PUBLIC RECORD

Dates: 20/11/2023 to 01/12//2023;
15/01/2024;
25/03/2024 - 27/03/2024

Medical Practitioner's name: Dr Seeniar NAVARATNAM

GMC reference number: 0981884

Primary medical qualification: MB BS 1964 University of Ceylon

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

Summary of outcome
No warning

Tribunal:

Legally Qualified Chair	Mr Kenneth Hamer
Lay Tribunal Member:	Ms Catherine Pease
Medical Tribunal Member:	Dr Keith Dunnett

Tribunal Clerk:	Miss Hinna Safdar

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Ben Rich, Counsel, instructed by Medical Protection
GMC Representative:	Ms Susie Kitzing, Counsel (November 2023) Ms Ceri Widdett, Counsel (March 2024)

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. 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 - 15/01/2024

Background

1. Dr Navaratnam qualified in 1964 from the University of Ceylon in Sri Lanka, and in 1974 was first appointed a Consultant in Rheumatology and Rehabilitaion at Basildon and Thurrock District Hospitals. Prior to the events which are the subject of this hearing Dr Navaratnam was a long standing locum consultant in rheumatology working at various NHS hospitals and private clinics. Dr Navaratnam has since retired.

2. The allegation that has led to Dr Navaratnam's hearing can be summarised as that, on 31 July 2021, at his home address, Dr Navaratnam consulted with Patient A and failed to provide adequate clinical care. It is alleged that Dr Navaratnam's failings related to treatment, history taking, investigation, examination, consent, communication, safety netting and record keeping. It is also alleged that Dr Navaratnam failed to perform the procedure in a clinically appropriate environment and dishonestly recorded findings from a physical examination of Patient A that had not taken place.

3. The initial concerns were first raised with the GMC some nine months later on 28 April 2022 by one of Patient A's sons, Mr B.

The Outcome of Applications Made during the Facts Stage

4. The Tribunal granted an application made on behalf of Dr Navaratnam by his counsel Mr Ben Rich, made pursuant to Rule 16 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), for Dr Navaratnam to call an expert witness, namely, Professor H. The Tribunal also granted an application for Professor H's expert report to be admitted as evidence.

The Allegation and the Doctor's Response

5. The Allegation made against Dr Navaratnam is as follows:

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

1. On the 31 July 2021 you consulted with Patient A and you:

   a. administered cervical facet joint injections ('the procedure') which were not clinically indicated; **To be determined**

   b. failed to take an adequate history including asking about the duration of Patient A's symptoms and progression; **To be determined**

   c. failed to perform a neurological examination to investigate reported neurological symptoms; **To be determined**

   d. failed to obtain appropriate consent for the procedure as you did not:

      i. provide adequate information around the risks and benefits of the proposed treatment including the risks of:

         i. nerve damage; **To be determined**

         ii. paralysis; **To be determined**

         iii. infection; **To be determined**

         iv. unmasking latent diabetes; **To be determined**

         v. local soft tissue atrophy; **To be determined**

         vi. pain; **To be determined**

         vii. bleeding; **To be determined**

         viii. the treatment not being effective; **To be determined**

   e. failed to allow Patient A a period of reflection on whether to proceed with the procedure or not; **To be determined**

   f. failed to provide Patient A with a:

      i. diagnosis; **To be determined**

      ii. rationale for the procedure; **To be determined**

   g. in the alternative to 1b, 1d and 1f, did not record having undertaken the actions as described;

      Admitted and found proved in relation to 1b and 1d

      To be determined in relation to 1f

h. failed to meet Patient A's language and communication needs in that you did not adequately communicate with:

i. Patient A; **To be determined**

ii. Mr B; **To be determined**

iii. Mr C; **To be determined**

i. failed to perform the procedure under image guidance including ultrasound guidance, CT or fluoroscopy; **To be determined**

j. failed to perform the procedure in a clinically appropriate environment as:

i. basic aseptic technique was not adhered to; **To be determined**

ii. the premises did not meet basic hygiene standards;

Admitted and found proved

iii. there was no access to resuscitative equipment, including a defibrillator and emergency airway management; **To be determined**

k. failed to ensure appropriate 'safety netting' advice was given to Patient A as you did not advise her on the risks of deterioration, bleeding or nerve injury occurring after the procedure such as to allow Patient A to understand how to manage these complications; **To be determined**

l. falsely recorded findings from a physical examination of Patient A in:

i. your medical notes; **To be determined**

ii. a letter to Mrs D; **To be determined**

m. knew that:

i. you had not examined Patient A; **To be determined**

ii. your examination findings were untrue. **To be determined**

2. Your actions as set out at paragraph 1l were dishonest by reason of paragraph1m. **To be determined**

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

The Admitted Facts

6. At the outset of these proceedings, through his counsel, Dr Navaratnam made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e), the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Witness Evidence

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

- Patient A, witness statement dated 13 December 2022 and in person with a translator;
- Mr B, witness statement dated 18 May 2023 and in person;
- Mr C, witness statement dated 27 July 2023 and via video link.

8. Dr Navaratnam provided his own witness statement dated 7 November 2023 and also gave oral evidence at the hearing. In addition, the Tribunal received evidence from the following witness on Dr Navaratnam's behalf:

- Ms E, witness statement dated 15 November 2023 and via video link.

Expert Witness Evidence

9. The Tribunal received evidence from three expert witnesses. Dr F, a Consultant Rheumatologist, and Dr G, a Consultant in Anaesthesia and Pain Medicine, were called to give evidence on behalf of the GMC. On behalf of Dr Navaratnam, Professor H, a Consultant Rheumatologist, also gave evidence to the Tribunal. All three experts produced written reports and gave their evidence via video link.

Documentary Evidence

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

- GMC Concerns Form, dated 28 April 2022;
- Email from complainant, dated 11 May 2022;
- Email from complainant, dated 17 May 2022;
- Dr Navaratnam's CV;
- Patient A's Medical Records from Clayhall Osteopaths;
- Patient A's Medical Records made by Dr Navaratnam;
- GP Records for Patient A;

- GMC Expert Report of Dr F, dated 8 September 2022
- GMC Supplementary Expert Report of Dr F, dated 27 October 2022;
- GMC Expert Report of Dr G, dated 30 August 2023;
- GMC Supplementary Expert Report of Dr F, dated 9 September 2023;
- Photograph of Dr Navaratnam's living room as set out on the day of Patient A's consultation;
- Expert Report of Professor H, dated 9 November 2023;
- Testimonial provided by Professor H XXX on 24 November 2022;
- Various testimonials on behalf of Dr Navaratnam, dated November 2023;
- Confirmation of Appraisal Completion on 16 April 2020, and 28 February 2022.

The Tribunal's Approach

11. In reaching its determination on the 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 Navaratnam 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 event occurred.

12. The Tribunal had regard to the advice of the Legally Qualified Chair (LQC) which included but was not limited to advice on the burden and standard of proof and Dr Navaratnam's good character; separate treatment; the wording of the Allegation; and approach to the evidence.

The Tribunal's Analysis of the Evidence and Findings

13. The Tribunal considered each paragraph and sub-paragraph of the Allegation separately and evaluated all the evidence in order to make its findings on the facts.

Paragraph1(a) – Not Proved

14. It was not in dispute that Dr Navaratnam administered one or more cervical facet joint injections into Patient A's neck. The GMC's case is that the procedure was not clinically indicated.

15. The LQC advised that the words "not clinically indicated" in paragraph 1(a) of the Allegation mean in the context of this case that Dr Navaratnam administered cervical facet joint injections when there was no clinical reason or need for them. Or putting it another

way, there was no medical call for them and nothing to warrant or justify cervical joint injections being administered to Patient A.

16. Dr F considered that the diagnosis here was not a cervical facet joint problem. He said that Patient A complained of tingling fingers and this would not occur with a cervical facet joint situation. Instead, Dr F considered that Patient A was suffering with nerve root irritation. Dr F said that as the diagnosis was incorrect, cervical facet joint injections were not the correct treatment and therefore the injections administered by Dr Navaratnam to Patient A were not clinically indicated. However, Dr F recognised that the procedure adopted by Dr Navaratnam might provide temporary relief.

17. Dr G' evidence was somewhat different. In his written report Dr G recognised that treatment with cervical facet joint injections is the subject of "much debate". Dr G referred to a 2021 document entitled "Consensus practice guidelines on interventions for cervical spine (facet) joint pain from a multispecialty international working group" which states that whilst cervical spine interventions are commonly performed, a failure of conservative management for a period of time is the threshold before consideration of injections. In his oral evidence Dr G said that this period is normally 12 weeks consistent with guidelines published by the National Institute of Clinical Excellence (NICE), and that "ideally there should be 12 weeks of conservative management". Conservative management typically involves a trial of analgesic and anti-inflammatory medications, physiotherapy or other modalities such as heat and/or ice, massage, and spinal mobilisation.

18. Professor H said that the nerve root exit is close to the facet joint and that it is not uncommon for facet joint inflammation to affect existing nerve roots. He said that facet joint inflammation is a common cause of acute pain, and that the procedure carried out by Dr Navaratnam in this case was "the pragmatic and sensible option and is commonly taught in his (Dr Navaratnam's) speciality". He concluded that the procedure here "was clinically indicated and helpful to a patient in severe pain and eager for relief."

19. Professor H added that "12 weeks of conservative management may be a guideline but sometimes they (rheumatologists) have to work outside of the guidelines. Because if they stick to the guidelines, they may have a patient who is in severe pain for 12 weeks". He also considered that the option of opiates such as Oramorph or Tramadol to manage pain for 12 weeks can cause the risk of addiction, and that opiate analgesia is not always in the best interests of the patient.

20. Professor H accepted that neck problems often get better on their own, or with physical therapy, but emphasised that facet joint injections are a fundamentally safe and simple procedure that offer a reasonable prospect of pain relief to desperate patients. They might otherwise suffer many weeks of agony while physiotherapy or nature took its course to resolve the issue, or while they waited for an MRI scan and image-guided injections (which could take many months).

21. The Tribunal bore in mind Ms Kitzing's submission on behalf of the GMC that Professor H lacked medico-legal experience and had not produced any literature supporting his view that early intervention with facet joint injections were appropriate in Patient A's case. The Tribunal did not accept that Professor H based his opinion simply on what his own practice was. During his evidence he referred on a number of occasions to what other colleagues did. Also he had made a wide study of the subject.

22. The Tribunal considered that Professor H had the necessary knowledge and experience to give skilled expert evidence, and that there was a reliable body of experience to underpin his evidence; see *Kennedy v. Cordia (Services) Ltd* [2016] UKSC 6, [2016] 1 WLR 597 at paragraph 44. Ms Kitzing rightly recognised that Professor H is an expert in his field. He was not uncritical of Dr Navaratnam. Professor H said that despite Dr Navaratnam being "confident" he had injected into the facet joint, one cannot ever be certain and that, contrary to Dr Navaratnam's view, patients also do better with having scans before treatment. The Tribunal noted that the nerve roots are close to the facet joints. However, there is no evidence that in this case Dr Navaratnam did not inject into the area of the facet joint.

23. The Tribunal noted that Dr F did not use the procedure of cervical facet joint injections at all in his practise and that Dr G mainly administered cervical facet joint injections in the context of treating chronic pain in a pain clinic as opposed to treating patients with acute pain problems. The Tribunal considered that Professor H gave his evidence in a logical and careful way and it was satisfied that his evidence was not affected by his prior knowledge of and working relationship with Dr Navaratnam or by him having previously given a testimonial for Dr Navaratnam. He was impartial in his presentation and assessment of the evidence.

24. The Tribunal considered the context under which Dr Navaratnam administered the injections. It was not an ideal situation, rather it was an emergency. Dr Navaratnam was unexpectedly telephoned by Mrs D, an osteopath, over the weekend to see Patient A urgently, who was in great distress. Patient A had been suffering pain for some two to three

weeks without any relief. She had been to her GP who had prescribed analgesics, Barts Hospital Emergency Department the day before who had recommended an MRI of her cervical spine and referral via her GP to a pain clinic, and to Mrs D, an osteopath, on the day she saw Dr Navaratnam. The Tribunal was told that referral to a pain clinic could take between three and six months. In the meantime Dr Navaratnam was faced with a patient struggling with severe pain.

25. The Tribunal determined that there had been no evidence adduced by the GMC that administering facet joint injections to Patient A on 31 July 2021 with the aim of providing temporary relief was unequivocally wrong or misplaced. Indeed, the Consensus practice guidelines on which Dr G placed much store (but about which Professor H had considerable misgivings) stated that many clinical studies evaluating cervical facet injections have required a course of conservative treatment, while others have not.

26. Dr G also recognised in his written report that whilst there should preferably be three months of conservative treatment prior to consideration of injections "flexibility should be allowed for consideration in extenuating circumstances". The Tribunal considered that in this instance, although the procedure was not in keeping with the time frame recommended by the NICE guidelines, Dr Navaratnam had sufficient experience to recommend and perform the procedure and that under the circumstances his decision to administer cervical facet joint injections was not an unreasonable one. It was, in the words of Professor H, a "pragmatic" course to adopt. Moreover, another healthcare professional, namely, Mrs D, an osteopath, had referred Patient A to Dr Navaratnam specifically for cervical facet joint injections.

27. The Tribunal preferred the evidence of Professor H to that of Dr F and Dr G, who had far less experience of acute situations than Professor H. The Tribunal was satisfied that Dr Navaratnam acted in accordance with a practice that would have been accepted by a responsible body of medical opinion as proper, under the particular circumstances on that day with this patient.

28. Accordingly, the Tribunal found paragraph 1(a) of the Allegation not proved.

Paragraph 1(b) – Not Proved

29. Paragraph 1(b) along with a number of other paragraphs of the Allegation alleges that Dr Navaratnam "failed" to do something or perform a task in one way or another. The word "failed" in this context means that Dr Navaratnam had a duty or obligation to complete the task alleged and that he did not do so. In *Daly v. Nursing and Midwifery Council* [2018] CSIH

51, the Inner House held that the word "failed" (in the sense of failed in a duty such as might amount to misconduct) would require proof of a recognised procedure which could realistically and feasibly be carried out.

30. Patient A attended Dr Navaratnam's home on 31 July 2021, arriving with her sons Mr B and Mr C at about 6 pm, and they left together sometime after 7 pm. The consultation lasted about one hour or a little longer. Patient A brought with her a referral letter from Mrs D, an osteopath whom she had seen earlier that day. The referral letter stated that Patient A was complaining of severe left neck pain with left median nerve distribution with an onset of 3 weeks duration.

31. The Tribunal had regard to the manuscript medical notes made by Dr Navaratnam dated 31 July 2022, and his clinic letter to Mrs D reporting on the consultation, also dated 31 July 2021. The handwritten medical note (replacing the shorthand) reads as follows:

> "31/7/21
> [Patient A] 01-01-1960
> Ref [Mrs D]
> GP [address]
> Pain in neck (Left) shoulder and arm. Worse above elbow. Tingling and numbness in (Left) index finger and middle finger. No weakness. Sleep disturbed. Cervical spine, range of movement slightly painful. Reduced. Right arm not affected.
> General health good. No diabetes. Family history nil. No hypertension.
> On examination: cervical spine posture ✓ cardiovascular, respiratory, abdomen ✓ Range of movement slightly painful. Full. Blood pressure 130/62. Going back to osteopath on 4th day, verbal consent, aseptic precautions [margin note]. Tender C5/6, C4/5 on left side. Kenalog 20 mg + 2/4 %. Marcan at both levels under local (analgesia). Advise wearing soft collar at night. MRI of cervical spine."

The clinic letter to the osteopath was as follows:

> "31-07-2021
> Dear Mrs [D]
> Re [Patient A] d.o.b : 01-01-1960,
> Thank you for referring the above patient whom I saw in my room at home on 31/07/2021. She was accompanied by her two sons. Her main complaint was

> as you have mentioned in your referral, Pain in her neck radiating to her left shoulder and arm, worse above her upper arm above her elbow. Associated with tingling in her middle and index fingers. Her sleep was disturbed but there was no weakness in her arm, hands or fingers. Her neck movements were painful and reduced. Her right arm was not affected. General health inquiry was not remarkable. No history of diabetes or hypertension. Family history Nil of note.
> On examination. No evidence of anaemia, lymphadenopathy, no skin rashes. Cardiovascular – no abnormality detected (NAD). Respiratory – NAD. Abdomen – NAD. Posture normal. Cervical spine: Range of movement slightly reduced by pain. Left shoulder movements full and pain free. Tenderness over C4/C5 facet joints and C5/C6 facet joints on the left only.
> Explained nature of condition and obtained verbal consent. Observing aseptic precautions using no touch technique injection of cervical facet joints at C4/C5 and C5/C6 under local analgesia and a mixture of 20mg of Kenalog and 0.5% bupivicane in to each facet joint was carried out without any unforeseen problems.
> Patient was comfortable after the procedure and advised to rest one night and to take paracetamol 500 mg x 2 tablets at night and to report any problems by telephoning me.
> I also advised her to go back to the osteopath the next day and request an MRI scan of the cervical spine to clarify the problem further.
> With kind regards, Copy G>P [address]
> Dr S Navaratnam
> Consultant Rheumatologist”

32. In his oral evidence, Dr Navaratnam said that the manuscript notes were made towards the end of the consultation while Patient A was resting following the procedure or shortly afterwards, and that the typed clinic note was written that evening and posted the following day to Mrs D, with a copy to Patient A’s GP. In his first expert report, Dr F said that assessment of the adequacy of medical notes should take into account both the handwritten contemporaneous notes and any subsequent written communication because handwritten notes are sometimes very brief and do not always reflect everything that has been discussed. A full clinic letter can compensate for this.

33. The Tribunal was satisfied that the handwritten medical note and clinic letter were contemporaneous documents prepared by Dr Navaratnam during or shortly after the

consultation and on the same day as the consultation. The Tribunal found there was no credible reason to doubt their genuineness and considered them to be a true record of what took place during the consultation. The documentation was detailed and the combination of the handwritten notes and clinic letter to Mrs D was extensive.

34. The Tribunal saw no reason to doubt Dr Navaratnam's evidence that he posted copies of the clinic letter to the osteopath and Patient A's GP as he said. The Tribunal noted that in the disclosure bundle of medical records the osteopath clinic produced a copy of the letter in question received by them and did not suggest that it was received other than shortly after its date. In an email Patient A's GP said that there was no letter from Dr Navaratnam amongst her patient records but the Tribunal did not attach any significance to this assertion. Dr Navaratnam also said in evidence that he may have sent an email to Mrs D with the clinic letter attached but no email was produced to the Tribunal.

35. It was apparent to the Tribunal that, amongst other things, Dr Navaratnam recorded in the documentation where Patient A's pain was, that she had sensation in her fingers and weakness and sleep disturbance. In the clinic letter to the osteopath, Dr Navaratnam recorded the areas in which Patient A had pain, where it was worse, where it came from, and the disturbance it had on her movements. Whilst Dr Navaratnam did not specifically mention the duration of Patient A's symptoms and their progression, he had this information in the referral letter from the osteopath. Bearing in mind that Mrs D was aware of the duration and progression of Patient A's symptoms there was not necessity to record the information again.

36. The Tribunal in any event considered it was most unlikely that Dr Navaratnam did not ask some basic questions about the history of the patient's symptoms, if only to confirm what Patient A had told the osteopath, such as "*how long had the pain been going on for*". In his witness statement, Mr B, who accompanied his mother to the consultation, said *"if he [Dr Navaratnam] asked questions, he'd ask it in English and immediately look to me to translate it in English…".* The Tribunal considered that this confirmed that questions were asked about Patient A's symptoms.

37. The Tribunal noted that Dr G' evidence was that, if the Tribunal accepted – as it did – that Dr Navaratnam took the history he had written down and knew about the duration then this was adequate. The Tribunal was satisfied that Dr Navaratnam took an adequate history including asking about the duration of Patient A's symptoms and progression.

38. Accordingly, the Tribunal found paragraph 1(b) of the Allegation not proved.

Paragraph 1(c) – Not Proved

39. In his clinic letter to Mrs D, Dr Navaratnam reported that Patient A's main complaint was pain in her neck radiating to her left shoulder and arm, worse above her the upper arm above the elbow. Dr Navaratnam's records show that he examined Patient A and that, amongst other things, he recorded that her cervical spine had a range of movements slightly reduced by pain and her left shoulder movements were full and pain free. The records also state that on examination there was tenderness over facet joints C4/C5 and C5/C6 on the left side.

40. Professor H said that "*You need to perform a neurological examination to exclude spinal cord compression which would necessitate immediate referral to A & E*".

41. In his witness statement, Dr Navaratnam said: *"I do not accept that I failed to perform a neurological examination. I carried out a thorough neurological examination, as is my usual practice, checking for sensory impairment in both upper limbs and muscle wasting and weakness in the arms and hands, making sure that there was no serious nerve damage in the neck area. I recorded "no weakness in her arm, hands or fingers" in my clinic letter. I also checked her reflexes with a tendon hammer. If there were any clinical signs of nerve impingement, I would not have injected."*

42. The Tribunal noted that performing a neurological examination is different to taking an adequate history of the patient's symptoms. However, the Tribunal considered that Dr Navaratnam was alive to neurological issues and that his notes and clinic letter overlap both matters. The Tribunal considered that while a full neurological examination may not have been performed, Dr Navaratnam carried out an adequate examination to assess the reported neurological symptoms.

43. Accordingly, the Tribunal found paragraph 1(c) of the Allegation not proved.

Paragraph 1(d) generally

44. The Tribunal noted that paragraph1(d) of the Allegation deals with Dr Navaratnam's advisory role and alleges that he failed to obtain "appropriate consent" from Patient A for the procedure by failing to provide "adequate information" around the risks and benefits of the proposed treatment. The key words here "adequate information". Whether the information provided was adequate and amounted to appropriate consent are matters for the Tribunal to judge having regard to the circumstances of the case.

Paragraphs 1(d)(i) and 1(d)(ii) – Not Proved

45. In his handwritten medical notes Dr Navaratnam recorded that he obtained "verbal consent" for the procedure, and his clinic letter to Mrs D states: "Explained nature of condition and obtained verbal consent". It was not suggested by the GMC that verbal consent was not adequate consent. In his oral evidence, Dr Navaratnam said that the needle he used to administer the injections to Patient A was not long enough to cause either paralysis or nerve damage. He said that the eventuality of either possibility was not provided to Patient A as these were not risks associated with the facet joint injections. He added that he had never had a patient who had experienced paralysis or nerve damage as a result of the procedure.

46. In his oral evidence, Dr G said that there was an obligation to tell patients of the risks of paralysis and nerve damage although the risks were "rare but severe". Dr F said that paralysis was "most unlikely", although he would not say that there was no risk of nerve damage. Professor H did not consider there was a risk of either nerve damage or paralysis and said that he had administered some 20,000 injections and that in his experience he had never had seen nerve damage or paralysis.

47. In *Montgomery v. Lancashire Health Board* [2015] AC 1430, at paragraph 87, the Supreme Court held that a doctor was "under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment". The court went on to say at paragraph 90 (repeated in *McCulloch v. Forth Valley Health Board* [2023] UKSC 26 at [72]) that information about anticipated benefits and risks of any proposed treatment should be comprehensible, but the doctor's duty is not fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp.

48. In the present case, in determining whether Dr Navaratnam provided adequate information the Tribunal considered whether there was a *material* risk of nerve damage or paralysis from the procedure. The Tribunal noted that Dr G and Dr F both agreed that the risks were rare, and this was supported by Professor H's experience. Patient A agreed in evidence that the needle was about one-half the length of her index finger. The Tribunal also bore in mind Dr Navaratnam's evidence that he did not want to trouble Patient A with information about possible nerve damage or paralysis if there was no reasonable likelihood of it occurring. He said: *"I did not want to make her (Patient A) worry".*

49. The Tribunal was not satisfied that the GMC had established to the requisite standard of proof that Dr Navaratnam failed to provide adequate information of the risks of nerve damage and paralysis.

50. The Tribunal therefore found paragraph 1(d)(i) and paragraph 1(d)(ii) of the Allegation not proved.

Paragraphs 1(d)(iii), 1(d)(vi), 1(d)(vii) and 1(d)(viii) – Not Proved

51. The Tribunal considered together the risks of infection, pain, bleeding and the treatment not being effective although the Tribunal reached separate decisions in relation to each allegation.

52. In his witness statement, Dr Navaratnam said: *"I provided an explanation of the risk and benefits of the treatment I provided, which included the risk of infection, increased pain and bleeding, and a risk of the treatment not being effective".* In his oral evidence, in relation to the risks of infection and bleeding, he said: *"I did warn her just before I injected. It's not big bleeding, its bleeding from the site, not bleeding profusely".* He further said in his evidence that he told Patient A "*there may be some blood and yes she did, she did bleed a little bit. I did warn her that it was a rare occurrence. When I was explaining the possible risks, I explained infection is a possible risk but we would be able to deal with it*." Dr Navaratnam added *"I did not write it down, we tell the patients but don't often record these things….The conversation took place during the injection*".

53. The Tribunal noted Patient A's witness statement, in which she said, *"Dr Navaratnam went upstairs and came back with an injection. He told me, via my son, that he was going to give me an injection but he didn't say what the injection was or what it was for. The only thing I asked my son to ask Dr Navaratnam was 'Will the pain go away now?' and I remember that Dr Navaratnam replied, 'I don't know'. He said something like 'you might get better or you might not'."*

54. Following the procedure there was some bleeding around the site of the injections. It is a reasonable inference that the bleeding was discussed by Dr Navaratnam with Patient A and that Dr Navaratnam reassured Patient A. In his clinic letter to Mrs D, Dr Navaratnam recorded that the facet joint injections were carried out "without unforeseen problems". Whilst bleeding was raised following rather than as a specific risk prior to the procedure, the Tribunal was nevertheless satisfied that adequate information of the risks of infection, pain and the treatment not being successful were provided at the time of the consultation, and

that Patient A gave appropriate consent to the procedure knowing the risks involved. Patient A was aware from seeing the osteopath beforehand that there could be no guarantee of success, and during the consultation was warned by Dr Navaratnam that the treatment may not be effective and that the pain may not go away. According to her witness statement, he told her: "I don't know" and something like "you might get better or you might not".

55. The Tribunal was conscious that the medical notes and clinic letter are a summary rather than a verbatim record and, as Professor H pointed out, not everything said in a consultation is necessarily recorded and that an experienced consultant would not take down "peripheral information".

56. In all the circumstances the Tribunal found paragraphs 1(d)(iii), 1(d)(vi), 1(d)(vii) and 1(d)(viii) of the Allegation not proved.

Paragraph 1(d)(iv) – Not Proved

57. In his witness statement, Dr Navaratnam said "*I do not agree that the procedure performed on Patient A carried a risk of unmasking latent diabetes (given the very small dose of corticosteroid administered)…".*

58. This was corroborated by Dr F who said in his oral evidence that there was no risk of unmasking latent diabetes (so no need to warn for consent), and Professor H who said that the risk of diabetes was *"very low".*

59. In her oral submissions, Ms Kitzing on behalf of the GMC accepted that the expert evidence was less certain of a necessity to inform Patient A of risk of unmasking latent diabetes.

60. The Tribunal therefore found paragraph 1(d)(iv) of the Allegation not proved.

Paragraph 1(d)(v) – Not Proved

61. In his witness statement, Dr Navaratnam said that he did not agree that the procedure performed on Patient A carried a risk of *"potential damage to local soft tissue atrophy (which does not occur with short-acting steroid preparations) or a risk of potential damage to other soft tissues (in particular because the needle used was not long enough to reach the dura or spinal canal)".*

62. Dr F accepted in his evidence that he did not always warn patients of the risk of soft tissue atrophy before obtaining consent and that much depends on the circumstances. The Tribunal also noted that in his evidence Professor H said that the dosage here was a very low dose and that, as the injection was deep, atrophy was very unlikely to occur because it was not a subcutaneous injection.

63. Again, Ms Kitzing accepted in her closing submissions that the expert evidence called by the GMC was less certain of a necessity to inform Patient A of the risk of atrophy.

64. Accordingly, the Tribunal found paragraph 1(d)(v) of the Allegation not proved.

Paragraph 1(e) – Not Proved

65. In the complaint form to the GMC (completed on Patient A's behalf by Mr B), it is claimed that Dr Navaratnam "*took my Mum straight to a hospital type bed he has in the corner of his living room and asked her to sit in a certain position. He didn't speak through any procedure or explain side effects, costs, consent, risks – nothing. He just said the treatment will consist of injecting steroids. He injected my [m]other in the same spot around 6 times, she was bleeding but he said that was normal*".

66. However, in her witness statement, Patient A said *"Dr Navaratnam went upstairs and came back with an injection. He told me, via my son, that he was going to give me an injection …".* Patient A was aware that she was visiting Dr Navaratnam's home for cervical spine treatment and it is clear that following any introductory discussion there was a period of time prior to the injections being administered. In his oral evidence, Dr Navaratnam said that during this interval (when he did not go upstairs but to an adjoining room) he went to wash his hands and was away for about five minutes, thereby affording Patient A the opportunity for a period of reflection prior to the procedure being performed.

67. The Tribunal was satisfied that there was a break in the sequence of events, albeit a short break, which would have afforded Patient A, who was accompanied to the consulation with two of her sons, a period of reflection. The Tribunal was not satsisfied that the GMC had proved to the requisite standard of proof that Dr Navaratnam failed to allow Patient A a period of refelction on whether to proceed with the procedure or not.

68. Accordingly, the Tribunal found paragraph 1(e) of the Allegation not proved.

Paragraphs 1(f)(i) and 1f(ii) – Not Proved

69. Patient A was referred to Dr Navartnam complaining of severe left neck pain with left median nerve distribution. The osteopath's referral letter contained a diagnosis of: *"Query (L) C5/C6 nerve root indentation due to associated disc bulges (possible broad based)".* Dr Navaratnam treated Patient A, as documented, with injections into the C4/C5 and C5/C6 facet joints. He says that in addition he injected her into the C6/C7 facet joint, which although not recorded the Tribunal has no reason to disbelieve.

70. The consulation lasted a little over one hour and was not rushed or hurried. Throughout Dr Navaratnam was pleasant and polite, despite some disagreement with one of Patient A's sons at the end of the consulation over his fees. The Tribunal rejected Patient A's evidence that the first 30 minutes, or 20 minutes according to her son Mr B, was taken with chatting before Dr Navaratnam began to focus on Patient A's treatment. It is inconceivable that, within the time-frame Patient A spent at Dr Navaratnam's house, during which there was a thorough consultation and treatment, any introductory remarks or preliminary discussion took longer than three or four minutes, or five minutes at the most.

71. Patient A's presentation was consistent with a diagnosis and treatment of cervical or nerve root pain and the Tribunal considered it more likely than not that Dr Navaratnam provided Patient A with such a diagnosis. The Tribunal noted Dr Navaratnam's contemporaneous clinic letter to Mrs D which stated: *"Explained nature of condition and obtained verbal consent".*

72. In his witness statement, Dr Navaratnam says: *"I explained my diagnosis of cervical root pain, which I felt was caused by degenerative changes (wear and tear) in the facet joints between the vertebrae, which was causing inflammation and triggering pain in nearby nerve endings. I had noted pain in the C4/C5, C5/C6 and C7/C7 area and explained that steroid injections at those sites would help relieve the pain (by reducing inflammation). However, I was also mindful that I could not rule out disc protrusion (which can coexist with intervertebral disc degeneration), hence my recommendation for an MRI scan as well".*

73. The Tribunal considered that the steps Dr Navaratnam took were consistent with a diagnosis of cervical or nerve root pain and that the rationale of the procedure (cervical facet joint injections) was that it might provide pain relief to Patient A. This was what Patient A was expecting when she attended his premises. At the end of the consultation Dr Navaratnam gave Patient A advice to wear a soft collar at night, to take paracetamol, and to go back to the osteopath and request an MRI scan of her cervical spine to clarify the problem further. This all implicitly provided Patient A with a rationale for the procedure he carried out.

74. Accordingly, the Tribunal found paragraphs 1(f)(i) and 1(f)(ii) of the Allegation not proved.

Paragraph 1(g) as an alternative allegation

75. Paragraph 1(g) of the Allegation is an alternative to paragraphs 1(b), 1(d) and 1(f) and alleges as a fact (as distinct from a failure in duty or obligation) that Dr Navaratnam did not record having undertaken the actions as described in paragraphs 1(b), 1(d) and 1(f) of the Allegation. Dr Navaratnam admitted paragraph 1(g) in relation to paragraphs 1(b) and 1(d), but not 1(f).

Paragraph 1(g) in relation to paragraph 1(f)(i) – Proved

76. The Tribunal accepted Mr Rich's submission that the history section of the medical notes effectively suggests a diagnosis. However, the charge in the Allegation is that Dr Navaratnam did not 'record' having provided to Patient A a diagnosis. There is no specific record in either Dr Navaratnam's handwritten medical notes or his clinic letter sent to the osteopath stating what his diagnosis of Patient A's condition was.

77. Moreover, in his witness statement Dr Navaratnam accepted that he did not document the diagnosis. He said: *"I accept that I did not document details about the duration/progression of symptoms (1b), the risks and benefits discussed as part of the consent process (1d) or a diagnosis (1.f.i)."*

78. The Tribunal therefore found paragraph 1(g) of the Allegation as it related to paragraph 1(f)(i) proved.

Paragraph 1(g) in relation to paragraph 1(f)(ii) – Not Proved

79. On the other hand, Dr Navaratnam's handwritten medical notes and his clinic letter to Mrs D do record in detail Patient A's complaints and pain she was suffering, her general health, his examination and findings, the steps he took to administer cervical facet joint injections, and the aftercare advice he gave her.

80. The Tribunal considered that taken together this provided a sufficient record of the rationale for the procedure undertaken.

81. Accordingly, the Tribunal found paragraph 1(g) of the Allegation as it related to paragraph 1(f)(ii) not proved.

Paragraph 1(h) – Not Proved

82. In his witness statement, Mr B said: *"We explained to Dr Navaratnam that mum doesn't speak much English and that we would translate for him. Dr Navaratnam did not speak Punjabi. Throughout the time we were in his house, if he asked mum any questions he would ask it in English, sometimes while looking at her and then immediately look at me to translate the question".*

83. In his witness statement, Mr C said that he and brother *"were translating everything for our mum*".

84. There was some discussion before the consultation got underway. Dr Navaratnam admitted in his evidence that at the outset he asked questions about Patient A and her sons' journey, Mr B's job and whether they had difficulty in finding his address. Dr Navaratnam added that he might also have asked about Patient A's husband. The Tribunal considered that the questions that Dr Navaratnam asked demonstrated nothing more than that he was conscious of Patient A's wellbeing. It would be normal practice for a doctor to introduce oneself to a new patient and their family, discussing every day matters to break the ice. Mr C also said that after the injections had been administered and the procedure completed, Dr Navaratnam said something like *"don't move my dear*" to Patient A and told her to stay still. Again this showed courtesy and Dr Navaratnam, in the view of the Tribunal, came across as compassionate and warm towards Patient A.

85. The Tribunal appreciated that Patient A and her two sons paint a very different picture and maintain that Dr Navaratnam asked irrelevant and intrusive personal questions and that the questioning went on far longer than claimed by Dr Navaratnam. They also dispute much of what was recorded in the consultation note or clinic letter. However, the Tribunal was satisfied, as stated above, that the discussion at the start of the consultation was not excessive, and that it was intended by Dr Navaratnam solely to put Patient A, who was experiencing severe pain, at ease. Although Patient A and her sons Mr B and Mr C gave consistent evidence it is possible that the passage of time, and perfectly natural discussions between them about the events, may have affected their memories and affected their approach to the consultation. Also, in her oral evidence Patient A agreed that it was difficult for her to concentrate at the time of the consultation because of the pain she was in.

86. The Tribunal considered that while Patient A did not speak English, Dr Navaratnam was able to communicate adequately and effectively with her with assistance from her two

sons. In his oral evidence, Dr Navaratnam said that he did try to communicate with Patient A but she could not answer much. She seemed to understand some English because she was nodding her head. This was consistent with occasions during Patient A's evidence before the Tribunal when she appeared to understand some questions. The contemporaneous documentation shows that numerous aspects relating to Patient A's complaints and her health generally were covered during the consultation. The Tribunal was satisfied that despite the obvious language barrier Patient A's needs were considered fully by Dr Navaratnam.

87. The Tribunal therefore found paragraph 1(h) of the Allegation in its entirety not proved.

Paragraph 1(i) – Not Proved

88. In determining whether Dr Navaratnam failed to perform the procedure under image guidance including ultrasound guidance, CT or fluoroscopy, the Tribunal was assisted by the evidence of the experts as to what would be accepted as proper by a responsible body of medical opinion.

89. In his expert written report, Dr G said that to ensure accuracy, cervical facet joint injections must be undertaken under image guidance, and to undertake such injections without image guidance would fall seriously below the standards expected of a reasonably competent consultant undertaking spinal interventions. In his oral evidence, Dr G added that when carrying out the procedures without image guidance, there is a risk that *"even in the most skilled hands"* the needle if long enough to go into the capsule could go through the other side of the capsule.

90. Dr F said in his oral evidence that the procedure needs to be done under image guidance, otherwise *"you are injecting blindly"*.

91. Professor H accepted that, whilst it was preferable for cervical facet joint injections to be administered under image guidance, nonetheless it was safe for the procedure to be performed without image guidance. He said that often in clinics the procedure is conducted without image guidance and where the needle is not long enough to reach deep structures. He said that it was common for the needle to not go as far as the joint and that he had never seen it reported that a needle had gone through the joint and come out the other side.

92. In his witness statement, Dr Navaratnam accepted that there is a risk of damage to nerves and blood vessels without radiological guidance, but said that the use of small needles (maximum 1 inch long) will not go deep enough to cause damage to deep tissues such as blood vessels and nerve roots. In her oral evidence, Patient A accepted that the needle used by Dr Navaratnam was about half the length of her index finger, which would make it quite a short needle. The Tribunal also bore in mind the circumstances under which the procedure was performed. Dr Navaratnam was unexpectedly and urgently telephoned at home by Mrs D, an osteopath, on a Saturday afternoon. He had previously had similar referrals from Mrs D but had not been expecting the call. Dr Navaratnam was told plainly by Mrs D (supported by the referral letter) that Patient A was in great distress. He was also told or inferred that Mrs D was not able to help and therefore, as a recognized rheumatologist, Patient A was referred to him. Mrs D's own notes recorded advice to "consult with rheumatologist".

93. Professor H considered that bearing in mind the circumstances it was "pragmatic" for the procedure to be administered without image guidance. He recognised that image guidance provides more certainty that the needle is in the right place and that pain relief would be better in this situation. Dr Navaratnam did not have image guidance available at his home (and in any event his dedicated clinic was being redecorated). It would, therefore, have taken some time to arrange suitable image guidance, and in the meantime Patient A would continue to be in great pain.

94. The Tribunal considered that whilst image guidance is preferable it is not a universally recognised practice. Notwithstanding the Consensus practice guidance claiming that image guidance has become "an essential component" in minimizing patient harm and optimizing results, administering cervical facet joint injections without image guidance is not uncommon or unreasonable and, as Professor H said in evidence, is done by some clinicians.

95. Moreover, in the somewhat unique circumstances of the present case where Patient A was in an acute situation, it would not have been in her best interests to refuse to proceed with the procedure without image guidance. Professor H considered that the risks of proceeding without image guidance were not there and that it was not an unsafe practice. No better alternative procedure was readily available and Patient A had discounted other forms of treatment.

96. In all the circumstances, the Tribunal was not satisfied that the GMC had satisfied it to the requisite standard of proof that the absence of image guidance was a failure by Dr Navaratnam.

97. Accordingly, the Tribunal found paragraph 1(i) of the Allegation not proved.

Paragraph 1(j)(i) – Not Proved

98. Dr Navaratnam's handwritten note of the consulation states "aseptic precautions" being taken. In his witness statement, Dr Navaratnam said that he took steps to ensure that the area in his living room where he saw Patient A was thoroughly cleaned and all equipment was sterile, and the procedure was carried out hygenically using a no touch technique.

99. He said: *"After washing my hands with soap and running water in an adjoining wash room, I wiped my hands with a sterile towel. I then proceeded with the steroid injections using a no touch technique and sterile precautions. I palpated the two spinous processes between which lie the facet joint. I surface-marked the facet joints with my clean thumb and wiped the skin with alcohol wipes. I used a cold numbing spray, and then filled a sterile 2ml syringe with local anaesthetic."*

100. Dr Navaratnam agreed that he did not wear gloves or a surgical mask when treating Patient A. Professor H did not criticize Dr Navaratnam for not wearing a mask. As to not wearing gloves, Professor H said he would have worn them. However, Dr Navaratnam said it was easier to "*feel the site"* without gloves. The Tribunal noted from the photograph of his living room taken by Mr C during the consultation that Dr Navaratnam was wearing a doctor's white coat. Dr Navaratnam said that he also had with him a disposable tray with needles, syringes, and vials of anaesthetic which he broke open in front of Patient A.

101. The Tribunal considered that Dr Navaratnam adhered to basic aseptic techniques, in the particular circumstances.

102. Accordingly, the Tribunal found paragraph 1(j)(i) of the Allegation not proved.

Paragraph 1(j)(iii) – Not Proved

103. The Tribunal bore in mind that both Dr F and Dr G were of the view that resuscitative equipment is a necessity, although a patient collapsing as a result of cervical facet joint injections is extremely rare. Professor H considered that it would be better to perform the procedure in a clinic where resuscitative equipment is available.

104. In her witness statement Patient A said she "really did not want to go to hospital". In his witness statement, Mr B said that he had earlier spoken to his mother about going to

hospital but she was "adamant" that she did not want to go to A & E because she was "scared of COVID". On 31 July 2021, the osteopath also reported to Mr B that his mother had said she did not want to go to a hospital. On the day before Patient A had been taken by ambulance to Barts Emergency Department, where she arrived on 30 July 2021 at 00:42 hours and was discharged at 03:53 hours. Patient A had no recollection of going to Barts when she gave evidence to the Tribunal.

105. Bearing in mind that access to resuscitative equipment is not a mandatory requirement, the low risk to patient safety, and Patient A's clear reluctance to go to a hospital the Tribunal was not satisfied that performing the procedure in the absence of resuscitative equipment was a failure by Dr Navaratnam.

106. The Tribunal therefore found paragraph 1(j)(iii) of the Allegation not proved.

Paragraph 1(k) – Not Proved

107. Dr Navaratnam's clinic letter to Mrs D states that after the procedure he provided advice to Patient A how best to manage her condition and to report to him any problems by telephoning him. Whilst the letter did not say in terms that Dr Navaratnam specifically mentioned to Patient A deterioration, bleeding or nerve injury occurring, his advice to notify him of "any" problems following the procedure was sufficiently broad to encompass such eventualities.

108. The Tribunal considered that it must have been apparent to Patient A and her two sons that Dr Navaratnam was willing to assist her to understand how best to manage any complications after the procedure. Despite Ms Kitzing's submission of apparent differences in Dr Navaratnam's witness statement and in his oral evidence, the Tribunal was satisfied that Dr Navaratnam provided appropriate and sufficient "safety netting" advice. His letter to the clinic on the advice he had given patient A to report "any problems by telephoning me" could not have been clearer.

109. Accordingly, the Tribunal found paragraph 1(k) of the Allegation not proved.

Paragraphs 1(l)(i) and 1(l)(ii) – Not Proved

110. Dr Navaratnam's medical notes and clinic letter duly record findings by him from a physical examination of Patient A. The Tribunal rejected any notion that Dr Navaratnam "falsely" or knowingly recorded these (or any) findings knowing them to be untrue. There was no credible evidence to suggest that the documentation was not contemporaneous or

was not an accurate summary of the consultation. Copies of the medical notes and clinic letter were promptly supplied by the Medical Protection Society on behalf of Dr Navaratnam to the GMC when requested in July 2022.

111. The Tribunal also considered it improbable that Dr Navaratnam did not physically examine Patient A or falsely recorded his findings. Whilst the Tribunal appreciated the evidence of Patient A and her two sons, and considered that they did their best to assist the Tribunal, it determined that due to the passage of time their memories may have been fallible. The Tribunal found Dr Navaratnam to be a good witness and accepted his evidence.

112. Accordingly, the Tribunal found paragraphs 1(l)(i) and (ii) not proved.

Paragraph 1(m) and Paragraph 2 – Not Proved

113. As a result of the Tribunal finding that Dr Navaratnam did not falsely record matters in his medical notes or letter to Mrs D, paragraph 1(m) and paragraph 2 of the Allegation fall away.

114. Accordingly, the Tribunal found paragraph 1(m) and pararaph 2 of the Allegation not proved.

The Tribunal's Overall Determination on the Facts

115. The Tribunal has determined the facts as follows:

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

1. On the 31 July 2021 you consulted with Patient A and you:

   a. administered cervical facet joint injections ('the procedure') which were not clinically indicated; **Determined and found not proved**

   b. failed to take an adequate history including asking about the duration of Patient A's symptoms and progression; **Determined and found not proved**

   c. failed to perform a neurological examination to investigate reported neurological symptoms; **Determined and found not proved**

   d. failed to obtain appropriate consent for the procedure as you did not:

      i. provide adequate information around the risks and benefits of the proposed treatment including the risks of:

i. nerve damage; **Determined and found not proved**

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

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

iv. unmasking latent diabetes; **Determined and found not proved**

v. local soft tissue atrophy; **Determined and found not proved**

vi. pain; **Determined and found not proved**

vii. bleeding; **Determined and found not proved**

viii. the treatment not being effective; **Determined and found not proved**

e. failed to allow Patient A a period of reflection on whether to proceed with the procedure or not; **Determined and found not proved**

f. failed to provide Patient A with a:

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

ii. rationale for the procedure; **Determined and found not proved**

g. in the alternative to 1b, 1d and 1f, did not record having undertaken the actions as described;

Admitted and found proved in relation to 1b and 1d

Determined and found proved in relation to 1f(i)

Determined and found not proved in relation to 1f(ii)

h. failed to meet Patient A's language and communication needs in that you did not adequately communicate with:

i. Patient A; **Determined and found not proved**

ii. Mr B; **Determined and found not proved**

iii. Mr C; **Determined and found not proved**

i. failed to perform the procedure under image guidance including ultrasound guidance, CT or fluoroscopy; **Determined and found not proved**

j. failed to perform the procedure in a clinically appropriate environment as:

i. basic aseptic technique was not adhered to; **Determined and found not proved**

ii. the premises did not meet basic hygiene standards;

Admitted and found proved

iii. there was no access to resuscitative equipment, including a defibrillator and emergency airway management; **Determined and found not proved**

k. failed to ensure appropriate 'safety netting' advice was given to Patient A as you did not advise her on the risks of deterioration, bleeding or nerve injury occurring after the procedure such as to allow Patient A to understand how to manage these complications; **Determined and found not proved**

l. falsely recorded findings from a physical examination of Patient A in:

i. your medical notes; **Determined and found not proved**

ii. a letter to Mrs D; **Determined and found not proved**

m. knew that:

i. you had not examined Patient A; **Determined and found not proved**

ii. your examination findings were untrue. **Determined and found not proved**

2. Your actions as set out at paragraph 1l were dishonest by reason of paragraph1m. **Determined and found not proved**

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

Determination on Impairment - 27/03/2024

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 Navaratnam'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 a document of Dr Navaratnam's reflections to consider.

Submissions

3. On behalf of the GMC, Ms Ceri Widdett said that the GMC's position on impairment was neutral. However, to assist the Tribunal Ms Widdett said that the case involved mutiple acts or omissions on the part of Dr Navaratnam.

4. Regarding the procedure carried out at Dr Navaratnam's home, Ms Widdett submitted that while the opinions of the experts opinions varied, there was however a consensus that it fell below expected standards of safety due to an increased risk of infection and lack of proper preparation or cleanliness. Ms Widdett submitted that the dispute between the experts as to it not being a clinically appropriate environment was whether it fell below or seriously below standards, which highlighted the seriousness of the matter.

5. Ms Widdett referreed to *Good medical practice,* 2013 edition, (GMP) which provides:

> *'**21** Clinical records should include:*
>
> ***a** relevant clinical findings*
>
> ***b** the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
>
> ***c** the information given to patients*
>
> ***d** any drugs prescribed or other investigation or treatment*
>
> ***e** who is making the record and when.*
>
> *…*
>
> ***25** You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.*
>
> ***a** If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.*
>
> ***b** If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.'*

6. Ms Widdett submitted that the inadequate documentation of symptoms and medical history was another area of concern with one expert, Dr F, noting Dr Navaratnam's actions fell seriously below the standard expected of a competent consultant rheumatologist. Ms Widdett further submitted that the lack of documentation regarding warning Patient A of any risks further underscored Dr Navaratnam's failure to meet professional standards.

7. Ms Widdett contended that the absence of clear diagnosis and rationale for the treatment in medical records raises doubts about the quality of the care Dr Navaratnam provided to Patient A. While some deficiencies may not be deemed seriously below the standards expected of a competent rheumatologist, they nevertheless signify lapses in professional conduct and raise questions about Dr Navaratnam's insight and reflection of his practice.

8. In conclusion, Ms Widdet emphasised the gravity of Dr Navaratnam's actions, the implications for patient safety, and the need for remedial action. She stated that Dr Navaratnam's failure to adhere to expected standards of conduct, maintain proper documentation, and ensure patient safety amounts to misconduct and warrants serious consideration of impairment and potential disciplinary action.

9. On behalf of Dr Navaratnam, Mr Rich focused on the issue of whether Dr Navaratnam's actions, particularly related to record-keeping and hygiene standards during his treating of Patient A, constituted serious misconduct warranting impairment.

10. Mr Rich submitted that the individual record-keeping errors were not serious, and that they should not be cumulated to suggest a pattern of inadequate record keeping amounting to serious misconduct. Mr Rich submitted that the lack of an explicit charge alleging a cumulative failure to keep proper records undermines the case for a finding of serious misconduct based on record-keeeping alone.

11. Mr Rich contended that some of the record-keeping failures, such as failure to record a diagnosis or warnings given to Patient A, may not be serious enough on their own to warrant a finding of misconduct. These are portrayed as relatively minor issues that are unlikely to cause harm or confusion to future clinicians.

12. Further, Mr Rich argued that while Dr Navaratnam may have fallen short of expected hygiene standards during a medical procedure conducted in a domestic setting, the circumstances mitigated the seriousness of the offence. Factors such as Patient A's condition,

the unavailability of the clinic room, and Dr Navaratnam's efforts to maintain a sterile environment should be considered as mitigating factors.

13. Mr Rich emphasised that Dr Navaratnam has reflected on his actions, acknowledged any shortcomings, and taken steps to improve his practices. This includes ceasing all practice from his home clinic room, demonstrating insight into the issues raised, and mitigating the risk of repetition.

14. Mr Rich argued that a finding of impairment was not necessary to uphold standards or maintain public confidence in the medical profession. Dr Navaratnam's overall good reputation and the contextual factors surrounding the incidents suggest that the public would view his actions as a lapse in judgment rather than indicative of broader professional incompetence.

15. In summary, Mr Rich contended that while there may have been shortcomings, they do not rise to the level of serious misconduct warranting impairment.

The Relevant Legal Principles

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

17. 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 serious misconduct, and then whether that finding of misconduct could lead to a finding of impairment.

18. The Tribunal must determine whether Dr Navaratnam's fitness to practise is impaired today, taking into account Dr Navaratnam'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.

19. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in her *Fifth Shipman Report* adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 (Admin)*. In particular, the Tribunal considered whether its findings of fact showed that Dr Navaratnam's fitness to practise is impaired in the sense that he:

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

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

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

20. The Tribunal also took into account the guidance of Mrs Justice Cox set out in the *Grant* case, specifically paragraphs 71 and 74 which state:

> 71. '*However, it is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations …., namely, the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.*
>
> *74. In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

The Tribunal's Determination on Impairment

Misconduct

21. The Tribunal first considered whether the facts found proved are a sufficiently serious departure from the standards of conduct reasonably expected of Dr Navaratnam, as a registered medical practitioner, to amount to misconduct.

Paragraph 1(g) as it relates to paragraph 1(b)

22. Dr Navaratnam admitted paragraph 1(g) as it relates to paragraph 1(b). The Tribunal has previously found that Dr Navaratnam did not fail to take an adequate history including asking Patient A about the duration of her symptoms and progression. The documentation was detailed and the combination of the handwritten medical notes and clinic letter to Mrs D was extensive.

23. Dr Navaratnam's contemporaneous medical note recorded that, amongst other things, Patient A had tingling and numbness in her left index finger and middle finger and sleep disturbance. Additionally, he recorded in his clinic letter that Patient A had pain in her neck radiating to her left shoulder and arm.

24. In *Spencer v. General Osteopathic Council* [2013] 1 WLR 1307 the court made clear that note-taking is very important for both osteopaths and doctors. In this case, whilst Dr Navaratnam did not record the duration of Patient A's symptoms and their progression, the information was contained in the referral letter from the osteopath and to whom he addressed his clinic letter. Bearing in mind that Mrs D was aware of the duration and progression of Patient A's symptoms there was no necessity to record the information again. A copy of the clinic letter was forwarded to Patient A's general practitioner, who equally was aware of the duration of her symptoms and their progression.

25. Mr Rich made the point that any physician subsequently reviewing Patient A would consider the medical notes and the clinic letter, and go on to ask Patient A themselves what the duration of her symptoms had been. The Tribunal agreed and considered that, whilst it would have been good practice for Dr Navaratnam to record the duration of the symptoms and their progression, a subsequent treating physician would not be misled by the absence of this information from the medical notes or the clinic letter.

26. The Tribunal did not consider that in this case other medical professionals would regard Dr Navaratnam's omission as deplorable. In the circumstances the Tribunal concluded that paragraph 1(g) as it relates to paragraph 1(b) was not in the particular circumstances of this case seriously below the standards expected of a competent practitioner and did not reach the threshold of seriousness to constitute misconduct. Nor did it amount to incompetence or negligence of a high degree so as to constitute misconduct.

Paragraph 1(g) as it relates to paragraph 1(d)

27. Dr Navaratnam admitted paragraph 1(g) as it relates to paragraph 1(d). The Tribunal had previously found that the GMC had not satisfied it that Dr Navaratnam failed in the sense of having a duty or obligation to provide Patient A with information about the risks of nerve damage, paralysis, unmasking latent diabetes or local soft tissue atrophy. Accordingly, there would be no reason to record that which Dr Navaratnam had no duty to discuss.

28. The Tribunal found that Dr Navaratnam provided adequate information of the risks of infection, bleeding, pain, and the treatment not being successful. Patient A gave appropriate consent to the procedure. Following the procedure there was some bleeding around the site of the injections about which Dr Navaratnam reassured Patient A. In his clinic letter to Mrs D, Dr Navaratnam said that the facet joint injections were carried out "*without unforeseen problems*".

29. The Tribunal recognised that paragraph 21(c) of GMP in particular provides that clinical records should include information given to patients. However, the Tribunal did not consider that in this case Dr Navaratnam's omission to record advice relating to the risks of infection, pain, bleeding and the treatment not being effective was of such significance that it amounted to serious misconduct, incompetence or negligence of a high degree so as to amount to misconduct.

30. As the Tribunal previously noted, and as Profession D said in evidence, medical notes and a clinic letter are a summary rather than a verbatim record and not everything said in a consultation is necessarily recorded. In this instance, there was a proper assessment of Patient A and proper treatment was given and recorded in the documentation. The Tribunal was also conscious that (as confirmed in the clinic letter) Dr Navaratnam advised Patient A to report any problems by telephoning him, and that she should go back to her osteopath the next day and request an MRI scan of her cervical spine.

<u>Paragraph 1(g) as it relates to 1(f)(i)</u>

31. The Tribunal had previously found that whilst it was more likely than not Dr Navaratnam provided Patient A with a diagnosis of cervical root pain, he did not record the diagnosis in the manuscript medical notes or clinic letter.

32. In his witness statement, Dr Navaratnam said: *"I explained my diagnosis of cervical root pain, which I felt was caused by degenerative changes (wear and tear) in the facet joints between the vertebrae, which was causing inflammation and triggering pain in nearby nerve endings…"* This was consistent with the referral letter from the osteopath which under Diagnosis stated: "*Query (L) C5/C6 nerve root indentation due to associated disc bulges (possible broad based)."*

33. In his manuscript medical notes Dr Navaratnam recorded: *"Pain in neck (Left) shoulder and arm. Worse above elbow. Tingling and numbness in (Left) index finger and middle finger."* In his clinic letter to Mrs D Dr Navaratnam said: *"Her main complaint was as you have mentioned in your referral letter. Pain in the neck radiating to her left shoulder and arm, worse above her upper arm above the elbow. Associated with tingling in her middle and index fingers."* The clinic letter went on to say that Dr Navaratnam had *"Explained (to Patient A) nature of condition and obtained verbal consent."*

34. In his report dated 8 September 2022, Dr F said: *"It seems likely from the available clinical details that patient A was suffering from nerve root irritation."* Professor H took a similar line and said: "*Based on the patient's history and the examination findings it is likely that degeneration of the cervical facet joints or else cervical nerve root entrapment are the most likely diagnoses."*

35. The Tribunal recognised that paragraph 21(a) of GMP states that clinical notes should include relevant clinical findings and Dr Navaratnam has recognised that he did not document the diagnosis. The Tribunal has given careful consideration as to whether this was serious misconduct or negligence of a high degree amounting to serious misconduct.

36. In the end the Tribunal was satisfied that the history section of the medical notes and clinic letter effectively suggested the diagnosis. A correct diagnosis of cervical root pain was given to Patient A and proper treatment given consistent with the diagnosis. Moreover, a diagnosis of cervical root pain was substantiated by a later MRI scan. In the circumstances, the Tribunal did not consider that fellow practitioners would be misled by Dr Navaratnam's omission to record a diagnosis of cervical root pain or regard it as deplorable. Ultimately, put in context, it was not sufficiently serious to amount to misconduct or negligence of a high degree.

Paragraph 1(j)(ii)

37. Dr Navaratnam admitted that he failed to perform the procedure in a clinically appropriate environment as the living room at his home where he saw Patient A did not meet basic hygiene standards.

38. All three experts agreed that the premises were unsuitable. In his report Dr F said: *"I consider that it was inappropriate for Dr Navaratnam to administer steroid injections at his residential address",* and went on to refer to "*a significantly increased risk of adverse effects".*

39. In his report, Dr G said:

> *"Cervical facet joint injections must be undertaken in an appropriate clinical environment. Basic aseptic technique must be adhered to and the procedure undertaken in a facility that meets basic hygiene standards and has access to resuscitative equipment, including a defibrillator and emergency airway management. One of the rare risks of cervical facet injections is that of a total spinal block in which the patient may stop breathing and become unconscious within seconds. Consequently, it is essential that procedures are only undertaken in the clinical environment where access to full resuscitation is available.*

> ….
> *Undertaking facet joint injections in an environment without appropriate clinical facilities and asepsis would represent a standard that falls seriously below that accepted for a consultant rheumatologist undertaking interventions."*

40. When Professor H was asked "*Based on the information currently available, do you consider the procedures performed by Dr Navaratnam on 31 July 2021 were carried out in a suitable environment?"* he answered:

> *"No. It would be normal for this kind of procedure to be carried out in a designated clinic area which is clean and comfortable to the patient. There is a risk of infection from this type of procedure. The risks of intra-articular steroid injection has been estimated in published articles. …. I have occasionally heard of private doctors giving intraarticular steroid injections at the patients' home during home visits, usually when the patient is elderly and infirm and unable to travel to the clinic. I assume that being a Saturday Dr Navaratnam was unable to access a hospital clinic area and so treated the patient at his own home."*

41. Dr Navaratnam explained the circumstances under which he came to perform the procedure in his living room. In his witness statement he said this:

> *"I had a dedicated clinic room for [seeing patients at my home address], which had a separate entrance in an extension of the house. All the patients except Patient A were seen in this clinic room. However, when Patient A came for her appointment in July 2021, my clinic room was being decorated and therefore, I did the consultation in my living room. I accept that I should not have agreed to see Patient A at that time and that the living room did not offer a suitable environment, although I took steps to ensure the procedure was undertaken safely. I apologise to Patient A and the GMC for undertaking the consultation in an unsuitable environment."*

42. In its determination of the facts, the Tribunal considered the context under which Dr Navaratnam administered the injections. It was not an ideal situation, rather it was an emergency. Dr Navaratnam was unexpectedly telephoned by Mrs D, an osteopath, over the weekend to see Patient A urgently, who was in great distress. Patient A had been suffering pain for some two or three weeks without any relief. She had been to her GP who had prescribed analgesics; Barts Hospital Emergency Department the day before who had recommended an MRI of her cervical spine, and referral via her GP to a pain clinic; and to Mrs D, an osteopath, on the day she saw Dr Navaratnam. The Tribunal was told that referral to a pain clinic could take between three and six months. In the meantime, Dr Navaratnam was faced with a patient struggling with severe pain.

43. It was clear that Patient A did not want to go to hospital again. In her witness statement she said: "*My GP told me to take painkillers for the pain and if it got any worse then I was to go to the hospital. However, I really did not want to go to hospital."* Mr B, one of her sons, said: *"the GP said that if the pain increased then my mum should take painkillers and consider going to A&E. However, my mum did not want to go to A&E because of the risk*

of COVID. I spoke to her about this, and she was adamant that she did not want to go to A&E because she was scared of COVID."

44. Ms Widdett submitted that treating Patient A in Dr Navaratnam's home would only have been appropriate in the case of serious injury or a life-or-death situation, neither of which arose here. Mr Rich submitted that the circumstances of the consultation are plainly a relevant factor and should be taken into account when considering misconduct.

45. In *Doughty v. General Medical Council* [1988] AC 164, Lord Mackay of Clashfern, giving the judgment of the Board, said at page 174A that whether misconduct was serious would depend on a number of factors. The factors in that case included such matters as the number of patients in respect of which the failure occurred, the importance of preserving records, the number of treatments criticised and the nature and extent of the failure to complete the treatment properly.

46. Paragraph 25 of GMP, under the heading "Respond to risks to safety" says that if patients are at risk because of inadequate premises, equipment or other resources, policies or systems, the doctor *"should put the matter right if that is possible"*.

47. The Tribunal was not persuaded that the fact Dr Navaratnam sought to ensure that the procedure was undertaken safely is a defence to paragraph 1(j)(ii) of the Allegation. Either the premises were an appropriate environment or they were not, whatever steps Dr Navaratnam may have taken by way of mitigation to ensure patient safety was maintained. The issue is whether Dr Navaratnam's failure to perform the procedure in a clinically appropriate environment as the premises did not meet basic hygiene standards amounts to serious misconduct. Similarly, the views of Patient A are not an overriding factor in relation to whether paragraph 1(j)(ii) of the Allegation amounts to serious misconduct.

48. The Tribunal was in no doubt that Dr Navaratnam was confronted by a patient in extreme pain who was at her wits' end. In theory Dr Navaratnam could have turned away Patient A or referred her to A&E, or sought to access a hospital clinic area, or prescribed analgesics. This was however, in the Tribunal's view, a unique situation where Patient A was in acute pain, and it would not have been in her best interests to refuse or defer treatment.

49. The Tribunal also bore in mind that this was a one-off incident and there is no suggestion that Dr Navaratnam was using his living room to see patients on a routine basis, had done so previously, or had done so since. This was, as the Tribunal set out in its determination on facts an "emergency" situation, albeit not a life-or-death situation or one of serious injury. It was however a case where Patient A was in a huge amount of pain, cervical facet joint injections were clinically indicated and the procedure was properly and safely performed.

50. In all the circumstances, the Tribunal concluded that Dr Navaratnam's actions in failing to perform the procedure in a clinically appropriate environment as the premises did not meet basic hygiene standards was not serious misconduct.

51. The Tribunal went on to consider whether its three findings of non-serious misconduct in relation to record-keeping or the total of four findings of non-serious misconduct amounted to serious misconduct. In *Schodlok v. General Medical Council* [2015] EWCA Civ 769 Vos LJ (with whom Moore-Bick LJ agreed) said at paragraph 63: *"In the normal case, I do not think that a few allegations of misconduct that are held individually not to be serious can or should be regarded collectively as serious misconduct*". Beatson LJ at paragraph 72 said: "*I recognise that a small number of allegations of misconduct that individually are held not to be serious misconduct should normally not be regarded collectively as serious misconduct".*

52. *Schodlok* was a case where the instances of non-serious misconduct involved comments by the doctor on separate occasions to different individuals and minor failings. Here the findings of non-serious misconduct all relate to a single patient on one day. However, the Tribunal determined that the separate incidents cumulatively did not amount to conduct that fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct.

Impairment

53. Consequently, the Tribunal considered that in these circumstances the question of impairment did not arise. However, having received submissions from the parties the Tribunal sought to address it.

54. The Tribunal had sight of Dr Navaratnam's reflective statement and found that there was good evidence of reflection, insight and remediation. The Tribunal considered that Dr Navaratnam has fully acknowledged and reflected on his past mistakes.

55. The Tribunal had regard to all three limbs of the overarching objective in section 1(1B) of the Medical Act 1983.

> *(a) to protect, promote and maintain the health, safety and well-being of the public;*
> *(b) to promote and maintain public confidence in the medical profession;*
> *(c) to promote and maintain proper professional standards and conduct for members of that profession.*

56. The Tribunal determined that Dr Navaratnam was not a risk to public safety. This was a one-off incident in an emergency situation and was unlikely to be repeated. The Tribunal noted that Dr Navaratnam has stated that he does not intend to practise from home again. Given Dr Navaratnam's insight and remediation, the Tribunal was satisfied that the risk of repetition is low and that public confidence in the medical profession and the need to maintain proper standards would not be undermined if a finding of impairment was not made.

57. Accordingly, the Tribunal concluded that Dr Navaratnam's fitness to practise is not impaired by reason of misconduct.

Determination on Warning - 27/03/2024

58. As the Tribunal determined that Dr Navaratnam's fitness to practise did not amount to misconduct and as such was not impaired, it considered whether in accordance with s35D(3) of the 1983 Act, a warning was required.

Submissions

59. On behalf of the GMC, Ms Widdett said that the GMC was not seeking a warning but the Tribunal was obliged to consider a warning as set out at paragraph 61 of the Sanctions Guidance (2020):

> *'**61** Where a tribunal finds a doctor's fitness to practise is not impaired, it cannot impose a sanction. However, it must consider, under rule 17(2)(n) whether to:*
> ***a** take no action*
> ***b** issue a warning if the doctor's conduct, behaviour or performance has significantly departed from the guidance in Good medical practice.'*

60. On behalf of Dr Navaratnam, Mr Rich conceded that the Tribunal should consider whether or not to impose a warning.

61. Mr Rich submitted that this was not a suitable case for a warning.

The Tribunal's Determination on Warning

62. The Tribunal had regard to the overarching objective, as well as the particular circumstances of this case, and applied the principle of proportionality, weighing the interests of the public with those of Dr Navaratnam. The Tribunal bore in mind that the reputation of the profession as a whole is more important than the interests of any individual doctor.

63. The Tribunal considered the *Guidance on warnings*, in particular paragraphs 16, 20 and 32, which state:

'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*
- *there is a significant cause for concern following an assessment of the doctor's performance.*

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 fitness to 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).*

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.
g relevant and appropriate references and testimonials.'

64. In the present case, the Tribunal found that whilst paragraphs 21 and 25 of GMP were engaged, Dr Navaratnam's acts or omissions did not constitute misconduct. In the view of the Tribunal there was no significant departure from GMP, and it would be wholly disproportionate to impose a warning in this case.

65. Moreover, each of paragraphs 32(a)- 32(f) of the Guidance on Warnings is engaged. The Tribunal has previously found that Dr Navaratnam has good insight, has expressed regret, and that this was an isolated incident. There is no likelihood of repetition and Dr Navaratnam has taken corrective steps to ensure that the concerns of the Tribunal are not repeated. He has a good disciplinary history.

66. The Tribunal concluded that the circumstances of this case do not warrant a formal response, and it would therefore not be appropriate to issue a warning.

67. There is no interim order to be revoked.

68. That concludes the case.