not relevant.

244. In response, Mr Smith submitted that the issue of good character is not a binary concept as suggested by Ms Widdett. He submitted that it goes beyond the mere statement that there are no previous findings against the doctor. He submitted that the testimonial evidence is relevant because it speaks to Dr Varghese's probity, propensity and credibility which the Tribunal is entitled to consider. He pointed out that at paragraph 21 of the judgement in *Donkin* that the Tribunal was criticised for having made no reference to the *'cogent evidence of positive good character'* when setting out their findings on dishonesty.

245. Mr Smith submitted that the Tribunal is not limited to considering the fact of good character but can also consider the quality of the good character evidence.

The Tribunal's decision

246. In reaching its decision, the Tribunal had regard to Rule 34(1) and the authorities submitted by Mr Smith. The Tribunal did not have sight of the disputed evidence at this stage.

247. Having considered the authorities provided by Mr Smith, the Tribunal noted that, in a case involving dishonesty such as this, it may be required to consider good character, and the weight to be attached to it, in assessing credibility and propensity at the facts stage. The Tribunal considered that, in order to decide the weight to be attached it might be necessary to assess its quality as was, for example, done in the case of *Donkin*.

248. The Tribunal therefore determined that the details of the good character as evidenced in the form of testimonials is relevant to the issues it has to determine at the

facts stage. The Tribunal was of the view that the case law was clear that testimonial evidence was relevant and admissible in these types of cases at stage 1 of the proceedings.

249. The Tribunal noted that the GMC did not suggest that the evidence would be prejudicial to its case, only that it considered it irrelevant. The Tribunal decided there would be no unfairness to the GMC in admitting the evidence.

250. Therefore, the Tribunal determined that it was fair and relevant for the testimonial evidence to be admitted at this stage in the proceedings.

ANNEX C – 28/11/2022

251. Following the handing down of the Tribunal's determination on the facts, and after he had read the determination, Mr Smith asked for clarification of an issue he had raised in submission on the facts and which had been subject of a discussion at the end of that submission. The submission concerned what Patient A was told by Dr Varghese about the size of the excision at the consultation on 21 November 2018.

252. Mr Smith's submission was that the risk of a large excision was something that Patient B was warned about by Doctor Varghese at the consultation on 21 November 2018. When discussed immediately following the submission (and before the Tribunal's consideration of the facts), Mr Smith did not dispute the Chair's note of Patient A's evidence in cross-examination which was:

Question: *'In effect, that you may need a larger excision?'*

Answer: *'Yes after examination under the microscope'.*

Mr Smith's submission was that this answer supported Dr Varghese's claim that a large excision was discussed at the first consultation.

253. The Tribunal reminded itself of paragraphs 27-43 of its determination on facts which deal with the consultation. The Tribunal has given further consideration to Mr Smith's submissions and the evidence.

254. The Tribunal reminded itself of Patient A's evidence. It considered the above answer from Patient A in the context of the previous question and answers which were about the size of the lesion. Then the Chair's note records the sequence of questions and answers as follows (including again the above question and answer for ease)

Question: *'There is no evidence of the size of the excision around it – Dr Varghese took only a small margin of tissue?*

Answer: *'That is not true'*

Question: *'….the leaflet given when you first saw Dr Varghese says it is sometimes larger….. Dr Varghese told you this?'*

Answer: *'Yes'*

Question: *'In effect, that you may need a larger excision?'*

Answer: *'Yes after examination under the microscope'.*

255. The Tribunal considered that Patient A was being asked about the leaflet which she did not read until after the consultation. It also considered that Patient A was talking about the size of the excision relative to the lesion and the amount of tissue being removed, rather than the size of the resulting excision itself.

256. The Tribunal was satisfied that overall Patient A's evidence about the consultation was that Dr Varghese did not advise her that there may be a large excision of the size which was the eventual result of the procedure. The Tribunal was satisfied that paragraphs 27-43 of its determination on the facts accurately reflects its findings of fact regarding the first consultation.

257. The Tribunal noted that in subsequent answers Patient A was emphatic that Dr Varghese had never informed her of the risk of a large excision.