PUBLIC RECORD

Dates: 01/08/2022 - 10/08/2022

Medical Practitioner's name:	Dr Tajammal MIRZA
GMC reference number:	6063888
Primary medical qualification:	MB BS 1993 University of Punjab (Pakistan)

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	No facts found proved	Consideration of impairment not reached

Summary of outcome

Case concluded

Tribunal:

Legally Qualified Chair	Mr Jetinder Shergill
Lay Tribunal Member:	Mrs Barbara Larkin
Medical Tribunal Member:	Dr Keith Dunnett

Tribunal Clerk:	Mr Andrew Ormsby

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Chris Gillespie, Counsel, instructed by the MDU
GMC Representative:	Mr Hugh Barton, 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 - 10/08/2022

Background

1. Dr Mirza qualified in 1995 from the University of the Punjab, Pakistan and completed his GP training in 2010. Prior to the events which are the subject of the hearing, Dr Mirza worked as a salaried GP at Wensum Valley Medical Practice, before working as a GP Clinical Lead from 2011-2017. He also worked as an Honorary Senior Lecturer and Associate Tutor at the University of East Anglia. Between 2017 and 2021 Dr Mirza was practising as a GP at Norwich Practices Health Centre, and since 2021 as a GP on a locum basis for HMP Norwich.

2. At the time of the events, Dr Mirza was also working for Push Doctor, an internet-based GP service providing online consultations for patients around the country. He worked for Push Doctor between October 2017 and January 2018. The Allegation relates to an online consultation carried out by Dr Mirza for Push Doctor.

3. It is alleged that, during an online consultation at 1pm on 29 December 2017 ('the consultation') with Patient A, Dr Mirza failed to arrange for Patient A to be examined in person by a doctor urgently, in that he did not advise Patient A that he should undertake one or more actions (i.e. contact the 111 service; go to an Urgent Care Centre; go to an A&E; telephone an ambulance). It is also alleged he made an inappropriate diagnosis; inappropriately advised Patient A to purchase medication over the counter; and inadequately recorded Patient A's medical history.

4. In terms of relevant background, Patient A and the main GMC witness, Miss B ('XX') were best friends. He was also friends with Miss B's mother, Ms D ('XX'). He went to spend Christmas with them at a caravan park at the start of December 2017. Miss B stated that when Patient A arrived at the caravan park, he looked noticeably thinner and had lost weight. He said it was '*just a tummy bug*' and did not want to *'make a fuss'*. She stated that Patient A made several complaints to her and Ms D of feeling unwell and told them that he had pains in his stomach. Miss B stated that these pains got progressively worse towards the end of December 2017. Patient A was losing more weight and he was unable to eat much or digest water without vomiting a brown liquid with an unpleasant smell. Miss B said that during this time, she had pleaded with Patient A to see a doctor or go to a walk-in centre, but that he had refused to do this as he did not want to inconvenience anyone or *'cause a hassle'*.

5. Sometime near the end of December 2017, Miss B came across an advert for Push Doctor which provided online consultations with a registered doctor for ten minutes at a cost of £20.00. Patient A agreed, seemingly because he had vomited brown smelly vomit in the hall which had to be cleaned up by Miss B. On the 29 December 2017 at around midday, Miss B booked an online consultation with Push Doctor for Patient A. She said there was no request to provide Patient A's symptoms or his medical history during the booking process. The appointment was for 1pm and Patient A saw Dr Mirza.

6. Miss B states she was present throughout the consultation. Ms D left the room as the online consultation started. Miss B said that as Patient A was in bed in pain and unable to move, he needed help holding the iPad for the consultation. She held up the iPad to his face throughout the consultation. She also introduced herself and showed Patient A's identity document to Dr Mirza at the start of the consultation. She goes on to state there were a number of other interventions she had in the consultation, which lasted 9 minutes 36 seconds. Dr Mirza does not record or recall any of that and believed Patient A was alone.

7. Miss B stated that she could see Dr Mirza on the screen and in a smaller window, inset on the same screen on the iPad, she could see what Dr Mirza could see. She gave details of the conversation that took place during the consultation and of her alleged prompting of Patient A to describe his brown vomit and that it had an unpleasant smell. Miss B was of the view Dr Mirza appeared rushed and unfocused, looking down when Patient A spoke (she was unsure if he was keeping notes). She does not recall any advice to seek urgent face-to-face medical assistance. She recalls the doctor advising Patient A to purchase Buccastem from a local pharmacy and she had to get a pen and paper to jot the name down and check the

spelling with Dr Mirza. Ms D recounts hearing Miss B during that specific interaction. Miss B says that ended the consultation and Dr Mirza's involvement with Patient A.

8. It is relevant to note events that occurred after the consultation. Miss B purchased the Buccastem at a pharmacist and at around 18:00 she gave Patient A the medication. He was then resting when Ms D noticed Patient A's breathing was laboured. The witnesses spoke of a rapid decline in Patient A's health from earlier in the day. An ambulance was called and at around 21:00 Patient A suffered a cardiac arrest, while Ms D was on the phone to the ambulance dispatch. Ms D performed CPR on Patient A and, when paramedics arrived, they took over CPR. After about 25 minutes the paramedics went outside to inform Miss B and Ms D that Patient A had died.

9. Ms C ('XX'), Patient A's cousin, was informed by a family member the next morning, after the police had identified next of kin. Ms C rang Patient A's mobile phone that morning and Miss B picked it up. They had subsequent conversations. Later in January 2018 Miss B came across post addressed to Patient A which contained the medical notes from the consultation. She forwarded them to Ms C. Ms C is a former nurse and was concerned by certain matters in the notes including treatment, diagnosis and inaccuracies. She lodged a complaint with the GMC on 7 February 2018. A post-mortem examination later established that the cause of death was faecal peritonitis due to a perforated caecum.

10. Dr Mirza stated that he had a *'fairly good recollection'* of his video consultation on 29 December 2017, particularly as patient A died very shortly after his consultation with him and because within one week of the consultation (whilst he was away on holiday) he was suspended by Push Doctor pending an investigation. Dr Mirza stated he had no recollection of anyone helping Patient A or being in the room with Patient A: "*… this is not something I would necessarily remember in circumstances where the patient is able to give a clear history."*

11. Dr Mirza also stated in his witness statement that Patient A was 'chatty' and that there were no signs of the patient being in discomfort. Dr Mirza went on to give an account of the online consultation with Patient A from his perspective:

> *'I was given a history of 5-6 weeks of nausea, in a patient who was usually fit and well. Patient A gave a history of being sick at least once per week and described a loss of appetite and weight. He reported being sick on solids, denied stomach pain when asked and confirmed he was passing urine normally, but was getting hiccups a lot. I*

feel sure that I was informed that the vomiting was once per week, hence what I recorded. I do not believe that I was told that he was vomiting daily, unless I misheard or typed this wrongly. If he was vomiting daily I would be worried about dehydration, kidney function, and my firm advice would have been that Patient A should have a face to face consultation that day.'

12. Dr Mirza denies that he was informed about brown vomit or stomach pain and indicated the reason he entered 'acid reflux' in the 'diagnosis' section of the consultation notes was because the computer system required a diagnosis to be selected from a drop-down menu, and there were no other suitable choices. Dr Mirza claims he had indicated to Patient A the seriousness of his condition, and whilst he suspected Patient A may have stomach cancer, did not inform him specifically of that as it required further face-to-face examination. He claims the notes correctly record that he informed Patient A to see a GP face-to-face and that he might require a 2-week hospital referral (i.e. under the 'cancer pathway') for an endoscopy. Miss B denies hearing any of that.

The Allegation

13. The Allegation made against Dr Mirza is as follows:

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

1. On 29 December 2017 you consulted with Patient A online via Push Doctor and you:

   a. failed to arrange for Patient A to be examined in person by a doctor urgently, in that you did not advise him that he should undertake one or more of the actions as set out in Schedule 1;
   To be determined

   b. inappropriately:

      i. diagnosed Patient A with acid reflux; **To be determined**

      ii. advised Patient A to purchase Buccastem over the counter;
      To be determined

c. inadequately recorded Patient A's medical history, in that you did not record that Patient A:

i. was vomiting:

1. at least once a day; **To be determined**

2. brown liquid; **To be determined**

ii. had abdominal pain. **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**

14. It should be noted that Schedule 1 sets out four issues as part of paragraph 1(a) of the Allegation:

- Contact the 111 service
- Go to an Urgent Care Centre
- Go to Accident and Emergency
- Telephone an ambulance

The Admitted Facts

15. At the outset of these proceedings, through his counsel, Mr Gillespie, Dr Mirza made an admission to the stem of paragraph 1 of the Allegation, namely that on 29 December 2017 he consulted with Patient A online via Push Doctor. He made no admissions to any of the remaining allegations.

The Facts to be Determined

16. In light of Dr Mirza's response to the Allegation made against him, the Tribunal is required to determine paragraphs 1 (a), (b) and (c) at this stage.

Witness Evidence

17. The Tribunal considered both written and oral evidence (given in person) from the following witnesses:

- Miss B (‘XX’);
- Ms D (‘XX’); and
- Ms C (‘XX’).

18. Dr Mirza relied on his own witness statement, dated 25 March 2022 and also gave oral evidence at the hearing. The Tribunal also received multiple written testimonials in support of Dr Mirza, but these were not relevant to the Tribunal’s consideration at this stage.

Expert Witness Evidence

19. The GMC relied on expert witness evidence from Dr E, GP principal and GP trainer dated 4 June 2018. Dr E was called by the GMC in order to assist the Tribunal in understanding the professional standards to be expected of a GP. He also gave oral evidence.

Documentary Evidence

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

- Online medical records of the Push Doctor consultation on 29 December 2017 (‘the Notes’);
- Ms C’s online complaint, dated 7 February 2018, including the Notes;
- Rule 12 request, dated 26 August 2020 including statement from Miss B; and
- Dr Mirza’s Rule 7 response, dated 4 June 2018.

The Tribunal’s Approach

21. 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 Mirza does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred. The Tribunal also notes that this is an emotive case because Patient A died within hours of having his online consultation with Dr Mirza. However, the charges are specific and whilst they

allege serious failings, the case has not been put that Dr Mirza directly contributed to Patient A's death.

22. It is important to also note that there is a somewhat unusual chronology and/or factual background to this case. The factual disputes between the GMC witnesses' accounts and Dr Mirza's are stark. Those factors have led the Tribunal to adopt a somewhat different approach to its decision namely, trying to resolve key factual matters first in order to weigh up the evidence before moving on to applying those findings to the Allegation.

23. There are also a number of concerns about the background to the case. The consultation took place nearly five years ago. The only contemporaneous documentary evidence from that day is the Notes. The GMC rely on the account put forward by Ms C in her GMC complaint ('Ms C's complaint'). That was some 6 weeks after the consultation (7 February 2018) and was the product of conversations Ms C had with Miss B, because Ms C was not with Patient A on 29 December 2017. Ms C took issue with the Notes in terms of their content and accuracy. The Tribunal directed that a redacted version be provided for its consideration because the original complaint had a significant amount of 'opinion' rather than what the Tribunal was familiar in dealing with i.e. a hearsay 'first complaint' type document. The redacted document, which was agreed between the parties, has a limited amount of 'first complaint' type evidence. Nothing much happened after the complaint was lodged.

24. Next in the chronology, was a delay of nearly two years when the case examiners were looking at the complaint. They had obtained an expert report from Dr E (dated 4 June 2018) and the case examiners also considered Dr Mirza's submissions. Dr E has never been provided with an account from Dr Mirza as to his version of events or what his usual practice is. It is important to note that here, as it is relevant to the Tribunal's consideration as set out later in its decision. In terms of the case examiners, they decided to close the complaint, partly because there was no direct witness evidence before them from anyone present at the consultation.

25. Ms C then decided to appeal the case examiner's decision because the GMC had failed to obtain any evidence from Miss B (despite the GMC being notified she was a material witness in Ms C's original complaint form). The Tribunal noted another unusual feature of this case in as much as MS C was informed that she had to obtain a statement from Miss B, whereas it might have been expected the GMC would undertake the investigation and obtain

a formal witness statement. Miss B provided her 'initial account' to the GMC in a document dated 18 August 2020.

26. The GMC decided to reopen the case and obtained formal witness statements on the following dates in relation to each witness: Miss B's dated 23 June 2021, supplemental statement dated 1 December 2021; Ms D's dated 23 June 2021; and Ms C's dated 14 January 2022. The Rule 7 letter was issued, instigating these proceedings against Dr Mirza. The Tribunal considered the delays in obtaining formal witness statements was another unusual feature of this case.

27. The Tribunal was given detailed written legal advice from the Legally Qualified Chair (LQC). This included specific advice in relation to contemporaneous documents and the applicability of general principles in how to deal with conflicts in what witnesses say in their evidence, particularly when there has been a passage of time. In relation to the unusual features of the case, he stated: "Those matters make the contemporaneous accounts all the more important in navigating the subsequent evidence we have seen and heard". Those principles arise most recently in the case of *Dutta v GMC* [2020] EWHC 1974 (Admin), and the Tribunal was advised to refresh its understanding of paragraphs 38-43 and 58. In essence, a Tribunal should start by considering the objective facts and contemporaneous documents and use oral evidence as a means of subjecting these to "critical scrutiny".

28. The divergence between what the Notes state and what GMC witnesses claim happened at the consultation are so stark that, contrary to the GMC's submissions, there are no obvious, uncontentious 'known or probable facts.' That is why the Tribunal has undertaken painstaking scrutiny of what was said and recorded by whom, and when, before even attempting to piece together that evidence to conclude 'known or probable facts'.

29. The Tribunal further noted that the Allegation does not set out the factual disputes (which have been known about throughout the case) in order that there should be specific facts 'found proved' or 'not proved' as would be expected. The factual disputes are fundamental to the case and as such would not be considered to be 'collateral facts' (i.e. those which can be made incidental to the ones charged in an Allegation). However, the Tribunal has taken a purposive approach to the case in carrying out its function under the over-arching objective. As such, what ought to have been clearly enumerated charges in the Allegation have been considered as a preliminary exercise before turning to the Allegation itself.

Resolving the factual disputes between the parties

Was Miss B present at the consultation?

30. The Tribunal noted Miss B's initial account in which she stated that she had held the iPad for Patient A 'so he could see the screen and the doctor would be able to see [Patient A]'. She also stated she sat to the right of Patient A throughout the consultation. She said in her statement she held the iPad to Patient A's face throughout, then in oral evidence said she was possibly in frame as her hand was holding the iPad, though the main focus was Patient A. Dr Mirza has no recollection of anyone else helping Patient A or being present in the room with Patient A during the consultation.

31. The Tribunal took into account that Miss B was very worried about Patient A. She had persuaded him to see a doctor and booked the appointment. Patient A had not had an appointment with a doctor in forty years and both of he and Miss B were best friends. It was likely that she wanted to make sure that Patient A was supported during the consultation. The Tribunal also noted Ms D's evidence of leaving the room as the consultation commenced, leaving Miss B with Patient A. Ms D was not present during the consultation itself and 'only overheard' Miss B confirming the spelling of Buccastem. Ms C's evidence was recounted to her by Miss B, but the GMC complaint cites Miss B as a first-hand witness. That adds to the consistency of Miss B's evidence that she was present.

32. The Tribunal concluded that it was more likely than not that Miss B had been present during the consultation. She had been present but had been holding the iPad and was sitting offscreen and had only participated peripherally. She may have introduced herself as claimed. She may have prompted Patient A as claimed. However, her interactions with Dr Mirza were peripheral to the consultation. Her involvement is therefore not inconsistent with Dr Mirza's account of not remembering anyone else other than Patient A participating in the consultation. That is because Patient A was sufficiently able to recount a history. It also considered Dr Mirza's evidence that had Patient A required someone to speak on his behalf that would have been of concern (and as such he would have recalled that – see also the issues about being 'chatty' below).

33. The Tribunal is satisfied that the circumstances of this purported factual dispute do not detract from the claims made by either Miss B as regards her presence at the consultation or the doctor's lack of recollection of someone else being at the consultation.

Was Patient A chatty or unable to talk properly?

34. The Tribunal considered whether Patient A was chatty or unable to talk properly because this was a live issue in the backdrop to what went on. Dr Mirza recalled Patient A being 'chatty' and Ms C's R12 response to the GMC raised objection to this given the length of the consultation and the 'very short answers' in the Notes. Her complaint said Miss B's statement also supports short answers as did Miss B's interventions to speak on Patient A's behalf. The ability of Patient A to answer questions was, at least obliquely, relied on by Dr Mirza in his assessment of how well or unwell Patient A was. That was why he asked social history questions (see below) as the Tribunal understands the evidence. There is therefore an apparent conflict in the accounts, and one which might detract from the recollection of events of witnesses and/or the reliability of the Notes.

35. Ms D confirmed to the Tribunal that Patient A could speak and answered the questions as asked. In general, he could be understood, and was clear, and he was not struggling to speak at that point. We were told that only happened when he went downhill (later that day). Ms D only heard Miss B say the spelling of Buccastem. In Miss B's initial account she refers, on various occasions, to "[Patient A] said", and that there were complete phrases referred to in her account as Patient A as if he had said them. This was consistent with her witness statement confirming Patient A answered questions loud enough for Dr Mirza to hear 'despite sounding unwell'; and that she was unsure if Dr Mirza was taking notes during the consultation but that he kept looking down when Patient A answered questions.

36. The Tribunal heard Dr Mirza's account of events and he confirmed Patient A was able to respond to his questions and that Dr Mirza was making a contemporaneous note of what he was being told. He also explained he asked about and recorded some social history regarding Patient A in order to understand if Patient A was lucid and oriented.

37. There was some suggestion that there was a communication barrier between Dr Mirza and Patient A. However, the Tribunal rejects that and in particular any (implicit) suggestion that Dr Mirza did not understand/could not be understood. The ground of complaint to the GMC was the reference to being 'chatty' but it did not form part of the Allegation. The Tribunal decided it was an important background fact that needed to be resolved in order to understand how Patient A was likely to have presented in the consultation and whether Dr Mirza was able to get a satisfactory history from Patient A. Those underlying factors were key to parts of the Allegation, and also in deciding how reliable or otherwise the Notes were. Taking all of the evidence into account, the Tribunal concluded

that Patient A was sufficiently able to communicate with Dr Mirza. He was able to recount his social history and symptoms. It was more likely than not Dr Mirza was looking down to type contemporaneous notes as Patient A was answering his questions. That is relevant to the Tribunal's assessment as to the reliability of that contemporaneous document.

Was Patient A's social history broadly correct?

38. The Tribunal noted that the GMC was relying on a number of asserted inconsistencies and factual inaccuracies in the Notes in order to claim that they are unreliable. A major part of those assertions arose from the social history entries, which Ms C took particular issue with in her complaint and evidence. Miss B set out in her initial account that: *"the doctor asked "What job do you do?" and Patient A said he sold motorsport merchandise in the UK and went back and forth to Spain to sell it for the 5 months or so of the racing season. He also said that he hadn't been well enough to go to work for the past 6 weeks. The doctor asked "Do you smoke?" and Patient A said "Yes"".* The Tribunal noted that the Notes have the following sequential entries: '*work motor sports merchandise*', '*off for 6 weeks*', '*smoker*', '*live in Spain*'. The entries are more in keeping with what Dr Mirza was told than not. The only inaccuracy was that Patient A did not live in Spain, but the Tribunal decided that did not undermine the Notes because there were two references in the conversation to Spain (one above and one which arose later – see below).

39. The Tribunal considered that the GMC's case referencing inaccuracies in Patient A's social history in the Notes was an unfair assessment of the totality of both those claimed inaccuracies, and the Notes in general. The entries were thematically correct. There was more in keeping with what was said than any inaccuracy as regards social history. Miss B's evidence tends to support both the reliability of what was recorded in the Notes, and that Patient A was sufficiently engaged in the consultation to have provided answers to questions not directly related to his condition, but which were used by the doctor as part of his assessment. It also tended to undermine claims that the consultation was rushed and unfocused.

Was the online consultation rushed and/or unfocused?

40. The Tribunal considered that this question could be considered to be subjective and noted that one person's rushed and unfocused consultation could be another person's efficient use of time. Further, it considered that Dr Mirza was working within the structure

and strictures of the Push Doctor guidelines and the GMC did not present any evidence that Dr Mirza had broken any such guidelines.

41. The Tribunal also took the Notes into account and considered them to be evidence of a full consultation taking background information as to health, symptoms, social history and medication. The claim of being unfocused appears to arise because Dr Mirza was looking down when Patient A was speaking. However, the Tribunal accepted Dr Mirza's account that he was required to take a contemporaneous note during the 9 minutes 36 seconds of a 10-minute consultation; and then the Notes could not be amended. The fact that the Notes reflect various aspects which are not in dispute (or found to be sufficiently thematically correct) support Dr Mirza's account that this was not a rushed consultation. Therefore, the Tribunal concluded that the online consultation had not been rushed and/or unfocused. This also tends to support the reliability of the Notes.

Was Dr Mirza informed of Patient A's stomach/abdominal pains?

42. The Tribunal noted both Miss B and Ms D stated Patient A had been in pain. The evidence closest in time was Ms C's complaint which said that both Miss B and Patient A had stated there was worsening abdominal pain. Miss B's initial account states Patient A often said he had tummy pain, that he did not get out of bed as the pains were more severe and his tummy was swollen. Patient A complained to Dr Mirza that the pains were getting worse.

43. The Tribunal examined the Notes that Dr Mirza made during the consultation and took into account the entries of *'n stomach pain'* and *'no abd pain'*. Dr Mirza's spoke about this in his evidence as he was told there was no stomach or abdominal pain. Dr Mirza said he made two entries in the Notes as he had asked about pain twice, first in relation to stomach pain before he heard other symptoms so he asked in relation to abdominal pain to make sure he had *'got it right'*. The Tribunal considered this was a plausible reason as to why there were two entries in response to the issue of stomach/abdominal pain, with three entries in between. The sequence of those entries in the Notes is likely to have been recorded as Patient A was further describing his symptoms, prompting Dr Mirza to double check. Having asked twice, it is more likely than not Patient A answered negatively rather than Dr Mirza mis-hearing or mis-recording, twice.

44. For the sake of completeness, the Tribunal further notes that: a) the expert's oral evidence was that abdominal pain is not invariably present in a patient with faecal peritonitis; and b) there was a rapid decline in Patient A's health later that day. It is plausible that, at the

time of the consultation, Patient A did not report pain, and that the sequence of events has been mis-remembered given the very distressing decline in Patient A's health on the same day. The Tribunal noted that Patient A had not seen a GP in forty years and was somewhat of a reluctant patient. It considered that this may have influenced how he presented.

45. Overall, the Tribunal concluded that, for whatever reason, Patient A did not indicate he was in pain when asked about it twice in the consultation. It considered that the Notes corroborated Dr Mirza's evidence that he believed that something was seriously wrong with Patient A's health. However, he was not specifically told that Patient A was in pain.

Was Dr Mirza told about vomiting on a daily basis?

46. The Notes record that Dr Mirza had written that Patient A had *'at least once a week has been sick and have* [sic] *no appetite and was struggling living on water as not eating as don't want to eat'.* Ms C's complaint says that because of nausea and vomiting Patient A had been unable to eat anything for 2 weeks and had taken to his bed and said to Dr Mirza he was vomiting 'at least once a day; not once a week and vomit was brown'. That account had been written six weeks after the events. Those events were relayed to Ms C by Miss B at some point between Patient A's death and the complaint.

47. Miss B's initial account, which is some two years later, states variously: every day he said he felt sick; over last week began to vomit at least once a day; on 29 December vomiting more often, turned brown; already off food make him sick, even water making him sick; felt awful, feeling very sick for weeks, gone off food as he would be sick, dramatic weight loss; had started 5-6 weeks ago with him just feeling really sick, but today he had been sick quite a few times that morning whenever he drank any water felt much worse today; for few weeks he had been sick at least once a day after his meals; and the doctor asked how often being sick [Patient A] said for few weeks sick at least once a day.

48. It is difficult to conclude that Dr Mirza having asked how often Patient A was being sick ignored 'once a day' though alternatively he states unless he misheard.

49. Miss B told the Tribunal that the vomiting started on 29 December (the day of the consultation); and that she had not actually seen Patient A vomit. She said she believed Patient A said he was being sick at least once a day. Ms D was asked when was the first time she was aware that Patient A was vomiting and she said 'that day'.

50. The Tribunal noted that there was a difference between feeling sick and being sick (i.e. vomiting) and considered that is likely to have been conflation between the two either at the time of the events or when recounting the events to Ms C and in the statements. That is a more probable explanation than the doctor being told and mis-hearing or mis-recording. It is also more probable when Miss B did not witness Patient A being sick. She said that he would go to the toilet and she did not know what he had been doing in there. The conflation may also have been down to the rapid decline on the 29 December 2017 and the very distressing circumstances that evening leading to mis-remembering. The Tribunal preferred the Notes of what Dr Mirza was told by Patient A. There was sufficiently probative evidence that the Notes were accurate and written contemporaneously; and that the likelihood of mis-hearing/mis-recording was unlikely given Dr Mirza suspected something seriously wrong. That led the Tribunal to conclude Patient A did not communicate he was being sick on a daily basis.

51. In the alternative, given no one witnessed Patient A being sick the GMC could not prove the assertion that Patient A was vomiting on a daily basis.

Was Dr Mirza told that Patient A was vomiting brown liquid?

52. Ms C's complaint suggests that Patient A was vomiting brown liquid once a day. Ms D's statement implies the vomiting of brown liquid had been going on for several weeks. No one witnessed Patient A bringing up brown liquid vomit. There is no direct evidence that either Miss B or Ms D were specifically told of this detail by Patient A. Miss B said she first became aware of Patient A vomiting smelly brown liquid on 29 December 2017 when she had to clean up after he had vomited in the hallway of the caravan. Miss B's witness statement suggests an inability to '*eat much or digest water without vomiting a brown liquid with an unpleasant smell*'. That appears to be a further conflation as the Tribunal was told that the vomiting, after taking water only, occurred after Patient A's dramatic decline later on the 29 December 2017.

53. The Tribunal noted Dr Mirza's Rule 7 response, dated 4 May 2020, in which he disputes that he was told about Patient A vomiting brown liquid, in particular:

> *'Dr Mirza is confident that at no time was he told that PA was vomiting brown liquid. Dr Mirza specifically asks about the nature of the vomit, consistency, colour etc and had there been a report of vomiting brown liquid he would have recorded this, as it is a stark and worrying symptom. Dr Mirza has recorded no blood in vomiting or stools,*

> *which denotes the fact that PA reported nothing unusual about the colour and consistency of the vomit. A report of vomiting brown liquid would have resulted in Dr Mirza recording this and arranging an immediate admission via A&E. Therefore, Dr Mirza is confident that this was not a reported feature of the presentation.'*

54. The Tribunal considered that the Notes support Dr Mirza's claim he asked about vomiting. Having asked about vomiting it could not reconcile the clinical significance of Patient A vomiting brown liquid and Dr Mirza not acting on such information if he had been told about it. The most probable conclusion was that, like the issue of abdominal pain referenced above, Dr Mirza was not told about brown liquid/ vomit. That conclusion is also in keeping with the contemporaneous evidence in the Notes, which the Tribunal has determined in other instances above are likely to be more reliable than other accounts.

55. An alternative view of the evidence is that Patient A vomiting brown liquid was likely to have been distressing and purportedly the reason why Patient A agreed to the online consultation. The Tribunal considered Miss B witness statement evidence where she states:

> *'At this point I intervened and said "He's vomiting up brown water" and then I said to* [Patient A] *"Tell the doctor it's brown and smelly". And* [Patient A] *said "Yes doc, and it's gone brown". The doctor said "OK. Is there any blood in the vomit or stool?" and* [Patient A] *said "Not that I can see because it's brown".'*

56. That account is given some two years after the distressing events. Miss B was asked whether she was sure that Patient A went on to say brown smelly sick and she said "definitely 100 percent tell him about it". If the first half of her witness statement account is taken at its highest, there is still a concern in the Tribunal's assessment of the evidence as to what was actually conveyed to Dr Mirza. The Tribunal has already set out above that Miss B's role in the consultation was peripheral. Ms D did not hear anything other than Buccastem being spelt out. If the claim is taken at its highest, the most likely outcome is that Miss B said what she claims to have said, but in her peripheral role this was not picked up by Dr Mirza. All Patient A said *"Yes doc, and it's gone brown".* Seemingly, Dr Mirza says 'Ok' to that. However, given the significance of him acknowledging 'it's gone brown' the Tribunal remained of the view it did not sit well with the totality of the rest of the evidence. This is a doctor who is otherwise clinically competent and who took a contemporaneous note. He unpacked a significant amount of other relevant information from the patient; and was concerned something serious was wrong with the Patient A. He had enquired about blood in the vomit and if he

had been told it was 'brown', it strikes the Tribunal as implausible he would not have acted to escalate matters given the clinical significance.

57. Taking all of those matters into account, the Tribunal attached more weight to the Notes as likely to be a more reliable, contemporaneous and accurate reflection of what information was conveyed to Dr Mirza. To the extent that there are other accounts of what was said, they were either said in a way which was unclear or that the accounts have become confused/conflated by the passage of time. As such, the GMC has failed to show on the balance of probabilities that Dr Mirza was told during the online consultation that Patient A was vomiting brown liquid.

The Tribunal's determination of the Allegation

58. Having set out a number of findings relating to factual matters, the Tribunal relies on those findings to inform its decision-making process for the Allegation.

Paragraph 1(a) of the Allegation

59. The Tribunal considered the allegation that on 29 December 2017 Dr Mirza consulted with Patient A online via Push Doctor and he failed to arrange for Patient A to be examined in person by a doctor urgently, in that he did not advise him that he should undertake one or more of the actions as set out in Schedule 1 (i.e. contact the 111 service; go to an Urgent Care Centre; go to an A&E; telephone an ambulance).

60. It considered that the way this allegation was drafted was illogical as one cannot fail to arrange something by not advising a patient to do something. That technical drafting issue is sufficient to find the matter not proved.

61. Had the Tribunal taken a purposive approach to this part of the Allegation, the gravamen appears to relate to Dr Mirza having been required to ensure that Patient A sought urgent medical help.

62. The only references to the matters in Schedule 1 appears to be under a title 'adequately assess Patient A'. That may be a hangover from an aged report, given that this is not a charge Dr Mirza faces. In a similar vein there is another reference under 'adequately and appropriately made any clinically indicated referrals within an appropriate timeframe.' That is not the charge before the Tribunal.

63. Further, the Tribunal was concerned that Dr E had not been provided with any evidence from Dr Mirza and had only compiled his report from material supplied by GMC witnesses. In the Tribunal's experience it would be usual practice for the doctor's response to be considered by the GMC expert, so that the expert had an understanding of the doctor's usual approach and any other rationale for his actions. That has not happened in this case and undermines the weight to be attributed to the expert report.

64. The Tribunal turned to the Notes. They record under the 'management plan': *need urgent F2F consultation; will require endoscopy; need to see with GP F2F; might require 2ww*. Dr Mirza states he conveyed this information to Patient A and that he did indicate the situation was serious and required a face-to-face appointment with a GP. This was denied by Miss B. However, the Tribunal noted in Miss B's initial account she states:

> *'The doctor asked "Do you smoke?" and* [Patient A] *said "Yes". He asked "Have you seen your GP?" and* [Patient A] *said he didn't have one, and I said "He's coming up to Scotland with me next week and I can ask my GP if he can see* [Patient A]*" and the doctor replied "OK".'*

65. The Tribunal considered that Dr Mirza's reference in the Notes that Patient A was going to Spain in five days and *'in Spain can see one'* was pertinent. Whilst the destination was incorrect, it tended to correlate with Miss B's claimed interaction with Dr Mirza that "…I can ask my GP…". It is more likely than not, that this response was as a result of Dr Mirza saying to Patient A that he needs to arrange a face-to-face consultation. Particularly so given Patient A had not been to a doctor in forty years. It corroborates Dr Mirza's assertion that there had been a discussion between him and Patient A regarding seeing a GP face to face. The Tribunal considers the Notes are more likely to be a reliable source of evidence of what was actually said to Patient A at the time, rather than the recasting of what occurred some years later after distressing events. The Tribunal considered that Patient A had been informed of the need to seek a face-to-face consultation because of a suspected serious health issue.

66. In the alternative, the Tribunal notes that Miss B's assertions this information was not conveyed to Patient A may well have arisen in the short time she went to obtain a pen and paper as she states she did.

67. Overall, the Tribunal decided that the GMC had not discharged the burden of proof to show that Dr Mirza had failed in a duty to ensure that Patient A was examined in person by a doctor urgently. The evidence was undermined by the manner in which delays had crept in and the effect that is likely to have had on memory. There is some concern as to the fairness of relying on somewhat outdated expert evidence which has not been brought up to date with a fuller version of how the evidence now stands, or that is coterminous with the charges the Tribunal has to consider. The GMC evidence was weak and a purposive approach did not resolve that.

68. Accordingly, the Tribunal determined that paragraph 1(a) of the allegation was found not proved.

Paragraph 1(b)(i) of the Allegation

69. The Tribunal considered the allegation that on 29 December 2017 Dr Mirza consulted with Patient A online via Push Doctor and he inappropriately diagnosed Patient A with acid reflux.

70. It noted Dr Mirza's account that under the Push Doctor IT system he had to choose an option from a 'drop-down' diagnosis box in order to close the consultation down and that the option he chose, 'acid reflux,' was the closest symptomatically from the options that were available. He took the view that he was not in a position to diagnose 'cancer' as that required a face-to-face examination, despite him suspecting cancer which was why he wrote the entry '*might require 2ww*'.

71. The Tribunal took into account the evidence that Dr Mirza had emailed Push Doctor on 19 December 2017 in order to highlight the problem with the drop-box system that it used and that this could lead to the recording of inappropriate diagnoses. That predated the consultation and tended to corroborate issues with the system. There was no option to record 'advice' which is what, in this case, Dr Mirza would have chosen to do. Dr Mirza confirms that he had asked Push Doctor specifically, in his email to them, to include the option to record 'advice' in the diagnosis box. This had not been done before 29 December 2017. The Tribunal accepted Dr Mirza's evidence that the Push Doctor system appeared to be 'clunky', too limited, and too prescriptive.

72. Furthermore, the diagnosis of acid reflux was never communicated to Patient A. That is about the only factual aspect that was agreed between the witnesses. Dr Mirza told the

Tribunal that the drop-down box diagnosis was almost meaningless; and that the management plan and safety netting demonstrated that there was a serious concern (i.e. the '2ww' reference).

73. The Tribunal concluded that although technically Dr Mirza had entered a diagnosis of acid reflux in the diagnosis drop down box, this was because no appropriate options were available. He had indicated in the management plan that he was concerned that Patient A had a serious medical condition which required a face-to-face consultation and possible endoscopy. Therefore, it found that Dr Mirza's actions were not inappropriate in the circumstances.

74. Accordingly, the Tribunal determined that paragraph 1(b)(i) of the allegation was found not proved.

Paragraph 1(b)(ii) of the Allegation

75. The Tribunal considered the allegation that on 29 December 2017 Dr Mirza consulted with Patient A online via Push Doctor and he inappropriately advised Patient A to purchase Buccastem over the counter.

76. The Tribunal took into account Dr Mirza's witness statement, dated 25 March 2022, in particular:

> *'The advice to take Buccastem was for immediate relief of the nausea, it was not intended to "treat" the patient, it was solely to offer interim relief pending further investigations.'*

77. The Tribunal also noted Dr E's expert report, dated 4 June 2018, in particular:

> *'... Buccastem is available for purchase over the counter but for the treatment of nausea associated with migraines. In my opinion it is not an appropriate treatment for acid reflux. If Dr Mirza considered acid reflux to be the most likely diagnosis he could have recommended appropriate medications such as gaviscon or ranitidine.'*

78. It considered that the expert report demonstrated the difficulties that the Tribunal faced as the expert witness had not been updated with Dr Mirza's evidence as to why the doctor chose the option of acid reflux from the Push Doctor diagnosis drop-down box. In

cross-examination, the expert accepted that Buccastem was suitable for giving symptomatic relief from nausea and vomiting.

79. In the circumstances, the Tribunal decided that Dr Mirza informing Patient A to buy Buccastem over the counter in order to alleviate nausea and vomiting was not inappropriate.

80. Accordingly, the Tribunal determined that paragraph 1(b)(ii) of the allegation was found not proved.

Paragraph 1(c)(i) 1 of the Allegation

81. The Tribunal considered the allegation that on 29 December 2017 Dr Mirza consulted with Patient A online via Push Doctor and he inadequately recorded Patient A's medical history, in that he did not record that Patient A was vomiting at least once a day.

82. The Tribunal relies on its detailed reasons set out above as to why it concluded Patient A did not say he was being sick on a daily basis.

83. Accordingly, the Tribunal determined that paragraph 1(c)(i) 1 of the allegation was found not proved.

Paragraph 1(c)(i) 2 of the Allegation

84. The Tribunal considered the allegation that on 29 December 2017 Dr Mirza consulted with Patient A online via Push Doctor and he inadequately recorded Patient A's medical history, in that he did not record that Patient A was vomiting brown liquid.

85. The Tribunal relies on its detailed reasons set out above as to why it concluded that the most probable conclusion was that Dr Mirza was not told about vomiting brown liquid (or the alternative that the GMC had failed to prove its case).

86. Accordingly, the Tribunal determined that paragraph 1(c)(i) 2 of the allegation was found not proved.

Paragraph 1(c)(ii) of the Allegation

87. The Tribunal considered the allegation that on 29 December 2017 Dr Mirza consulted with Patient A online via Push Doctor and he inadequately recorded Patient A's medical history, in that he did not record that Patient A had abdominal pain.

88. The Tribunal relies on its detailed reasons set out above as to why it concluded that Patient A did not indicate he was in pain when Dr Mirza asked him about it twice in the consultation.

89. Accordingly, the Tribunal determined that paragraph 1(c)(ii) of the allegation was not proved.

The Tribunal's Overall Determination on the Facts

90. The Tribunal has determined the facts as follows:

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

1. On 29 December 2017 you consulted with Patient A online via Push Doctor and you:

    a. failed to arrange for Patient A to be examined in person by a doctor urgently, in that you did not advise him that he should undertake one or more of the actions as set out in Schedule 1;
    Not proved

    b. inappropriately:

        i. diagnosed Patient A with acid reflux; **Not proved**

        ii. advised Patient A to purchase Buccastem over the counter;
        Not Proved

    c. inadequately recorded Patient A's medical history, in that you did not record that Patient A:

        i. was vomiting:

1. at least once a day; **Not proved**

2. brown liquid; **Not proved**

ii. had abdominal pain. **Not proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.' **Not proved**

91. As the Facts have not been found proved it therefore follows that Dr Mirza's fitness to practise cannot be found to be impaired.

92. The Tribunal has had to analyse the evidence and rationalise its decision-making. These have been distressing events for the GMC witnesses and whilst our approach has been to set out reasons for preferring one source of evidence over another, it is not the Tribunal's intention to be critical of the witnesses. All three witnesses did their best to assist the Tribunal with their best recollection of the distressing events in 2017.

93. That concludes this case.

SCHEDULE 1

1 Contact the 111 service

2 Go to an Urgent Care Centre

3 Go to Accident and Emergency

4 Telephone an ambulance