PUBLIC RECORD

Dates: 25/04/2022 - 29/04/2022

Medical Practitioner's name:	Dr Kadiyali SRIVATSA
GMC reference number:	3371349
Primary medical qualification:	MB BS 1981 Bangalore

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

Summary of outcome
Erasure

Immediate order imposed

Tribunal:

Lay Tribunal Member (Chair)	Mrs Joy Hamilton
Medical Tribunal Member:	Dr Michelle Taggart
Medical Tribunal Member:	Dr Julius Parker

Legal Assessors:	Ms Judith Walker (25-27 April 2022) Mr Patrick Cox (27-29 April 2022)
Tribunal Clerk:	Ms Maria Khan

Attendance and Representation:

Medical Practitioner:	Not present and not represented
Medical Practitioner's Representative:	N/A
GMC Representative:	Ms Katie Jones, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 27/04/2022

Background

1. Dr Srivatsa qualified in 1981 with an MBBS from Bangalore, India. The Tribunal has not been provided with a formal CV for Dr Srivatsa but in his responses to Oxford Health NHS Foundation Trust ('the Trust'), he mentions that he had worked in the UK since 1983 *"in acute and intensive care before retraining as a GP".*

2. The allegation that has led to Dr Srivatsa's hearing can be summarised as follows: Dr Srivatsa worked for Oxfordshire Urgent Care Services as a locum GP. In an email, dated 14 July 2020, Dr I, Medical Advisor to the GP out of hours ('OOH') service, at the Trust, referred Dr Srivatsa to the GMC following concerns raised about Dr Srivatsa's clinical practice. The first two concerns, raised by Dr Srivatsa's clinical colleagues, related to two incidents that took place on 16 May 2020 (Patient A) and 18 May 2020 (Patient B) in relation to alleged poor note keeping and a prescription request. The third concern was referred by Dr I to the GMC on 20 July 2020. As a result of the concerns raised, the Trust reviewed 15% of Dr Srivatsa's cases to ascertain whether there were any ongoing performance issues and decided to analyse eight of Dr Srivatsa's telephone consultations using a Royal College of General Practitioners ('RCGP') modified template. The minimum acceptable score for record keeping is 16, and Dr Srivatsa's score, based on the cases examined, was 11.38. As a result, the Trust decided to terminate his contract as a locum GP.

3. On 21 July 2020, Dr I forwarded a fourth concern to the GMC, following a complaint raised by the father of a 14 month old boy (Patient D) subsequent to a consultation which took place on 24 May 2020. This related to concerns around Dr Srivatsa's alleged instant diagnosis without an assessment, and of inadequate clinical examination, and Dr Srivatsa's behaviour towards the patient's mother.

<u>Patient A</u>

4. On 16 May 2020, Dr Srivatsa attended a consultation with Patient A, a 43 year old male, who presented with a groin swelling. He had injected heroin 10 days previously. The left groin and the top of his left leg had become swollen, with significant pain.

Patient B

5. On 18 May 2020, Dr Srivatsa conducted a telephone consultation with Patient B, a 54 year old male who had a history of prostate cancer and was taking Oramorph for groin pain, and had presented with an inability to pass urine.

Patient C

6. Patient C's sister undertook a telephone consultation with Dr Srivatsa on 23 May 2020 in relation to her concerns about Patient C's use of cocaine.

Patient D

7. Dr Srivatsa undertook a face to face consultation with Patient D, a child aged 14 months, on 24 May 2020, after an initial triage telephone consultation during which Patient D's mother was advised to bring him in. Patient D had an acute illness, was at risk of deterioration, and his parents needed advice on how to manage his symptoms.

Patient E

8. Dr Srivatsa undertook a face to face consultation with Patient E, with a parent, on 24 May 2020. Patient E was suffering with groin and abdominal pain. It is alleged that Dr Srivatsa gave a diagnosis of a urinary tract infection ('UTI') without obtaining a urine sample. The family consulted a family member who is a urologist, and their GP, for a second and third opinion and both concluded this diagnosis could not be made without at least carrying out a urine test.

Patient F

9. Patient F was aged 60 and had a painful swollen leg. He undertook a telephone consultation with Dr Srivatsa on 24 May 2020.

Patient G

10. Dr Srivatsa conducted a telephone consultation with Patient G's mother. Patient G was aged six at the time of this consultation.

Patient H

11. Dr Srivatsa undertook a face to face consultation with Patient H. When consulting with Patient H on 24 May 2020, it is alleged that Dr Srivatsa performed a testicular

examination but did not record any details of offering the patient a chaperone or make adequate notes of the consultation.

The Outcome of Applications Made during the Facts Stage

12. On 25 and 26 April 2022, the Tribunal granted the GMC's applications, made pursuant to Rule 17(6) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), for the amendment of the Allegation. Ms Jones, Counsel on behalf of the GMC, asked the Tribunal to amend the Allegation to correct a number of typographical errors in respect of the numbering, anonymisation of the patients listed within the Allegation, as well as the correction of some of the wording. In response to a query raised by the Tribunal in respect of paragraph 2b(ii) and (iii), the GMC invited the Tribunal to delete the words *'carry out'* and replace these with *'arrange'*. The Tribunal considered that these amendments could be made without any injustice to the doctor and so agreed to them. The amendments were then included in the Allegation, as set out in full below.

13. The Tribunal, on 25 April 2022, also granted the GMC's application, made pursuant to Rules 15, 40 and 31 of the Rules, that notice had been properly given to Dr Srivatsa and that it would be appropriate to proceed with the hearing in his absence. The Tribunal's full decision on the application is included at Annex A.

14. In response to a question raised by the Tribunal, Ms Jones provided clarification about the approach which the GMC suggested the Tribunal should adopt when considering the paragraphs within the Allegation. She stated that a number of the paragraphs were alternatives, explaining that if the Tribunal found one aspect of an alternative proved , the other may fall away.

Ms Jones provided a list of the alternative paragraphs as follows:

1. Charge 1.c.i-v is in the alternative to charge 1.a.i.-v. and charge 1.c.vi. is in the alternative to charge 1.b.;
2. Charge 2.e.i-iii is in the alternative to charge 2.a.i.-v.;
3. Charge 2.e.iv. is in the alternative to charge 2.d.;
4. Charge 2.e.v. is not in the alternative (as this relates specifically to pain relief medication, not treatment for cancer, which is not specifically charged at 2.a.);
5. Charge 4.c. is in the alternative to charges 4.a. and 4.b.;
6. Charge 5.b.is in the alternative to charge 5.a.;
7. Charge 6.e.i. is in the alternative to charge 6.a.;
8. Charge 6.e.ii. is in the alternative to charge 6.c.;
9. Charge 6.e.iii. is in the alternative to charge 6.d.;
10. Charge 7.b. is in the alternative to charge 7.a.;
11. Charge 8.c.iii. is in the alterative to charge 8.a.;
12. Charge 8.c.iv. is in the alternative to charge 8.a.;
13. Charge 8.c.v. is in the alternative to charge 8.b.

The Tribunal agreed this was the appropriate approach to the allegation and applied it to its consideration of the relevant paragraphs.

The Allegation and the Doctor's Response

15. The Allegation made against Dr Srivatsa is as follows:

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

1. On or around 16 May 2020 Patient A attended a consultation with you. You failed to provide good clinical care to Patient A in that you did not:

    a. adequately examine the:

        i. approximate size of the groin lump;
        To be determined

        ii. presence or absence of redness, swelling and warmth;
        To be determined

        iii. extent of swelling in Patient A's leg;
        To be determined

        iv. presence or absence of scrotal swelling;
        To be determined

        v. presence or absence of inguinal lymph nodes;
        To be determined

    b. adequately assess Patient A's temperature;
    To be determined

    c. adequately record in Patient A's records the:

        i. approximate size of the groin lump;
        To be determined

        ii. presence or absence of redness, swelling and warmth;
        To be determined

        iii. extent of swelling in Patient A's leg;
        To be determined

        iv. presence or absence of scrotal swelling;
        To be determined

v. presence or absence of inguinal lymph nodes;
To be determined

vi. temperature of Patient A;
To be determined

d. consider an adequate differential diagnosis of:

i. injection site infection;
To be determined

ii. deep vein thrombosis.
To be determined

2. On or around 18 May 2020 Patient B consulted with you over the telephone. You failed to provide good clinical care in that you did not:

a. take an adequate medical history of Patient B's:

i. prostate cancer including the extent and spread of the cancer, any complications and current treatment;
To be determined

ii. pain including the type and severity of pain;
To be determined

iii. constipation including the duration and severity of constipation, food and fluid intake, when a bowel movement was last passed, the presence or absence of abdominal pain, and the presence or absence of vomiting;
To be determined

iv. urinary symptoms including when he last passed urine and whether he had any suprapubic pain;
To be determined

v. previous treatment required when taken to hospital with similar symptoms in the past;
To be determined

b. adequately assess Patient B in that you did not:

i. arrange a face to face consultation for Patient B to be seen as a priority;
To be determined

ii. ~~carry out~~ arrange an abdominal examination to check for bladder distention;
Amended under Rule 17(6)
To be determined

~~ii~~ iii. ~~carry out~~ arrange an abdominal and rectal examination to check for abdominal masses and rectal impaction;
Amended under Rule 17(6)
To be determined

c. record an adequate diagnosis in that you did not consider:

i. other causes of Patient B's urine retention;
To be determined

ii. other causes of Patient B's constipation;
To be determined

d. put in place an adequate or appropriate treatment plan for urinary retention;
To be determined

e. make an adequate record of:

i. an adequate history of Patient B's presenting symptoms as set out at paragraph 2a;
To be determined

ii. a past medical history;
To be determined

iii. a medication history;
To be determined

iv. an adequate management plan;
To be determined

v. details of Patient B's prescribed Oramorph treatment.
To be determined

3. On 23 May 2020 you undertook a telephone consultation with Patient C's sister and failed to put in place an adequate or appropriate treatment plan in that you did not give advice on sources of help and information for problem drug use.
To be determined

4. On or around 24 May 2020 Patient D attended a consultation with you, along with his mother. You failed to provide good clinical care in that you did not:

   a. assess Patient D's:

      i. temperature;
      To be determined

      ii. heart rate;
      To be determined

      iii. respiratory rate;
      To be determined

      iv. oxygen saturation;
      To be determined

      v. hydration of mucous membranes;
      To be determined

      vi. skin turgor;
      To be determined

      vii. capillary refill time;
      To be determined

      viii. rash, namely the distribution and nature of it;
      To be determined

   b. provide adequate advice to Patient D's mother to:

      i. continue feeds, encourage fluids, offer additional water if tolerated, offer small amounts of food;
      To be determined

      ii. use paracetamol if Patient D appears distressed by fever;
      To be determined

      iii. avoid overdressing and overheated rooms;
      To be determined

      iv. monitor fluid intake and frequency of loose stools;
      To be determined

      v. contact their registered GP if the symptoms persisted beyond 2-3 days;

To be determined

vi. seek urgent medical advice in the event of deterioration or parental ~~control~~ concern
Amended under Rule 17(6)
To be determined

c. record the actions listed at paragraphs 4a and 4b above.
To be determined

5. On or around 24 May 2020 Patient E attended a consultation with you, along with his father. You failed to provide good clinical care in that you did not:

a. assess Patient E's temperature;
To be determined

b. record Patient E's temperature.
To be determined

6. On 24 May 2020 you undertook a telephone consultation with Patient F and failed to provide good clinical care in that you did not:

a. obtain an adequate medical history from Patient F including:

i. the duration of the swelling;
To be determined

ii. which part of Patient F's leg was affected;
To be determined

iii. whether it was painful as well as tender;
To be determined

iv. whether any joints were affected;
To be determined

v. Patient F's past medical history;
To be determined

vi. Patient F's drug history.
To be determined

b. adequately assess Patient F;
To be determined

c. appropriately diagnose Patient F;
To be determined

d. implement any treatment plan;
To be determined

e. maintain an adequate record of the consultation in that you did not record:

i. an adequate medical history as set out at paragraph ~~10a~~ 6a;
Amended under Rule 17(6)
To be determined

ii. any diagnosis;
To be determined

iii. a treatment plan.
To be determined

7. On 24 May 2020 you undertook a telephone consultation with Patient G. You failed to provide good clinical care in that you did not:

a. obtain an adequate medical history of Patient G's:

i. respiratory symptoms;
To be determined

ii. pulling at ears;
To be determined

iii. limb or joint symptoms;
To be determined

iv. diarrhoea;
To be determined

v. food and fluid intake;
To be determined

vi. recent contacts;
To be determined

vii. travel;
To be determined

viii. past medical history;

To be determined

ix. drug history;
To be determined

b. adequately record your actions at paragraph ~~11a~~ 7a;
Amended under Rule 17(6)
To be determined

c. reliably assess:

i. Patient G's presenting symptoms;
To be determined

ii. whether Patient G should be seen in a face to face consultation.
To be determined

8. On 24 May 2020 Patient H attended a consultation with you. You failed to provide good clinical care in that you did not:

a. offer Patient H a chaperone;
To be determined

b. assess Patient H's temperature;
To be determined

c. make an adequate record of:

i. information given to Patient H about the nature and purpose of the examination;
To be determined

ii. Patient H's verbal consent to proceed with a testicular examination;
To be determined

~~ii~~ iii. whether a chaperone was offered;
Amended under Rule 17(6)
To be determined

iv. whether a chaperone was accepted or declined by Patient H;
To be determined

v. Patient H's temperature.
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 Facts to be Determined

16. The Tribunal is required to determine whether Dr Srivatsa failed to provide good clinical care to the eight patients referred to in the Allegation, with whom he undertook either telephone or face to face consultations.

Witness Evidence

17. Dr Srivatsa did not provide a witness statement.

Expert Witness Evidence

18. The Tribunal received evidence from an expert witness, Dr J. He was called by the GMC and gave oral evidence on day one of the hearing, supplementary to his written report dated 31 December 2020. Dr J had 26 years' experience as GP Principal in daytime practice, and OOH general practice. He had additional experience as a GP Postgraduate trainer (Educational Supervisor) in daytime practice, and as a GP Clinical Supervisor in OOH practice. During his evidence, Dr J stated that he had recently retired from his substantive post as a GP but continued to work as a sessional GP in daytime practice and OOH general practice, maintaining his licence to practise. Dr J's evidence was directed at assisting the Tribunal in understanding the professional standards to be expected of a reasonably competent GP and assessing the extent to which Dr Srivatsa met this standard in respect of his consultations with the eight patients referred to in the Allegation.

Documentary Evidence

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

- Dr I's initial referral, dated 14 July 2020
- Description of concerns
- Emails from Dr I outlining further concerns, dated 20 and 21 July 2020
- Witness statement of Patient E's mother, dated 26 August 2020
- Complaint investigation report
- Letter of complaint from Patient D's father, undated
- Dr Srivatsa's response to concern 4, his reflections and his correspondence with Dr I
- Eight patient reviews with commentary
- Medical records of Patient A
- Medical records of Patient B
- Medical records of Patient E
- Medical records of Patient D
- Medical records of eight patient reviews
- Expert report from Dr J, dated 31 December 2020
- Email from Dr J clarifying typographical error, dated 7 April 2021
- Proof of Service Bundle

- Letter from Dr Srivatsa to the GMC with the subject heading 'Reply and evidence to court', dated 24 March 2022

The Tribunal's Approach

20. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Srivatsa 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.

21. The tribunal should consider each of the particulars of the allegations separately, assessing the evidence in relation to each and deciding whether it finds the facts alleged in the particular allegation to be proved.

22. Dr Srivatsa has not attended the hearing and has given no oral evidence or provided a signed witness statement, however there are documents which contain his responses to the complaints raised, and his views on proceedings. It is important that this hearing is fair to Dr Srivatsa. Dr Srivatsa's written replies are hearsay and the Tribunal may have regard to them when weighing the evidence before it. In assessing the weight of Dr Srivatsa's evidence, the Tribunal should bear in mind that Dr Srivatsa is not available for cross examination and therefore his statements cannot be challenged.

23. In determining the facts, the Tribunal will have to consider and assess the credibility and weight of all the evidence provided including the documentary evidence which has been put before it. This was touched on in the case of *Dutta v the GMC [2020] EWCA 1974 (Admin)* where it was said that :

> *"The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts. " This case of course relies very much on documentary evidence and you will wish to look critically at the documents before you which provide information about the nature and content of the consultations which are the subject of the charges."*

24. In respect of the expert witness evidence in this case, the Tribunal has read Dr Dr J's expert report and has also heard oral evidence from him when he provided additional evidence in response to questions from the Tribunal.

25. Where the expert witness has given opinion evidence, the Tribunal is the arbiter. It is not bound to accept expert opinion but it must explain clearly why it is deviating from this.

26. It is alleged in all stems of the Allegation, except for paragraph 3, that Dr Srivatsa failed to provide good clinical care to the patient, and specific actions not carried out. Some allegations contain the word 'adequately' and 'appropriate'. The Tribunal must give these words their everyday meaning, and the standard that Dr Srivatsa's actions should be judged against are those of a reasonably competent GP working in an OOH service.

27. The Tribunal should work through the particulars of the allegations set out in each of the eight charges, deciding if it finds each one proved or not, bearing in mind the standard of proof is the balance of probability. Having gone through that process for each charge, the Tribunal should then turn to the stem of the charge and decide whether it finds the stem proved.

28. The Tribunal should bear in mind that the word *"failed"* in this context does not simply mean that Dr Srivatsa did not do something, it means that Dr Srivatsa had a duty or obligation to act in a particular way and that he failed to carry out that duty or obligation. In deciding if he failed in his duty to provide good care to a patient, the Tribunal should assess this against the standard of a reasonably competent GP working in an OOH service.

29. If the Tribunal finds the standard of care provided is below that expected then it could properly find as a fact that Dr Srivatsa failed to provide good clinical care to the particular patient. The Tribunal's assessment of how far below the standard expected that care was, may be more relevant at the impairment stage of the proceedings when it will have to decide whether its findings of fact constitute misconduct which is so serious that it could form the basis of impaired fitness to practise.

30. In this respect the tribunal may be assisted by the evidence of the expert, Dr J, and it should also have regard to relevant parts of Good Medical Practice (2013) ('GMP') for instance in respect of record keeping, chaperones or any other aspects of care under consideration in the allegations.

The Tribunal's Analysis of the Evidence and Findings

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

32. This evaluation included the written and oral evidence of expert witness, Dr J. Having considered all the evidence in respect of each paragraph of the Allegation the Tribunal found Dr J to be credible and accepted his opinions due to his lengthy experience as a GP in daytime practice as well as in OOH work.

Paragraph 1a i - v

33. The Tribunal accepted that while Dr Srivatsa had recorded the presence of a hard lump in his examination notes there was no comment on its size, and this was an important factor when thinking about diagnosis and treatment. Dr Srivatsa recorded in the examination notes:

> *"Difficulty to walk, afebrile, hard lump in the groin and tender, cannot sit and left thigh and leg swollen"*

There was no evidence that he recorded the presence of redness or warmth. While Dr Srivatsa did mention the swelling of the left leg and thigh, it was not particularised as to what exactly was swollen, and the Tribunal found this to be an incomplete description. Additionally, there was no further analysis as to the extent of the swelling in Patient A's leg, no record at all of any scrotal swelling and no indication to suggest that Dr Srivatsa examined for inguinal lymph nodes.

34. Accordingly, the Tribunal found paragraph 1a i - v proved in its entirety.

Paragraph 1b

35. Taking a patient's temperature in this type of clinical setting is a relevant assessment that would be expected of any reasonably competent GP and the Tribunal could not find any reason for Dr Srivatsa not to have assessed Patient A's temperature. Accordingly, the Tribunal found paragraph 1b proved.

Paragraph 1c i - v

36. In respect of 1c i - v the Tribunal has determined and found proved 1a i - v. These charges are direct alternatives and as the Tribunal has found Dr Srivatsa did not adequately examine Patient A in respect of these particulars, he cannot be found to have failed to record them. Therefore the Tribunal found paragraph 1c i – v to be not proved.

Paragraph 1c vi

37. In respect of paragraph 1c vi this paragraph is a direct alternative to 1b which the Tribunal has determined and found proved. As Dr Srivatsa cannot be found to record what he did not do, the Tribunal found paragraph 1c vi to be not proved.

Paragraph 1d i -ii

38. Dr Srivatsa had recorded his diagnosis as *"Looks like thrombophlebitis with lump ? cause"*. As he did not record anything else, the Tribunal was not satisfied that Dr Srivatsa considered an adequate differential diagnosis of either an injection site infection or deep vein thrombosis. Accordingly, the Tribunal found paragraph 1d i – ii proved in its entirety.

Stem of paragraph 1

39. Good clinical care requires a doctor to carry out an adequate examination and consider differential diagnoses. In view of its findings above, the Tribunal found paragraph 1 to be proved.

Paragraph 2a i - v

40. Patient B's consultation was over the telephone and the Tribunal took into consideration that a medical history taken over the telephone may need to be more detailed than when taken face to face, as a GP conducting a telephone consultation cannot physically examine the patient. During this consultation Dr Srivatsa had noted little background about the cancer or details of the patient's pain. An example of an OOH telephone triage history can be seen in the records of Patient A and comparison showed the difference in the depth of questioning and detail, compared to that of Dr Srivatsa's.

41. The Tribunal determined that it would have been useful to understand the history and severity of Patient B's pain. Tools for assessing levels of pain are available, and Dr Srivatsa could have made reference to one of these.

42. In this specific scenario, given that Patient B had a known cancer, to take the history of constipation was crucial as this could have been caused by several factors including his current medication, yet this was not addressed by Dr Srivatsa.

43. Dr Srivatsa made a comment about dysuria, but did not enquire about when Patient B had last passed urine. He did not ask further questions about suprapubic pain. Urinary retention is an acute medical condition which requires urgent management and Dr Srivatsa should have asked further questions.

44. Dr Srivatsa recorded in the history, *"Past had similar problem was taken to hospital"* but Patient B had several problems and the history neither clarified which element of his symptoms was the similar problem, nor what treatment Patient B had received in hospital on previous occasions. The Tribunal determined that it was usual to ask what happened in the same situation in the past. If another doctor looked at this history this information would be useful for the ongoing care of the patient. It was important to give sufficient detail and knowing what happened in the past in a similar situation would be a helpful part of the history.

45. The Tribunal found paragraph 2a i - v, therefore, proved in its entirety.

<u>Paragraph 2b i - iii</u>

46. The Tribunal determined that Patient B had a complicated medical history and urinary retention cannot be managed via a telephone consultation. The diagnosis recorded by Dr Srivatsa was: *"Diagnosis: Retention of urine and constipation"* and therefore Patient B should have had a face to face consultation. In his report, Dr J stated:

> *" retention of urine and constipation may both be associated with a serious underlying condition (such as bowel obstruction) and require a face to face consultation, including physical examination, to be assessed adequately. In particular, urinary retention requires an abdominal examination to check for bladder distention and constipation requires an abdominal and rectal examination to check for abdominal masses and rectal impaction. My opinion is that Dr Srivatsa should have arranged a face to face*

consultation for Patient B at the GP OOH service, to be seen as a priority (within two hours).”

Dr J also advised that urinary retention could be caused by a number of conditions and usually required treatment by catheterization.

47. Based on the urgency and potential risk to Patient B, Dr Srivatsa should have arranged an abdominal and rectal examination to check for bladder distention, abdominal masses, and rectal impaction but he did not do so. He did not arrange a physical examination for Patient B either with himself or another doctor.

48. Accordingly, the Tribunal found paragraph 2b i - iii proved in its entirety.

Paragraph 2c i - ii

49. From the diagnosis recorded by Dr Srivatsa it was unclear whether he had written the diagnosis or whether it was diagnostic code, and there was no indication that he had considered any other causes. An adequate diagnosis could be simple; not listing causes for a diagnosis is not necessarily inadequate and a doctor could write ‘constipation/urinary’ without anything else. However, in the opinion of Dr J, Dr Srivatsa’s diagnosis was inadequate *“because possible underlying causes of Patient B’s symptoms were not recorded”.* With a comprehensive history, the narrative is easier to follow by the next treating doctor. In this case it would be difficult, based on little or no history, for the next doctor viewing the records to see what had happened. The Tribunal determined that there was no evidence to show any consideration was made by Dr Srivatsa as to other causes of Patient B’s urine retention and constipation and accordingly found paragraph 2c i -ii proved in its entirety.

Paragraph 2d

50. Dr Srivatsa recorded the following treatment plan in addition to the prescribed medication*: “Treatment: Try taking bath and relax to pass urine, also hot water bag”.* The expert witness was explicit in his report in relation to the adequacy of this plan and wrote that *“this was not an adequate or appropriate treatment plan for urinary retention”.* Taking this into account, the Tribunal found paragraph 2d of the Allegation proved.

Paragraph 2e i - iv

51. The Tribunal has found paragraph 2a i, ii, and iii proved and therefore Dr Srivatsa cannot record what he did not do, meaning the Tribunal could not find paragraph 2e i, ii, and iii proved. Similarly, the Tribunal found paragraph 2e iv not proved on that basis that it had found paragraph 2d proved. Accordingly the Tribunal found paragraph 2e i -iv not proved.

Paragraph 2e v

52. The Tribunal was unable to find any evidence that the details of Patient B's prescribed Oramorph treatment had been adequately recorded. As the Oramorph could have been a potential cause of the constipation it would have been relevant to record more information. Patient B had requested a further prescription of Oramorph but Dr Srivatsa had not recorded either the dose that Patient B was currently taking or the length of time he had been on the medication, information that was required to be able to prescribe appropriately. He also omitted to record the dosage that he intended to prescribe. Based on these omissions the Tribunal found paragraph 2e v proved.

Stem of paragraph 2

53. On the basis that good clinical care includes adequate history taking, adequate assessment of the patient to determine whether a face to face consultation is necessary and to carry out relevant examinations, recording adequate and differential diagnoses, this was not good clinical care and the Tribunal found paragraph 2 to be proved.

Paragraph 3

54. In his record of the telephone consultation with Patient C's sister, Dr Srivatsa wrote, *"No clinical problem".* There was no record that any advice was given to Patient C's sister about sources of help and information for problem drug use. Dr Srivatsa specifically pointed out in the record that there was no need to refer Patient C to mental health services. There was no evidence to show that he considered Patient C's drug use to be a problem and did not put an adequate or appropriate treatment plan in place. As a minimum Dr Srivatsa could have advised Patient C's sister to encourage Patient C to consult his own GP. It was neither adequate nor correct to write *"No clinical problem"* and general advice should have been given to Patient C's sister.

55. Based on this analysis, the Tribunal found paragraph 3 proved.

Paragraph 4a i, ii, iv, v, vi, vii

56. The Tribunal could find no evidence that Dr Srivatsa had assessed Patient D's temperature, heart rate, oxygen saturation, hydration of mucous membranes, skin turgor, and capillary refill time and according found paragraph 4a i, ii, iv, v, vi, and vii all proved.

Paragraph 4a iii, viii

57. In the examination recorded by Dr Srivatsa, he noted that Patient D's respiratory rate was normal and therefore the Tribunal found paragraph 4a iii not proved.

58. The Tribunal took into consideration that the history recorded by the triage doctor would be available to Dr Srivatsa. His subsequent record of the history along with the triage history would have formed an overall record, and it would not be expected for Dr Srivatsa to

repeat notes already made. The Tribunal found paragraph 4 viii not proved on the basis that notes about the rash, referring to blanching and its site, had already been made.

Paragraph 4b i - vi

59. The treatment plan recorded by Dr Srivatsa was:

> *"Treatment: Nil, Educated mother, advice to give lukewarm water bath and observe. If rash turns out not to blanch call back"*

As there was no mention in the treatment plan of any of the points in paragraph 4b i, ii, iii, and iv, the Tribunal found these all proved.

60. While there was mention of the course of action to be taken should the rash not blanch, there was no mention of what should be done specifically if there were prolonged symptoms lasting beyond two or three days and therefore the Tribunal found 4b v proved.

61. The Tribunal took into consideration that sufficient explanation needed to be given to Patient D's parents about what to do in the event of any deterioration in his symptoms, and when to seek urgent medical advice. As there was no record that this discussion had taken place, the Tribunal found paragraph 4b vi to be proved.

62. Accordingly the Tribunal found paragraph 4b i -vi proved in its entirety.

Paragraph 4c

63. As paragraph 4c is an alternative to paragraphs 4a and 4b which have, in the most part been proved, the Tribunal found paragraph 4c to be not proved. In relation to paragraph 4a iii and viii the Tribunal has found that Dr Srivatsa did assess these two matters and did record them. In respect of the remainder of 4a and all of 4b, the Tribunal found these paragraphs to be proved and as Dr Srivatsa cannot record what he did not do, the remainder of paragraph 4c is found not proved. Accordingly, paragraph 4c is not proved in its entirety.

Stem of paragraph 4

64. Overall, the Tribunal found paragraph 4 to be found proved in that Dr Srivatsa did not provide good clinical care to Patient D.

Paragraph 5a

65. In the triage notes it was specifically stated that Patient E's temperature had not been recorded. Despite this being an indicator to Dr Srivatsa, he noted, *"mild fever, no chills"* and failed to take a temperature reading. In his letter to Dr I dated 23 June 2020, he stated:

> *"The boy was well, I clinically examined his chest, abdomen and did not feel it was necessary to record his temperature, because he was not warm to touch. I have worked as a doctor for more than thirty years in acute and intensive care before I retrained to be a GP. I have never measured or recorded temperature, nor found it help me diagnose any illness in the UK. I have published a letter in GP Update, explaining why doctors must not give too much importance to temperature."*

The Tribunal accordingly found paragraph 5a to be proved.

Paragraph 5b

66. As Dr Srivatsa did not assess Patient E's temperature, it follows that he could not have recorded it. Therefore, the Tribunal found paragraph 5b not proved.

Stem of paragraph 5

67. The Tribunal considered that taking the temperature of a child presenting with Patient E's symptoms was a standard requirement in providing good clinical care and accordingly, the Tribunal found paragraph 5 to be proved.

Paragraph 6a i - vi

68. In relation to Dr Srivatsa obtaining an adequate medical history from Patient F, the expert witness wrote in his report that Dr Srivatsa had not recorded key aspects of the history such as: the duration of swelling, which part of the leg was affected, whether it was painful as well as tender, whether any joints were affected, previous medical history and drug history. The Tribunal was unable to find any evidence that Dr Srivatsa had detailed this information adequately and according found paragraph 6a i – vi proved in its entirety.

Paragraph 6b

69. Based on the standard of the history taking being so poor, it was not possible for the Tribunal to ascertain whether Dr Srivatsa had adequately assessed Patient F. It was of the view that a more detailed history should have been taken and found paragraph 6b to be proved.

Paragraph 6c

70. Dr Srivatsa only noted *"pain in limb"* and did not record a diagnosis. The Tribunal accordingly found paragraph 6c to be proved.

Paragraph 6d

71. There was no evidence of a treatment plan being made and Dr Srivatsa recorded *"no follow up"* in the Follow Up section of the record. The Tribunal therefore found paragraph 6d to be proved.

Paragraph 6e i

72. Paragraph 6e i is an alternative to paragraph 6a which has been found proved in its entirety. As Dr Srivatsa cannot record what he did not do, the Tribunal found paragraph 6e i to be not proved.

Paragraph 6e ii

73. Paragraph 6e ii is an alternative to paragraph 6c which has been found proved. As Dr Srivatsa cannot record what he did not do, the Tribunal found paragraph 6e ii to be not proved.

Paragraph 6e iii

74. Paragraph 6e iii is an alternative to paragraph 6d which has been found proved. As Dr Srivatsa cannot record what he did not do, the Tribunal found paragraph 6e iii to be not proved.

Stem of paragraph 6

75. On the basis of the charges found proved, Dr Srivatsa failed to provide good clinical care to Patient F and accordingly, the Tribunal found paragraph 6 proved overall.

Paragraph 7a i - ix

76. In terms of obtaining an adequate medical history, Dr J listed multiple symptoms that could have been significant and although he did not prioritise any of the symptoms, he was clear that answers to questions about any of them may have enabled Dr Srivatsa to make an accurate diagnosis. Which questions would be key ones to ask would depend on the previous conversation about the state of the patient. The Tribunal has gone through the questions and considered on the balance of probabilities which were important and identified which, regardless of the preceding conversation, a reasonably competent GP would have asked about a child presenting with these symptoms.

77. Having determined which symptoms should have been explored the Tribunal made the following findings:

i. respiratory symptoms: this should be explored in a child with fever – proved

ii. pulling at ears: this was not a standard requirement in this situation - not proved

iii. limb or joint symptoms: this was not a standard requirement in this situation – not proved

iv. diarrhoea: where a young child has stomach ache this would be a standard question to ask -proved

v. food and fluid intake: despite no vomiting, asking what a young child is eating and drinking when they have a temperature is standard – proved

vi. recent contacts: in his report Dr J made general reference to the consultation taking place during the Covid pandemic but, when asked which questions he felt were key in respect of this consultation, he did not indicate recent contacts or travel to be included – not proved

vii. travel: see above in respect of vi – not proved

viii. past medical history: always a relevant issue to ask questions about - proved

ix. drug history: always a relevant issue to ask questions about - proved

Paragraph 7b

78. The Tribunal has found paragraph 7a i, iv, v, viii, and ix proved and therefore Dr Srivatsa cannot record what he did not do. In respect of paragraph 7a ii, iii, vi, vii the Tribunal found these not proved on the basis that these issues were not necessarily requisite to an adequate examination. Accordingly, the Tribunal similarly considered it was not inadequate not to record them and therefore found paragraph 7b not proved.

Paragraph 7c i - ii

79. The evidence from Dr J is that Dr Srivatsa did not record the information needed to reliably assess Patient G's presenting symptoms. As Dr Srivatsa had ample information to draw from but did not use this, and there was the risk of Patient G having an unrecognised medically serious condition, the Tribunal found paragraph 7c i proved

80. As sufficient history was not taken in the telephone consultation with Patient G's mother to assess whether Patient G should be seen face to face, the Tribunal found paragraph 7c ii to be proved.

81. Accordingly the Tribunal found paragraph 7c i - ii proved in its entirety.

Stem of paragraph 7

82. On the basis of the charges determined and found proved, Dr Srivatsa failed to provide good clinical care to Patient G. Ultimately, he did not reliably assess the presenting

symptoms and see the patient face to face and the Tribunal was of the opinion that this carried more weight than individual symptoms not being assessed. Dr Srivatsa did not reliably assess the patient and therefore did not provide good care. The purpose of assessing is to determine what to do next and what the safest course of action is. It would be difficult to make decisions based on so little information and accordingly, the Tribunal found paragraph 7 proved overall.

Paragraph 8a

83. There was no reference in Dr Srivatsa's notes as to whether a chaperone had been offered or not. However no evidence was adduced that a chaperone was not offered. In these circumstances the Tribunal could not conclude that it was more likely than not that Dr Srivatsa had not offered a chaperone. Accordingly the Tribunal found paragraph 8a to be not proved.

Paragraph 8b

84. Dr J opined that as Patient H's symptoms could have been caused by an infection, Dr Srivatsa should have recorded his temperature. As there was no evidence that the temperature was taken or assessed, the Tribunal found paragraph 8b proved.

Paragraph 8c i - v

85. The Tribunal determined the following:

i. no record – Determined and found proved

ii. no record – Determined and found proved

iii. no record – this is in the alternative to paragraph 8a in respect of which the Tribunal concluded that Dr Srivatsa may have offered a chaperone but if he had, he had not recorded it. Accordingly this paragraph is found proved

iv. no record – this is in the alternative to paragraph 8a and for the reasons given above in respect of iii above this paragraph is found proved

v. this is in the alternative to 8b. As Dr Srivatsa cannot record what he did not do, this paragraph is found not proved

Stem of paragraph 8

86. On the basis of the charges determined and found proved, Dr Srivatsa failed to provide good clinical care to Patient G and accordingly, the Tribunal found paragraph 8 proved overall.

The Tribunal's Overall Determination on the Facts

87. The Tribunal has determined the facts as follows:

1. On or around 16 May 2020 Patient A attended a consultation with you. You failed to provide good clinical care to Patient A in that you did not:

    a. adequately examine the:

        i. approximate size of the groin lump;
        Determined and found proved

        ii. presence or absence of redness, swelling and warmth;
        Determined and found proved

        iii. extent of swelling in Patient A's leg;
        Determined and found proved

        iv. presence or absence of scrotal swelling;
        Determined and found proved

        v. presence or absence of inguinal lymph nodes;
        Determined and found proved

    b. adequately assess Patient A's temperature;
    Determined and found proved

    c. adequately record in Patient A's records the:

        i. approximate size of the groin lump;
        Not proved

        ii. presence or absence of redness, swelling and warmth;
        Not proved

        iii. extent of swelling in Patient A's leg;
        Not proved

        iv. presence or absence of scrotal swelling;
        Not proved

        v. presence or absence of inguinal lymph nodes;
        Not proved

vi. temperature of Patient A;
Not proved

d. consider an adequate differential diagnosis of:

i. injection site infection;
Determined and found proved

ii. deep vein thrombosis.
Determined and found proved

2. On or around 18 May 2020 Patient B consulted with you over the telephone. You failed to provide good clinical care in that you did not:

a. take an adequate medical history of Patient B's:

i. prostate cancer including the extent and spread of the cancer, any complications and current treatment;
Determined and found proved

ii. pain including the type and severity of pain;
Determined and found proved

iii. constipation including the duration and severity of constipation, food and fluid intake, when a bowel movement was last passed, the presence or absence of abdominal pain, and the presence or absence of vomiting;
Determined and found proved

iv. urinary symptoms including when he last passed urine and whether he had any suprapubic pain;
Determined and found proved

v. previous treatment required when taken to hospital with similar symptoms in the past;
Determined and found proved

b. adequately assess Patient B in that you did not:

i. arrange a face to face consultation for Patient B to be seen as a priority;
Determined and found proved

ii. ~~carry out~~ arrange an abdominal examination to check for bladder distention;

Amended under Rule 17(6)
Determined and found proved

~~ii~~ iii. ~~carry out~~ arrange an abdominal and rectal examination to check for abdominal masses and rectal impaction;
Amended under Rule 17(6)
Determined and found proved

c. record an adequate diagnosis in that you did not consider:

i. other causes of Patient B's urine retention;
Determined and found proved

ii. other causes of Patient B's constipation;
Determined and found proved

d. put in place an adequate or appropriate treatment plan for urinary retention;
Determined and found proved

e. make an adequate record of:

i. an adequate history of Patient B's presenting symptoms as set out at paragraph 2a;
Not proved

ii. a past medical history;
Not proved

iii. a medication history;
Not proved

iv. an adequate management plan;
Not proved

v. details of Patient B's prescribed Oramorph treatment.
Determined and found proved

3. On 23 May 2020 you undertook a telephone consultation with Patient C's sister and failed to put in place an adequate or appropriate treatment plan in that you did not give advice on sources of help and information for problem drug use.
Determined and found proved

4. On or around 24 May 2020 Patient D attended a consultation with you, along with his mother. You failed to provide good clinical care in that you did not:

a. assess Patient D's:

i. temperature;
Determined and found proved

ii. heart rate;
Determined and found proved

iii. respiratory rate;
Not proved

iv. oxygen saturation;
Determined and found proved

v. hydration of mucous membranes;
Determined and found proved

vi. skin turgor;
Determined and found proved

vii. capillary refill time;
Determined and found proved

viii. rash, namely the distribution and nature of it;
Not proved

b. provide adequate advice to Patient D's mother to:

i. continue feeds, encourage fluids, offer additional water if tolerated, offer small amounts of food;
Determined and found proved

ii. use paracetamol if Patient D appears distressed by fever;
Determined and found proved

iii. avoid overdressing and overheated rooms;
Determined and found proved

iv. monitor fluid intake and frequency of loose stools;
Determined and found proved

v. contact their registered GP if the symptoms persisted beyond 2-3 days;
Determined and found proved

vi. seek urgent medical advice in the event of deterioration or parental ~~control~~ concern
Amended under Rule 17(6)
Determined and found proved

c. record the actions listed at paragraphs 4a and 4b above.
Not proved

5. On or around 24 May 2020 Patient E attended a consultation with you, along with his father. You failed to provide good clinical care in that you did not:

a. assess Patient E's temperature;
Determined and found proved

b. record Patient E's temperature.
Not proved

6. On 24 May 2020 you undertook a telephone consultation with Patient F and failed to provide good clinical care in that you did not:

a. obtain an adequate medical history from Patient F including:

i. the duration of the swelling;
Determined and found proved

ii. which part of Patient F's leg was affected;
Determined and found proved

iii. whether it was painful as well as tender;
Determined and found proved

iv. whether any joints were affected;
Determined and found proved

v. Patient F's past medical history;
Determined and found proved

vi. Patient F's drug history.
Determined and found proved

b. adequately assess Patient F;
Determined and found proved

c. appropriately diagnose Patient F;
Determined and found proved

d. implement any treatment plan;
Determined and found proved

e. maintain an adequate record of the consultation in that you did not record:

i. an adequate medical history as set out at paragraph ~~10a~~ 6a;
Amended under Rule 17(6)
Not proved

ii. any diagnosis;
Not proved

iii. a treatment plan.
Not proved

7. On 24 May 2020 you undertook a telephone consultation with Patient G. You failed to provide good clinical care in that you did not:

a. obtain an adequate medical history of Patient G's:

i. respiratory symptoms;
Determined and found proved

ii. pulling at ears;
Not proved

iii. limb or joint symptoms;
Not proved

iv. diarrhoea;
Determined and found proved

v. food and fluid intake;
Determined and found proved

vi. recent contacts;
Not proved

vii. travel;
Not proved

viii. past medical history;
Determined and found proved

ix. drug history;
Determined and found proved

b. adequately record your actions at paragraph ~~11a~~ 7a;
Amended under Rule 17(6)
Not proved

c. reliably assess:

i. Patient G's presenting symptoms;
Determined and found proved

ii. whether Patient G should be seen in a face to face consultation.
Determined and found proved

8. On 24 May 2020 Patient H attended a consultation with you. You failed to provide good clinical care in that you did not:

a. offer Patient H a chaperone;
Not proved

b. assess Patient H's temperature;
Determined and found proved

c. make an adequate record of:

i. information given to Patient H about the nature and purpose of the examination;
Determined and found proved

ii. Patient H's verbal consent to proceed with a testicular examination;
Determined and found proved

~~ii~~ iii. whether a chaperone was offered;
Amended under Rule 17(6)
Determined and found proved

iv. whether a chaperone was accepted or declined by Patient H;
Determined and found proved

v. Patient H's temperature.
Not 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 - 28/04/2022

88. 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 Srivatsa's fitness to practise is impaired by reason of his misconduct.

The Evidence

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

90. The Tribunal also received documentary evidence provided by the GMC. This evidence included:

- Responses from Dr Srivatsa to Rule 7 allegations, dated 9 April 2021 and 14 April 2021
- Correspondence received from Dr Srivatsa sent to GMC, dated 6 April 2022. This included a link to a video that Dr Srivatsa had uploaded to YouTube.

Submissions

91. On behalf of the GMC, Ms Jones submitted that when applying its judgement the Tribunal must consider all three limbs of the statutory overarching objective.

92. Ms Jones submitted that it may be useful for the Tribunal to consider the facts it had found proved in relation to specific paragraphs of GMP and whether these had been breached in this case.

93. Ms Jones reminded the Tribunal that misconduct, in the context of these proceedings, is serious professional misconduct. It means some act or omission falling short of what would be appropriate in the circumstances, and the authorities are clear that seriousness should be given its proper weight.

94. Ms Jones submitted that once the Tribunal had made a decision about whether the conduct was serious misconduct it should then consider whether Dr Srivatsa's fitness to practise is impaired today, and referred the Tribunal to the case of *Meadow v GMC [2006] EWCA Civ 1390* in which it was held:

> *'…the purpose of FTP (Fitness to Practice) proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus 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.'*

95. Ms Jones further submitted that the Tribunal may be assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin:*

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. Has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future'*

96. Ms Jones submitted that in this case the first limb of this test was engaged and, based on the findings proved and the expert opinion of Dr J, clearly highlighted the actions of a doctor who presented a risk to patients.

97. Ms Jones brought the Tribunal's attention to the evidence provided for this stage of the hearing. She submitted that this may assist the Tribunal when it came to considering insight, remediation, and the risk of repetition. In his response to the Allegation, with all the evidence having been provided to him, Dr Srivatsa wrote that he did not accept any of it. He did not refer to anything he had done correctly, in reference to each case, and did not demonstrate any understanding of what he had done wrong, or what he could have done better. Ms Jones submitted that this displayed a lack of insight into his actions.

98. Ms Jones added that the common theme running through the responses highlighted a doctor who entirely defended his approach, believed it was correct, but did not refer to any professional literature which supported his practice. Dr Srivatsa also placed blame on computer systems, his regulator, and colleagues for any failings.

99. Ms Jones submitted that it was difficult to see any evidence of insight or remediation, rather there was evidence of neither.

100. Ms Jones asked the Tribunal to take into consideration the responses from Dr Srivatsa and the content of the video he had uploaded to YouTube in which he displayed his attitude to the medical profession and his regulator. Ms Jones submitted that looking at the position today, in relation to Dr Srivatsa's fitness to practise being impaired, nothing had changed as he did not accept any of the parts of the Allegation which had been found proved. This was

relevant when considering the risk of repetition should he come back to the UK to resume practice.

101. Ms Jones submitted that in addition to the consideration of whether the practitioner poses a risk to the public, the case of *CHRE v NMC & Grant [2011] EWHC 927 (Admin)* makes it clear that tribunals should, at the impairment stage, consider whether a finding of impairment is necessary in order to maintain public confidence in the profession and the regulator. Given the seriousness of the Allegation and the overall picture presented to the Tribunal, this was such a case. A finding of impairment was necessary as it was clear that Dr Srivatsa's fitness to practise was impaired.

The Relevant Legal Principles

102. 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.

103. 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 misconduct which was serious could lead to a finding of impairment. In this context *"misconduct"* means serious professional misconduct.

104. The Tribunal must then determine whether Dr Srivatsa's fitness to practise is impaired today, taking into account Dr Srivatsa's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied, whether Dr Srivatsa has shown insight into his misconduct, and whether there is any likelihood of repetition.

105. However, even if the Tribunal found that matters were remediable, had been remedied, and considered that repetition would be extremely unlikely, there will be instances where the need to uphold professional standards and public confidence in the profession would be undermined if a finding of impairment were not made.

The Tribunal's Determination on Impairment

Misconduct

106. The Tribunal first considered whether the facts found proved against Dr Srivatsa amount to misconduct. Misconduct can be found in circumstances where there have been serious departures from expected standards of conduct and behaviour, which can be identified by reference to GMP.

107. Throughout its deliberations, the Tribunal has taken account of the statutory overarching objective of protecting the public, which includes protecting the health, safety, and wellbeing of the public, maintaining public confidence in the profession, and promoting

and maintaining proper professional standards and conduct for the members of the profession.

108. The Tribunal considered that paragraphs 7, 13, 15, 16a, 19, and 21 of GMP are engaged in this case:

> *7 You must be competent in all aspects of your work, including management, research and teaching.*
>
> *13 You must take steps to monitor and improve the quality of your work.*
>
> *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*
>
> *b. promptly provide or arrange suitable advice, investigations or treatment where necessary*
>
> *c. refer a patient to another practitioner when this serves the patient's need*
>
> *16 In providing clinical care you must:*
>
> *a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*
>
> *19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
>
> *21 Clinical records should include:*
>
> *a. relevant clinical findings*
>
> *b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
>
> *c. the information given to patients*
>
> *d. any drugs prescribed or other investigation or treatment*
>
> *e. who is making the record and when.*

109. The Tribunal took into consideration that it had found multiple failings relating to eight different patients that had occurred in a relatively short space of time. It also took into account the expert witness's report and oral evidence about the ways in which Dr Srivatsa's failures had fallen seriously short of the standards expected of a reasonably competent GP

working in an OOH setting. The Tribunal concluded that these represented significant concerns in relation to providing safe and competent care to patients, particularly in an OOH setting due to the range of patients and the undifferentiated symptoms they present with, and where the GP is expected to make immediate decisions in relation to the assessment, diagnosis and management of patients.

110. The Tribunal had regard to the expert witness report relating to the numerous specific instances where Dr Srivatsa's actions had fallen seriously below the standards expected of a reasonably competent GP. These included:

- The five categories in which he fell seriously below standards in providing care to Patient B
- The inadequate history taking during the telephone consultation with Patient B, who had prostate cancer
- Failing to advise Patient D's parents what to do in the case of deterioration and when to seek urgent medical advice
- The failings in relation to Patient F, who had presented with a pain in his leg. Dr Srivatsa's failures to adequately assess the patient or implement a treatment plan could have put the patient at the risk of significant harm
- The three categories in which he fell seriously below standards in providing care to Patient G

111. In all the circumstances the Tribunal has concluded that, overall, Dr Srivatsa's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct which was serious.

Impairment

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

113. From the evidence provided for this stage of the hearing, the Tribunal found it clear that Dr Srivatsa did not believe the way he practised required improvement or that there were any inadequacies in his clinical work. He blamed the way medical practice in the UK is set up and stated that in his 40 years of work he had always practised in the same manner. He stated that:

> *"As a doctor, I have always relied upon the patient's history and offered advice and treatment because I have forty years of experience to diagnose various illnesses. Things the doctors are talking about are family history, allergy and past illness, travel checks, habits, alcohol and smoking, which are irrelevant when I manage emergencies."*

The Tribunal considered this showed no insight into why he had been referred to the GMC and what he could do to remediate.

114. The Tribunal considered Dr Srivatsa's statements in his email to Dr I, dated 23 June 2020:

> *"I have never measured or recorded temperature, nor found it help me diagnose any illness in the UK. I have published a letter in GP Update, explaining why doctors must not give too much importance to temperature."*
>
> *"I have seen and treated urinary tract infections since 1983 in the UK based on clinical acumen, (My Guest Lecture, Reading University) and have never missed or made any error."*

These statements highlighted further to the Tribunal Dr Srivatsa's lack of insight into his professional role, and a lack of understanding of the standards expected of him.

115. The Tribunal noted that Dr Srivatsa did not accept any of the failings in the Allegation. His refusal to accept any of those failings meant it was impossible for him to remediate those failings.

116. The Tribunal was unable to find any evidence of insight or remediation in the evidence presented before it. Rather, it found a profound lack of insight as evidenced particularly by the statements in paragraph 26 above.

117. The Tribunal considered that this lack of insight into the concerns raised or how one should reflect on feedback pointed to a risk of repetition. Far from accepting the need for reflection, Dr Srivatsa remained of the view that he did not need to change and that his current way of practising is acceptable.

118. The Tribunal also had regard to the contents of the video that Dr Srivatsa had uploaded to YouTube, in which he displayed annoyance about the GMC having gone into his records. The Tribunal was of the view that his failure to recognise that the GMC has a duty to investigate the performance of any doctor in respect of whom legitimate concerns had been raised illustrated that there was a significant risk of repetition.

119. Taking into account the numerous breaches of the fundamental tenets of the profession, the lack of insight and steps taken to remediate, as well as the high risk of repetition, the Tribunal was in no doubt that Dr Srivatsa was liable in the future to act so as to put a patient or patients at unwarranted risk of harm. In addition, public confidence in the medical profession and the need to uphold proper standards for that profession would be adversely affected if it were not to make a finding of impairment in this case.

120. The Tribunal has therefore determined that Dr Srivatsa's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 29/04/2022

121. Having determined that Dr Srivatsa'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

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

Submissions

123. Ms Jones reminded the Tribunal of its findings at the impairment stage in relation to the seriousness of Dr Srivatsa's misconduct relating to eight patients. In addition to this, Ms Jones referred the Tribunal to the paragraphs of its stage 2 determination that related to Dr Srivatsa's profound lack of insight and remediation, the numerous breaches of fundamental tenets of the profession, and the high risk of repetition.

124. Ms Jones submitted that taking all of that and applying it to the Sanctions Guidance (November 2020 edition) ('the SG'), the only appropriate sanction in this case would be one of erasure.

125. Ms Jones drew the Tribunal's attention to the overarching objective and the paragraphs of the SG, which she submitted supported the imposition of erasure as the appropriate sanction in this case.

126. Ms Jones submitted that taking no action was only appropriate in exceptional circumstances, and she submitted there were none in this case.

127. Ms Jones submitted that this was a case where undertakings would not be appropriate and therefore the Tribunal need not consider this option.

128. In relation to imposing conditions on Dr Srivatsa's registration, Ms Jones submitted that in this case the misconduct had been serious and wide ranging. Despite having had contact with the GMC, Dr Srivatsa had not engaged with the regulatory process. Dr Srivatsa now resided in Germany and had expressed a wish to be voluntarily erased from the medical register in the UK. He did not appear to have any intention of returning to practise in the UK and therefore conditions would not be workable.

129. Moving on to the sanction of suspension, Ms Jones submitted that suspension is appropriate when there has been an acknowledgement of fault and the Tribunal is satisfied that the behaviour was unlikely to be repeated. The Tribunal had noted in its impairment determination that there had been no acceptance of fault and that the risk of repetition was high, given the lack of insight or remediation.

130. Ms Jones submitted that there had been multiple and varied breaches of GMP concerning eight patients. Bearing that in mind and having regard also to the lack of insight and remediation, continued registration would be incompatible with the aims of the overarching objective.

131. Ms Jones further submitted that Dr Srivatsa had shown an unwillingness to engage with his regulator and there was sufficient evidence available to show that he was unlikely to engage, given the clear attitude he had expressed in the correspondence provided in the stage 2 evidence bundle.

132. Ms Jones submitted that a period of suspension would be appropriate if the Tribunal was satisfied that Dr Srivatsa had shown insight and acceptance of his behaviour, and did not pose a risk of repeating that behaviour. However, the Tribunal had found that there was no insight and there was a risk of repeating the behaviour, therefore suspension was not the appropriate sanction in this case.

133. Ms Jones then went on to invite the Tribunal to consider the sanction of erasure. She highlighted the fact that there had been a consistent and repeated set of particularly serious departures from the principles of GMP, albeit over a short period of time as the concerns were dealt with promptly and Dr Srivatsa subsequently left his employment.

134. Ms Jones submitted there had been a deliberate disregard for the principles set out in GMP. Dr Srivatsa had stated in no uncertain terms that he did not agree with various aspects of them. While there was no evidence that Dr Srivatsa had caused harm to patients, there had been a significant risk of harm being caused, and the Tribunal was entitled to take that risk into account in its deliberations.

135. Ms Jones guided the Tribunal through the paragraphs of the SG specifically relating to erasure and a doctor's insight and submitted that there was no evidence Dr Srivatsa was likely to develop any. Ms Jones highlighted Dr Srivatsa's attitude generally towards his regulator, GMP, and colleagues and submitted that the only appropriate, proportionate, and necessary sanction in this case was one of erasure.

The Relevant Legal Principles

136. This stage of the proceedings is governed by Rule 17(2)m of the Rules and the Tribunal's task now is to decide what sanction, if any, should be imposed upon the registration of the Doctor.

137. When considering sanction, the Tribunal must have particular regard to the statutory overarching objective:

a. To protect, promote and maintain the health, safety and wellbeing of the public;
b. To promote and maintain public confidence in the medical profession; and

c. To promote and maintain proper professional standards and conduct for members of that profession.

138. In reaching its decision, the Tribunal must take into account the SG. The purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it may have a punitive effect. If the Tribunal departs from the Guidance the relevant paragraph should be referenced, and reasons for departing from the Guidance given.

139. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal exercising its own judgement, taking account of the SG. It must consider the least restrictive sanction first and then, if necessary, consider the other sanctions, taking into account the submissions that have been heard. The Tribunal must consider its determination on impairment and take those matters into account during its deliberations on sanction.

The Tribunal's Determination on Sanction

140. Before considering what action, if any, to take in respect of Dr Srivatsa's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

Aggravating Factors

141. The Tribunal identified the following aggravating factors in the case of Dr Srivatsa:

- Lack of insight which was evidenced by his refusal to accept his failings, his refusal to engage meaningfully with the regulatory process, and his assertion that the GMC had no right to investigate his performance
- A failure to work collaboratively with colleagues

Mitigating Factors

142. The Tribunal was unable to identify any mitigating factors

Undertakings

143. Undertakings were not offered so therefore not appropriate.

No action

144. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Srivatsa's case, the Tribunal first considered whether to take no action. The Tribunal considered that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances, of which there were none in this case.

145. The Tribunal determined that given the seriousness of Dr Srivatsa's misconduct, and the absence of any exceptional circumstances in this case, taking no action was neither appropriate, proportionate nor in the public interest.

Conditions

146. The Tribunal next considered whether imposing conditions on Dr Srivatsa's registration would be sufficient. It was assisted by paragraphs 82 and 85 of the SG which state:

> *82 Conditions are likely to be workable where:*
>
> *a the doctor has insight*
>
> *b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings*
>
> *c the tribunal is satisfied the doctor will comply with them*
>
> *d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.*
>
> *85 Conditions should be appropriate, proportionate, workable and measurable.*

147. The Tribunal was of the view that as there was no evidence that Dr Srivatsa would engage with conditions, and there was no evidence of insight, formulating conditions would be difficult. Additionally, he no longer practiced in the UK. The purpose of conditions is to constrain a doctor's practice whilst giving them an opportunity to address and remediate any failings so that they can return to unrestricted practice. In this case, Dr Srivatsa did not accept he had any issues with his performance, and lacked insight. Therefore, the Tribunal concluded that imposing conditions on his registration was not appropriate.

Suspension

148. In considering whether to impose a period of suspension, the Tribunal had regard to paragraphs 92, 93, and 97 a, e, and f, of the SG which state:

> *92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e., for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*
>
> *93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions.*

97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.

b to d (not relevant)

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 (not relevant)

g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.

149. The Tribunal took into consideration the number of times Dr Srivatsa's misconduct had fallen seriously below the expected standards, his lack of insight, and his opinion that his practice was of an acceptable standard.

150. The Tribunal found this case unusual in that Dr Srivatsa's clinical failures, if considered alone, might not be fundamentally incompatible with continued registration. However, whilst he had maintained contact with the GMC, he had not properly engaged with the GMC and addressed in any way his failings. Along with his lack of acceptance of the risk that he posed to patients, the lack of reflection and the profound lack of insight and remediation, the Tribunal could not be satisfied that Dr Srivatsa would not repeat his behaviour, thus there was an ongoing risk to patient safety. In the circumstances, the Tribunal concluded that a period of suspension would not serve the aims of the overarching objective.

Erasure

151. In view of the serious nature of Dr Srivatsa' misconduct and having concluded that a suspension order would be inappropriate and insufficient, the Tribunal went on to consider the sanction of erasure. The Tribunal was of the view that the factors set out in sub-paragraphs 109 a, b, c, and j of the SG were applicable in this case:

109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.

b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.

c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients.

d-i not engaged

i Persistent lack of insight into the seriousness of their actions or the consequences.

152. The Tribunal also took into account paragraphs 130 and 131 of the SG which state:

130 A particularly important consideration in these cases is whether a doctor has developed, or has the potential to develop, insight into these failures. Where insight is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.

131 Remediation (where a doctor addresses concerns about their knowledge, skills, conduct or behaviour) can take a number of forms, including coaching, mentoring, training, and rehabilitation (this list is not exhaustive), and, where fully successful, will make impairment unlikely.

153. The Tribunal considered that a lack of willingness on Dr Srivatsa's part to accept or learn from his failings and make efforts to remediate was particularly concerning, and meant that there was a continued risk to patient safety. It concluded that the sanction of erasure was necessary to protect and promote the health, safety, and well-being of the public, maintain public confidence in the medical profession and to uphold proper professional standards and conduct for members of the medical profession.

154. The Tribunal has therefore directed that Dr Srivatsa's name be erased from the Medical Register.

Determination on Immediate Order - 29/04/2022

155. Having determined that Dr Srivatsa's name be erased from the medical register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

156. On behalf of the GMC, Ms Jones submitted that based on the Tribunal's previous findings an immediate order of suspension was necessary to protect patient safety and referred the Tribunal to the relevant paragraphs of the SG to follow in its deliberations.

The Tribunal's Determination

157. In reaching its decision, the Tribunal has exercised its own judgement and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or is in the best interests of the practitioner. It has also borne in mind the guidance given in paragraphs 172 – 178 of the SG relating to immediate orders and that if it were to deviate from that guidance, it should give reasons for doing so.

158. The Tribunal determined that in light of the seriousness of its findings, and in the particular circumstances of this case, an immediate order of suspension was necessary in order to protect the public and public confidence in the medical profession.

159. This means that Dr Srivatsa's registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

160. The interim order currently imposed on Dr Srivatsa's registration will be revoked when the immediate order takes effect.

161. That concludes the case

ANNEX A – 28/04/2022 Determination on Proof of Service and Proceeding in Absence

Service

162. Dr Srivatsa is neither present nor represented at this hearing.

163. The Tribunal therefore first considered whether notice of this hearing had been properly served on Dr Srivatsa in accordance with Rules 15 and 40 of the Rules and paragraph 8 of Schedule 4 of the Medical Act 1983, as amended. In doing so, the Tribunal has taken into account all the information placed before it, together with Ms Jones' submissions on behalf of the General Medical Council ('GMC').

164. The Tribunal was provided with a copy of the Proof of Service Bundle which included the following documentary evidence:

- Screen shot of Siebel showing Dr Srivatsa's contact profile, undated
- Email from Dr Srivatsa informing the GMC that he now lives in Germany, dated 30 July 2021
- Correspondence from Dr Srivatsa showing the email address is active, dated 18 February 2022
- Email with Notice of Allegation ('NOA') from the General Medical Council to Dr Srivatsa, dated 14 March 2022
- Proof of service for NOA, dated 14 March 2022
- Email from the GMC to the Medical Practitioners Tribunal Service ('MPTS') informing that Notice of Hearing ('NOH') is ready to be issued, dated 15 March 2022
- Email from MPTS to Dr Srivatsa attaching copy of NOH, dated 17 March 2022
- Letter from MPTS to Dr Srivatsa attaching copy of NOH, dated 21 March 2022
- Returned letter from MPTS to Dr Srivatsa attaching copy of NOH, dated 30 March 2022
- Email correspondence to Dr Srivatsa with Timetable from GMC, dated 21 March 2022
- Email response from Dr Srivatsa, dated 24 March 2022
- Attachment from email response sent by Dr Srivatsa, dated 24 March 2022

165. Email correspondence from Dr Srivatsa indicated that he was now residing in Germany. This explained the reason for the letter sent from the MPTS to his registered home address in the UK, attaching a copy of the NOH, having been returned. However, the onus is upon a doctor to ensure they provide the GMC with their up to date contact information.

166. While Dr Srivatsa had neither read nor responded to the NOH emails from the MPTS to his registered email address, based on the ongoing email correspondence between Dr Srivatsa and the GMC up until 24 March 2022 using the same email address, the Tribunal was satisfied that the email address registered with the GMC was live and currently being used by Dr Srivatsa.

167. In his response on 24 March 2022 to an email from the GMC dated 22 March 2022, Dr Srivatsa acknowledged he had received the email which was explicit in referring to this hearing.

Proceeding

168. Having been satisfied that notice of this hearing has been properly served, the Tribunal then considered, in accordance with Rule 31 of the Rules, whether to proceed with the hearing in Dr Srivatsa's absence.

169. The Tribunal has borne in mind that the discretion to proceed in the absence of a doctor should be exercised with the utmost care and caution. It also bore in mind the need to balance Dr Srivatsa's interests against the public interest.

170. The Tribunal took into account Ms Jones' submissions that Dr Srivatsa had voluntarily absented himself from these proceedings. Ms Jones submitted that adjourning the hearing today would not resolve matters as Dr Srivatsa had indicated that he would not be attending. Ms Jones reminded the Tribunal that Dr Srivatsa had neither sought an adjournment nor indicated that he wished to be represented.

171. In making its decision the Tribunal took into account the submissions made by Ms Jones on behalf of the GMC but exercised its own judgement. The Tribunal had regard to the legal advice as well as the principles in *R v Jones [2001] EWCA Crim 168 and Adeogba and Visvardis [2016] EWCA Civ 162.*

172. The Tribunal noted in particular that the following were relevant considerations:

- The nature and circumstances of the doctor's behaviour in absenting himself;
- Whether the behaviour was voluntary and therefore that the doctor waived the right to be present;
- Whether an adjournment would result in the doctor attending on a subsequent occasion;
- Whether the doctor, although absent, wished to be represented, or whether he had waived his right to be represented;
- The extent of any disadvantage to the doctor and the GMC;
- The importance of the fair, economical and expeditious disposal of allegations; and
- The general public interest.

173. The Tribunal was satisfied that Dr Srivatsa was aware of the investigation and hearing date and that there had been correspondence with the GMC on more than one occasion by email confirming this. Dr Srivatsa had made it clear that he would not be attending the hearing, or be represented, and that he would not be submitting any written representations.

174. The Tribunal has balanced Dr Srivatsa's interests with the public interest in deciding whether to proceed in his absence. The Tribunal was of the view that Dr Srivatsa has voluntarily absented himself from today's proceedings. It noted that Dr Srivatsa has not requested an adjournment of this hearing and there is no evidence to indicate that he would attend this hearing on a future date.

175. The Tribunal has borne in mind that Dr Srivatsa may be disadvantaged if this hearing were to proceed in his absence. However, it has balanced this disadvantage with the need for hearings to be heard expeditiously and has considered that any disadvantage would be a consequence of his voluntary absence from this hearing.

176. The Tribunal considered and balanced the statutory overarching objective and the economic, efficient, and expeditious disposal of the proceedings against the interests of Dr Srivatsa. Given the Tribunal's determination that Dr Srivatsa had voluntarily absented himself and the likely prejudice to the proceedings if the hearing did not go ahead today, the Tribunal determined that the balance fell in favour of proceeding with the hearing.

177. The Tribunal concluded that it would be fair and in the interests of the public for this hearing to proceed. The Tribunal was satisfied that it could proceed without any significant risk of injustice to Dr Srivatsa. It therefore exercised its discretion to proceed in Dr Srivatsa's absence.