PUBLIC RECORD

Dates: 22/03/2021 - 31/03/2021

Medical Practitioner's name: Dr Rafal IGNACZUK

GMC reference number: 6132299

Primary medical qualification: Lekarz 2005 Akademia Medyczna im Feliksa Skubiszewskiego Lublin

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

Summary of outcome

Case concluded

Tribunal:

Legally Qualified Chair	Mr Angus Macpherson
Medical Tribunal Member:	Dr Andrew Cohen
Medical Tribunal Member:	Dr Tushar Vince

Tribunal Clerk:	Ms Anne Bhatti

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Ivill, Counsel, instructed by Medical Defence Union
GMC Representative:	Ms Goring, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 31/03/2021

Background

1. Dr Ignaczuk qualified from the Medical University of Lublin in Poland in 2005. He worked as a Gynaecology Registrar. He moved to the United Kingdom and qualified as a General Practitioner ('GP') in January 2017. At the time of the events the subject of this inquiry, Dr Ignaczuk practised as a locum GP at the Chard Road Surgery, Plymouth ('the Practice'). Since July 2019, he has been practising as a locum GP at the Oaklands Surgery, Somerset.

2. Patient A initially attended Dr Ignaczuk's surgery on 2 May 2018 complaining about breathlessness on exertion; several consultations took place thereafter between Dr Ignaczuk and Patient A either in person or on the telephone. Patient A's wife, Mrs B was in attendance at all the face-to-face consultations. The Allegation that has led to Dr Ignaczuk's hearing can be summarised as follows: on three separate occasions, 5 June, 23 July and 26 July 2018, Dr Ignaczuk consulted with Patient A and failed to provide good clinical care.

3. It is alleged that Dr Ignaczuk: on 5 June 2018 failed to obtain an adequate medical history including the presence or absence of a wheeze and chest pain; on 23 July 2018 failed to ask about the presence or absence of other symptoms of cardiovascular disease including chest pain, discomfort and palpitations; and also failed to diagnose, or exclude coronary heart disease ('CHD').

4. It is also alleged that on 26 July 2018, Dr Ignaczuk failed: to obtain a detailed history of Patient A's symptoms, including the presence or absence of chest pain, discomfort and palpitations; to arrange any follow including further diagnostic tests to confirm or exclude

CHD; to advise Patient A to seek GP review if symptoms worsened and to seek urgent advice if he experienced chest pain or discomfort.

5. It is further alleged that Dr Ignaczuk failed to address the complaint received from Mrs B when this was communicated to him by Ms E, as set out in Schedule 1.

6. The initial concerns were raised with the GMC on 18 April 2019 by Mrs B.

The Outcome of Applications Made during the Facts Stage

7. The Tribunal granted the GMC's application, made pursuant to Rule 17 (2) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to amend the Allegation. The Tribunal's full decision on the application is included at Annex A.

8. In the course of cross-examination of Dr Ignaczuk, the Tribunal rejected the objection of Mr Ivill, Counsel for Dr Ignaczuk, to questions asked by Ms Goring, Counsel for the GMC. These related to paragraph 4 of the Allegation. Mr Ivill's objection was on the basis that paragraph 4 of the Allegation implied a time limit for Dr Ignaczuk to address Ms E's correspondence, and that the questioning went beyond that time limit. Ms Goring explained that the purpose of the questions was to find out whether Dr Ignaczuk had addressed the correspondence from Ms E.

9. The Tribunal was of the view that paragraph 4 of the Allegation was drafted sufficiently widely to allege that Dr Ignaczuk had not addressed the complaints communicated to him by Ms E. Ms Goring's questions were therefore appropriate. The Tribunal was also mindful that Mr Ivill would have an opportunity to re-examine on the matter further, after Ms Goring had completed her cross-examination.

The Allegation and the Doctor's Response

10. The Allegation made against Dr Ignaczuk, as amended, is as follows:

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

Patient A

1. On 5 June 2018 you consulted with Patient A and you failed to:

a. obtain an adequate medical history including the presence or absence of:

i. wheeze; To be determined

ii. chest pain. To be determined

2. On 23 July 2018 you consulted with Patient A and you failed to:

a. ask about the presence or absence of other symptoms of cardiovascular disease including:

i. chest pain; To be determined

ii. discomfort; To be determined

iii. palpitations. To be determined

b. diagnose, or exclude Coronary Heart Disease ('CHD'); To be determined

3. During your telephone consultation with Patient A on 26 July 2018 you failed to:

a. obtain a detailed history of Patient A's symptoms, including the presence or absence of:

i. chest pain; To be determined

ii. discomfort; To be determined

iii. palpitations; To be determined

b. arrange any follow up for Patient A, including further diagnostic tests to confirm or exclude CHD; To be determined

c. advise Patient A to seek:

i. GP review if symptoms worsened; To be determined

ii. urgent advice if he experienced chest pain or discomfort; To be determined

Failure to engage

4. You failed to address the complaint received from Patient A's wife when this was communicated to you by Ms E as set out in Schedule 1. To be determined

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

The Facts to be Determined

11. In light of Dr Ignaczuk's response to the Allegation made against him, the Tribunal is required to determine the alleged facts as set out above.

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

- Mrs B, by video link;

13. Dr Ignaczuk provided his own witness statement dated 5 August 2020 and also gave oral evidence at the hearing.

Expert Witness Evidence

14. The Tribunal also received evidence from two expert witnesses. On behalf of the GMC, Dr C produced two expert reports dated 4 September 2019 and a supplementary report dated 15 January 2021. Dr C qualified in 1988 and worked as a GP trainer for 10 years and has 25 years' experience working as a GP.

15. On behalf of Dr Ignaczuk, Dr D produced two expert reports, dated 22 October 2019 and 14 December 2020. Dr D qualified as a doctor in 2004 and as a GP in 2009. He had been working as an undergraduate tutor at University College London Medical School since 2013. In addition, he was a member of NICE GP Reference Panel which involves reading new or revised NICE guidelines and giving feedback on their applicability to general practice.

16. A joint expert report was prepared by Dr C and Dr D dated 25 February 2021.

Documentary Evidence

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

- Correspondence between Mrs B and Access Health Care, a subsidiary of Devon Doctors Limited dated 27 December 2018, 4 January 2018, 14 March 2019 and 15 April 2019;
- Mrs B's complaint to the GMC dated 18 April 2019;
- Patient A's redacted medical records and discharge notes dated between May 2018 and January 2019;
- Email/text messages relating to Devon Doctors' local investigation dated between 29 January 2019 and 9 May 2019;
- A Rule 7 response from Dr Ignaczuk dated 24 October 2019.

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 Ignaczuk 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 in question occurred.

19. In the context of the submission by Mr Ivill that, in not arranging follow up for Patient A and/or not referring Patient A for further diagnostic tests (paragraph 3 (b) of the Allegation), Dr Ignaczuk was following the practice of a body of reasonably competent GPs, the Legally Qualified Chair referred the Tribunal to the Bolam test:

> *'It is sufficient if a doctor follows a practice adopted by a recognised body of medical opinion. If there is such a body of medical opinion and it is followed then the medical practitioner will not be liable for any adverse outcome despite the existence of another medical practice that would have adopted a different course which could or would have produced a better outcome.'* ***Bolam v Friern Hospital Management Committee [1957] 2 All ER 118***

He explained that the case of ***Administratrix of the Estate of Patrick Nigel Bolitho (deceased) v City and Hackney Health Authority [1997] 4 All ER 771*** added a qualification. In that case it was established that a doctor could be liable for negligence in respect of diagnosis and treatment despite a body of professional opinion sanctioning his conduct, where it had not

been demonstrated to the judge's satisfaction that the body of opinion relied on was reasonable or responsible.

20. In an action involving clinical judgment, there is therefore a two-step procedure to determine the question of alleged medical negligence:

> *(a) whether the medical practitioner acted in accordance with a practice accepted as proper for an ordinarily competent medical practitioner by a responsible body of medical opinion; and*
>
> *(b) if "yes", whether the practice survives Bolitho judicial scrutiny as being "responsible" or "logical".*

The Tribunal's Analysis of the Evidence and Findings

21. 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.

Mrs B

22. The Tribunal found Mrs B evidence to be rather confused. The Tribunal considered that, in her initial letter of complaint dated 27 December 2018, she had confused the symptoms which Patient A suffered on 19 December 2018 with those he was experiencing between May and July 2018. In her oral evidence, she found it difficult to recollect events with accuracy and was unable to provide sufficient clarity to satisfy the Tribunal as to when the events to which she referred occurred.

Dr C

23. The Tribunal found Dr C's evidence to be thorough and measured. He did support his opinion with medical guidance and literature.

Dr D

24. The Tribunal found Dr D to be a pragmatic expert who seemed familiar with the types of issues Dr Ignaczuk was facing and understood why Dr Ignaczuk had approached the management of Patient A in the way he did. Dr D did not generally support his opinion by reference to medical guidance and literature.

Dr Ignaczuk

25. The Tribunal found Dr Ignaczuk to be a helpful witness. He provided full and expansive answers and acknowledged where his practice could be improved. It found his oral evidence to be reliable and consistent with his written witness statement.

The context

26. The Tribunal noted that Patient A had several appointments with Dr Ignaczuk, and that it was only at the initial appointment, on 2 May 2018, that Patient A attended the surgery of his own volition. As the paragraphs of the Allegation allege that Dr Ignaczuk *failed* [Tribunal emphasis] to carry out certain matters on 5 June, 23 July and 26 July 2019, the Tribunal was concerned to reach a view as to what had occurred at this very first appointment since this may have affected what was properly expected of him at these later consultations.

2 May 2018

27. Patient A was a 71-year old male who attended Chard Road Surgery with his wife, Mrs B, and reported to Dr Ignaczuk that he was suffering from breathlessness on exertion. Dr Ignaczuk carried out several investigations and diagnostic tests to try and find a diagnosis.

28. The Tribunal considered whether Patient A and/or Mrs B reported to Dr Ignaczuk during the face-to-face consultation that Patient A was suffering from chest pain. In Mrs B's oral evidence, she mentioned that she did tell Dr Ignaczuk that Patient A had chest pain. However, Mrs B could not recall upon which date she had said this to him. In his evidence, Dr Ignaczuk denied that this was the case. He explained that if this had been said, the manner in which he provided care for Patient A would have been completely different and arguably more straight forward; he would have referred him to a cardiologist or a Rapid Access Chest Pain Clinic.

29. The Tribunal also considered whether Dr Ignaczuk asked about chest pain when Patient A had told him he was experiencing breathlessness. The Tribunal noted that Dr Ignaczuk was an experienced doctor and that, prior to working as a GP, he was a Gynaecology Registrar. On 2 May 2019, he took a detailed history from Patient A, conducted a thorough examination and ordered further tests. He recorded Patient A's symptoms, including certain negative symptoms as follows: *'no cough and shortness of breath when lying flat in bed'*. In his oral evidence, he stated that, although not documented, the first thing he would do, if he

was told that his patient was suffering from breathlessness on exertion, would be to ask about chest pain.

30. Having reviewed the investigations which Dr Ignaczuk requested, the Tribunal noted that he included tests relevant to the heart. He had undertaken a bed side oxygen saturation test which demonstrated saturations of 99% (breathing air). He had ordered an ECG, a full blood count for anaemia and tests for diabetes, bone health, thyroid function, cholesterol and lipid levels. These comprehensive investigations could all be considered relevant to cardiac health. The Tribunal was of the view that Dr Ignaczuk recognised that Patient A's breathlessness was quite possibly attributable to a cardiac condition rather than a respiratory condition. Dr Ignaczuk in his evidence stated that the first thing a GP would ask when presented with a patient with Patient A's symptoms would be to ask whether they had chest pain. He stated that he simply omitted to record his reply.

31. The Tribunal noted the comments in Dr C's report at paragraph 38 dated 4 September 2019:

> *'My opinion is that this represents a good examination in line with the standard expected of a reasonably competent GP. Dr Ignaczuk did not record Patient [A]'s blood pressure (BP) but did arrange for this to be checked by Ms M (Health Care Assistant) when Patient [A] returned for his blood tests and ECG, and my opinion is that this was adequate and appropriate.'*

32. The Tribunal acknowledged that the fact that Dr Ignaczuk did record negative symptoms but failed to record a negative response to a question as to whether Patient A had chest pain is not in his favour. However, on the basis of his patient record, as well as on the basis of his evidence, the Tribunal reached the view that Dr Ignaczuk was a diligent doctor. The Tribunal considered that it would be most surprising if Dr Ignaczuk had not asked Patient A whether he had chest pain in a consultation when the reason for Patient A's attendance was breathlessness on exertion. On the balance of probabilities, the Tribunal accepted Dr Ignaczuk's explanation that he simply forgot to record Patient A's answer in the medical notes. It concluded that Dr Ignaczuk did ask Patient A whether he suffered from chest pain and received a negative reply.

Paragraph 1 (a) (i)

33. The Tribunal noted that, on 5 June 2018, Patient A attended the surgery to obtain his test results, and that this appointment was therefore requested by Dr Ignaczuk. The Tribunal considered the evidence of both experts who stated that it was not a failing not to ask about

wheeze. Given that Dr Ignaczuk had examined Patient A's chest on the 2 May 2018, that Patient A reported that his symptoms had improved on 5 June 2018 and that Dr Ignaczuk had requested a chest x-ray, the Tribunal accepted the joint expert opinion that Dr Ignaczuk was not obliged to enquire specifically about wheeze. Accordingly, the Tribunal found paragraph 1(a) (i) of the Allegation not proved.

Paragraph 1 (a) (ii)

34. The Tribunal noted it's finding in relation to the consultation on 2 May 2018. Further, it noted that the experts expressed the view that it was not necessary for Dr Ignaczuk to ask Patient A whether he was suffering from chest pain if he had made that enquiry on 2 May 2018. Therefore, the Tribunal found paragraph 1(a) (ii) of the Allegation not proved.

Paragraph 2 (a) (i) and (ii)

35. The Tribunal considered that both chest pain and discomfort could be considered together in this case albeit they can be subtly different. Again, the Tribunal took into consideration the fact that on 23 July 2018, Dr Ignaczuk initiated the consultation by asking Patient A to attend the surgery. It also noted that Dr Ignaczuk did not record in his medical notes that he had asked Patient A whether he had chest pain or discomfort. Dr Ignaczuk's evidence was that he would have asked about it; however, it had not been recorded because, as before, he did not record every negative answer given by the patient. The Tribunal was mindful that Mrs B, in her evidence, did not specifically state that Dr Ignaczuk had not asked about chest pain or discomfort. No evidence was received from Patient A.

36. The Tribunal considered the joint expert report dated 25 February 2021:

> *'Dr Ignaczuk states he would have asked about chest pain. In our opinion a reasonably competent GP would have asked [Patient A] to describe his symptoms in more detail. In other words, to retake the history. We agree further questions would have included the presence or absence of chest pain, or a feeling of heaviness on the chest, or tightness in the chest. We agree that failure to ask about the presence or absence of chest pain was below the standard expected of a reasonably competent GP because of the clinical importance of this symptom.'*
>
> …

If the experts consider any of the actions referred to in the notice to have fallen below an acceptable standard, could they specify whether such a failing is to be defined as 'serious'?

We have each specified our views on the failing of history-taking on 23rd and 26th Jul 2018.

[Dr C] *considers that the presentation of shortness of breath on exertion, which resolved rapidly with rest, in the absence of any respiratory condition to explain it, is a recognised presentation of ischaemic heart disease.* [Dr C] *considers that a reasonable body of general practitioners would agree with this opinion, based on established clinical guidance and credible reference sources.*

[Dr C] *considers that the failure to consider ischaemic heart disease on the basis of this symptom was a serious failing because of the clinical importance of the diagnosis of ischaemic heart disease, and because a reasonably competent GP should take steps to rule out ischaemic heart disease, even if the probability is relatively low.*

[Dr D] *considers that the failing to retake the history on 23rd and 26th Jul 2018 was serious, because the symptom of breathlessness can signify something potentially deleterious to one's health. Although serious, he is of the opinion that this failing is something amenable to remediation. The importance of history-taking is something that becomes more apparent, the long one practises in primary care.'*

37. The Tribunal noted Dr Ignaczuk's record of the consultation on 23 July 2018: '*SOBOE [shortness of breath on exertion] has not changed, mainly when walking uphill*'. However, in his oral evidence Dr Ignaczuk acknowledged that Patient A's overall condition may perhaps have been slightly worse than before. His blood oxygen saturation was now 96% and he had '*minimal bobasal (sic) crepitations*' in his chest. The results of the chest x-ray with digital tomosynthesis were then to hand. In the light of those and the examination findings above, Dr Ignaczuk asked Patient A to undertake a B-type natriuretic peptide ('BNP') test. This test helps to identify heart failure.

38. In the Tribunal's view the matters referred to in the previous paragraph reveal that Dr Ignaczuk continued to investigate whether Patient A had a heart condition which could explain his ongoing breathlessness on exertion. The Tribunal noted that he must have listened to Patient A's chest as he noted minimal crepitations.

39. The Tribunal considered whether Dr Ignaczuk would have taken the steps outlined above without having made the basic enquiry as to whether Patient A had chest pain. It has reached the conclusion, relying upon its reasoning in relation to the consultation on 2 May 2018, that he would not have done. On the balance of probabilities, the Tribunal found that Paragraphs 2 (a) (i) and (ii) of the Allegation not proved.

40. In any event, even if Dr Ignaczuk did not in fact ask about the presence or absence of chest pain and/or discomfort, the Tribunal found that this was not a failure because Dr Ignaczuk was closely concerned with investigating Patient A's heart. He had asked about chest pain on 2 May 2018. He initiated the BNP investigation and listened to Patient A's chest. Further he asked Patient A to return following a short period of time and was therefore concerned about his safety. In those circumstances it would not be a failing not to ask the question about chest pain and discomfort.

Paragraph 2 (a) (iii)

41. The Tribunal considered whether during the consultation with Patient A on 23 July 2018, Dr Ignaczuk had failed to obtain a detailed history of Patient A's symptoms including the presence or absence of palpitations. The Tribunal noted that Dr Ignaczuk acknowledged he did not ask Patient A whether he had palpitations. By this time Patient A had had a normal ECG. In his witness statement, Dr Ignaczuk stated:

> *'I did not ask Patient A about palpitations but there was no suggestion that his symptoms had become worse. In addition, the first chest x-ray did not show any signs of an enlarged heart or retained fluid in the lungs which would suggest that Patient A's heart was pumping too weakly and a second x-ray had been arranged.'*

42. Although an ECG, which measures the electrical activity of the heart, may be normal it does not preclude an underlying abnormality of the heart. Evidence from the medical experts suggests that a patient with a normal ECG at rest is most unlikely to have an abnormal heart rhythm on exertion. On the basis of the normal ECG, Dr Ignaczuk admitted that he did not ask about palpitations. In addition, neither expert said in oral evidence that it was a matter he should have asked about. Therefore, the Tribunal concluded that paragraph 2 (a) (iii) was not proved.

Paragraph 2 (b)

43. The Tribunal considered whether on 23 July 2018, Dr Ignaczuk failed to diagnose, or exclude CHD. The Tribunal considered the expert evidence from Dr C in his report dated 4 September 2019:

> *'On 23.07.18, Dr Ignaczuk arranged for Patient [A] to have the following blood tests: FBC and BNP (B-type natriuretic peptide). BNP is a hormone secreted by heart muscle and an elevated level of BNP in the bloodstream can be an indication of heart failure. BNP is usually considered to be a rule-out test for heart failure in that a normal level (less than 100 nanograms per litre) makes heart failure unlikely. My opinion is that this was an appropriate test in view of Patient [A]'s symptom of SOBOE and Dr Ignaczuk's findings on examination of minimal bi-basal crepitations. A FBC is also appropriate as this would identify anaemia that can be a cause of SOB.*
>
> *My opinion is that as a BNP test result is available within a couple of days it is a reasonable diagnostic strategy to obtain this result first before planning further investigation or referral. This is because a normal BNP test makes heart failure unlikely and this means that other diagnostic possibilities for SOBOE (such as CHD) should be addressed.'*

Dr C stated it was reasonable to wait for results.

44. The Tribunal noted that the joint expert report dated 25 February 2021 read:

> *'*[Dr D] *considers that the omission to retake the history on 23rd Jul 2018 (or on 26th Jul 2018) was a failing. He considers this to be below an expected standard of general practitioners, but not seriously below. This view is expressed in the context of the rest of the documentation being of a high standard.*
> *If features from the history then suggested exertional chest pain or raised a suspicion of ischaemic heart disease (for example, feeling sweaty or lightheaded when the breathlessness came on), then Dr* [Dr D] *agrees with* [Dr C's] *suggested management plan.*
> *In* [Dr D]*'s experience a direct referral for an exercise treadmill test is not always possible; but he agrees with the need for a cardiology referral if ischaemic heart disease is suspected.'*

However, in oral evidence, both experts parted company from their reports. Both experts stated that it was reasonable to undertake further diagnostic tests for the purpose of excluding or assisting in diagnosing a heart condition. On 23 July 2018, Dr Ignaczuk awaited the BNP test results. The Tribunal therefore concluded that paragraph 2 (b) of the Allegation was not proven.

Paragraph 3 (a) (i) and (ii)

45. The Tribunal went on to consider whether, during Dr Ignaczuk's telephone consultation with Patient A on 26 July 2018, he had failed to obtain a detailed history of Patient A's symptoms, including the presence or absence of chest pain and discomfort. The Tribunal considered both paragraphs of the Allegation together. The Tribunal noted the comments in the joint expert report:

> *'i) chest pain*
> *We agree that a more detailed history ought to have been obtained on 23rd and 26th Jul 2018 and that chest pain should have been asked after.*
> *ii) discomfort*
> *We agree that a more detailed history ought to have been obtained on 23rd and 26th Jul 2018 and that discomfort should have been asked after.'*

46. The Tribunal considered Dr C's oral evidence that if Dr Ignaczuk had asked about chest pain on 2 May 2018 and 23 July 2018, then not asking on 26 July 2018 was not a failing. In Dr D's oral evidence, he confirmed that it was not a failing if chest pain had been asked about earlier. Dr C said that it was not necessary to ask about discomfort if chest pain had been asked. The Tribunal also considered the comments from Patient A as set out in the medical records which state that Patient A was, '*pleased with results and explanation*' provided by Dr Ignaczuk during their consultation on 26 July 2018.

47. The Tribunal concluded that, as Dr Ignaczuk had asked Patient A about chest pain on 2 May 2018 and 23 July 2018, in the light of the experts' opinion it was not a failure on the part of Dr Ignaczuk not to ask about chest pain and discomfort on 26 July 2018. Therefore, paragraph 3 a (i) and (ii) of the Allegation are not proven.

Paragraph 3 (a) (iii)

48. The Tribunal went on to consider whether Dr Ignaczuk failed to ask Patient A about whether he had palpitations on 26 July 2018. Dr Ignaczuk admitted that he had not done so and provided a similar explanation to that set out above in respect of paragraph 2 (a) (iii) of the Allegation. The Tribunal considered the evidence from both experts who confirmed that it was not necessary and not a failing not to ask about palpitations. The Tribunal concluded that paragraph 3 (a) (iii) of the Allegation was not proven.

Paragraph 3 (b)

49. The Tribunal considered whether Dr Ignaczuk, during his consultation with Patient A on 26 July 2018, failed to arrange any follow up for Patient A, including further diagnostic tests to confirm or exclude CHD. The Tribunal noted Dr Ignaczuk's evidence in his witness statement:

> *'I did not arrange for further investigations to confirm or exclude coronary heart disease as Patient A did not have any features which were suggestive of coronary heart disease, specifically chest pain and discomfort with exertional breathlessness.'*

Dr Ignaczuk had felt he had done enough to exclude CHD.

50. Dr C stated in the joint expert report that he did think it was a failure as he would have referred Patient A to a cardiologist:

> *'*[Dr C] *considers that an appropriate course of action would be direct referral for an exercise tolerance test or a routine referral to cardiology outpatients.'*

51. Dr D in his report dated 14 December 2020:

> *'In the absence of dementia or a learning disability (neither of which applied to [Patient A]) I do not think formal follow up was necessary. I think it was reasonable to think he would make an appointment if he felt necessary.'*

52. In their joint report the experts stated:

> *'We agree this question rests on the outcome of the proposed history that we believe Dr Ignaczuk should have taken on 23rd Jul and/or 26th Jul 2018. If there had been any features of ischaemic heart disease then a referral ought to have been made in which case follow up is implied.*
>
> *In the absence of this occurring, we agree that a formal follow up appointment did not need to be made (although we agree this is separate to safety-netting advice, see below).'*

53. The Tribunal did not derive much clarity from the differing, even shifting positions of the experts.

54. The Tribunal considered this paragraph of the Allegation in the context of the evidence from Dr Ignaczuk, which it accepted, that he had provided Patient A with safety

netting advice. Dr Ignaczuk's case was that he had exhausted the relevant tests to exclude CHD. He was of the view that the most likely explanation for Patient A's single symptom of breathlessness on exertion was that it was a feature of getting older. The Tribunal noted that a BNP test does not in fact exclude CHD; therefore it is not impossible that Patient A was demonstrating an atypical presentation of a heart condition. Such a presentation was, according to the medical literature more likely in the more elderly, people with diabetes and women.

55. The issue for the Tribunal was whether in these circumstances, Dr Ignaczuk was under an obligation to arrange follow up for Patient A including further diagnostic tests to confirm or exclude CHD. Essentially, this is whether he should have referred Patient A to a cardiologist or a Rapid Access Chest Pain Clinic. The GMC's case, relying on Dr C, was that as Patient A was still presenting with breathlessness on exertion, Dr Ignaczuk should have referred, especially as Dr Ignaczuk had relatively limited experience as a GP. Dr D said that referral was not required in these circumstances where a GP was carrying out primary care, was closely in touch with his patient and had given safety netting advice. Dr D opined that Dr Ignaczuk had done everything which he could have done as a GP to rule out CHD.

56. The Tribunal accepted that Dr D's approach reflected that of a reasonably competent body of GPs. As a GP, Dr Ignaczuk had ruled out CHD because there was no chest pain and he had done all the tests that he could reasonably think of at the time to exclude coronary heart disease and respiratory disease. This had left him with the conclusion that the breathlessness on exertion was as a result of Patient A getting older.

57. The Tribunal concluded that this was not a failing in the context of Dr Ignaczuk having given Patient A safety netting advice and on account of the degree of communication which subsisted between Patient A and Dr Ignaczuk. Dr Ignaczuk could have arranged for Patient A to return to him in one to two months' time, but in the context of a patient who was regularly attending the surgery, and did not have a history of chest pain, he did not consider that this was necessary. Accordingly, the Tribunal found Paragraph 3 (b) of the Allegation not proven.

Paragraph 3 (c) (i)

58. The Tribunal considered whether Dr Ignaczuk advised Patient A to seek GP review if symptoms worsened. The evidence from Dr Ignaczuk read:

'In accordance with my usual practice, I would have advised Patient A to come back if his symptoms became worse and to call 999 if his breathing became significantly worse.'

Dr Ignaczuk said in his oral evidence that it was common not to record any safety netting advice which was given to a patient. The Tribunal noted that there was no evidence from Mrs B that Patient A was not provided with this advice.

59. Dr C and Dr D accepted that if Dr Ignaczuk did give safety netting advice as aforesaid, it would be appropriate.

60. The GMC's position was that because Dr Ignaczuk had said it was his usual practice, the Tribunal could not be satisfied that he had in fact given this advice. The Tribunal noted that Dr Ignaczuk described in detail what his usual practice would be in this scenario. It accepted his account. It noted the lengths which Dr Ignaczuk had gone to find a diagnosis for Patient A. It found it most unlikely that he would not have advised Patient A to seek a review if symptoms worsened. It therefore found paragraph 3 (c) (i) of the Allegation was not proven.

Paragraph 3 (c) (ii)

61. In considering whether Dr Ignaczuk had advised Patient A to seek urgent advice if he experienced chest pain or discomfort, the Tribunal took into account the conclusion Dr Ignaczuk had reached, namely that that Patient A was likely to be experiencing breathlessness on exertion as a result of the aging process. The Tribunal was satisfied that the advice which Dr Ignaczuk did give Patient A, namely to call him or to call 999 if his symptoms got worse, was adequate. It found that he was not under a duty to specifically tell him to seek urgent advice if Patient A experienced chest pain or discomfort. Therefore, paragraph 3 (c) (ii) of the Allegation is not proven.

Paragraph 4

62. The Tribunal went on to consider whether Dr Ignaczuk had failed to address the complaint received from Patient A's wife when this was communicated to him by Ms E on behalf of the Practice. The Tribunal considered the email dated 26 March 2019 from Ms E:

'I've gone through my emails and I emailed Dr [Ignaczuk] – 29/01, 06/02, 19/02, 14/03 and 15/03. I haven't had any replies to the emails. I text him on 12/02 and he replied on 18/02 and came into Stirling Road to go through the patients notes. I tex[t]ed again

05/03, 14/03 and 15/03 and he replied the same day each time. His last text confirmed he was waiting for us to resend some paperwork for the MDU which we did.'

63. The Tribunal noted that the fact of the complaint was communicated to Dr Ignaczuk on 12 February 2019. Earlier emails had been sent to him by Ms E to his NHS email address but he explained in oral evidence that he had not read them as he was relying on his internal practice email account at the time.

64. The Tribunal noted that Dr Ignaczuk had read the complaint by 18 February 2019. Dr Ignaczuk never addressed the complaint directly to Ms E, the person who had forwarded the complaint to him. He stated that he sent his response to the Patient Advisory Group ('PAG') on 1 June 2019 on the instruction of the Devon Doctors Group, the owners of Chard Road Surgery, which by then had taken over the management of the complaint. His explanation for not addressing the complaint earlier is that he needed to see and obtain the relevant medical notes from Chard Road Surgery. When they were forwarded to him, they had not been copied properly and had to be sent again. Although thereafter he prepared a response, he needed to have the response approved by his defence union and that took some time. He also acknowledged that he found it difficult to apply himself to responding to the complaint.

65. The Tribunal was of the view that Dr Ignaczuk had an obligation to respond to the complaint which he had received. In evidence Dr Ignaczuk acknowledged that he did not do so in a timely manner. He did not reply directly to Ms E. However, paragraph 4 of the Allegation does not stipulate that the response had to be within a time frame, nor that it should be directed at Ms E or at any particular individual. If his response was directed to the PAG on 1 June 2019, and constituted a proper address to the complaint, paragraph 4 will not be proved.

66. The Tribunal was not provided with Dr Ignaczuk's response, although he held it up in the course of his evidence so that it was visible to the hearing, and it was disclosed to the GMC since the GMC provided a copy of it to Dr C for the purpose of enabling him to prepare his expert evidence. The Tribunal is unclear as to why the document was not disclosed in the course of evidence.

67. The facts set out above establish to the Tribunal's satisfaction that Dr Ignaczuk did indeed respond to the complaint. The remaining issue is whether that response addressed the complaint so that Dr Ignaczuk properly discharged his obligations to Patient A and Mrs B under Good Medical Practice. The GMC did not challenge Dr Ignaczuk on the content of his response. The Tribunal has therefore no evidence to indict the propriety of the response. In these circumstances, the Tribunal does not find paragraph 4 of the Allegation proved.

The Tribunal's Overall Determination on the Facts

68. The Tribunal has determined the facts as follows:

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

Patient A

1. On 5 June 2018 you consulted with Patient A and you failed to:

    a. obtain an adequate medical history including the presence or absence of:

        i. wheeze; **Determined and found not proved**

        ii. chest pain. **Determined and found not proved**

2. On 23 July 2018 you consulted with Patient A and you failed to:

    a. ask about the presence or absence of other symptoms of cardiovascular disease including:

        i. chest pain; **Determined and found not proved**

        ii. discomfort; **Determined and found not proved**

        iii. palpitations. **Determined and found not proved**

    b. diagnose, or exclude Coronary Heart Disease ('CHD'); **Determined and found not proved**

3. During your telephone consultation with Patient A on 26 July 2018 you failed to:

    a. obtain a detailed history of Patient A's symptoms, including the presence or absence of:

        i. chest pain; **Determined and found not proved**

        ii. discomfort; **Determined and found not proved**

iii. palpitations; **Determined and found not proved**

b. arrange any follow up for Patient A, including further diagnostic tests to confirm or exclude CHD; **Determined and found not proved**

c. advise Patient A to seek:

i. GP review if symptoms worsened; **Determined and found not proved**

ii. urgent advice if he experienced chest pain or discomfort; **Determined and found not proved**

Failure to engage

4. You failed to address the complaint received from Patient A's wife when this was communicated to you by Ms E as set out in Schedule 1. **Determined and found not proved**

69. As the Facts have not been found proved it therefore follows that Dr Ignaczuk's fitness to practise is not impaired.

70. That concludes the case.

Confirmed
Date 31 March 2021 Mr Angus Macpherson, Chair

ANNEX A – 22/03/2021

Application to amend the Allegation

71. Ms Goring, on behalf of the GMC, made an application in two parts, under Rule 17(6) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004, ('the Rules'), to amend the paragraphs of the original Allegation in their entirety. The original Allegation read:

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

Patient A

1. On 5 June 2018 you consulted with Patient A and you failed to:

a. obtain an adequate medical history including the presence or absence of:

i. cough;

ii. wheeze;

iii. sputum;

iv. haemoptysis;

v. fever;

vi. night sweats;

vii. ankle swelling;

viii. paroxysmal nocturnal dyspnoea ('PND');

ix. palpitations;

x. chest pain;

xi. a family history of cardiovascular problems.

b. in the alternative to paragraph 1a, record that as set out at paragraph 1.ai - xi above;

c. assess Patient A's:

i. temperature;

ii. heart rate;

iii. oxygen saturation;

d. in the alternative to paragraph 1c, record that as set out at Paragraph 1.c.i – iii above;

e. refer Patient A to:

i. a Rapid Access Chest Pain Clinic;

ii. in the alternative to paragraph 1ei, an appropriate specialist, such as a:

1. cardiologist; or

2. consultant in acute medicine;

f. consider the possible diagnosis of coronary heart disease ('CHD');

g. take adequate steps to establish a diagnosis of hypertension prior to prescribing felodipine;

h. provide Patient A with any safety netting advice;

i. in the alternative to paragraph 1h, record provision of any safety netting advice;

j. record your findings on examination of Patient A's heart and lungs.

2. At your consultation with Patient A on 27 June 2018 you failed to:

a. obtain any information about the symptom of shortness of breath on exertion ('SOBOE');

b. in the alternative to paragraph 2a, record obtaining any information about the symptom of SOBOE;

c. assess Patient A's:

i. temperature;

ii. oxygen saturation;

iii. respiratory rate;

d. in the alternative to paragraph 2c, record that as set out at Paragraph 2.c.i – iii above;

e. refer Patient A to:

i. a Rapid Access Chest Pain Clinic;

ii. in the alternative to paragraph 2ei, an appropriate specialist such as a:

1. cardiologist; or

2. consultant in acute medicine;

f. consider the possible diagnosis of CHD;

g. account for Patient A's SOBOE when making a diagnosis;

h. arrange a further appointment within a week;

i. record:

i. your findings on examination of Patient A's heart and lungs;

ii. information regarding Patient A's symptoms of SOBOE;

iii. an appropriate management plan for Patient A's symptoms.

3. During your telephone consultation with Patient A on 2 July 2018 you failed to:

a. obtain an adequate medical history including the presence or absence of:

i. chest pain;

ii. orthopnoea;

iii. palpitations;

b. in the alternative to paragraph 3a, record that as set out above at paragraph 3.a.i – iii;

c. assess Patient A's SOBOE;

d. in the alternative to paragraph 3c, record any assessment of Patient A's SOBOE;

e. arrange any follow up for Patient A;

f. provide Patient A with any safety netting advice;

g. in the alternative to paragraph 3f, record provision of safety netting advice.

4. On 23 July 2018 you consulted with Patient A and you failed to:

a. ask about the presence or absence of other symptoms of cardiovascular disease including:

i. chest pain;

ii. discomfort;

iii. orthopnoea;

iv. PND;

v. ankle swelling;

vi. palpitations;

b. in the alternative to paragraph 4a, record that as set out at paragraph 4.a.i – vi above;

c. assess Patient A's:

i. temperature;

ii. respiratory rate;

iii. blood pressure;

d. in the alternative to paragraph 4c, record that as set out at Paragraph 4.c.i – iii above;

e. diagnose, or exclude CHD;

f. record your findings on examination of Patient A's heart.

5. During your telephone consultation with Patient A on 26 July 2018 you failed to:

a. obtain a detailed history of Patient A's symptoms, including the presence or absence of:

i. chest pain;

ii. discomfort;

iii. orthopnoea;

iv. PND;

v. ankle swelling;

vi. palpitations;

b. in the alternative to paragraph 5a, record that as set out at Paragraph 5.a.i – vi above;

c. arrange further diagnostic tests to confirm or exclude CHD;

d. refer Patient A to:

i. a Rapid Access Chest Pain Clinic;

ii. in the alternative to paragraph 5di, an appropriate specialist such as a:

1. cardiologist; or

2. consultant in acute medicine;

e. arrange any follow up for Patient A;

f. in the alternative to paragraph 5e, record arranging any follow up with Patient A;

g. advise Patient A to seek:

i. GP review if symptoms worsened;

ii. urgent advice if he experienced chest pain or discomfort;

h. in the alternative to paragraph 5g, record that as set out at Paragraph 5.g.i – ii above;

i. adequately record:

i. any investigations or referrals;

ii. a diagnosis;

iii. treatment of symptoms.

Failure to engage

6. You failed to respond to any of Ms E's written requests as set out in Schedule 1 asking you to address the complaint received from Patient A's wife.

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

72. The Allegation as amended would read as follows:

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

Patient A

1. On 5 June 2018 you consulted with Patient A and you failed to:

a. obtain an adequate medical history including the presence or absence of:

i. wheeze;

ii. chest pain.

2. On 23 July 2018 you consulted with Patient A and you failed to:

a. ask about the presence or absence of other symptoms of cardiovascular disease including:

i. chest pain;

ii. discomfort;

iii. palpitations.

b. diagnose, or exclude Coronary Heart Disease ('CHD');

3. During your telephone consultation with Patient A on 26 July 2018 you failed to:

a. obtain a detailed history of Patient A's symptoms, including the presence or absence of:

i. chest pain;

ii. discomfort;

iii. palpitations;

b. arrange any follow up for Patient A, including further diagnostic tests to confirm or exclude CHD;

c. advise Patient A to seek:

i. GP review if symptoms worsened;

ii. urgent advice if he experienced chest pain or discomfort;

Failure to engage

4. You failed to address the complaint received from Patient A's wife when this was communicated to you by Ms E as set out in Schedule 1.

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

73. Ms Goring explained that the application to amend the Allegation relied heavily upon the joint expert report of Dr C for the GMC and Dr D for Dr Ignaczuk dated 25 February 2021 and the case examiners' further reflections. Upon receipt of this information the GMC have reconsidered their position. She submitted that it was appropriate to withdraw the Allegation in its entirety and for the new Allegation to be substituted. She submitted that Mr Ivill, Counsel for Dr Ignaczuk, had no objection to the application. She submitted that these amendments can be made without injustice.

74. Mr Ivill did not oppose the application to amend the Allegation.

The Tribunal's decision

75. The Tribunal considered the contents of the new Allegation which was based upon the information in the joint expert report. The Tribunal concluded that the new Allegation did not prejudice either party and would not cause injustice to Dr Ignaczuk. The Tribunal therefore determined to grant the application to amend the Allegation as proposed.

SCHEDULE 1

Correspondence received from Ms E

Email
29 January 2019
6 February 2019
19 February 2019
14 March 2019
15 March 2019
Text Message
12 February 2019
18 February 2019
5 March 2019
14 March 2019
15 March 2019