PUBLIC RECORD

Dates: 07/04/2022 - 08/04/2022 and
19/04/2022 – 27/04/2022

Medical Practitioner's name:	Dr Panagiota PALOUKI
GMC reference number:	7154372
Primary medical qualification:	Ptychio Iatrikes 2002 University of Crete

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

Summary of outcome

Erasure

Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Emma Boothroyd
Lay Tribunal Member:	Mr Keith Moore
Medical Tribunal Member:	Mrs Deborah McInerny

Tribunal Clerk:	Mr Matthew Rowbotham

Attendance and Representation:

Medical Practitioner:	Present and not represented
GMC Representative:	Ms Shirlie Duckworth, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 25/04/2022

1. This determination will be read in private. However, as this case concerns Dr Palouki's misconduct, a redacted version will be published at the close of the hearing with those matters relating to XXX removed.

Background

2. Dr Palouki qualified in 2002 with a Ptychio Iatrikes from the University of Crete. Prior to the events which are the subject of the hearing Dr Palouki practised in Obstetrics and Gynaecology in Greece. From 2013, Dr Palouki held various locum roles in the UK, becoming a Clinical Fellow in Fertility in 2016. Dr Palouki became a Member of the Royal College of Obstetrics and Gynaecology in February 2018.

3. The allegation that has led to Dr Palouki's hearing can be summarised as failing to adequately consult and treat Patient A, who was suffering a miscarriage, including behaving inappropriately and making inaccurate records. Dr Palouki is also alleged to have consulted with Patient B and not informed her of scan results and that her case needed to be discussed at a multi-disciplinary meeting before commencing IVF treatment. Following the consultation with Patient B, Dr Palouki is alleged to have dictated or authorised a letter to Patient B that contained incorrect information.

4. Additionally, Dr Palouki is alleged to have knowingly recorded incorrect follicle scan results from several patients that she knew were inaccurate. She is also alleged to have not notified other staff, or seek their assistance, when it was apparent that the scan results were inaccurate.

5. Dr Palouki is also alleged to have not attended a locum shift and not informed anyone that she would not be doing so.

6. In addition, during a meeting at Birmingham Women's and Children's NHS Foundation ('BWCT'), Dr Palouki is alleged to have produced confidential patient records taken from another hospital without permission.

7. Dr Palouki is also alleged to have attended a meeting whilst under the influence of alcohol, and asked a colleague to state that she was not under the influence when the incident was investigated. In addition, XXX.

8. Further, Dr Palouki is alleged to have dishonestly not informed a hospital and a locum agency that she was under investigation by the GMC when asked.

9. The initial concerns were raised with the GMC in 2018, following an internal investigation and referral from BWCT.

The Allegation and the Doctor's Response

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

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

University Hospital NHS Foundation Trusts (formerly Heart of England NHS Trust) ('UHFT')

1. On 3 June 2017 you consulted with Patient A, who was suffering a miscarriage and you:

a. were rude and abrupt;

b. inappropriately pushed and pulled Patient A into a seated position on the hospital bed;

c. kept grabbing at Patient A's face and turning it to face you;

d. failed to:

i. make an initial assessment of Patient A's vital signs, including her:

1. airway;
2. pulse;

3. blood pressure;
4. respiratory rate;

ii. explain to Patient A the procedure involved for delivering the placenta and membranes;

iii. obtain informed consent from Patient A to deliver the placenta and membranes;

iv. estimate Patient A's blood loss;

v. consider administration of the medication, syntometrine;

vi. assess whether there was any placental separation;

e. pulled on the umbilical cord more than once, despite Patient A informing you that:

i. the placenta would not deliver naturally;

ii. she would need to have an operation to remove the placenta;

f. failed to make an adequate record of your treatment of Patient A, including:

i. any initial assessment;

ii. whether you had obtained informed consent to attempt to deliver the placenta and membranes;

iii. Patient A's blood loss;

iv. your attempt to deliver the placenta and membranes.

To be determined

2. On or around 27 July 2018 you failed to:

a. attend your locum shift at UHFT;

b. notify anyone that you would not be in work.

Admitted and found proved

Birmingham Women's and Children's NHS Foundation ('BWCT')

3. On 8 June 2018 you recorded incorrect scan results for more than one patient (the 'Scan Patients').

To be determined

4. You knew you recorded incorrect scan results for more than one Scan Patient as you knew:

a. you could not see or take accurate measurements of the follicles;

b. the follicle measurements you had taken were not correct.

Admitted and found proved

5. You failed to:

a. inform a colleague(s) that:

i. you were having difficulties in scanning the Scan Patients and/or reading the follicle measurements;

ii. your follicle measurements for more than one of the Scan Patients were incorrect.

b. seek assistance from a more experienced colleague;

c. rescan any of the Scan Patients to obtain further follicle measurements.

Admitted and found proved

6. On 21 June 2018 you consulted with Patient B with regard to fertility matters ('the June Consultation') and you failed to:

a. discuss the results of the scan undertaken before the consultation on 21 June 2018;

b. inform Patient B of the requirement for her case to be discussed at a multi-disciplinary meeting before IVF treatment could be commenced;

c. make an adequate record of your clinical findings of the speculum examination performed, in that you did not document the appearance of the cervix and vagina.

To be determined

7. Following the June Consultation you dictated and/or authorised a clinic letter, dated 20 July 2018, to Patient B which contained inaccurate information, in that it stated:

a. Patient B had pain during sexual intercourse;

b. Patient B's scan results were discussed;

c. Patient B could not tolerate the speculum examination.

To be determined

8. You knew the information contained in the letter at paragraph 7 was incorrect.

To be determined

9. On 13 September 2018 you arrived at BWCT for a meeting under the influence of alcohol ('the Incident').

Admitted and found proved

10. On 28 September 2018 you:

a. emailed the Investigating Officer at BWCT and gave Ms C's name as someone to ask about the Incident;

b. sent Ms C, a staff member at BWCT, a text:

i. and you asked Ms C to say you were 'not under the influence of alcohol', when you knew that was untrue;

ii. telling Ms C 'you will help me a lot please. XXX. Please' which was inappropriate.

Admitted and found proved

11. During a meeting at BWCT on 19 September 2018 you produced confidential patient records which had been taken from other hospitals without:

a. adequate redaction/anonymisation;

b. the requisite permission from:

i. the patients;

ii. the hospitals.

Admitted and found proved

Additional matters

12. During a telephone call on 12 November 2018 you were notified by the General Medical Council ('GMC') that:

a. information had been received which raised concerns about your fitness to practise;

b. the GMC had opened an investigation into your fitness to practise.

Admitted and found proved

13. In correspondence sent to you by email on 13 November 2018, the GMC notified you that they had opened an investigation into your fitness to practise.

Admitted and found proved

14. On 22 November 2018 in accepting a post at James Paget Hospital you stated in an email 'I am not under investigation from the GMC' which:

a. was untrue;

b. you knew was untrue.

To be determined

15. On 22 November 2018 DRC Locums contacted you to ask if you 'have any investigation on on (sic) GMC' and you:

a. failed to notify DRC Locums of your GMC investigation during a telephone call on 23 November 2018 (the Telephone Call');

b. you knew you were under a GMC investigation during the Telephone Call.

To be determined

16. Your conduct at paragraph(s)

a. 3 was dishonest by reason of paragraph 4;

b. 7 was dishonest by reason of paragraph 8;

c. 10b was dishonest by reason of paragraph 9;

d. 14a was dishonest by reason of paragraphs 12, 13 and 14b

e. 15a was dishonest by reason of paragraphs 12, 13 and 15b.

Admitted in part, to be determined

17. XXX.

Admitted and found proved

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

a. misconduct in respect of paragraphs 1 to 16;

b. XXX

To be determined

The Admitted Facts

11. At the outset of these proceedings, Dr Palouki 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.

The Facts to be Determined

12. In light of Dr Palouki's response to the Allegation made against her, the Tribunal is required to determine whether Dr Palouki provided inadequate care to Patients A and B, made inadequate records of scans and consultations, and dishonestly stated that she was not under investigation by the GMC to two organisations.

Witness Evidence

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

- XXX;
- XXX.

XXX.

14. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence on the basis that Dr Palouki agreed their evidence:

- Dr F, Consultant Obstetrician and Gynaecologist at BWCT, dated 28 October 2021
- Patient A, dated 16 November 2021
- Ms G, Director of the Fertility Centre at BWCT, dated 29 October 2021
- Dr H, Clinical Director at BWCT during the time of the incident, 27 October 2021
- Ms I, Head of Operational Human Resources at BWCT, dated 8 November 2021
- Ms J, Radiology Health Care Assistant at BWCT, 8 November 2021
- Patient B, dated 10 November 2021
- Ms K, Radiology Office Manager at BWCT, dated 11 November 2021
- Dr M, Consultant Gynaecologist in the Fertility Unit at BWCT, dated 18 November 2021 and 31 January 2022 34-35
- Dr L, Speciality Doctor in the Fertility Centre at BWCT during the time of the incident, dated 7 December 2021
- Ms N, Health Care Assistant at BWCT, dated 20 December 2021

- Ms O, Consultant Paediatrician in the Intensive Care Unit at BWCT, dated 16 January 2022
- Ms P, GMC as an Investigation Officer, dated 17 November 2021
- Ms Q, Governance Manager for a healthcare recruiting agency - ID Medical, dated 17 November 2021
- Mr R, Head of Group Quality and Compliance at the locum agency DRC Locums, dated 15 February 2022

15. Dr Palouki gave oral evidence at the hearing, but produced no written statement.

Expert Witness Evidence

16. The Tribunal received oral evidence from Dr S, an expert witness on behalf of the GMC. Dr S qualified in 1987, becoming a Member of the Royal College of Obstetricians and Gynaecology in 1992, and a Fellow in 2004. He had been practising as a Consultant Obstetrician & Gynaecologist since 1999. Dr S produced reports dated 23 July 2020 and 19 January 2022 regarding Dr Palouki's fertility scans and another report regarding her care of Patient's A and B dated 1 December 2021. These reports, and Dr S's oral evidence, assisted the Tribunal in understanding Dr Palouki's standard of care and conduct.

Documentary Evidence

17. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to, XXX; correspondence between colleagues at BWCT; correspondence between colleagues at University of Birmingham NHS Trust; transcripts of interviews conducted by BWCT and University of Birmingham NHS Trust; statements taken by University of Birmingham NHS Trust from Dr Palouki's colleagues; notes of an investigation by University of Birmingham NHS Trust and the Trusts' referral to the GMC; correspondence between the GMC, Dr Palouki, ID Medical and James Paget Hospital; correspondence between the GMC, Dr Palouki and DRC locum agency; XXX; a reference letter, letters of recommendation and certificates on Dr Palouki's behalf; a certificate of good standing from the Ministry of Health and Social Solidarity in Greece; and XXX.

The Tribunal's Approach

18. 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 Palouki 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 Tribunal was mindful that this standard does not vary according to the seriousness of the alleged facts, but that the evidence required to support serious allegations, such as dishonesty, should be more cogent.

19. The Tribunal considered each allegation separately. It was mindful of the advice given by the Legally Qualified Chair to consider the evidence relating to each allegation and not to draw conclusions based on previous findings about the reliability or credibility of evidence relating to other allegations. It was also mindful that it should take care not to speculate but that it was entitled to draw reasonable inferences based on reliable evidence.

20. In certain allegations, Dr Palouki is alleged to have 'failed to have acted'. The Tribunal was mindful that it must find that Dr Palouki had a professional obligation to act, such as stated in Good Medial Practice or common law, before going on to consider whether Dr Palouki did fail to act.

21. The Tribunal noted that the witness statements of witnesses who were not called to give oral evidence under oath would ordinarily be classed as hearsay evidence. However, Dr Palouki indicated that she accepted the witnesses' statements and that they had become agreed evidence. The Tribunal will therefore attach what weight is necessary to each statement and be mindful that Dr Palouki's comments regarding this evidence had not been put to the witnesses.

22. The Tribunal noted that there had been expert witness evidence produced in this hearing, which the Tribunal will take into account. If the Tribunal does not accept the evidence of an expert witness, it should give clear reasons why it has not done so.

23. The Tribunal was mindful that Dr Palouki faces allegations of dishonesty. It will have regard to the case of *Ivey v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] UKSC 67* which states:

> *'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.'

24. The Tribunal noted that Dr Palouki is of good character, with no previous fitness to practise concerns. Whilst good character is not a defence to the allegations Dr Palouki faces, it can be taken into account when assessing her evidence and the likelihood of her acting in the ways alleged.

The Tribunal's Analysis of the Evidence and Findings

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

Paragraph 1

26. Throughout its consideration of this allegation, the Tribunal was mindful that Dr Palouki could not clearly recall parts of this consultation, and gave evidence of a general approach she would employ to indicate that she would not have behaved in the way alleged. The Tribunal noted that Patient A had given an account close to the time of the event, and her evidence, when given later in her witness statement, had not changed from that account.

27. The Tribunal was also mindful that a health care assistant ('HCA') was also in attendance during the consultation. The Tribunal had evidence that the HCA was so concerned about Dr Palouki's behaviour that she took it upon herself to speak to the senior midwife on the ward during the shift following the consultation about her concerns. Following the HCA's comments, an internal review was conducted.

28. As part of this review, Patient A was called to give her account of the consultation. These notes were documented on 19 June 2017 in Patient A's medical records. The Tribunal was mindful that Patient A had not met Dr Palouki before, and noted that Patient A had

not initially raised a complaint. It therefore considered that Patient A would have no reason to be untruthful, or embellish her account of the consultation.

29. The Tribunal therefore considered that Patient A's and the HCA's accounts were more reliable and focused on the consultation, than that of Dr Palouki's, and noted that they were recorded much closer to the incident. In addition, the Tribunal reminded itself that Dr Palouki had accepted the evidence adduced in this hearing, and that any challenges she had made to the evidence had not been put to the witnesses.

30. The Tribunal noted that the allegation indicated that Dr Palouki's consultation with Patient A occurred on 3 June 2017, but that the notes of the consultation were dated 4 June 2017. The Tribunal heard that the consultation occurred during the course of a nightshift, spanning the night of the 3rd and 4th of June 2017. It noted that both parties were clear that the consultation took part at some stage throughout this nightshift, and accepted that although the date in the medical record is 4 June, the consultation referred to in the allegation was agreed upon and clear to Dr Palouki. In these circumstances the Tribunal did not see a need to formally amend the allegation.

Paragraph 1a, b and c

31. The Tribunal considered these allegations together, as they jointly arose from Patient A's complaint.

32. The Tribunal considered that it would be unusual for an HCA to be so concerned about a doctor's behaviour that they would inform a senior colleague. This added weight to the likelihood that Dr Palouki had acted in the way alleged.

33. The Tribunal had regard to the senior midwife's note made in Patient A's records, in which Patient A described the consultation as an 'awful experience' in which Dr Palouki was 'rude + abrupt' and that she had 'grabbed [Patient A's] face' and started 'shouting at her', probably because Patient A was sleepy.

34. In her GMC witness statement, Patient A explained:

> *'It was at this point Dr Palouki arrived and started manhandling me. Dr Palouki kept pushing and pulling me into a seated position on the bed as if I was a child.'*

'This was an extremely traumatic experience for me, and Dr Palouki was supposed to make things easier, but she managed to make it even more traumatic by pulling and pushing me, shouting at me and ignoring me when I was trying to explain my history.'

35. The Tribunal heard from Dr Palouki that she may have shouted at Patient A and grabbed her face, because she was faint and felt that this may revive her. Dr Palouki also said that Patient A may have misinterpreted her manner as 'rude and abrupt' given that English was not her native language, but that her usual tone was 'reassuring'. The Tribunal also heard that Dr Palouki was 'probably dealing with three caesareans' on this night shift, and was 'being bleeped every 5 minutes'. The Tribunal reminded itself that Dr Palouki had no recall of the consultation and was to an extent giving evidence on what she assumed she would have done based on her usual practice. The Tribunal considered that this evidence offered some room for a different interpretation of events by Dr Palouki.

36. Given the contemporaneous evidence of the HCA, the corroborating evidence of Patient A and the wider context given by Dr Palouki, the Tribunal were satisfied that on the balance of probabilities, Dr Palouki had acted in the way alleged. It found sub-paragraphs 1a, b and c proved.

Paragraph 1di1, 2, 3 and 4

37. The Tribunal first considered whether Dr Palouki had a duty to make the initial assessments. The Tribunal had regard to the expert report of Dr S, which states:

I would have also expected that Dr Palouki would make an assessment of Patient [A]'s vital signs including her airway, breathing and circulation and document accordingly which has not been done.

38. The Tribunal accepted the evidence of Dr S, and noted that this evidence was unchallenged by Dr Palouki.

39. The Tribunal noted that it had no evidence that Dr Palouki had made a record of her findings if she had carried out the assessments, and that it was expected of her to make these records. However, it noted that the allegation states that Dr Palouki 'failed to make an initial assessment'. The Tribunal considered that Dr Palouki could have made some of

these assessments via observing and interacting with Patient A, and checking previous assessment results.

40. For example, Dr Palouki spoke with Patient A, and in this way, she could have made an initial assessment of Patient A's airway and respiratory rate. Further, Dr Palouki could have taken Patient A's wrist to check her pulse. There was no evidence before the Tribunal that Dr Palouki had not done this, despite the lack of a note of the results in Patent A's medical record. Patient A said in her witness statement that Dr Palouki examined her and there was no evidence that this did not include checking her pulse. The Tribunal was therefore not satisfied that the GMC had discharged its burden of proof in relation to these allegations.

41. The Tribunal considered that Dr Palouki could not have made an assessment of Patient A's blood pressure without any equipment whereas the other aspects could have been done relatively quickly and as part of an initial examination. The Tribunal found no evidence that Dr Palouki had used a blood pressure machine with Patient A, and noted that Dr S had explained that it would have been vital to take Patient A's blood pressure given the blood loss she had experienced during her miscarriage. It therefore found that, on the balance of probabilities, Dr Palouki had not made an initial assessment of Patient A's blood pressure.

42. The Tribunal therefore found allegation 1di1, 2 and 4 not proved and allegation 1di3 proved.

Paragraph 1dii and iii

43. The Tribunal accepted the unchallenged expert evidence of Dr S, which states:

> *'…it appears that the placenta was retained and therefore it was reasonable to plan to deliver the placenta and membranes. However, the first course of action is to explain to the patient the procedure involved and ensure that the patient has given informed consent. If Patient [A]'s version of events is accepted, it appears that Patient [A] had not given informed consent for the attempt to deliver the placenta…'*

The Tribunal therefore found that Dr Palouki did have a duty to obtain informed consent from Patient A before carrying out the procedure.

44. The Tribunal had regard to Patient A's account of the consultation, which states:

> *'I told her firmly on several occasions that the placenta will not be delivered naturally and that I would need to have an operation to remove the placenta. I knew this because the same thing happened to me in the past and it resulted in me losing two babies. She ignored me and continued to try and get the placenta out by pulling the umbilical cord.'*

The Tribunal noted that Patient A's account was that she had not given consent, and, further, explained to Dr Palouki that another course of action should be taken when Dr Palouki began tugging the umbilical cord.

Dr Palouki stated in her oral evidence that she obtained verbal consent from patient A. She stated that this was a fast moving situation and she was keen to prevent Patient A from having to undergo an unnecessary and possibly risky surgical procedure. Dr Palouki stated that she had no recollection of Patient A saying that she did not agree that this was the correct approach. Dr Palouki also stated that as the doctor she was the professional and although patient A had an input into her care it was ultimately for her to decide the course of action. Dr Palouki indicated that in her view patients in the UK had more of a "word" in their treatment than was the case in Greece.

45. The Tribunal reminded itself that Dr Palouki had accepted Patient A's evidence, and had not taken the opportunity to challenge it. In addition, the Tribunal favoured Patient A's evidence over that of Dr Palouki's. Taking into account Dr Palouki's lack of recollection of the consultation and her evidence that Patient A was not a medical professional it considered that her evidence could not be relied upon. It therefore found that, on the balance of probabilities, Dr Palouki had failed to adequately explain to Patient A and thereby gain informed consent regarding the procedure to deliver the placenta and membranes. It therefore found paragraphs 1dii and iii proved.

<u>Paragraphs 1div, v and vi & ei and ii</u>

46. The Tribunal had regard to Dr S's expert report, which states:

> *'…I would then have expected Dr Palouki to make an assessment of the blood loss and initially consider administration of the drug syntometrine (this is an oxytocic drug containing oxytocin 5 IU and 500mcg of ergometrine; the former causes rhythmic*

uterine contractions and the latter causes a sustained uterine contraction). This drug facilitates a uterine contraction, delivery of the placenta and membranes and control of the blood loss. Once there was a plan to deliver the placenta, I would then have expected an assessment as to whether there was any placental separation and once this had occurred, then the umbilical cord can be pulled with counter pressure being exerted on the lower aspect of the uterus just above the symphysis pubic bone through the abdomen to enable the placenta and membranes to be delivered. It is not apparent from the documents whether Dr Palouki undertook any of these actions. It must be noted that unsafe delivery of the placenta can place the woman at risk of pain, haemorrhage and/or uterine inversion.'

47. The Tribunal accepted Dr S's evidence and concluded that Dr Palouki did have a duty to act / not act in the way alleged.

48. The Tribunal had regard to Patient A's evidence, which states:

'When the baby was delivered, Dr Palouki started to tug on the umbilical cord. I told her firmly on several occasions that the placenta will not be delivered naturally and that I would need to have an operation to remove the placenta. I knew this because the same thing happened to me in the past and it resulted in me losing two babies. She ignored me and continued to try and get the placenta out by pulling the umbilical cord. This caused severe pain and just added to the already horrible experience. This went on for about 5 – 10 minutes, until Dr Palouki eventually left to go and arrange for me to have the placenta surgically removed.'

49. The Tribunal noted that Patient A stated that she had previous experience of delivering a placenta, that she did not wish to have the umbilical cord pulled and that Dr Palouki did not appear to have carried out any of the assessments or considerations alleged.

50. The Tribunal noted that there were no records of Dr Palouki's actions, and that Dr Palouki had struggled to recall this specific consultation. Further, Dr Palouki had not questioned Patient A's evidence.

51. Dr Palouki looked at her consultation note and stated that she didn't consider that there was anything wrong with her actions. Dr Palouki stated that she did prescribe syntometrine. Dr Palouki stated that she had successfully delivered the placenta and

membranes on the second pull of the umbilical cord and saved Patient A from an unnecessary and possibly risky operation.

52. The Tribunal had regard to the medical records of Patient A which confirmed that Dr Palouki had failed to deliver the placenta and membranes. The note made by Dr Palouki is illegible and Dr S has suggested it reads "need to remove the placenta and membranes" alternatively it could read "tried to remove the placenta and membranes." In the Tribunal's view there was no evidence within the records that either Patient A had been prescribed syntometrine or that the actions taken by Dr Palouki to deliver the placenta and membranes were in accordance with the appropriate and safe technique. There is no evidence within the records that Dr Palouki estimated Patient A's blood loss.

53. Dr Palouki's recollection of the incident was in stark contrast to the information contained within the medical records and the recollection of Patient A. The Tribunal considered that Dr Palouki was mistaken in relation to the outcome of her attempt to deliver the placenta and membranes and her recollection could not be relied upon.

54. For these reasons the Tribunal preferred the evidence of Patient A and the medical records when forming an understanding of the events that occurred. Given Patient A's evidence, it therefore found paragraphs 1div, v and vi & ei and ii proved.

Paragraph 1f

55. The Tribunal had regard to Dr S's expert report, which states:

> *Dr Palouki has not documented her initial assessment of Patient [A] when she was asked to attend. I would have expected documentation of:*
> *• The patient's vital signs (pulse, blood pressure, respiratory rate)*
> *• Amount of blood loss*
> *• Informed consent with regards to an attempt to deliver the placenta and membranes.*

And it reminded itself of the excerpt quoted in the Tribunal's consideration of paragraphs 1div, v and vi & ei and ii above.

56. The Tribunal found that Dr Palouki did have a duty to make an adequate record of the information contained in the allegation, as it had accepted Patient A's version of events.

57. The Tribunal noted that the only reference to Dr Palouki's actions were her notes made in Patient A's medical record, which states:

    *'…Placenta still in uterus, (**tried??/need??)** to remove it, but patient still in a lot of pain'.*

    The Tribunal did not consider this to be an adequate record of Dr Palouki's actions, and notes that it had not seen any other records regarding the consultation.

58. The Tribunal therefore found paragraph 1f proved in its entirety.

Paragraph 2

59. The Tribunal noted that Dr Palouki had admitted this allegation, and gave various explanations for the reasons she was unable to attend her shift. The Tribunal found that these explanations did not alter its conclusion in accepting Dr Palouki's admission and finding the allegation proved.

Paragraph 3

60. The Tribunal had regard to Dr Palouki's evidence, in which she now admitted this allegation. Dr Palouki explained that she had recorded the results she had been given by the scanning machine. However, she stated that the 'tracker ball' on the machine was faulty, as some gel had got into the machine, and that this was likely to have given inaccurate results.

61. The patients who had been scanned by Dr Palouki were then rescanned and accurate readings were taken.

62. Given Dr Palouki's admission and evidence, and the documentation showing the difference in scanning results, the Tribunal found this allegation proved.

Paragraphs 4 and 5

63. The Tribunal noted that Dr Palouki had made admissions to these paragraphs. Dr Palouki's evidence was that she had not had much training performing these scans; that she was very busy; that she had usually been supervised, but was not on this occasion;

and that other colleagues were also busy. She therefore did not feel that she could seek support with this issue.

Paragraph 16a

64. The Tribunal considered this allegation at this point, as it relates to the actions alleged in Paragraphs 3, 4 and 5 of the Allegation.

65. The Tribunal had regard to the test set out in *Ivey* and first assessed Dr Palouki's knowledge of the facts. It noted that Dr Palouki had admitted allegation 3 and 4, that she knew she had taken incorrect scan results and had gone on to record them.

66. Further, the Tribunal noted that Dr Palouki did not go on to alert any colleagues of the problems with the scanning machine or that it was likely she had taken inaccurate readings and that she had recorded these incorrect readings. The Tribunal found that Dr Palouki's explanation that there was gel on the tracker ball causing the incorrect readings was a development of Dr Palouki's account of the incident, and did not take away from her state of knowledge at the time. The Tribunal was therefore satisfied that Dr Palouki was fully aware that the readings were inaccurate and she knew them to be so at the time she recorded them.

67. The Tribunal considered that an ordinary decent person would consider a doctor to have acted dishonestly if they had knowingly taken inaccurate readings and recorded these readings. The Tribunal considered that regardless of the reason for the inaccurate readings, the position remains that Dr Palouki recorded results that she was aware at the time were incorrect and took no steps to alert anyone to this position. It found that both limbs of the test set out in *Ivey* to have been met.

68. The Tribunal therefore found Paragraph 16a proved.

Paragraph 6

69. The Tribunal noted that Dr Palouki cannot recall this consultation in any detail. The Tribunal therefore had to rely on Patient B's version of events and the medical records and letter that had been adduced in order to reach its conclusions. The Tribunal noted that Dr Palouki had not challenged Patient B regarding this evidence, and had accepted her evidence.

70. In Patient B's GMC witnesses statement, she states:

> *'The appointment was regarding fertility treatment. We [Patient B and her husband] had been trying for a baby and we wanted to find out if we were able to get in vitro fertilisation ('IVF') treatment. We had even prepared a list of questions we wanted to ask the doctor. […] She kept repeating the phrases "don't worry about it" and "you're fine" whenever we would ask a question. She didn't give us any useful information. […] In the beginning of the appointment, she told me I needed a scan of my throat. My husband and I were very confused because we were there to discuss fertility treatment.[…] she didn't go into much detail about anything and wasn't answering our questions. We asked Dr Palouki whether she thought we were ready for IVF treatment and she said yes and confirmed she would refer us. […] Dr Palouki then performed a speculum examination on me and we left shortly after. The whole appointment took roughly 15 minutes.'*

The Tribunal noted that Patient B could not recall discussing any scan results in her subsequent letter of complaint and specifically stated that the scan results were not discussed.

71. The Tribunal had regard to Dr S's expert evidence, which states:

> *'The documentation (history sheets and letter) is below but not seriously below, the standard expected. This is because Dr Palouki has reflected some clinical findings and management plan in both the clinical notes and letter including the description of the scan, blood tests, semen analysis and requirement for an MDT discussion. In addition, Dr Palouki has described the background history of Patient B which is reasonable practice. However, aspects of the documentation are inconsistent and incomplete:*
>
> *• there is documentation of painful sexual intercourse in the letter which is not documented in the history sheets but is inconsistent in the letter as described*
> *• the description of the speculum examination findings is incomplete. Although it is noted that the speculum examination was very uncomfortable, there is no documentation of the appearance of the cervix and vagina which would be reasonably expected.*

However if Patient B's version of events is accepted then there have been failures in communication with Patient B.

72. The Tribunal noted that Dr S opined, and accepted, that Dr Palouki did have a duty to act in the way alleged.

73. The Tribunal had regard to the record Dr Palouki made of the consultation. It includes some numbering and lettering suggestive of results, such as *'PM: 53%, NF: 3%'* the notes then state:

'Uterus seen 05x33x40
LO + RO not seen
Not possible to inert the probe with either fornix
despite several attempts
Is there any possibility of a vagina septum remains?!
TA ovaries are seen close to the uterine corpus

…Speculum that you could barely tolerate.
Pin head hole > period blood
tiny quantity coming out.
Chaperoned by Crystal.
Verbally consented
for MDT'

74. When considering the discussion of scan results with Patient B, the Tribunal had regard to Patient B's witness statement, which states:

Dr Palouki also mentioned in her letter that she had discussed my scan results with me. This is not true. She never mentioned any scan at any point during our appointment.

75. The Tribunal also had regard to a letter Dr Palouki sent to Patient B following their consultation, it states:

Today I have reviewed you with your partner and the scan results.

76. The Tribunal could not find a note in the medical records of Dr Palouki discussing Patient B's scan results with Patient B, only a record of what may have been the results. It also noted that Dr Palouki's letter states that she had 'reviewed' the results of Patient B, and not 'discussed' them. The Tribunal found that it could not infer from the letter or notes whether Dr Palouki was asserting within those documents that the results were discussed. It therefore found that, as it had found Patient B's evidence to be more reliable and specific to this consultation, then on the balance of probabilities the results were not discussed with Patient B. It therefore found paragraph 6a proved.

77. The Tribunal considered allegation 6b, that Dr Palouki had not informed patient B that her treatment was going to be considered at a multi-disciplinary meeting ('MDT'). The Tribunal noted that Dr Palouki had recorded in the note of the consultation that Patient B was "for MDT refer to FC".

78. The Tribunal also considered that Patient B had stated in her witness statement that she was unhappy that she discovered that she would need further treatment before being referred for fertility treatment. Patient B did not state that she was unhappy that it was not discussed with her that her case would need to be reviewed at an MDT. In her initial complaint to BWH Trust, Patient B wrote:

> *'I understand you will review my case in a MDT meeting. i just ask you not to take into consideration what Dr Palouki wrote regarding last meeting (21june18) because its false!'*

79. The Tribunal noted that Patient B was keen to ensure that information contained in the clinic letter was not put before the MDT as potentially it could affect her suitability for fertility treatment. However, there is no suggestion that the MDT was not discussed with Patient B or that she was not aware of it having to go ahead before fertility treatment could commence. Therefore, given that Dr Palouki made a note of the outcome of the consultation as for MDT and refer to FC and Patient B appeared to be aware of this, the Tribunal found that on the balance of probabilities Dr Palouki did inform Patient B about her case being reviewed at an MDT. It therefore found this allegation not proved.

80. The Tribunal noted that Dr Palouki had mentioned Patient B's speculum in her notes, but that Dr S had stated that an adequate record of a speculum examination would have included documenting the appearance of the cervix and vagina. Given that this did not

appear to be documented, and that Dr S had stated that it should have been, the Tribunal found paragraph 6c proved.

Paragraph 7a

81. The Tribunal noted that it had preferred Patient B's account of the consultation. In her complaint to BWH Trust, she stated:

> *'NEVER did i mention i still have pain during sexual intercourse'*

82. It found that there was no evidence in the record made by Dr Palouki of the consultation to support that Patient B stated during that consultation that she had pain during sexual intercourse. It also reminded itself that Dr Palouki had accepted Patient B's evidence and had not sought to challenge it. It therefore found this allegation proved.

Paragraph 7b

83. The Tribunal was mindful of its findings of paragraph 6a of the Allegation, including the excerpt from the letter Dr Palouki wrote to Patient B following the consultation.

84. The Tribunal noted that the letter does not state that the scan results were discussed, only that a review of the scan results was undertaken. The Tribunal therefore found that whilst the letter could give the impression the scan results were discussed, the letter itself did not explicitly state this. Therefore, the Tribunal found this paragraph not proved.

Paragraph 7c

85. The Tribunal noted that Patient B stated that she had perceived there were no issues with the examination, stating in her complaint to BCW Trust:

> *'she also exageratted the speculum examination claiming i could barely tolerate this which was not the case! Also i was having period during this time she did not mention this!'* (sic)

86. The Tribunal noted that was in contrast to Dr Palouki's record of the consultation, in which she stated that Patient B could *'hardly tolerate'* the examination, and this

assessment is repeated in her letter to Patient B. In her oral evidence Dr Palouki stated that she would have recorded this if the woman made a lot of noises indicating she was uncomfortable or in pain.

87. The Tribunal considered that there was some scope for a difference of interpretation of Patient B's discomfort during the exam. Whilst Patient B may have felt she could tolerate the exam the Tribunal considered it was also likely that Dr Palouki may have reasonably interpreted that she was in discomfort and had recorded her clinical judgement of that examination. Patient B stated that Dr Palouki "exaggerated" the speculum examination which would suggest that there was some discomfort evidenced by Patient B which Dr Palouki exaggerated as barely tolerating. It is clear from the letter written by Patient B that she did not want this information considered by the MDT as she may have perceived this would be considered as an adverse indicator for fertility treatment. Given all these considerations, the Tribunal could not be satisfied that the information in the letter about the speculum examination was inaccurate. It therefore found paragraph 7c not proved.

Allegation 8

88. The Tribunal was mindful that its determination is based on its findings of Allegation 7, and that it had only found allegation 7a proved.

89. The Tribunal noted that Patient B, in her complaint, explains that her period was not mentioned in the consultation or letter, stating:

> *'she also exageratted the speculum examination claiming i could barely tolerate this which was not the case! Also i was having period during this time she did not mention this!'*

Tribunal notes that Dr Palouki did discuss Patient B's period in the letter, stating:

> *'there was just a tiny hole and some blood from your period was noted'*

The Tribunal considered that Patient B had been mistaken about this point, and that her complaint regarding the letter may be less reliable in this regard.

90. Further, the Tribunal found that the letter gave a general overview of the discussion points that the notes indicate were raised in the consultation. The Tribunal noted that although the letter was issued to Patient B sometime after the consultation, it was dictated by Dr Palouki on the day of the consultation. The Tribunal therefore considered that Dr Palouki, when dictating the letter, was recalling parts of the consultation from memory, parts from the notes she made and also taking into consideration previous records of consultations Patient B had had with other clinicians. The Tribunal found that it was likely that certain parts of the letter were discussed with Patient B, but that Dr Palouki had drawn in information from other sources when creating the letter.

91. In addition, the Tribunal considered that Dr Palouki would have had no motivation to include incorrect information in the letter, and would not have needed to have suggested something different occurred in the consultation in the letter.

92. Given the Tribunal's view of the letter and Dr Palouki's motives, it considered that whilst the letter may have been inaccurate about the description of painful sexual intercourse given during that consultation, Dr Palouki had not set out to knowingly put incorrect information into the letter. It was clear from the notes that this had been an issue previously. The Tribunal concluded that it was more likely that Dr Palouki had made an unwitting mistake about whether it was still an issue based on her recollection of the consultation. It therefore found paragraph 8 not proved.

93. The Tribunal subsequently found paragraph 16b not proved, as Dr Palouki could not have acted dishonestly if she did not know that she was including incorrect information in the letter.

Paragraph 9, 10, 11

94. The Tribunal reminded itself that Dr Palouki admitted these allegations, and that it was satisfied that there was documented evidence to demonstrate the Dr Palouki's actions and XXX.

Paragraph 12, 13, 14 and 16d

95. The Tribunal noted that Dr Palouki had admitted paragraphs 12 and 13, in that she had been informed that she was under investigation by the GMC.

96. The Tribunal had regard to the email sent by Dr Palouki to a locum agency, ID Medical, regarding the role at James Paget Hospital, dated 22 November 2018, which states:

> *'I am writing to confirm that I am happy to accept the SHO post at James Paget commencing from Monday 26th November 2018 for 3 make months. I am not looking to work via DRC for this assignment and I can confirm that I am not under investigation from the GMC. Kindest regards Dr. P. Palouki,*

97. The Tribunal noted that, given Dr Palouki's admission to Allegation 13 that the GMC notified her that it had opened an investigation into her fitness to practise in an email dated 13 November 2018, she would have known, when writing the email to the HR department at James Paget Hospital just 9 days later, that she was under investigation.

98. The Tribunal noted Dr Palouki's evidence that her recollection of this incident was fuzzy, and that she wasn't aware what was being asked of her. She explained that she was being booked for shifts from two different agencies, which may have caused the confusion, and that she was already employed at a hospital in Southampton and had no need to accept this post.

99. Nevertheless, the Tribunal was satisfied that given the timings of the emails and her admissions, it was clear that Dr Palouki was under investigation and that she would have known she was under investigation. It found paragraph 14 proved.

100. The Tribunal noted that Dr Palouki is of previous good character, and therefore is less likely to have acted in the way alleged. However, the Tribunal considered that Dr Palouki's statement, that she was not under investigation by the GMC, was an attempt to obtain a role that she may not have been able to obtain if she had stated she was under investigation. In effect, she was knowingly trying to keep the information from James Paget Hospital. The Tribunal found that an ordinary decent person would consider this to be dishonest. It therefore found paragraph 16d proved.

<u>Paragraph 15 and 16e</u>

101. The Tribunal noted Dr Palouki's admissions to paragraphs 12 and 13, in that she had received information that she was under investigation by the GMC on 13 November 2018. The Tribunal had regard to the SMS sent to Dr Palouki from DRC Locums on 22 November 2018 and noted her telephone response on 23 November 2018.

'Hi Dr Palouki – I just wanted to reconfirm if you have any investigation on GMC. its important reply to me…'

'Panagiota Palouki
SWD said she had internal investigation going on within trust of Birmingham womens and Children NHS Trust
She said ID has got her this long term job with full rota and she will work at JP only through them
She wont cover Peterborough at all and hung up while i was discussing.'

102. The Tribunal considered that a reasonable inference could be drawn from the SMS that the sender was enquiring about any GMC investigations. Dr Palouki appeared to have only disclosed information regarding an internal investigation during her phone call the agency a day later. It could see no evidence that Dr Palouki had informed DRC Locums of her GMC investigation. The Tribunal rejected her evidence that she was unaware of what was being asked of her as it had clearly been set out in a text message the day before.

103. The Tribunal had regard to its reasoning set out in its finding of paragraph 14 of the Allegation, and was satisfied that Dr Palouki knew she was under investigation by the GMC at the time of her phone conversation with DRC Locums on 23 November 2018. The Tribunal therefore found paragraph 15 proved.

104. The Tribunal noted that doctors use locum agencies in order to obtain work, and that this possibility may be compromised if the doctor is under investigation by the GMC. It therefore considered that it was more likely that Dr Palouki had avoided telling DRC Locums that she was under investigation by the GMC to ensure that she is still offered roles. The Tribunal considered that the ordinary decent person would find this behaviour to be dishonest. It therefore found paragraph 16e proved.

The Tribunal's Overall Determination on the Facts

105. The Tribunal has determined the facts as follows:

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

University Hospital NHS Foundation Trusts (formerly Heart of England NHS Trust) ('UHFT')

1. On 3 June 2017 you consulted with Patient A, who was suffering a miscarriage and you:

a. were rude and abrupt;

b. inappropriately pushed and pulled Patient A into a seated position on the hospital bed;

c. kept grabbing at Patient A's face and turning it to face you;

d. failed to:

i. make an initial assessment of Patient A's vital signs, including her:

1. airway;
2. pulse;
3. blood pressure;
4. respiratory rate;

ii. explain to Patient A the procedure involved for delivering the placenta and membranes;

iii. obtain informed consent from Patient A to deliver the placenta and membranes;

iv. estimate Patient A's blood loss;

v. consider administration of the medication, syntometrine;

vi. assess whether there was any placental separation;

e. pulled on the umbilical cord more than once, despite Patient A informing you that:

i. the placenta would not deliver naturally;

ii. she would need to have an operation to remove the placenta;

f. failed to make an adequate record of your treatment of Patient A, including:

i. any initial assessment;

ii. whether you had obtained informed consent to attempt to deliver the placenta and membranes;

iii. Patient A's blood loss;

iv. your attempt to deliver the placenta and membranes.

1 a, b, c, di(3),ii,iii,iv,v,vi, e and f Determined and found proved,

di(1, 2 and 4) Determined and found not proved

2. On or around 27 July 2018 you failed to:

a. attend your locum shift at UHFT;

b. notify anyone that you would not be in work.

Admitted and found proved

Birmingham Women's and Children's NHS Foundation ('BWCT')

3. On 8 June 2018 you recorded incorrect scan results for more than one patient (the 'Scan Patients').

Determined and found proved

4. You knew you recorded incorrect scan results for more than one Scan Patient as you knew:

a. you could not see or take accurate measurements of the follicles;

b. the follicle measurements you had taken were not correct.

Admitted and found proved

5. You failed to:

a. inform a colleague(s) that:

i. you were having difficulties in scanning the Scan Patients and/or reading the follicle measurements;

ii. your follicle measurements for more than one of the Scan Patients were incorrect.

b. seek assistance from a more experienced colleague;

c. rescan any of the Scan Patients to obtain further follicle measurements.

Admitted and found proved

6. On 21 June 2018 you consulted with Patient B with regard to fertility matters ('the June Consultation') and you failed to:

a. discuss the results of the scan undertaken before the consultation on 21 June 2018;

b. inform Patient B of the requirement for her case to be discussed at a multi-disciplinary meeting before IVF treatment could be commenced;

c. make an adequate record of your clinical findings of the speculum examination performed, in that you did not document the appearance of the cervix and vagina.

6a and c Determined and found proved, 6b Determined and found not proved

7. Following the June Consultation you dictated and/or authorised a clinic letter, dated 20 July 2018, to Patient B which contained inaccurate information, in that it stated:

a. Patient B had pain during sexual intercourse;

b. Patient B's scan results were discussed;

c. Patient B could not tolerate the speculum examination.

7a Determined and found proved, 7b and c Determined and found not proved

8. You knew the information contained in the letter at paragraph 7 was incorrect.

Determined and found not proved

9. On 13 September 2018 you arrived at BWCT for a meeting under the influence of alcohol ('the Incident').

Admitted and found proved

10. On 28 September 2018 you:

a. emailed the Investigating Officer at BWCT and gave Ms C's name as someone to ask about the Incident;

b. sent Ms C, a staff member at BWCT, a text:

i. and you asked Ms C to say you were 'not under the influence of alcohol', when you knew that was untrue;

ii. telling Ms C 'you will help me a lot please. XXX. Please' which was inappropriate.

Admitted and found proved

11. During a meeting at BWCT on 19 September 2018 you produced confidential patient records which had been taken from other hospitals without:

a. adequate redaction/anonymisation;

b. the requisite permission from:

i. the patients;

ii. the hospitals.

Admitted and found proved

Additional matters

12. During a telephone call on 12 November 2018 you were notified by the General Medical Council ('GMC') that:

a. information had been received which raised concerns about your fitness to practise;

b. the GMC had opened an investigation into your fitness to practise.

Admitted and found proved

13. In correspondence sent to you by email on 13 November 2018, the GMC notified you that they had opened an investigation into your fitness to practise.

Admitted and found proved

14. On 22 November 2018 in accepting a post at James Paget Hospital you stated in an email 'I am not under investigation from the GMC' which:

a. was untrue;

b. you knew was untrue.

Determined and found proved

15. On 22 November 2018 DRC Locums contacted you to ask if you 'have any investigation on on (sic) GMC' and you:

a. failed to notify DRC Locums of your GMC investigation during a telephone call on 23 November 2018 (the Telephone Call');

b. you knew you were under a GMC investigation during the Telephone Call.

Determined and found proved

16. Your conduct at paragraph(s)

a. 3 was dishonest by reason of paragraph 4;

b. 7 was dishonest by reason of paragraph 8;

c. 10b was dishonest by reason of paragraph 9;

d. 14a was dishonest by reason of paragraphs 12, 13 and 14b

e. 15a was dishonest by reason of paragraphs 12, 13 and 15b.

16a, d and e Admitted and found proved, 16b and c Determined and found not proved

17. XXX

Admitted and found proved

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

a. misconduct in respect of paragraphs 1 to 16;

b. XXX

To be determined

Determination on Impairment - 26/04/2022

106. This determination will be read in private. However, as this case concerns Dr Palouki's misconduct, a redacted version will be published at the close of the hearing with those matters relating to XXX removed.

107. 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 Palouki's fitness to practise is impaired by reason of her misconduct and XXX.

The Evidence

108. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. No further evidence was received at this stage.

Submissions

<u>On behalf of the GMC</u>

109. Ms Duckworth submitted that Dr Palouki had, overall, failed to maintain good standards of practice and act within the guidelines of good medical practice.

110. Ms Duckworth submitted that misconduct could be defined as conduct that is regarded as deplorable by fellow practitioners or properly informed members of the public as set out in *General Medical Council v Meadow [2006] EWCA Civ 1390 (26 October 2006)* and involves some act or omission which falls short of what would be proper in the circumstances as defined in *Roylance v GMC [2001] 1 AC 311.*

111. Ms Duckworth submitted that Dr Palouki's misconduct is wide ranging, and this in itself makes it serious, in particular regarding her treatment of Patients A and B, and her conduct when performing and recording scans.

112. Ms Duckworth submitted that Dr Palouki's conduct in relation to the allegations found proved regarding Patient A was deemed to have fallen seriously below the standard expected of a medical professional by Dr S in his expert report, and therefore amounted to serious misconduct.

113. Ms Duckworth submitted that the Tribunal should exercise caution when considering Dr S's opinions of Dr Palouki's overall treatment of Patient B, as Dr S considered some matters found not proved by this Tribunal and allegations not put before this Tribunal. However, Ms Duckworth submitted that Dr S did conclude that Dr Palouki would reasonably have been expected to discuss the scan results with Patient B, and in not doing so, Dr Palouki's conduct fell below, but not seriously below, the standard expected of a medical professional.

114. However, Ms Duckworth submitted that the Tribunal could fully rely on Dr S's conclusions with regard to Dr Palouki's conduct when taking and recording scans. She submitted that Dr S had opined that Dr Palouki's conduct fell seriously below the standard expected.

115. Ms Duckworth drew the Tribunal's attention to paragraphs of Good Medical Practice (2013 edition) ('GMP'), which Dr Palouki had breached. This included:

> *7 You must be competent in all aspects of your work, including management, research and teaching.*
>
> *14 You must recognise and work within the limits of your competence.*
>
> *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 needs.

17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment […]

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible.[…]

31 You must listen to patients, take account of their views, and respond honestly to their questions.

46 You must be polite and considerate.

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

48 You must treat patients fairly and with respect whatever their life choices and beliefs.

49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:

a their condition, its likely progression and the options for treatment, including associated risks and uncertainties
b the progress of their care, and your role and responsibilities in the team
c who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care

116. Ms Duckworth submitted that Dr Palouki's serious misconduct was compounded by the Tribunal's findings of dishonesty. In particular, her dishonesty in relation to her response to locum agencies stating she was not under investigation by the GMC and when texting a colleague to ask her to falsely state that she was not under the influence of alcohol when attending for a meeting. Ms Duckworth submitted that Dr Palouki had prioritised her own interests over that of the medical profession and had not made patients her first

concern. Ms Duckworth submitted that these actions were a breach of paragraphs 65 and 68 of 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.*

117. In addition, Ms Duckworth submitted that Dr Palouki's actions in producing confidential patient records in a meeting, when she did not have permission to do so, was a further occasion of Dr Palouki putting her interests before that of the medical profession, and breached paragraph 50 of GMP, which states:

> *50 You must treat information about patients as confidential.[…]*

118. Ms Duckworth submitted that Dr Palouki's failure to attend a locum shift on 27 July 2018 put patient safety at risk. She submitted that the Tribunal may not be satisfied by Dr Palouki's explanations of why she did not attend or communicate her non-attendance to anyone.

119. Ms Duckworth submitted that it would be difficult for the Tribunal to assess whether Dr Palouki's clinical work XXX. However, she submitted that the Tribunal may wish to take into consideration Patient B's account of her consultation with Dr Palouki, in which Patient B described Dr Palouki as XXX. Ms Duckworth said this might be because of the stress of work or XXX.

120. In terms of Impairment, Ms Duckworth drew the Tribunal's attention to the case of *Cheatle v General Medical Council [2009] EWHC 645 (Admin) (27 March 2009)*

> *'In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the*

doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct.'

Ms Duckworth submitted that because there is a wide range of Dr Palouki's serious misconduct which occurred over a period of time, it cannot be viewed as isolated.

121. Ms Duckworth drew the Tribunal's attention to Dame Janet Smith's test for impairment in *The Fifth Shipman Report,* cited in *CHRE v NMC and P Grant [2011] EWHC 927 (Admin)* which states:

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

122. Ms Duckworth submitted that Dr Palouki had caused distress to Patients A, B and those who had their scans taken and recorded incorrectly. Further, her failure to attend her locum shift and her dishonesty in not disclosing that she was under investigation by the GMC to the locum agencies had an impact on patient care and effective regulation of the profession.

123. In addition, Ms Duckworth submitted that Dr Palouki's dishonesty was a breach of the fundamental tenets of honesty and trust and had brought the medical profession into disrepute. For these reasons, Ms Duckworth submitted Dr Palouki is impaired by reason of her misconduct.

124. XXX

Dr Palouki

125. Dr Palouki submitted that it may have been the locum agencies who had been dishonest in recording that she had accepted a job offer whilst under investigation by the GMC, in

an attempt to frame her. She submitted that she was working as a registrar in Southampton at the time, and questioned why she would accept an offer to be a senior house officer at another hospital.

126.XXX

127.Dr Palouki submitted that it was not her intention to return to practise in the UK, especially after going through this hearing process. She submitted that she is satisfied with her medical post in Greece, and has family and friends there.

The Relevant Legal Principles

128.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.

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

130.When considering misconduct, The Tribunal had regard to the case of *Roylance,* which states:

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

131.The Tribunal was mindful that it could consider the mitigating circumstances of Dr Palouki's case, but that any personal mitigation should not downgrade any finding of serious misconduct to any lesser misconduct.

132. Should the Tribunal find misconduct, the Tribunal was mindful that it does not necessarily need to go on to make a finding of impairment. It had regard to the cases of *Cheatle* and *Grant* as outlined in the GMC's submissions.

133. The Tribunal noted that a proper consideration of impairment also involves an assessment of the degree of insight on the part of the practitioner, and *'that, first, his or her conduct which led to the charge is easily remediable; that, second, it has been remedied; and, third, that it is highly unlikely to be repeated' R (Cohen) v GMC [2008] EWHC 581 (Admin).* The Tribunal noted that Dr Palouki continued to deny some of the allegations she faced. It reminded itself that this is not of itself evidence that she lacks insight and she was entitled to defend the allegations against her.

The Tribunal's Determination on Impairment

Misconduct

134. The Tribunal first considered Dr Palouki's treatment of Patient A. The Tribunal considered that, in relation to allegation 1a, b and c, there was a possibility that that Patient A had misinterpreted Dr Palouki's actions as rude and abrupt in the context of a challenging set of circumstances. Nevertheless, Patient A was distressed by the experience and the HCA was so concerned as to report the matter to a senior midwife. On balance, the Tribunal considered that Dr Palouki's attitude towards Patient A was rude and abrupt and caused her distress in an already very upsetting situation. The Tribunal considered that this amounted to serious professional misconduct.

135. The Tribunal considered that Dr Palouki's actions in not gaining informed consent from Patient A, and, further, ignoring Patient A's explanation as to why she did not give consent, were concerning. The Tribunal noted that Dr Palouki persisted with her actions in the face of Patient A explaining why the procedure would not work. It also considered that not estimating Patient A's blood loss and continuing to pull the umbilical cord was inappropriate and could have had a serious impact on Patient A's health. It was mindful that Patient A needed a surgical procedure after this incident, and that she had been put in a potentially dangerous position because Dr Palouki had not assessed her blood pressure or estimated her blood loss.

136. The Tribunal had regard to Dr S's expert report which stated that Dr Palouki's conduct when treating Patient A fell seriously below the standard expected of a doctor. The Tribunal also considered that Dr Palouki's actions had breached paragraphs 15,17,31,46,47,48,49 of GMP as outlined in Ms Duckworth's submissions.

137. Given these considerations, it found that Dr Palouki's actions would be considered deplorable by fellow practitioners, and amounted to serious misconduct.

138. The Tribunal next considered Dr Palouki's conduct when she failed to attend a locum shift, and did not inform anyone that she was not going to attend. The Tribunal noted that this incident had not, in itself, prompted investigation into Dr Palouki's conduct. Nevertheless, it was mindful that Dr Palouki had not offered a clear explanation of why she had not attended the shift, nor why she had not told anyone she was unable to. Instead, Dr Palouki had sought to minimise the impact of her actions and stated that everyone had missed shifts.

139. The Tribunal considered that Dr Palouki's actions breached paragraph 38 of GMP, which states:

> *38 Patient safety may be affected if there is not enough medical cover. So you must take up any post you have formally accepted,[…] unless the employer has reasonable time to make other arrangements.*

140. The Tribunal found that Dr Palouki's conduct regarding this allegation were consistent with a pattern of behaviour and her general attitude towards her obligations. However, on its own, despite the breach of GMP, the Tribunal considered that Dr Palouki's conduct was not so serious as to amount to serious misconduct.

141. When considering Dr Palouki's conduct whilst administering and recording the follicle scan results, the Tribunal was mindful of Dr S's expert opinion. He stated that her conduct fell seriously below the standard expected. The Tribunal also had regard to the paragraphs of GMP outlined in Ms Duckworth's submissions, in particular paragraph 19, which the Tribunal considered Dr Palouki had breached.

142. The Tribunal noted that the only reason the patients were re-scanned was because another doctor reviewed Dr Palouki's results and found them to be abnormal. The Tribunal considered that Dr Palouki had therefore caused distress to patients, who were

already emotionally invested in their IVF process, by recording the incorrect scan readings. Her conduct had the potential to cause the cycle of IVF to fail.

143. Given these considerations, the Tribunal found that Dr Palouki's conduct amounted to misconduct, and that this misconduct was serious professional misconduct.

144. The Tribunal considered Dr Palouki's care of Patient B. It noted that Dr S had found that Dr Palouki's failure to discuss scan results with Patient B had fallen seriously below the standard expected of a doctor, as it had not met Patient B's expectations.

145. However, the Tribunal was mindful that Dr S's opinion was formed from reviewing all the allegations, some of which were not found proved before this Tribunal. It noted that Patient B's distress appeared to stem from the inaccurate clinic letter which detailed pain during intercourse and being unable to tolerate the speculum examination which she said was untrue. Patient B did not want the contents of the clinic letter discussed at a multi-disciplinary team meeting in relation to IVF treatment because they were inaccurate. Patient B's distress and complaint did not arise from Dr Palouki's failure to discuss the scan results with her or tell her that an MDT meeting was required. In relation to the expectations of Patient B, the complaint letter and statement made it clear that she was upset that she wasn't told that she may need further treatment before IVF could be considered but this was not an allegation before this Tribunal.

146. The Tribunal found that Dr Palouki should have discussed and documented the scan results with Patient B. But, her conduct in not doing so fell below, but not seriously below, the standard expected of a doctor. The Tribunal considered that Dr Palouki did fall short in her recording of the consultation and her preparation of the subsequent letter, but her failings were not so serious as to amount to misconduct.

147. The Tribunal next considered Dr Palouki's actions in attending a professional meeting under the influence of alcohol and asking a colleague, via text, to say that she was not under the influence. The Tribunal was mindful that, until this hearing, Dr Palouki had denied attending the meeting under the influence of alcohol. XXX.

148. The Tribunal noted that Dr Palouki had attempted to include a junior colleague in her dishonesty with the aim of misleading an investigation into her conduct. The Tribunal considered this was extremely serious. The Tribunal was in no doubt that her actions in

attending a professional meeting into her conduct under the influence of alcohol was not conduct expected of a doctor and amounted to serious professional misconduct.

149. When considering Dr Palouki's use of confidential patient material in a meeting, the Tribunal was mindful that Dr Palouki was attempting to demonstrate her medical abilities in a private forum. The Tribunal had no evidence before it that Dr Palouki was attempting to use this information for any other purpose or that it had been shared more widely.

150. Nevertheless, the Tribunal considered that Dr Palouki would have known that she should not have accessed this information without authorisation and should have ensured that it was anonymised before it was shared. The Tribunal considered that there was a potential for the information to have been lost and that, in any event, this breach may have distressed patients to know that their medical records were being used in this way. Further, Dr Palouki's actions were a serious data breach which required addressing by the organisations involved. The Tribunal considered that Dr Palouki had breached patient confidentiality and in doing so had placed her own needs above those of her patients.

151. Given these considerations, the Tribunal found that Dr Palouki's actions did amount to serious misconduct.

152. The Tribunal next considered Dr Palouki's conduct when responding to locum agencies stating that she was not under investigation by the GMC following their enquiries.

153. The Tribunal noted Dr Palouki's submissions that she was not looking for a job and may have misunderstood what the locum agencies were requesting, or that the locum agencies had attempted to frame her.

154. However, the Tribunal dismissed Dr Palouki's submissions as it had found that Dr Palouki was aware of the investigation and had said in both an email and a telephone call that she was not subject to a GMC investigation. The Tribunal considered that Dr Palouki's actions undermined the role of the medical regulator and her responsibilities as a regulated professional doctor. The Tribunal considered that it was of the utmost importance for potential employers to be able to rely on what doctors say about their status to ensure safe and effective care for patients. Regardless of whether Dr Palouki was intending to take up the post, it was her responsibility to be open and honest about

the GMC investigation. Given these factors, the Tribunal found that Dr Palouki's actions amounted to serious misconduct.

155. The Tribunal went on to consider whether Dr Palouki was impaired by reason of her actions that had amounted to serious misconduct.

156. The Tribunal was mindful that some concerns, such as her dishonesty, may be difficult to remediate, but that other issues, such as her treatment of Patients A and B and her scanning abilities may be easier to remediate. However, the Tribunal found little evidence of any remediation. There was no evidence before the Tribunal of courses attended or properly informed testimonials demonstrating safe and effective practice and communication with patients. The Tribunal therefore considered that the issues raised by the allegations, such as being able to communicate effectively with patients or Dr Palouki's clinical failings had not been adequately addressed. The Tribunal acknowledged Dr Palouki's oral evidence that she was working effectively in Greece at a senior level.

157. The Tribunal noted that Dr Palouki appeared to have little understanding of her misconduct, and that she felt people were 'making a big deal out of this'. This indicated to the Tribunal that Dr Palouki had yet to gain insight into the seriousness of her actions, particularly the dishonesty aspects.

158. Given the lack of insight into her actions and the lack of remediation, the Tribunal found that there was a high likelihood of Dr Palouki repeating her actions.

159. The Tribunal was also mindful of the seriousness of Dr Palouki's actions which encompassed wide ranging failures compounded by several instances of dishonesty. Given the seriousness of the misconduct and the effect on public confidence in the profession it concluded that there would be a public interest in finding Dr Palouki's fitness to practise impaired.

160. In view of the overall considerations of this case, the Tribunal determined that Dr Palouki's fitness to practise was impaired by reason of serious misconduct.

XXX

161. XXX.

162.XXX.

163.XXX.

164.XXX.

165.XXX.

166.XXX.

Determination on Sanction - 27/04/2022

167.This determination will be read in private. However, as this case concerns Dr Palouki's misconduct, a redacted version will be published at the close of the hearing with those matters relating to XXX removed.

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

The Evidence

169.The Tribunal has taken into account evidence received during the facts stage of the hearing where relevant to reaching a decision on sanction. No further evidence was received at this stage.

Submissions

On behalf of the GMC

170.Ms Duckworth submitted that sanctions are not designed to punish a doctor but may have a punitive effect. The primary purpose of a sanction is to uphold the overarching objective. She submitted that patients must be able to trust doctors, and that a doctor's conduct must justify this trust.

171.Ms Duckworth submitted that the benchmark Dr Palouki was expected to meet was that set out in Good Medical Practice ('GMP'). She submitted that the Tribunal had found that

Dr Palouki had committed serious breaches of GMP, in a number of different ways, and on a number of different occasions. Given these considerations, Ms Duckworth submitted that taking no action would not be appropriate.

172. When considering the mitigating factors of this case, Ms Duckworth submitted that Dr Palouki had gained insight XXX and that there had been a lapse of time since the incidents. In addition, there have been no previous fitness to practise concerns regarding Dr Palouki. Further, Dr Palouki appeared to have been under some work-related stress at the time of the incidents.

173. However, Ms Duckworth submitted that Dr Palouki had a responsibility to recognise the affect of XXX and take action where this may have impaired patient safety. Additionally, Ms Duckworth submitted that whilst some incidents may have occurred due to cultural differences, Dr Palouki had worked in the UK for a reasonable amount of time and would have been expected to familiarise herself with standards expected of UK employment. Further, some misconduct, such as inviting Ms C to engage in dishonest behaviour, could not easily be explained as the result of cultural differences.

174. Ms Duckworth submitted that the Tribunal had found little evidence of Dr Palouki remediating her misconduct or sufficiently understanding the seriousness of her actions. In addition, she submitted that the Tribunal had also found that Dr Palouki had not gained insight into her actions and dishonesty, and that this therefore meant there was a high likelihood of repetition. Ms Duckworth submitted that any apologies Dr Palouki had made for her actions may be viewed as equivocal or grudgingly made.

175. Ms Duckworth submitted that given Dr Palouki's lack of insight, this was not a case suited to the sanctions of undertakings or conditions, as she would not recognise the steps needed to remediate. These sanctions would also not address the wide-ranging failures Dr Palouki had made, which were compounded by her dishonesty, nor would they satisfy the public interest.

176. Ms Duckworth drew the Tribunal's attention to paragraph 97 of SG, which states

> *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 In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.
[…]
f No evidence of repetition of similar behaviour since incident.
g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.

Ms Duckworth submitted that the Tribunal had not seen evidence of any steps taken by Dr Palouki to mitigate her misconduct, and therefore cannot be satisfied that she is unlikely to repeat her behaviour.

177. Ms Duckworth submitted that, given the findings of the Tribunal, nothing short of erasing Dr Palouki's name from the medical register would be appropriate. She drew the Tribunal's attention to paragraphs 108 and 109 of SG, which state:

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

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 Abuse of position/trust.

e Violation of a patient's rights/exploiting vulnerable people
[…]
h Dishonesty, especially where persistent and/or covered up
i Putting their own interests before those of their patients
j Persistent lack of insight into the seriousness of their actions or the consequences.

178. Ms Duckworth submitted that Dr Palouki had been reluctant to take remedial action; reluctant to apologise; reluctant to address her failings over a period of time; failed to be open and honest; displayed a lack of candour during interviews; attempted to dishonestly involve a colleague in covering up an issue; been dishonest with locum agencies; and XXX.

179. Ms Duckworth concluded by submitting that Dr Palouki had shown a reckless disregard for patient safety causing the potential for patient harm; demonstrated repeated and sustained dishonesty; and shown a persistent lack of insight into her actions or remediation for them. Given these aggravating factors, and the possibility that she may repeat her actions, Ms Duckworth submitted that the only appropriate sanction would be to erase Dr Palouki's name from the medical register.

Dr Palouki

180. Dr Palouki submitted that she was willing to gain insight into her actions and apologise for and remediate her mistakes. This included gaining better communication skills, apologising for the non-anonymisation of medical records, understanding that she had not documented everything she should have during consultations, and working on her scanning abilities. She accepted that these areas were below the standard required. Dr Palouki submitted that, for example, she had completed a masters in foetal maternal medicine and would be capable of performing scans that could find foetal abnormalities in any hospital setting.

181. However, she submitted that she should not have to apologise when other parties, such as the locum agencies, had told 'a pack of lies', and she submitted had tried to frame her.

182. Dr Palouki submitted that she had been working across the UK since 2013 as a clinical fellow and working in medicine since 2002. She submitted that no complaints were made about her work until the alleged incidents.

183.Dr Palouki submitted that she was working in an area beyond her skills at Birmingham hospital. In relation to Patient A, she submitted that she was attempting to avoid Patient A requiring surgery, and that the incident occurred during a busy night where she was constantly being beeped.

The Tribunal's Determination on Sanction

184.The Tribunal considered the aggravating and mitigating factors in this case.

Aggravating

185.The Tribunal considered that Dr Palouki had a lack of insight into her misconduct, and this was an aggravating feature. It noted that Dr Palouki had not demonstrated an appreciation or acceptance of the concerns that have been raised about her practice and dishonesty. The Tribunal found that Dr Palouki had, at times, given explanations that were incompatible with the evidence, for example in relation to the outcome of her attempt to deliver the placenta for Patient A. Dr Palouki had also suggested that she had been "framed" by the locum agencies but had not challenged this evidence at the facts stage or provided any credible evidence in support of such an assertion. The Tribunal considered that this was her attempt to deflect responsibility and create a false narrative of events.

186.The Tribunal noted that Dr Palouki had, on several occasions, strenuously denied being under the influence of alcohol when attending for a meeting. This included during a local disciplinary meeting, XXX and at the early stages of this GMC investigation. The Tribunal found that this suggested that Dr Palouki did not appreciate or understand her responsibility to be open and honest with those investigating concerns and this aggravated her lack of insight.

187.The Tribunal also considered that Dr Palouki had failed to work collaboratively with colleagues, including attempting to involve Ms C in dishonest conduct when asking her to provide false evidence during an internal investigation.

188.The Tribunal did not accept Dr Palouki's explanation that parts of her conduct would be acceptable in Greece. For example, it found that dishonesty is not a cultural concept, and would not have been accepted in Greece. Further, it was mindful that Dr Palouki had

worked in the UK since 2013, and that by the time the incidents occurred, she should have been familiar with good practice in the UK.

189. The Tribunal also considered that Dr Palouki's failure to raise her concerns when she was aware that she had recorded the incorrect results from the scanner, was an aggravating feature as this put patients at risk of a failed IVF cycle.

Mitigating

190. The Tribunal noted that it had no evidence of any fitness to practice concerns before the alleged incidents. In addition, Tribunal noted a testimonial that explained Dr Palouki had been working as an Assistant Obstetrician in Gynaecology-Obstetrics since April 2019 without "interruption".

191. The Tribunal accepted that Dr Palouki was inexperienced in scanning at the time of the scanning incident and had usually worked under supervision.

192. The Tribunal noted that Dr Palouki had explained that she was experiencing work related stress during the incidents.

193. Dr Palouki had offered limited apologies for parts of her misconduct, and, for example, now shows an acceptance and understanding that she should not use confidential medical record records without permission.

194. Dr Palouki cooperated fully throughout the hearing.

Sanction

195. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgement.

196. In reaching its decision, the Tribunal has taken account of the SG and of the overarching objective. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Palouki's interests with the public interest. It has borne in mind that the purpose of sanctions is not to be punitive, but to protect patients and the wider public interest, although the sanction may have a punitive effect.

197.The Tribunal had regard to the case of *Bolton v Law Society [1994] 1 WLR 512,*

> *'the reputation of the profession is more important than the fortunes of any one individual member. Membership of a profession brings many benefits, but that is a part of the price'*

198.The Tribunal noted that it is entitled to depart from the SG but must give clear and cogent reasons for doing so.

199.In coming to its decision as to the appropriate sanction, if any, to impose in Dr Palouki's case, the Tribunal first considered whether to conclude the case by taking no action.

No action

200.The Tribunal determined that in view of the serious nature of the Tribunal's findings at the facts stage and on impairment, it would be neither sufficient, proportionate nor in the public interest, to conclude this case by taking no action.

Conditions

201.The Tribunal next considered whether it would be sufficient to impose conditions on Dr Palouki's registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable, and measurable.

202.The Tribunal was mindful that Dr Palouki's dishonesty was at the top end of the spectrum. It was wide ranging and encompassed a number of different aspects which were related to Dr Palouki's clinical practice. The Tribunal found that it would be difficult for it to compose a set of appropriate conditions that would address these failures as well as mark the seriousness of this aspect.

203.Further, the Tribunal found that Dr Palouki's lack of insight into her misconduct meant that she had shown little evidence of the areas of practise she needed to develop if she was subject to a set of conditions. The Tribunal was not confident Dr Palouki would comply with reporting conditions given her failure to be open with the Trust inquiry and the locum agencies. In addition, the Tribunal noted that Dr Palouki was currently based in Greece and had indicated that she had no intention of returning to the UK. Given all these factors, the Tribunal considered that imposing conditions on Dr Palouki's practice would not be workable, appropriate, or proportionate.

204.The Tribunal therefore determined not to impose conditions.

Suspension

205.Tribunal then went on to consider whether suspending Dr Palouki's registration would be appropriate and proportionate. It had regard to paragraph 92 of SG, which states:

> *'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'*

and paragraph 97 of SG, as set out in Ms Duckworth's submissions.

206.The Tribunal considered the aggravating features of this case. It noted the scale of Dr Palouki's misconduct, which included putting patients at risk of harm, multiple examples of dishonesty and undermining the public's confidence in the medical profession. Further, it noted that Dr Palouki had not gained sufficient insight into her misconduct in order to satisfy the Tribunal that her misconduct was highly unlikely to be repeated.

207.The Tribunal found that Dr Palouki had not met the requirements set out in paragraphs 92 and 97 of SG. In addition, it was not persuaded that Dr Palouki would develop insight into her actions, and so a suspension would therefore serve little purpose. It therefore determined that suspending Dr Palouki's registration would be inappropriate and not fulfil the overarching objective.

Erasure

208.The Tribunal had regard to paragraph 128 of SG, which states:

> *128 Dishonesty, if persistent and/or covered up, is likely to result in erasure*

The Tribunal noted its findings at earlier stages where it had concluded that Dr Palouki had been dishonest on a number of occasions and that this dishonesty was at the highest

end of the spectrum. It was mindful that this undermined Dr Palouki's integrity and found that Dr Palouki had not demonstrated the probity a good doctor requires.

209.The Tribunal also remined itself that it had found that Dr Palouki had chosen her own interests over that of the medical profession and her patients on more than one occasion. The Tribunal considered that Dr Palouki was unable to take responsibility when she has made mistakes or errors and sought to blame patients and others for her failings. This attitude had put patients at risk. Given the evidence before the Tribunal it had little confidence that Dr Palouki would be able to address this attitudinal failing and it considered that when faced with difficulty it was likely Dr Palouki would again be dishonest. The Tribunal considered that this pervasive attitude is fundamentally incompatible with continued registration as a doctor in the UK.

210.Given these considerations, the Tribunal determined that erasing Dr Palouki's name from the medical register was the appropriate sanction in this case. It found that this sanction would protect the public and send a message to the profession that Dr Palouki's behaviour was unacceptable, and maintain public trust in the profession.

45. The Tribunal had regard to the impact of such an order on Dr Palouki, but it considered that the public interest was such that these considerations outweighed those of Dr Palouki.

Determination on Immediate Order - 27/04/2022

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

Submissions

<u>On behalf of the GMC</u>

212.Ms Duckworth submitted that imposing an immediate order was necessary given the Tribunal's findings. This included Dr Palouki's wide ranging dishonesty and the number of aspects relating to her poor clinical practice.

213.Ms Duckworth submitted that the scale of Dr Palouki's misconduct had put patients at risk of harm and undermined public confidence in the medical profession. Further, she

submitted that the Tribunal had found that Dr Palouki lacked sufficient insight into her misconduct and was likely to repeat it.

214. Ms Duckworth submitted that imposing an immediate order would protect the public's confidence in the medical profession and reinforce the Tribunal's decision to erase Dr Palouki from the medical register.

Dr Palouki

215. Dr Palouki submitted that there would not be a risk to patients as she was not practising in the UK.

The Tribunal's Determination

216. The Tribunal had regard to the section regarding immediate orders in the Sanctions Guidance (November 2020) ('SG'), including paragraph 172, which states:

> *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.*

217. The Tribunal also had regard to all the circumstances of this case and all the determinations it has made so far when making this determination.

218. The Tribunal noted that given it had determined to impose the sanction of erasure, it would now need to consider if an immediate order of suspension was appropriate. Its was mindful that this may be on the grounds of protecting the public interest or to uphold patient safety.

219. The Tribunal was mindful that although Dr Palouki is not currently practising in the UK, it would be open to her to return to unrestricted practice within the appeal period if it did not impose an immediate order. Given Dr Palouki's lack of probity, the risk she poses to

patient safety, and the Tribunal's overall determination of her serious misconduct at earlier stages of this hearing, the Tribunal considered that Dr Palouki's practise did need to be restricted during any appeal period. The Tribunal therefore imposed an immediate order of suspension on Dr Palouki's registration, and considered that to do otherwise would not address its previous concerns around Dr Palouki's practice.

220. This means that Dr Palouki's registration will be suspended from when notification is deemed to have been served. The substantive direction, as already announced, will take effect 28 days from when written notice of this determination has been served upon Dr Palouki, 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.

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

XXX

XXX