PUBLIC RECORD

Dates: 22/05/2023 - 31/05/2023

Medical Practitioner's name:	Dr Sameer KHAN
GMC reference number:	5208829
Primary medical qualification:	MBBS 1999 Dr NTR University of Health Sciences - Deccan College of Medical Sciences

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

Summary of outcome

Warning

Tribunal:

Legally Qualified Chair	Mr Lindsay Irvine
Lay Tribunal Member:	Mr Keith Moore
Medical Tribunal Member:	Dr Pavan Rao

Tribunal Clerk:	Mr Larry Millea

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Chris Gillespie, Counsel, instructed by MDDUS
GMC Representative:	Dr Alexis Dite, 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 - 30/05/2023

Background

1. Dr Khan qualified in 1999 as MBBS (Bachelor of Surgery Bachelor of Medicine) from Deccan Medical College, Hyderabad, and prior to the events which are the subject of the hearing, Dr Khan worked in a number of Consultant, Registrar and SHO (Senior House Officer) hospital roles in acute medicine.

2. At the time of the events Dr Khan was practising as a locum Consultant in Acute Medicine within the Shrewsbury and Telford NHS Hospitals NHS Trust ('the Trust'), including time at the Royal Shrewsbury Hospital ('the Hospital').

3. The allegation that has led to Dr Khan's hearing can be summarised as, whilst working as a Consultant in Acute Medicine from 3 June to 8 November 2019, Dr Khan, on one or more occasions, asked junior doctors to record patient examinations which had not been carried out and/or repeat the examination findings as recorded by the previous doctor. It is alleged that his actions were dishonest. It is further alleged that Dr Khan made inappropriate comments to Dr A.

4. The initial concerns were raised with the GMC following a local Trust investigation after Dr A raised concerns about Dr Khan's behaviour with their employer on 25 October 2019. Following this internal investigation, Dr Khan was subsequently told that his contract would be terminated.

The Outcome of Applications Made during the Facts Stage

5. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to amend the Allegation as set out below. This application was to correct a typographical error and was not opposed by Mr Gillespie, counsel on behalf of Dr Khan.

6. The Tribunal partially granted a half-time application of no case to answer, made on Dr Khan's behalf under Rule 17(2)(g). The Tribunal's written determination can be found at Annex A.

The Allegation and the Doctor's Response

7. The Allegation made against Dr Khan is as follows:

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

1. While working as a Consultant in Acute Medicine at the Royal ~~Stoke~~ Shrewsbury Hospital, Shrewsbury and Telford Hospitals NHS Trust ('the Trust') from 3 June 2019 to 8 November 2019 you: Amended under Rule 17(6), Deleted under Rule 17(2)(g)

    a. ~~on one or more occasions during ward rounds asked junior doctors to record~~:

        i. ~~patient examinations which had not been carried out~~; Deleted under Rule 17(2)(g)

        ii. ~~examination findings as recorded by the previous doctor to have examined the patient(s)~~; Deleted under Rule 17(2)(g)

    b. made inappropriate comments to Dr A, in that you said:

        i. in relation to Dr A feeling stressed, 'if you are being raped, why fight it. Why not enjoy it?', or words to that effect; Admitted and found proved

ii. 'how old is she? She should be up there', or words to that effect, and pointed up to the sky, when talking about an elderly patient; To be determined

2. You knew:

a. ~~that the examinations as referred to in paragraph 1.a.i. had not been carried out~~; Deleted under Rule 17(2)(g)

b. ~~that the examination findings referred to in paragraph 1.a.ii. did not reflect an examination that had been carried out during those patient reviews~~. Deleted under Rule 17(2)(g)

3. Your actions as described at paragraph:

a. ~~1.a.i. were dishonest by reason of paragraph 2a~~; Deleted under Rule 17(2)(g)

b. 1~~.a.ii. were dishonest by reason of paragraph 2b~~. Deleted under Rule 17(2)(g)

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

The Admitted Facts

8. At the outset of these proceedings, through his counsel, Mr Gillespie, Dr Khan made admissions to one sub-paragraph of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced this sub-paragraph of the Allegation as admitted and found proved.

Witness Evidence

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

- Dr B, Consultant Physician and Nephrologist at the Hospital and Care Group Medical Director for Unscheduled care at the time of events, in person, who also provided a written witness statement dated 7 April 2021;

- Dr C, Consultant Physician and Endocrinologist, Clinical Director at the Trust and Acute Medicine Lead at the time of events, in person, who also provided a written witness statement dated 7 April 2021;
- Dr A, Trust Grade Doctor and Senior House Officer at the Hospital at the time of events, in person, who also provided a written witness statement dated 29 October 2021, and;
- Dr D, Year 1 Anaesthetic Trainee in Acute Medicine at the Trust, in person, who also provided a written witness statement dated 3 November 2021.

10. Dr Khan provided his own witness statement, dated 10 February 2023 and also gave oral evidence at the hearing.

Documentary Evidence

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

- A number of Trust email threads in relation to the complaints made against Dr Khan by Dr A and Dr D and the Trust investigation, various dates October to December 2019;
- Dr Khan's CV, undated.

The Tribunal's Approach

12. 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 Khan 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. When considering the standard required to prove an allegation, the Tribunal had regard to the case of *Byrne v General Medical Council [2021] EWHC 2237 (Admin) (10 August 2021)* which states:

> *'(1) There is only one civil standard of proof in all civil cases, and that is proof that the fact in issue more probably occurred than not.*

(2) There is no heightened civil standard of proof in particular classes of case. In particular, it is not correct that the more serious the nature of the allegation made, the higher the standard of proof required.

(3) Following the case of *Re B [2008] UKHL 35 the inherent probability or improbability of an event is a matter which can be taken into account when weighing the probabilities and in deciding whether the event occurred. Where an event is inherently improbable, it may take better evidence to persuade the judge that it has happened. This goes to the quality of evidence.*

(4) However, it does not follow, as a rule of law, that the more serious the allegation, the less likely it is to have occurred. So whilst the court may take account of inherent probabilities, there is no logical or necessary connection between seriousness and probability. Thus, it is not the case that "the more serious the allegation the more cogent the evidence need to prove it".'

13. On the advice of the LQC, the Tribunal also bore in mind the principle in the case of *Pope v General Dental Council [2015] EWHC 278 (Admin),* that if it, having weighed all the evidence in relation to an allegation considers the case evenly balanced, then the GMC will not have discharged its burden and will not have proved its case.

14. The Tribunal considered all of the evidence adduced before making findings as to the credibility of any witness. Further, when assessing a witness's credibility, it noted it should not rely exclusively on a witness's demeanour when giving evidence as set out in *R (on the application of Dutta) v GMC [2020] EWHC 1974 (Admin)*. It was for the Tribunal to determine which evidence assisted in discharging its duties to make findings and decide the weight to be given to that evidence. The Tribunal noted that decisions must be based upon the evidence alone and the Tribunal must not speculate.

15. It was open to the Tribunal not to rule out the whole of a witness's evidence based on issues of credibility; credibility can be divisible**.** *Khan v The General Medical Council [2021] EWHC 374 (Admin).*

16. The Tribunal heard that Dr Khan was of good character. His good character must be, and was, taken into account by the Tribunal when assessing his credibility and the likelihood of him having acted in the manner alleged. His good character was not a defence to the

Allegation, it was a factor to take into account when considering all of the evidence in the round. The weight to assign to his good character was a matter for the Tribunal to determine.

The Tribunal's Analysis of the Evidence and Findings

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

Paragraph 1(b)(ii)

18. In reaching its determination the Tribunal first considered whether, on the balance of probabilities, Dr Khan acted in the manner alleged.

19. The Tribunal examined the various accounts of this alleged incident provided by Dr A. The first account was in her email of 25 October 2019, where she stated:

> *"He also gave up on the last patient and just said "you see her, write what you like". This is not a post-take ward round environment which is safe."*

20. In her email of 17 November 2019, Dr A stated that:

> *"Another patient he just omitted to see. It was the last one of the ward round. First of all he said a comment which summed his approach up, that because she was old, he didn't really care. She was in her late 80s I think… Because of how lovely she looked I said in passing "Oh doesn't she look sweet". He retorted "how old is she? She should be up there" and pointed up to the sky, and laughed. Maybe I am wrong but most of the time when people say this phrase, they imply dead. He then took one glance at her and said "I can't be bothered, write what you want" and walked off. I stayed to review the patient but being an SHO this obviously was not a "post-take ward round" the patient needed and deserved. I was very unhappy with this but again, stupidly did not say anything."*

21. In her GMC witness statement Dr A stated of this incident that:

> *"I do not recall the patient's name nor any identifying information, but I do remember that this was the last patient and the other consultant had not picked her up as she was our patient. As Dr Khan and I were walking into the ward [the patient] was on her*

way back from the bathroom and was walking really slowly, using a walking frame. Dr Khan got very bored – I could tell this from his body language and gesturing, he essentially displayed impatience and a desire to 'push on', turned to me and said something like he could not be bothered and walked off. Dr Khan did not have one word with [the patient].

Fortunately, [the patient] was not complicated so I was not scared to deal with her…

…I had expected Dr Khan to review [the patient] and explain what was going on. Dr Khan did not carry out a physical examination at all. When Dr Khan made the comment that [the patient] 'should be up there' I shook my head and did not respond. I do not recall how Dr Khan reacted to my response."

22. The Tribunal considered that Dr A's accounts, though containing varying amounts of detail, were generally consistent on what she says occurred. It noted that this event was referenced throughout her statements and was satisfied that on the evidence before it, these accounts were referencing the same patient and alleged event.

23. The Tribunal was of the view that Dr A had reasonably provided further detail of her recollection in response to the local investigation as she had been asked to do and the additional details did not appear to the Tribunal to be embellishment, i.e., including detail which would be more damaging to Dr Khan. It considered that Dr A's description was consistent in respect of the allegation itself and that the elaboration was understandable and could not reasonably be attributed to malice or bias. It generally accepted the submission made on behalf of the GMC that Dr A's description of this event was '*clear, consistent and forthright*'.

24. The Tribunal noted the submission made by Mr Gillespie that the Tribunal had also observed in its determination on the half time application (Annex A) that there was evidence, in another context, of Dr A having a rather jaundiced perception of Dr Khan. However, as set out in that determination, the Tribunal considered that the allegations to which this comment referred, which were deleted under Rule 17(2)(g), were far more prone to misinterpretation and subjective perception. When it came to determining whether Dr Khan had said the words alleged, there was little scope for Dr A to be influenced by other doctors on this matter, with no suggestion that she had discussed this matter with other doctors or that others had accused Dr Khan of saying similar remarks. In respect of this specific allegation, the Tribunal concluded that this was a matter where either Dr A or Dr Khan's

version of events was accurate and that this was a factual matter that it should determine based on the evidence before it, namely the conflicting accounts of Dr A and Dr Khan.

25. The Tribunal, having considered the evidence of Dr A on the matter, went on to consider Dr Khan's evidence and the submissions made on his behalf. In his written statement, Dr Khan firstly denied the words alleged and then stated that he "*would never make such a comment and cannot recall saying this*". In his oral evidence, he maintained the same position and that he would not say such a thing about a patient.

26. The Tribunal noted that by his own admission in his oral evidence, Dr Khan agreed that when the unit was very busy he would try and make light-hearted comments to make the atmosphere better. He also admitted to making the rape comment set out at paragraph 1(b)(i). Whilst it was submitted on his behalf that his admission to an arguably more serious inappropriate comment made it less likely that he would not admit to this paragraph had he said it, the Tribunal concluded that, conversely, this contention applied similarly to the improbability of Dr A inventing a less serious inappropriate comment.

27. The Tribunal bore in mind that Dr Khan is otherwise of good character, but in the light of his admission to paragraph 1(b)(i) and his acknowledged tendency to make humorous and 'crass' comments, it determined that this did not significantly reduce the likelihood of him making the comments alleged at this paragraph of the Allegation.

28. The Tribunal noted that there was no suggestion that Dr Khan acted in this sort of way towards patients, and his oral evidence was that he would never do so. The Tribunal also noted that the evidence received during the hearing indicated that the AMU (Acute Medical Unit) where he worked was a stressful environment, such that it had brought Dr A to tears. In the light of his admitted tendency to use humour to make light of such pressures, the Tribunal did not consider entirely credible Dr Khan's assertion that he would never have said such words. However, it accepted that he may have said these words off the cuff and in the moment. Further, given that he was not made aware of this allegation at the same time as the others, the Tribunal could not exclude the possibility that he may not specifically remember that he had done so.

29. Ultimately, the Tribunal considered the accounts of Dr A more credible and convincing over Dr Khan's denials. Given Dr A's consistent and clear description of this event, first recorded reasonably contemporaneous to the events, and Dr Khan's admitted

propensity to make humorous and at times 'crass' comments, it determined that on the balance of probabilities, Dr Khan had said the words alleged.

30. Having found the allegation that Dr Khan said *"how old is she? She should be up there"*, or words to that effect, and pointed up to the sky, when talking about an elderly patient, the Tribunal went on to confirm whether his actions in doing so were inappropriate.

31. As per its findings above, the Tribunal accepted that this was an off-hand remark made within the context of a stressful working environment and that Dr Khan would on occasion attempt to use humour to diffuse such situations. It also noted that Dr A had commented of the patient *"oh doesn't she look sweet"*, and that Dr Khan's comments were in response to this.

32. The Tribunal considered that whilst the evidence does not indicate that Dr Khan said the words now found proven in the immediate vicinity of the patient, or other patients, he nonetheless said it within the clinical setting while acting in a supervisory role.

33. The Tribunal was of the opinion that whilst Dr Khan may have intended this as a humorous or 'light-hearted' response to Dr A, his comments about a patient were inherently and obviously not acceptable, but particularly within this clinical setting. The fact that Dr Khan was a senior doctor with junior doctors accompanying him and should reasonably be expected to lead by example, further indicated to the Tribunal the inappropriateness of his actions.

34. The Tribunal determined that Dr Khan's words/actions were inappropriate, and accordingly found this paragraph of the Allegation proved.

The Tribunal's Overall Determination on the Facts

35. The Tribunal has determined the facts as follows:

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

1. While working as a Consultant in Acute Medicine at the Royal ~~Stoke~~ Shrewsbury Hospital, Shrewsbury and Telford Hospitals NHS Trust ('the Trust')

from 3 June 2019 to 8 November 2019 you: Amended under Rule 17(6), Deleted under Rule 17(2)(g)

a. ~~on one or more occasions during ward rounds asked junior doctors to record~~:

i. ~~patient examinations which had not been carried out~~; Deleted under Rule 17(2)(g)

ii. ~~examination findings as recorded by the previous doctor to have examined the patient(s)~~; Deleted under Rule 17(2)(g)

b. made inappropriate comments to Dr A, in that you said:

i. in relation to Dr A feeling stressed, 'if you are being raped, why fight it. Why not enjoy it?', or words to that effect; Admitted and found proved

ii. 'how old is she? She should be up there', or words to that effect, and pointed up to the sky, when talking about an elderly patient; Determined and found proved

2. You knew:

a. ~~that the examinations as referred to in paragraph 1.a.i. had not been carried out~~; Deleted under Rule 17(2)(g)

b. ~~that the examination findings referred to in paragraph 1.a.ii. did not reflect an examination that had been carried out during those patient reviews~~. Deleted under Rule 17(2)(g)

3. Your actions as described at paragraph:

a. ~~1.a.i. were dishonest by reason of paragraph 2a~~; Deleted under Rule 17(2)(g)

b. 1~~.a.ii. were dishonest by reason of paragraph 2b~~. Deleted under Rule 17(2)(g)

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

Determination on Impairment - 31/05/2023

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

The Evidence

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

3. Dr Khan provided written reflections, dated May 2023 and also gave oral evidence at the hearing.

4. The Tribunal also received in support of Dr Khan a number of testimonials from colleagues, of various dates, all of which it has read.

5. The Tribunal also received: a number of patient questionnaire forms, various dates; colleague feedback questionnaires, various dates; a colleague feedback report dated 31 May 2018, and; a number of CPD certificates of completion, various dates, including *Maintaining Professional Boundaries* dated March 2020.

Submissions

<u>On behalf of GMC</u>

6. On behalf of the GMC, Dr Dite, counsel, submitted that Dr Khan's actions, in saying the words that he did, breached multiple paragraphs of *Good Medical Practice* (2013 edition) ('GMP') and that this behaviour fell seriously short of the standards expected of a doctor in respect of both the rape comment and the elderly patient comment.

7. Dr Dite submitted that Dr Khan's colleagues and seniors considered that the rape comment alone was outrageous and was enough to end his contract at the hospital, and that Dr A was, in her own words, 'shocked' and 'alarmed' by this comment. He emphasised the need to bear in mind that the comment was said by a senior male consultant to a female junior doctor. He submitted that this comment was inherently unacceptable, fell seriously below the standards expected and amounted to misconduct.

8. In respect of Dr Khan's comment about the elderly patient, Dr Dite submitted that this was exacerbated by the fact that it occurred in a clinical setting. He submitted that the Tribunal should consider what a member of the public would think if they overheard such a comment about a patient from a doctor, let alone members of a patient's family or the patient themselves. He submitted that this also fell seriously short of the standards expected, amounting to misconduct.

9. Dr Dite submitted that Dr Khan's fitness to practise is currently impaired owing to his misconduct. He submitted that the Tribunal might agree that the need to maintain public confidence and promote proper standards and conduct are both engaged in this case.

10. Dr Dite submitted that it is right to note that Dr Khan has expressed remorse for his actions, on multiple occasions. However, he submitted, the Tribunal may consider that Dr Khan does not recall making the comment about the elderly patient and, in his oral evidence, struggled to explain why exactly he made the rape comment and describe clearly why it was wrong, beyond simply stating that it was *"bad"*.

11. Dr Dite submitted that the need to uphold the statutory overarching objective not only requires consideration of any risk to the public, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined were a finding of impairment not made. He submitted that the Tribunal should therefore ask itself what a member of the public would think if Dr Khan, having said what he did, was found not to be impaired.

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

12. On behalf of Dr Khan, Mr Gillespie, counsel, set out his submissions in writing to the Tribunal, expanding upon them orally. He submitted that Dr Khan's actions in respect of the rape comment did indeed breach multiple paragraphs of GMP and that other practitioners

would have found the comment deplorable. He submitted that misconduct was therefore conceded in regard to this paragraph of the Allegation.

13. Mr Gillespie submitted that Dr Khan's comment in respect of the elderly patient, although in poor taste, did not reach the same level of seriousness and did not amount to misconduct. He submitted that the patient did not hear the words, that they may have been said off the cuff in the moment, and that as acknowledged by the Tribunal in its facts determination, he may have forgotten that he said these words at all.

14. Mr Gillespie submitted that Dr Khan's fitness to practise is not currently impaired. He submitted that no issue of patient safety arises, nor is there any issue as to dishonesty, and so the case now concerns bringing the profession into disrepute and breaching fundamental tenets of the profession. He submitted that the rape comment was singular and not a pattern of sexually risqué comments, does not represent Dr Khan's commitment to patients or general work ethic and there has been no repetition in the three and a half years since.

15. Mr Gillespie submitted that Dr Khan has demonstrated insight and remediation and understands the upset he caused, and that his comments do not reflect a deep-seated or sinister attitudinal problem. He submitted that Dr Khan has described how he feels he *"overestimated"* his relationship with Dr A and realises that his attempts either to be humorous or to create a more relaxed and informal atmosphere for junior doctors had the potential to make others uncomfortable and has adjusted his behaviour accordingly to avoid any future repetition.

16. Mr Gillespie submitted that the remediation conducted by Dr Khan, including the boundaries course and his written reflections, and the lack of repetition of such conduct since, demonstrate that he has developed insight, remediated and that there is a low risk of repetition. He drew the Tribunal's attention to the positive feedback and testimonials provided on his behalf.

17. Mr Gillespie submitted that in light of the evidence and in the specific circumstances of this case involving an otherwise respected doctor, a finding of impairment was therefore not necessary in order to uphold the statutory overarching objective.

The Relevant Legal Principles

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

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

20. With regard to misconduct, the Tribunal reminded itself of the decision of the High Court in *Roylance v General Medical Council (No.2) [2000] 1 AC 311:*

> *"'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 misconduct which would qualify. The professional misconduct must be serious"*

21. It also took account of the case of *Nandi v GMC ([2004] EWHC (Admin))* as to seriousness where it is referred to as "*conduct which would be regarded as deplorable by fellow practitioners.*"

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

23. Whilst there is no statutory definition of impairment, the Tribunal followed the test of impairment set out by Dame Janet Smith in the *Fifth Shipman Report*, and approved by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin*. The Tribunal asked whether Dr Khan:

> *a. 'Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b. Has in the past or is liable in the future to bring the medical profession into disrepute; and/or

c. Has in the past breached or is liable to breach in the future one of the fundamental tenets of the medical profession; and/or

…'

24. The Tribunal also bore in mind that it must consider whether a finding of impairment is required in order to uphold the second and third limbs of the overarching objective – to promote and maintain public confidence in the medical profession and to promote and maintain proper professional standards and conduct for members of the profession.

The Tribunal's Determination on Impairment

Misconduct

25. The Tribunal first considered whether Dr Khan's actions amounted to misconduct which was serious. Although Mr Gillespie, on behalf of Dr Khan, conceded that there was misconduct in this case in relation to the rape comment, the Tribunal considered this matter of its own accord.

26. In reaching its determination, the Tribunal considered that paragraphs 1, 36, 37, 47 and 65 of GMP, as set out below, were applicable in this case.

1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.

36 You must treat colleagues fairly and with respect.

37 You must be aware of how your behaviour may influence others within and outside the team.

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

privacy.

65 *You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*

27. In respect of the rape comment made by Dr Khan, the Tribunal took account of GMP. It considered that Dr Khan's actions were exacerbated by the fact that he was in a senior supervisory position in relation to Dr A who was a trainee and that he was a male doctor making this comment to a female colleague.

28. The Tribunal considered that fellow members of the medical profession would find this behaviour and this comment deplorable. It noted the evidence of Dr D, who in his written GMC statement said of this: *"To me, this comment was just outrageous."* It also recalled that both Dr C and Dr B had both confirmed in their oral evidence that the making of this comment alone was sufficient to warrant the termination of Dr Khan's contract.

29. The Tribunal also bore in mind that Dr Khan's actions took place within a clinical setting and, understandably, caused real distress and upset to Dr A.

30. The Tribunal concluded that Dr Khan's actions served to undermine confidence in the medical profession and breached fundamental tenets of the profession particularly treating colleagues with respect, amounting to misconduct which was serious.

31. In respect of Dr Khan's comment about the elderly patient, the Tribunal considered that paragraphs 65 and 47 of GMP, as set out above, were applicable in these circumstances.

32. The Tribunal recalled that it had earlier found that this event also occurred within a clinical setting whilst Dr Khan and Dr A were finishing ward rounds. Dr Khan was in a supervisory role and should have been expected to lead by example. The Tribunal noted that this comment referred to a specific patient and was disrespectful in any context and that although it was not said directly to the patient or (apparently) heard by anyone else, it had the potential to be.

33. The Tribunal noted that this comment had a clear negative impact on Dr A's perception of Dr Khan and the care he was providing for his patients.

34. The Tribunal considered that Dr Khan's actions were exacerbated by the setting and the potential impact this could have had beyond Dr A. It noted but respectfully disagreed with the submissions made on behalf of Dr Khan that although it was in poor taste, the comment does not reach the same level of seriousness as the rape comment. The Tribunal determined that due to Dr Khan's seniority, the location and the potential impact, this still amounted to misconduct which was serious.

35. The Tribunal therefore concluded that Dr Khan's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

Impairment

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

37. The Tribunal was satisfied that whilst patient safety was not put at risk, principles (b) and (c) of *Grant* were engaged. The Tribunal considered that the misconduct already found to be serious and in breach of GMP has brought the profession into disrepute and breached fundamental tenets of the profession.

38. However, the Tribunal was of the opinion that Dr Khan's misconduct was remediable. His misconduct constituted two isolated and quite different inappropriate comments neither of which were indicative to the Tribunal of a long standing and deep-seated attitudinal issue on the part of Dr Khan. Dr Khan has had a long medical career with no evidence of similar behaviour before or since. Dr Khan has recognised how inappropriate his remarks were and whilst he did not make an immediate apology on the spot to Dr A for the rape comment, when it was first put to him that there had been a complaint, he readily offered his apology. He continued to apologise at the hearing and the Tribunal was satisfied that he was expressing genuine remorse.

39. Whilst Dr Khan denied the comment about the elderly patient, he has accepted the findings of the Tribunal that he did say this. The Tribunal recognised in its earlier determination on the facts that it was entirely possible that he had made such a comment in passing, in an attempt to lighten the mood, but had not realised and/or forgotten this. It was satisfied that Dr Khan was similarly regretful and remorseful for this comment too.

40. In considering Dr Khan's insight, the Tribunal noted that his initial response to Dr B was indicative of early insight, and that this has been consolidated by the further work he has done since, including the courses he has undertaken, particularly the Boundaries Course, and his reflective statement.

41. The Tribunal noted and acknowledged that Dr Khan found it difficult to fully articulate in his oral evidence why he said what he did and his understanding of the impact but observed that this is expressed more clearly and to a satisfactory level within his written reflections. In reaching this conclusion, the Tribunal noted that English is not Dr Khan's first language and that he was giving oral evidence in stressful and no doubt pressured circumstances. As such, the Tribunal was of the view that his difficulty expressing himself in his oral testimony did not undermine the extent of his insight and understanding.

42. The Tribunal considered that Dr Khan's reflections, both generally and in respect of the courses he has taken, were extensive and thorough and that overall, he had very good insight into the inappropriateness of his actions.

43. The Tribunal went on to consider Dr Khan's remediation and concluded that he had undertaken as much as could reasonably be expected of him.

44. The Tribunal noted the positive feedback and testimonials provided on Dr Khan's behalf and that there have been no similar incidents in the over 3-year period since, during which Dr Khan has been working full-time in a clinical setting. The evidence demonstrates Dr Khan's normal, professional character and good relationships with junior doctors. The written submissions of Mr Gillespie set out some of the comments received about him, as per below:

> *"Supportive at work. Always approachable." [from a junior doctor]*
>
> *"Excellent teacher for knowledge and communication for patients and relatives. Very supportive and provides constructive feedback." [from a junior doctor in training]*
>
> *"Very pleasant consultant to work with. Always go an extra mile for patients and colleagues." [from a doctor]*
>
> *"…creates a very friendly atmosphere for his juniors…" [from a doctor]*

"…an approachable consultant who supports his juniors and allows them to develop clinical decision making whilst providing senior support appropriately." [from a doctor]

"…He takes time in supervising and teaching the junior doctors." [from a doctor]

"Very helpful, makes sure to look after juniors. Approachable, can ask for help at any time." [from a junior doctor in training]

"…very approachable and always keen to help his junior colleagues." [from a doctor]

"…Provides good teaching…" [from a junior doctor in training]

45. The Tribunal determined that the risk of repetition in this case was low given the efforts made to remediate by Dr Khan and his well-developed insight. It noted that, influenced by the three-day Boundaries course, he has changed his approach to working with colleagues in that he no longer tries to use humour to lighten the tension, in order to avoid any possible offence, maintaining a professional relationship with his colleagues.

46. The Tribunal then went on to consider whether a finding of impairment was necessary in order to uphold the second and third limbs of the overarching objective, namely, *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.*

47. The Tribunal determined that in light of the remediation undertaken, a good level of insight and low risk of repetition, a fully informed member of the public would not have their confidence undermined were a finding of impairment not made. The Tribunal noted the strong contribution Dr Khan had made during the covid pandemic and that in addition to his efforts and contribution to the profession, he had been working under extremely stressful and pressured conditions with no repetition of similar behaviour.

48. The Tribunal also determined, that for the reasons set out above, standards in the profession would not be undermined were a finding of impairment not made, and so the need to uphold the overarching objective did not warrant a finding of current impairment.

49. The Tribunal has therefore determined that Dr Khan's fitness to practise is not impaired.

Determination on Warning - 31/05/2023

1. As the Tribunal determined that Dr Khan's fitness to practise was not impaired it considered whether in accordance with s35D(3) of the 1983 Act, a warning was required.

Submissions

2. On behalf of the GMC, Dr Dite submitted that for the same reasons as set out by the GMC at the impairment stage and as there had been significant departures from the standards set out in *Good Medical Practice* (2013 edition) ('GMP') a warning should be issued in this case. He referred the Tribunal to the *Guidance on Warnings* (March 2021) ('the Guidance').

3. Dr Dite submitted that there are factors, as set out by the Tribunal in its determination on impairment, which indicate this is necessary and proportionate. He submitted that the misconduct occurred in a clinical setting, in a supervisory context, from a male to a female doctor. This misconduct served to undermine the reputation of the profession and cause distress.

4. Dr Dite submitted that issuing a warning would be in the interests of maintaining both standards within the profession and public confidence. He submitted that the misconduct was sufficiently serious that if there were a repetition, this would likely result in a finding of impaired fitness to practice, and that there is a need to record formally the particular concerns in case of any repetition.

5. Dr Dite submitted in summary that these were comments that breached fundamental tenets of the profession, have been found to amount to serious misconduct, that caused real distress to Dr A and had the potential to cause even more of an impact if they had been overheard by others. Therefore, he submitted, it should be formally marked that this was unacceptable and that they should not be repeated.

6. On behalf of Dr Khan, Mr Gillespie submitted that following the finding of serious misconduct made by the Tribunal, Dr Khan accepts that some marking of this would be appropriate.

7. Mr Gillespie submitted that whatever decision the Tribunal makes, the decisions as a whole need to flow, and that given the Tribunal's comments on the seriousness of the misconduct and the lack of impairment, a warning would logically flow from those components in this case.

The Tribunal's Determination on Warning

8. In reaching its determination, the Tribunal bore in mind the relevant paragraphs of the Guidance, as set out below.

> **11** *Warnings allow the GMC and MPTS tribunals to indicate to a doctor that any given conduct, practice or behaviour represents a departure from the standards expected of members of the profession and should not be repeated. They are a formal response from the GMC and MPTS tribunals in the interests of maintaining good professional standards and public confidence in doctors. The recording of warnings allows the GMC to identify any repetition of the particular conduct, practice or behaviour and to take appropriate action in that event. Breach of a warning may be taken into account by a tribunal in relation to a future case against a doctor, or may itself comprise misconduct serious enough to lead to a finding of impaired fitness to practise.*

9. The Tribunal concluded that any future repetition would have a significant impact on the assessment of Dr Khan's insight, and that a warning could be properly taken into account by any future Tribunal should this occur.

> **14** *Warnings should be viewed as a deterrent. They are intended to remind the doctor that their conduct or behaviour fell significantly below the standard expected and that a repetition is likely to result in a finding of impaired fitness to practise. Warnings may also have the effect of highlighting to the wider profession that certain conduct or behaviour is unacceptable.*

> **16** *A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:*
>
> - *there has been a significant departure from Good medical practice, or*
> - *…*

20 The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.

a There has been a clear and specific breach of Good medical practice or our supplementary guidance.

b The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor's fitnessto practise has not been found to be impaired.

c A warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely relating to a doctor's health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.

d There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).

10. The Tribunal concluded that the departures from the standards expected, as set out in its determination on impairment, were significant. It considered that although distinct in their own nature, they nevertheless indicated a lack of respect for colleagues and the dignity of patients, falling far short of the standards of conduct that could be reasonably expected of a registered doctor.

11. The Tribunal also concluded that any repetition of similar misconduct would likely result in a finding of impaired fitness to practise against Dr Khan.

26 In deciding whether to issue a warning the decision maker should apply the principle of proportionality, weighing the interests of the public with those of the practitioner. It is important to bear in mind, of course, that warnings do not restrict the practitioner's

practice and should only be considered once the decision maker is satisfied that the doctor's fitness to practise is not impaired.

12. The Tribunal was of the opinion that in light of the nature of the misconduct and the need to maintain standards within the profession, the public interest outweighed any impact a warning would have on Dr Khan.

32 If the decision makers are satisfied that the doctor's fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of factors to determine whether a warning is appropriate. These might include:

a the level of insight into the failings
b a genuine expression of regret/apology
c previous good history
d whether the incident was isolated or whether there has been any repetition
e any indicators as to the likelihood of the concerns being repeated
f any rehabilitative/corrective steps taken
g relevant and appropriate references and testimonials.

13. The Tribunal reminded itself that its determination that Dr Khan's fitness to practise is not impaired was influenced to a significant degree by its judgement of the mitigating factors set out at paragraph 32 of the Guidance. It determined that, notwithstanding those factors, it was still proportionate to issue a warning. It noted that its determination on impairment was based on the evidence before it and that if Dr Khan's misconduct were repeated, the Tribunal's judgement of those factors would be undermined, and there was a need to guard against this which the issuing of a warning would fulfil.

14. The Tribunal considered that Dr Khan's actions had the potential to bring the profession into disrepute and it was necessary to send a message to the profession as a whole and the wider public that such behaviour is unacceptable.

15. The Tribunal therefore determined to issue the following warning in accordance with Section 35D(3) of the Medical Act 1983 and Rule 17(2)(m) of the Rules:

On dates between 3 June 2019 to 8 November 2019, Dr Khan made inappropriate comments to a junior doctor in a clinical setting.

This conduct does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good medical practice and associated guidance.

In this case, the following paragraphs of *Good Medical Practice* are particularly relevant:

> ***36*** *You must treat colleagues fairly and with respect.*
>
> ***37*** *You must be aware of how your behaviour may influence others within and outside the team.*
>
> ***47*** *You must treat patients as individuals and respect their dignity and privacy.*

Whilst this failing in itself is not so serious as to require any restriction on Dr Khan's registration, it is necessary in response to issue this formal warning. This warning will be published on the medical register in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy.

16. There is no interim order to revoke.

17. That concludes this case.

ANNEX A – 25/05/2023

Application of no case to answer under Rule 17(2)(g)

1. At the conclusion of the GMC's case, Mr Gillespie, counsel, on behalf of Dr Khan, made an application pursuant to Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), which states:

> *"the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld".*

2. This application related to the following paragraphs of the Allegation:

1(a)(i), 1(a)(ii), 1(b)(ii)
2(a), 2(b),
3(a), 3(b)

Submissions on behalf of Dr Khan

3. Mr Gillespie set out his submissions in writing to the Tribunal, expanding upon them orally. He submitted that there was insufficient evidence for the Tribunal to conclude that the paragraphs set out above should continue to be heard. He referred the Tribunal to Rule 17(2)(g) of the Rules and reminded the Tribunal that the test to be applied was that set out *in R v Galbraith [1981] 1WLR 1039 (*as set out below).

4. Mr Gillespie submitted that the GMC's case is entirely dependent on the evidence of two, at the time very junior, doctors and that at no time has the Trust examined patient records relating to any patient seen by Dr Khan when he was assisted on his ward round by either Dr A and/or Dr D, and the GMC has adduced no evidence before this Tribunal of any such records.

5. Mr Gillespie submitted that given the serious nature of the allegations and, in particular, Dr A's evidence that some patients had deteriorated as a result of Dr Khan's lack of care, what is striking is the paucity of the material on which the allegations are based. Mr Gillespie accepted that there is some evidence of the allegations as a result of the written and oral witness statements of Dr A and Dr D, but submitted that in the absence of patient records,

these statements and allegations are entirely without context and can properly be described as 'tenuous, weak or vague'.

6. Mr Gillespie submitted that other contextual matters include the relative lack of experience of the doctors raising the issue and the fact that, according to Dr D, it was only after Dr A had been upset by the rape comment that the patient safety matters were reported to the Trust. He submitted that whilst the latter point is on one view the sort of issue a fact-finding Tribunal could determine with reference to the burden and standard of proof, given the possibility of an animus on the part of Dr A as a result of the comment, it was all the more important to separate the issues of Dr Khan's comment and his clinical behaviour, and to investigate the clinical issues fully and properly. He submitted that Dr A was prepared to state in evidence that she did not believe Dr Khan had other duties in A&E without any basis for her belief other than that that was her opinion. He submitted that not only does this represent, in effect, a new allegation, it is inherently unbelievable that no one in the management team realised that Dr Khan was being paid the full rate as a locum consultant for approximately ten minutes work.

7. Mr Gillespie submitted that whilst issues of credibility are normally to be considered at the fact-finding stage, the combination of the obvious animus displayed by Dr A and the total lack of any investigation by either the Trust or the GMC, is such that her evidence cannot be relied upon.

8. Mr Gillespie submitted that so far as Dr D is concerned, his evidence highlights the importance of securing and analysing the contemporaneous documentation. He submitted that, understandably, his recollection of particular conversations is limited given the passage of time. Further, he submitted, the Tribunal has no way of judging whether Dr D's assessment of clinical need was justified or not.

9. Mr Gillespie submitted that the absence of context makes the Tribunal's job impossible given that it has no evidence of: the number of patients involved; the conditions with which those patients presented; the severity or otherwise of those conditions; whether the patients had been seen already by a consultant or senior doctor and when; any negative outcomes for a particular patient, and; what any properly instructed expert might have said in relation to the assessment and management of any particular patient

10. Mr Gillespie submitted that the Tribunal should ask itself how, in the absence of any records, it could possibly adjudicate between the allegation that Dr Khan acted in the way alleged and his response.

11. In respect of paragraph 1(b)(ii) of the Allegation, Mr Gillespie submitted that the Tribunal has no evidence as to whether that patient should have been examined or not, and as to whether the alleged comment was made or not. This is a matter of whether the Tribunal accepts his submission as to the extent to which it can even at this stage rely on Dr A as a witness.

Submissions on behalf of the GMC

12. On behalf of the GMC, Dr Dite, counsel, submitted that as paragraphs 2 and 3 would follow-on from a finding that paragraph 1(a) was proved, the decision for the Tribunal is really whether there is sufficient evidence adduced that it could, taking the evidence at its highest, find paragraphs 1(a)(i) and 1(a)(ii) proved. He submitted that in addition to considering whether it could be found that examinations had not been carried out or that previous findings were replicated, there is the separate matter of whether Dr Khan said the words alleged at paragraph 1(b)(ii).

13. Dr Dite submitted that the evidence is such that its strength or weakness depends on the view of the Tribunal in regard to witness credibility, taking into account whether or not Dr A was operating under an animus. He submitted that this evidence comes down to the accounts of Dr A and Dr D as to what occurred, supported by the oral evidence, witness statements and documentary evidence of Dr B and Dr C. He submitted that the emails provided recorded the meeting and discussion between Dr B, Dr A and Dr D, accompanied by the emails of both junior doctors setting out their concerns at the time. He submitted that the GMC's position is that the evidence is not so tenuous or inherently unreliable that the case should be stopped, as submitted by Mr Gillespie.

14. Dr Dite submitted that on the evidence before it, when taken at its highest, the Tribunal could find that Dr Khan did ask Dr A and Dr D to make records of patient notes that did not reflect reality. He submitted that they were clear that this is what occurred in their emails written at the time and have consistently maintained this throughout their oral evidence. He submitted that Dr A's emails raising her concerns came shortly after a ward round with Dr Khan and that she describes him instructing her to document in the notes examination findings which had not occurred. She then went on to give an example in that e-

mail that *"He will ask you to document in the notes examination findings which have not occurred. e.g. if a patient was found to have bilateral crepitations on admission, he will not listen to the chest but ask you to pretend he has by writing it in the notes."*

15. Dr Dite submitted that this account is reiterated consistently by Dr A throughout her written accounts and oral evidence, and that Dr D was particularly clear in his evidence to the Tribunal that what he described in his statement was a significant event for him and did in fact happen as described.

16. Dr Dite submitted that the evidence has not been undermined to such an extent that there is no case to answer at this stage and that whilst these were two relatively junior doctors they were nonetheless professionals who are recalling specific conversations that they had with Dr Khan and that those instructions from Dr Khan did in fact happen.

17. Dr Dite submitted that the question at this stage is not whether a more thorough investigation should have been conducted by the Trust or the GMC, but that the Tribunal should focus on the evidence that has been adduced and take that evidence that its highest when considering the application of no case to answer. He submitted that whether the allegations are found proved comes down to witness reliability and credibility, meaning that if taken at its highest, there is sufficient evidence that the allegations could be found proved and that all paragraphs of the Allegation should proceed.

18. In respect of paragraph 2(b)(ii), Dr Dite submitted that there is evidence of that comment from Dr A in both her written accounts and her oral evidence, and that it could be found proved on that basis. He submitted that it was quite clear in her evidence that this comment was made to her, that the conversation about that elderly patient happened and that she was robust in her response when challenged about it. He submitted that the Tribunal also has the context that Dr Khan admits to making an inappropriate comment specified in paragraph 1(b)(i) and that clearly this aspect of the case should also be allowed to continue.

The Relevant Legal Principles

19. The Tribunal reminded itself that at this stage of the proceedings it was not considering whether it would or would not find each paragraph proved but whether, taking the GMC evidence at its highest, sufficient evidence had been adduced for there to be a case for Dr Khan to answer. The Tribunal bore in mind that if it finds that there is sufficient evidence for the

hearing to proceed on a particular paragraph, it will have to decide in the light of all the evidence before it at the end of the fact-finding stage, whether that paragraph has in fact been found proved or not. In considering whether or not sufficient evidence has been adduced to find some or all of the facts proved, the test to be applied by the Tribunal is as set out in ***R v Galbraith [1981] 2 All ER 1060*** which states (with adapted wording for the Tribunal)

> *"How then should the Tribunal approach a submission of 'no case'?*
>
> *(1) If there is no evidence that the fact alleged has been committed by the medical practitioner, there is no difficulty. The Tribunal will of course stop the case.*
> *(2) The difficulty arises where there is some evidence, but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
> > *(a) Where the Tribunal comes to the conclusion that the GMC evidence, taken at its highest, is such that a properly directed Tribunal could not properly find the fact proved upon that evidence, it is the Tribunal's duty, upon a submission being made, to stop the case in relation to that alleged fact.*
> >
> > *(b) Where however the GMC evidence is such that its strength or weakness depends on the view to be taken of a witness' reliability, or other matters which are generally speaking within the province of the Tribunal, and where on one possible view of the facts there is evidence upon which a Tribunal could properly find the fact proved, then the Tribunal should not make a direction of no case to answer."*

20. The Tribunal was reminded by the LQC of the case of ***Husband V GDC [2019] EWHC2210 (Admin)*** which confirms that it is incumbent on the Tribunal to consider the whole of the evidence which has been produced at the stage of the no case to answer application and the task for it is to decide whether the charge **could** be made out not whether it **would** be made out.

Tribunal's Decision

21. In considering each paragraph for which Mr Gillespie submitted that there was no case to answer, the Tribunal had regard to the detailed submissions made by both parties and the totality of the evidence before it.

Paragraph 1(a)

22. The Tribunal first considered the direct evidence in support of this paragraph of the Allegation, beginning with that of Dr A. The evidence provided by Dr A included:

- Email from Dr A raising concerns regarding Dr Khan 25 October 2019;
- Email from Dr B to Dr A regarding concerns 14 November 2019;
- Dr A's email with further information regarding the concerns 17 November 2019;
- Dr A's GMC witness statement dated 29 October 2021.

23. The Tribunal noted that in her original email of 25 October 2019 raising these concerns, Dr A provided a general example rather than details of a specific patient, stating that:

> *"He will ask you to document in the notes examination findings which have not occurred. e.g. if a patient was found to have bilateral crepitations on admission, he will not listen to the chest but ask you to pretend he has by writing it in the notes."*

24. In her follow-up email of 17 November, Dr A stated:

> *"He would ask us to document what he found on examination by just getting us to write down what the previous doctor had document. For instance, he would say "what did they put when they clerked him?....Just put that". Not once did I actually see him listen to a patient's chest when he was on an acute medical ward round, which felt mad."*

25. In her GMC witness statement of 29 October 2021, Dr A states that Dr Khan *"would falsify patient records by asking me and other junior doctors to document things that had not happened in the notes."*

26. The Tribunal noted the various accounts of Dr A and considered that the details contained within these, as well as speaking in general terms and examples, had inconsistencies within such details as were provided. Dr A admitted that her email of 14 November 2019 detailing her concerns was made after discussion with colleagues, and the Tribunal considered that this and subsequent accounts may therefore have been influenced by Dr A talking to others. In this account she stated that *"He would ask us to document what*

he found on examination by just getting us to write down what the previous doctor had documented."

27. Dr A's GMC witness statement suggests a number of occasions of Dr Khan falsifying records, but only one was alluded to in Dr A's emails, in addition to the reference to the elderly lady patient. Whilst a number of examples of such behaviour are suggested, they are not specified or set out in any detail in any of Dr A's accounts, and due to the passing of time she is unable at this point to recall specific patients or circumstances.

28. The Tribunal then considered the evidence of Dr D, which included:

- Email from Dr D detailing concerns about Dr Khan, dated 11 December 2019;
- Dr Ds GMC witness statement dated 3 November 2021.

29. In his email of 11 December 2019, Dr D stated of Dr Khan that:

> *"However, what made me very uncomfortable was the fact that he has not performed any clinical examination in many of the patient we reviewed and when he noticed that I was not documenting anything regarding the examination (this is because when I document someone`s review I write what has happened, as I have been thought) he asked me to "copy the last examination performed" by someone else (which could have been an F1 or best scenario an SHO, so without a Consultant`s level of experience) and when I questioned this practice I was told that I would have gotten in trouble if someone had found no examination documented."*

30. In his GMC witness statement, Dr D stated that:

> *"Dr Khan made me uncomfortable that he did not perform clinical examinations in many of the patients that were admitted. I recall when we had done the ward round of a full bay (6 beds) and he did not examine any of the patients. I think this probably happened in approximately October/November 2019. I remember that for the first three patients I documented the short conversation between them and Dr Khan. After the fourth patient was seen, Dr Khan noticed that I wasn't documenting that there had been an examination.*
>
> *…*
>
> *After another patient I didn't document that there had been an examination, he stopped and grabbed hold of the notes and showed me that I didn't write any*

examination for the patient. He said I would get in trouble of I didn't write it. He said something along the lines of "what's the problem, just document what's been written in the previous one." The previous examination of a patient on the ward rounds would usually have taken place within the last 12 hours by a consultant. In this example, I said that the last entry was by a Foundation Year 1 doctor and should be a consultant. He then said that this was fine and just to document it."

31. The Tribunal noted that there appeared to be elaboration over time in the accounts of Dr D and that his latter account, some two years after the event, contained more detail and was more certain of events, despite the passage of time and that he had no access to these patient records when completing the later statement.

32. In his oral evidence, Dr D estimated that in about 10 - 15% of cases a patient would have previously been seen by a consultant, but the evidence of Dr B was that this would have been higher.

33. In his GMC witness statement, Dr D also states that *"Apparently, Dr Khan didn't do this with everyone."*, suggesting a discussion between junior doctors leaving open the possibility that it may have influenced his statement and perception of events.

34. The Tribunal concurred with Dr Dite's submission that Dr A and Dr D's oral evidence was largely consistent with their written accounts and that these were not subject to detailed challenge. However, the Tribunal noted that both accepted that owing to the passage of time they no longer have an independent recollection of the events but relied heavily on their written statements as to what had occurred.

35. During their oral evidence, the Tribunal was provided with no further supporting evidence or facts in relation to the specific events, patients and what occurred, save for Dr A making a new assertion that Dr Khan would spend less than a minute with each of the fourteen patients he had to see in the AMU (Acute Medical Unit) and then effectively disappear. She demonstrated in her oral evidence a scepticism about whether Dr Khan had other duties in A&E. The Tribunal agreed with Mr Gillespie's submission that this claim was not supported by any evidence and the Tribunal considered that this was indicative of a jaundiced perception of Dr Khan by Dr A.

36. The Tribunal then went on to consider the contextual evidence, which included:

- Dr B's record of a conversation he had apparently with both Dr A and Dr D on 4 November 2019, which consists of nine lines;
- Dr B's record of a conversation he had the same day with Dr Khan, which is as follows:

"I went through all the concerns that had been shared with me. He was repeatedly apologetic and said that if he needed to be more thorough he would be. He also tried to explain what he meant by medical note entries."

37. The Tribunal considered Dr B's evidence, noting how the matter was dealt with and his approach to gathering and recording the evidence. Dr B's account of his meeting with Dr A and Dr D differed from their version of events. The relative formality of the meeting and the participants described by him differed from their account which was of a more informal type and with different participants. The evidence was that if a written note of this meeting was taken it was only sufficient to draft the email afterwards, but Dr B could not say whether he had taken a written note.

38. In his email, Dr B stated that *"For example, their perception [Dr A and Dr D} was that he [Dr Khan] was instructing them to complete entries in the notes that incorrectly indicated that he had examined the patient. On occasions he had instructed them to see the patient and then make an entry in the notes under his name."* The Tribunal noted that the meeting notes had some inconsistencies with the accounts of Dr A and Dr D, such as the claim that Dr Khan asked them to complete entries under his name, which was not alleged elsewhere. It also noted that whilst there is evidence of a meeting between Dr B and Dr Khan, this note is vague and does not assist in understanding Dr Khan's account of events or motivations at the time.

39. It was clear from the oral evidence of Dr A and Dr D that the meeting did not appear to them to be a formal one, but rather a discussion, which conflicted with the account of Dr B. There is no documentary evidence or contemporaneous notes of this meeting, save for the email of Dr B and the oral accounts provided some years after the events.

40. In dealing with the issue of patient examinations not being carried out, as alleged, the Tribunal considered the evidence of Dr B and Dr C, who were at the time, and are, senior clinicians with considerable experience of ward rounds. Both described how in order to ascertain what sort of examination was necessary and whether it was appropriately carried out, specific details and assessment of the patient would be necessary. Dr B conceded that some patients would be sicker than others and require prioritisation, whereas some patients

would require fewer intensive observations and examinations. Also, he added that on occasion patients could be in the AMU for over 24 hours.

41. The Tribunal reminded itself that in order to be able to find paragraph 1(a) proved there would have to be evidence that patient examinations were not carried out. In that regard it examined Dr B's and Dr C's oral evidence as to the extent to which an examination was required. Again the Tribunal took note that this would be influenced by the need to prioritise patients on the basis of their level of sickness, the number of patients in AMU, when they were admitted and if they had been previously examined either in A&E or in the AMU by a consultant. Dr B conceded that not all patients required an equal approach and equal time and a good consultant would make best use of resources with his experience helping with that task. He also described the ward round assessment of patients as a team effort with the consultants *"supported by a range of professionals."* Dr C, while agreeing that a consultant could nor record an examination he had not done, stated that certain parts of the examination could be delegated and that while what was required by way of examination was evidence based, the clinical experience of a consultant counted also. In that regard a consultant would obviously have more clinical experience than a junior doctor.

42. The Tribunal considered that the GMC had provided some evidence in support of paragraph 1(a) of the Allegation, but that this evidence was weak and tenuous and vague owing to the inconsistencies, the passage of time, and the lack of any specific examples or details. The Tribunal noted again Dr B's reference in his email, to Dr A and Dr D's *"perceptions"* of what had occurred suggesting that at the time they made their complaints, their account was seen by him (Dr B) as their opinions rather than actual fact. The Tribunal considered that the evidence of Dr B and Dr C together with a complete absence of any specific patient details indicated the real possibility that they may have been mistaken in these perceptions, depending on the specific circumstances of the relevant patients.

43. The Tribunal was of the opinion that both Dr A and Dr D were honestly providing their version of events, based upon their perception at the time, and now in retrospect based on their earlier written accounts. However, the Tribunal concluded that even if this evidence was taken at its highest, this would be insufficient to find the allegations proved. The Tribunal heard evidence that there are degrees to which examinations and medical notes are required, and that these are context and patient-specific. Given that the Tribunal was provided with no specific examples of patients who were not properly examined or any related medical records or assessments of Dr Khan's treatment of such patients, even if it accepted the testimonies of Dr A and Dr D, this would be insufficient to prove that, on the

balance of probabilities, Dr Khan had asked them to *"record patient examinations that had not been carried out or examination findings as recorded by the previous doctor to have examined the patient(s)"* as set out in the Allegation.

44. Given the evidence the Tribunal heard regarding the variability of what would be required of Dr Khan for individual patients in the context of the busy hospital setting, it concluded that it would not be possible to find these allegations proved on the basis of the unsupported perceptions of two junior doctors who had worked with Dr Khan for approximately eight to twelve shifts over a period of four weeks or so. It noted that Dr A's perceptions of Dr Khan's examinations were more than likely coloured by the comment in paragraph 1(b)(i) which Dr Khan has admitted.

45. Accordingly, the Tribunal found that the evidence, taken as a whole and when taken at its highest, was so weak, vague and tenuous that no Tribunal could find the specific wording as set out at paragraphs 1(a)(i) and 1(a)(ii) of the Allegation proved. It therefore determined that there was no case to answer in respect of this paragraph and granted Mr Gillespie's application.

Paragraph 1(b)(ii)

46. The Tribunal considered the evidence in support of this paragraph of the Allegation, which constituted the various accounts provided by Dr A. This evidence constituted:

- Email from Dr A raising concerns regarding Dr Khan 25 October 2019;
- Email from Dr B to Dr A regarding concerns 14 November 2019;
- Dr A's email with further information regarding the concerns 17 November 2019;
- Dr A's GMC witness statement dated 29 October 2021.

47. The Tribunal noted that Dr A did not mention the wording set out in this paragraph of the Allegation in her original email raising concerns on 25 October 2019, but that it first appeared in her follow-up email dated 17 November 2019, after Dr Khan's employment at the Hospital had ended.

48. However, during her oral evidence, Dr A was adamant about what she heard Dr Khan say in respect of the elderly patient.

49. The Tribunal considered that the evidence in respect of this paragraph is the accounts of Dr A and Dr Khan. The Tribunal, having concluded that Dr A was giving her honest perception of events in respect of paragraph 1(a), was not persuaded that Dr A's reliability as a witness was so undermined and weakened that her account could be wholly discredited at this stage such that there was no case to answer.

50. The Tribunal considered that her account of this event was not subject to the same issues of perception as her interpretation of events alleged at paragraph 1(a) and that it is a specific allegation based solely on her account, which may turn on witness reliability or credibility.

51. Accordingly, the Tribunal determined that a Tribunal considering the evidence, and taking it at its highest, could find proved that Dr Khan said the words alleged, and therefore refused the application of no case to answer in respect of this paragraph.

Paragraphs 2 and 3

52. In light of its findings in respect of paragraphs 1(a)(i) and 1(a)(ii) of the Allegation, as set out above, the Tribunal determined that it necessarily followed that there is no case to answer in respect of paragraphs 2 and 3 of the Allegation.