MPTS Medical Practitioners Tribunal Service

PUBLIC RECORD

**Dates**: 20 to 30 March 2023
3 April 2023 (the Tribunal was in camera only)
23 September 2023

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| **Medical Practitioner's name:** | Mr Anil DESAI |
| **GMC reference number:** | 3363746 |
| **Primary medical qualification:** | MB BS 1982 Bombay University |

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

**Summary of outcome**

No action (warning not considered)

**Tribunal:**

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| Legally Qualified Chair | Mr Julian Weinberg |
| Lay Tribunal Member: | Mrs Barbara Larkin |
| Medical Tribunal Member: | Dr Barry Adams-Strump (20 to 30 March and 3 April 2023 |
| Medical Tribunal Member: | Dr Sarah Jeffery (23 September 2023) |

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| Tribunal Clerk: | Ms Keely Crabtree |

**Attendance and Representation:**

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| Medical Practitioner: | Present and represented |
| Medical Practitioner's Representative: | Mr Andrew Colman, Counsel, instructed by Medical Protection |

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| GMC Representative: | Mr Christopher Hamlet, Counsel |

## Attendance of Press / Public

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

## Overarching Objective

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

## Determination on Facts – 30/03/2023

1. Mr Desai qualified in 1982 with a Bachelor of Medicine, and Bachelor of Surgery (MB BS) from the University of Bombay, India. Between 1982 to 1985 he worked as a Senior House Officer (SHO) in General Surgery, Accident and Emergency and Urology at Burnley General Hospital, Lancashire. In 1985 Mr Desai attained his Fellowship of the Royal College of Surgeons of England (FRCS) and went on to practise in the Urology Department at Eastbourne District General Hospital for 12 months.

2. In 1987 Mr Desai became a Senior SHO (registrar equivalent) at the Leigh Infirmary before being appointed as Registrar in Surgery at Wigan Infirmary in 1988. Mr Desai went on to be appointed as Surgical Registrar at Wexham Park Hospital in July 1989 and he was promoted to a Senior Registrar position in 1990. In 1992, Mr Desai was appointed as a Fixed Term Consultant Surgeon at Wexham Park Hospital. He was appointed as a substantive Gastroenterology Surgeon with an interest in laparoscopic surgery at Wexham Park Hospital in February 1996.

3. Mr Desai was included on the Specialist Register for Gastroenterology and General Surgery from 5 March 1996.

4. Mr Desai retired from his NHS post at Wexham Park Hospital in April 2017. He continued to practise privately at The Princess Margaret Hospital ("the Hospital") in Windsor where he had worked since 1992 and the Bridge Clinic in Maidenhead where he had worked

since 1999. During his post at Wexham Park Hospital he was the Clinical Governance Lead for the Department of Surgery from 1998 to 2005.

5. Mr Desai was the Lead Surgeon for colorectal cancer for four years and the Clinical Director and later the Clinical Lead for six and a half years between 2010 and 2017. He also provided locum services as a Consultant Colorectal Surgeon from April to June 2018 at Wexham Park Hospital.

## Patient A

6. Mr Desai provided exclusive private management of Patient A's recurring rectal polyp between 1999 and 2019. During this period Mr Desai undertook at least 12 endoscopic procedures on Patient A, either by flexible sigmoidoscopy, proctoscopy or colonoscopy. In addition, Mr Desai performed five surgical procedures attempting to remove and eradicate a polyp and carried out at least four outpatient consultations with Patient A.

7. Patient A then had further colonoscopies in 2000 and 2001. In 2003 Patient A had a colonoscopy which identified a large recurrent carpet polyp, measuring 20x20mm ('the polyp') in her rectum. Following this, she had a surgical submucosal excision of the polyp which was described by Mr Desai as a complete removal.

8. In March 2004 Patient A had a flexible sigmoidoscopy and then in July 2004, went on to have two areas of recurrence of the polyp removed under anaesthetic with diathermy snare.

9. Patient A had a flexible sigmoidoscopy and removal of a further recurrence of the polyp in August 2005 and again in September 2006. On this latter procedure the polyp was described as 20mm by 20mm and was removed piecemeal.

10. Patient A had a colonoscopy in October 2007 when a further recurrence was identified and although an attempt was made to resect this endoscopically, the diathermy failed and the procedure was abandoned.

11. Patient A had a further colonoscopy in February 2008 to complete the resection of the polyp identified in October 2007. In October 2010 Patient A had a flexible sigmoidoscopy and excision of the polyp. In March 2012 Patient A was admitted for a further surgical excision of the recurrent rectal polyp under general anaesthetic.

12. Patient A was admitted again to Hospital in March 2014 and March 2015 when Mr Desai made further attempts to eradicate the polyp.

13. In February 2016 Patient A was seen in clinic and Mr Desai recorded that on digital rectal examination, the polyp was palpable but had not worsened, and in January 2017 recorded that the polyp had not increased in size and felt benign.

14. On 30 January 2017 Mr Desai saw Patient A for a routine review. Patient A reported that her episodes of rectal bleeding had significantly decreased over the preceding twelve months. Mr Desai took her history and carried out a digital rectal examination and a proctoscopy. On examination, the right-sided polyp, which Mr Desai and Patient A had agreed to keep under observation in 2016, had not increased in size and felt benign.

15. In November 2017 Mr Desai described the polyp as feeling softish and asked Patient A's general practitioner to measure the CEA and CA19-9 (two tumour markers of bowel cancer) on a blood test to help Mr Desai to decide if a further surgical resection should be performed.

16. Patient A next saw Mr Desai in March 2019. She stated that she had asked to see Mr Desai because she had diarrhoea and rectal bleeding. On performing a digital rectal examination, he described the polyp as being the same size as the previous year. Mr Desai arranged for a further attempt at a surgical resection of the polyp which was performed on 21 November 2019 when the larger parts of the polyp were removed for biopsy.

17. Mr Desai telephoned Patient A a few days after this operation to inform her that the biopsies showed that she had cancer. Mr Desai also wrote to a colleague at Northwick Park Hospital on 29 November explaining that the biopsies had shown a cancer and asking the colleague to take over the care of Patient A for management of the cancer.

18. On 20 December 2019, Patient A went on to have Computerised Tomography (CT) scan and on 24 December 2019, a Magnetic Resonance Imaging (MRI) scan to stage the tumour. Following neoadjuvant chemoradiotherapy she underwent an abdominoperineal resection of the rectum with a permanent colostomy.

19. The allegation that has led to Mr Desai's hearing can be summarised as that, between July 2004 and November 2019 Mr Desai failed to maintain adequate records and that between February 2016 and March 2019 failed to provide good clinical care to Patient A. It is further alleged that in a letter, dated 21 November 2017, Mr Desai asked Patient A's GP to

perform blood tests, which were inappropriate, as the tests requested are used for diagnosing advanced metastatic cancer and monitoring cancer treatment.

20. The initial concerns were raised with the GMC on 13 November 2020 by Mr B (Patient A's husband).

## The Outcome of Applications Made during the Facts Stage

21. The Tribunal granted Mr Colman's application, on behalf of Mr Desai, made pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended, ('the Rules') to admit the hearsay evidence of Dr F. The Tribunal's full decision on the application is included at Annex A.

22. The Tribunal granted Mr Hamlet's application, on behalf of the GMC, made pursuant to Rule 17(6) of the Rules to amend sub paragraphs 2(a) and 2(b) of the Allegation. The Tribunal's full decision on the application is included at Annex B.

## The Allegation and the Doctor's Response

23. The Allegation made against Mr Desai is as follows:

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

1. Between July 2004 to November 2019 you treated Patient A for a recurring rectal polyp and you failed to maintain adequate clinical records, in that you did not record that on one or more occasion you had suggested to Patient A that she should have an AP (abdomino-perineal resection with permanent stoma). **Admitted and found proved**

2. Between February 2016 to March 2019, you failed to provide good clinical care to Patient A in that you did not:

   a. recognise the extent of the risk that the polyp may become a cancer; **To be determined**

   b. discuss the extent of the risk described in paragraph 2a with Patient A (in the alternative to paragraph 2a); **To be determined**

c. ask for an expert in complex polyp removal to assess Patient A; To be determined

d. advise Patient A to seek a second opinion; To be determined

e. attempt to remove the polyp; To be determined

f. arrange for someone else to remove the polyp; To be determined

g. refer Patient A to the local colorectal cancer MDT. To be determined

3. In a letter dated 21 November 2017, you asked Patient A's GP to perform a CEA and Ca19-9 blood test to help decide if further resection was required, which was inappropriate as those tests are used are for diagnosing advanced metastatic cancer and monitoring cancer treatment. Admitted and found proved

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

24. At the outset of these proceedings, through his Counsel, Mr Desai, made admissions to some paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. Pursuant to Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs of the Allegation as admitted and found proved.

## Witness Evidence

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

- Patient A by telephone link;
- Mr B by telephone link.

26. The Tribunal also received evidence on behalf of the GMC in the form of a witness statement from the following witness whose evidence was not relied upon at the facts stage:

- Mr C, Mr Desai's Responsible officer (RO).

27. Mr Desai provided his own witness statement dated 23 March 2023 and also gave oral evidence at the hearing. In addition, the Tribunal received evidence from the following witness on Mr Desai's behalf:

- Mr E, Consultant General & Colorectal Surgeon at the Hospital, by telephone link.

28. The Tribunal also received evidence on behalf of Mr Desai in the form of a hearsay witness statement from the following witness who was not called to give oral evidence:

- Dr F.

## Expert Witness Evidence

29. The Tribunal also received an expert report on behalf of the GMC dated 16 June 2021 and supplemental expert reports dated 13 December 2021, 8 August 2022, 22 March 2023 and 27 March 2023 prepared by Mr G. The Tribunal also heard evidence from Mr G by video link.

## Documentary Evidence

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

- Mr Desai's Rule 7 response dated 22 October 2021;
- Mr Desai's response to the supplemental report dated 16 February 2022;
- GMC complaint dated 13 November 2020
- Patient A's medical records;
- Mr Desai's consultation notes;
- Patient A's Endoscopy results dated 21 November 2019;
- Patient A's Histology report dated 28 August 2020;
- Patient A's Histopathology reports dated June 1999, September 2003, March 2004, August 2005, September 2006, October 2010, March 2014 and March 2015;
- Patient A's blood test results dated 29 November 2017;
- Patient A's Endoscopy report dated 6 March 2014;
- Endoscopy photographs dated 6 March 2014;
- Patient A's CT scan dated 20 December 2019;

- Patient A's MRI scans dated 24 December 2019 and 4 May 2020;
- Patient A's operation notes dated June 2000, August 2005 and October 2010;
- Diagram drawn from the histology report of 20 August 2020;
- 'Big Bang Tumour Growth and Clonal Evolution' (Sun and Ors) 2018 paper;
- British Society of Gastroenterology/ Association of Coloproctologists of Great Britain and Ireland guidelines for the management of large non-pedunculated colorectal polyps;
- Guidelines for colorectal cancer screening and surveillance in moderate and high-risk groups.

## The Tribunal's Approach

31. 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. Mr Desai 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.

32. The Tribunal heard and accepted the Legally Qualified Chair's (LQC) advice including in relation to the consideration of hearsay and expert evidence.

## The Tribunal's Analysis of the Evidence and Findings

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

Paragraph 2(a)

34. At the outset, Mr Hamlet stated that the GMC's case in relation to paragraph 2 was predicated on the Tribunal finding that the polyp referred to in paragraph 2(a), was the recurring rectal polyp that Mr Desai had treated Patient A for between 2004 and 2019, and it was this polyp that had become cancerous.

35. The Tribunal therefore first considered whether or not it was in fact the same polyp that Mr Desai had been treating that had become cancerous. The Tribunal was mindful that there was conflicting evidence in relation to this but nevertheless had regard to the fact that the following was agreed between the parties:

- According to the histopathology report of March 2014, the microscopic description referred to '*Fragments from villous adenoma with low grade dysplasia. There is no invasive malignancy';*
- According to the histopathology report of March 2015, the microscopic description referred to '*Fragments from tubulovillous adenoma with low grade dysplasia. There is no invasive malignancy in the biopsy';*
- By November 2019, Patient A had been diagnosed with a malignant rectal cancer.

36. The Tribunal was therefore safely able to conclude that as at March 2015, the polyp had not become a cancer, but had by November 2019. The Tribunal considered that in order for it to determine the extent of the risk over the period covered by this particular of the Allegation, consideration had to be given as to whether the GMC had discharged its burden of proof to establish when the polyp had become cancerous and therefore whether Mr Desai had recognised the extent of the risk that it would become malignant.

37. Mr G's evidence that it was the polyp that had become cancer. In support of his assertion, he referred the Tribunal to the histology report dated 28 August 2020, which identified the invasive lesion arising from a pre-existing tubulovillous adenoma in the same area as that of the recurring polyp. There was no evidence of tumour elsewhere in the bowel.

38. The Tribunal had regard to Mr G's expert report dated 13 December 2021, as follows: *'The crucial document is the histology report of the abdomino-perineal resection of the rectum and anus. It reports the invasive lesion is arising from a pre-existing tubulovillous adenoma with low and high-grade dysplasia measuring 42 mm in maximum dimension starting 7mm above the dentate line. It goes on to report that the invasive lesion is 4 mm from the nearest right lateral CRM (circumferential resection margin). This report means that the cancer arose within a very large benign tubulovillous adenoma and that the cancer was extending into the wall of the rectum on the right hand side. This corresponds with the position of the polyp as described by Mr Desai in the Rule 7 response that he had been keeping under review.'*

39. It was Mr Desai's position that the malignant cancer was a discrete polyp from the one that he had been treating. He relied on the MRI scan dated December 2019. Mr Desai also relied upon the evidence of Dr F and Mr E both of whom, unlike Mr G, had been directly involved in Patient A's care.

40. The Tribunal had regard to the evidence of Mr E who accepted that he had no personal recollection of the cancer in question but that he had relied upon the MDT report which stated that *'the invading edge of the tumour is centred at the left posterior wall…'.* Dr F also confirmed that his recollection of the position of the malignant cancer came from a review of the MDT notes. Both Dr F and Mr E stated that there was no mention of any right sided disease in the MRI or MDT notes and they confirmed that their recollection was that the malignancy was solely on the left side.

41. Mr E recognised that there was an inconsistency between the histology report, the MRI scan and the MDT notes for which he could not account but in any event, he stated that it '*made no difference to the management of Patient A's care'.*

42. It was also Mr Desai's case that having not previously identified a malignant tumour and having satisfied himself between February 2016 to March 2019 that the polyp was benign, he had considered that it was a possibility that the malignant cancer was a '*Big Bang Tumour Growth*' which referred to exceptionally fast-growing cancers.

43. Mr G rejected the hypothesis that this tumour was a *'big bang'* tumour, emerging suddenly in late 2019, he stated:

> *"tumours don't come out of nowhere and ….[the paper] is not talking about established cancers…this is a patient who for 20 years has had a recurring polyp. This is not an interval polyp. It's a cancer that has developed in a persistent polyp..[which] the pathologist said arose from a pre-existing tubulovillous adenoma."*

44. The Tribunal noted that in relation whether Patient A developed a 'big bang tumour', neither Mr Desai nor Mr G could determine with any certainty whether that was the case. Both had surmised that their positions were correct despite the absence of any medical evidence that might support either of their respective positions.

45. The Tribunal recognised the inconsistency between the histology report and the MDT notes. However, it accepted Mr G's evidence that the histology report was more likely to reflect Patient A's true medical position and that above all else, that was the document the Tribunal should rely upon when assessing from where the malignant cancer originated.

46. The Tribunal noted that the histology report dated 28 August 2020, stated unequivocally:

*'The invasive lesion is arising from a pre-existing tubulovillous adenoma with low and high- grade dysplasia measuring 42 mm in maximum dimension.'*

47. Notwithstanding the contents of the MDT meeting notes and the MRI scan, the Tribunal therefore concluded that it was more likely than not that the recurring rectal polyp that Mr Desai had been treating, had become cancerous.

48. Having determined that it was more likely than not that the polyp had become a cancer, the Tribunal then went on to consider whether Mr Desai had recognised the extent of the risk that the polyp may become a cancer.

49. Mr Desai told the Tribunal in evidence that he had always recognised the risk that the right-side polyp that he had kept under observation since before 2004, or any other polyp, could become a cancer. Patient A readily accepted that she was aware that this might be the case throughout her treatment by Mr Desai. Therefore, he stated that he had monitored any changes to this polyp and Patient's A condition overall through regular examinations, more or less annually. Mr Desai said that between February 2016 and March 2019 he had examined Patient A four times by way of digital palpation and use of a proctoscope.

50. Mr Desai said that he had sought to do what he thought was best for Patient A, who was desperate to avoid faecal incontinence or a colostomy.

51. Mr Desai said that on 29 February 2016 he reviewed Patient A's histology results dated 14 March 2014 and 25 March 2015 and discussed them with Patient A. On both occasions, the polyp on the right side of the rectal wall was found to show low grade dysplasia. He recalled that he had advised Patient A that since this was a small recurrence of a benign, non-cancerous polyp, with mild abnormal changes in the cells which had been removed twice, it would be appropriate in her case to simply to keep the polyp under observation. Mr Desai said that he had explained to Patient A that the polyp felt soft and if it ever became larger or firm to feel, he would invite her in for another submucous resection.

52. Mr Desai said that in the past, Patient A had declined his offer to come in for resection of recurrent polyps and deferred surgery for several months. She had therefore readily agreed to this approach. Mr Desai said that he would have, as was his standard practice, told her to get back to him should the rectal bleeding become more frequent.

53. Mr Desai said that at the time, Patient A was 79 years of age, and this soft polyp was extending to the anal sphincter. He was reluctant to resect this soft polyp a third time as any damage to the sphincter could have caused significant complications or even faecal incontinence given the patient's age. Mr Desai said that he had discussed this with Patient A who understandably wanted to avoid these risks. It was agreed that he would treat this polyp conservatively for the time being, which would involve keeping it under review and digitally palpating the polyp at later appointments to monitor for any changes. Mr Desai said that he had written to Patient A's GP on 29 February 2016 to confirm the outcome of this consultation.

54. Mr Desai said that despite the lack of changes in the size and feel of the recurring polyp, he wanted reassurance that the polyp, which he and Patient A had agreed to keep under observation since 29 February 2016, was indeed benign, especially in light of Patient A's symptoms of rectal bleeding and abdominal bloating on 21 November 2017. Mr Desai said that he had therefore requested tumour markers to identify if further investigations such as a rectal examination under anaesthetic (EUA), biopsies, MRI and a CT would be required, as he continually recognised the risk of Patient A developing cancer.

55. Mr Desai said that Patient A's test results came back as normal and given that the polyp had not changed in size or feel, he continued to keep it under observation being aware that it could become a cancer, even though in his clinical opinion, it had not. Mr Desai said that at the time, he did not consider that further biopsies of the right-sided soft polyp were clinically justified given that the polyp was less than 10mm and therefore a low risk for cancer, and remained unchanged in size and appearance on digital palpation. Furthermore, it had shown only low-grade dysplasia and no malignancy on two previous occasions in 2014 and 2015.

56. Mr Desai said that with hindsight, he now accepted that he should have carried out sigmoidoscopies and should have taken biopsies from the polyp between 2016 and 2019. Mr Desai recognised that a sigmoidoscopy might have detected a 'red flag' that the polyp might become a cancer because unlike a proctoscopy, a sigmoidoscopy was able to provide photographic images and had the additional benefit of being able to 'look back' and therefore assess a wider area. The Tribunal, however, recognised that whilst these further options were available to Mr Desai, it would be a matter of pure speculation to conclude what the result of such procedures and testing would have been at any particular point in time.

57. Mr Desai said that on 6 March 2019 Patient A attended a review consultation. She reported having had a bout of food poisoning a month before which had not completely settled and three days earlier some rectal bleeding. Patient A also complained that recently she had started feeling tired all the time.

58. Mr Desai said that he established that Patient A had not had excessive bleeding and that she had not passed any clots. Her bowels were opened regularly with no recent change. Mr Desai said that he had performed a digital rectal examination and a proctoscopy. He said that he was satisfied that the right-sided polyp, which he had agreed to keep under observation in 2016, was the same size as when he had last examined her and remained soft to the feel.

59. Mr Desai said that he advised Patient A to visit her GP for a blood test and if it showed any abnormality, he would invite her in to discuss the treatment options for the polyp. Following this consultation, Mr Desai said that he had written a letter to Patient A, dated 6 March 2019 and also copied in her GP. Mr Desai said that whilst he did not have these blood test results, he was confident that Patient A's Haemoglobin level was around 135, which is within normal range.

60. Patient A said that Mr Desai had discussed cancer with her, and that he had told her that if the polyps were allowed to advance then they could turn cancerous, but she had felt confident that he was monitoring it through her annual examinations and that the right checks were being done to ensure that she did not develop cancer. Patient A said that although Mr Desai communicated with her about cancer, his explanations were not lengthy.

61. Patient A said that when she had attended her consultation and examination in 2016, Mr Desai had examined her bowel with what she thought was a flexible camera as he normally did. However, this time he said something *like 'it's not as bad as I thought, so you won't need to come in for removal this year'*.

62. Patient A said that from that point onwards, when Mr Desai examined her each year, he would use the camera scope and then say that the polyps had not changed in size. Patient A said that she recalled that he would say things like *'they don't look sinister'* or *'they haven't changed in size'* and he would then say that she did not need to have polyp removal surgery. Patient A's recollection of the examination was consistent with the evidence of Mr Desai in that in addition to carrying out a digital rectal examination he would have carried out proctoscopy which was his usual practice.

63. Patient A said that she was relieved more than anything that she did not need to have polyp removal surgery and thought that it was a good sign that the polyps were not showing signs of changing and that her condition had stabilised. Patient A said that she remembered that at a consultation around 2018 to 2019 Mr Desai had said something like *'You have had this condition for nearly 20 years, and I don't think they will turn cancerous now'*.

64. Patient A said that she remembered that at her appointment in March 2019 Mr Desai had examined her bowel with the flexible camera and said that the polyps were the same size as the previous year, and that she did not need surgery. She said that she had told him that she was feeling really tired all the time, so Mr Desai referred her back to her GP for a full Haemoglobin test.

65. The Tribunal noted Mr Desai's letter to Patient A dated 6 March 2019, as follows:

> *'On examining you, digital rectal examination showed that the polyp was of the same size as it was last year.*
>
> *I have advised you to visit your GP surgery and have a blood test to check your haemoglobin level. If the blood test shows any abnormality then I would be happy to get you in and deal with the polyp again.'*

66. Patient A stated that in November 2019, she felt like something was not right. She was bleeding more often, and did not feel well. She contacted Mr Desai's secretary and asked to be booked in for a polyp removal surgery because she felt something was not right. Mr Desai said that on 21 November 2019, he admitted Patient A for an EUA, and a transanal resection of recurrent rectal polyps. The EUA identified a carpet of polyps in the lower rectum. Mr Desai said that he had excised two large polyps with a harmonic scalpel and diathermised other smaller polyps. He then sent samples of the polyps for histology.

67. Patient A said that after the surgery, Mr Desai came to her room with the anaesthetist, and said something like *'We've taken the polyps out and they've gone for biopsy, but they don't look sinister'*. She recalled that at this point he had asked whether she would have the 'big operation', the full colorectal surgery, and again she had said no.

68. Mr Desai said that on 25 November 2019, Histopathologist and Cytopathologist, Dr H, produced a report. Mr Desai said that he did not receive this report until the morning of 29

November 2019. The conclusion of the histology was *'moderately differentiated adenocarcinoma arising in a tubulovillous adenoma'.* Mr Desai said that given the importance of the results he contacted Patient A by telephone upon receipt of the histology result to inform her about the results and that he would urgently refer her to a surgical colleague who would provide treatment for the malignancy. He also recalled that he had offered to refer Patient A to another colleague in the NHS as she would have needed further treatment on the NHS.

69. Patient A said that after her surgery in November 2019, Mr Desai called her on the telephone, and said, words to the effect of, *'I'm sorry I've got bad news for you, but the biopsy had come back to say that you have got cancer'*. Patient A said that she believed he then said that he would refer her back to the NHS for treatment.

70. Patient A said that she subsequently underwent radiotherapy in early 2020, and full colorectal surgery in August 2020, resulting in the requirement to wear a stoma bag for the rest of her life.

71. The Tribunal also had regard to Mr G's expert report dated 16 June 2021, as follows:

> *'In the period between February 2016 to March 2019 Dr Desai failed to adequately monitor the polyp and failed to make any attempt to remove the polyp. During this period Dr Desai simply confirmed that the polyp was still present by a digital rectal examination and failed to look at it endoscopically. It would appear that he abandoned any attempts to control the polyp and gave no thought to the possibility that it might become a cancer.'*

72. The Tribunal rejected the evidence of Mr G that Mr Desai had abandoned any attempts to control the polyp for the following reasons. Firstly, the Tribunal did not consider it credible that having cared for Patient A as a private patient since before 2004 and having carried out a large number of examination and surgical procedures, that as an experienced surgeon he should now decide to abandon any attempt to control the polyp. Secondly, the Tribunal accepted that Mr Desai had examined Patient A using a proctoscope in addition to digital palpation because the Tribunal accepted that was his usual procedure to do so and that Patient A recalled that he had examined her with what she recalled as being a 'camera scope' even though she would not have known what type of scope was used.

73. The Tribunal had regard to the 'British Society of Gastroenterology/ Association of Coloproctologists of Great Britain and Ireland guidelines, which state:

> *'GUIDANCE ON SURVEILLANCE FOLLOWING DETECTION OF COLORECTAL ADENOMAS*
> *…*
> *Patients can be offered surveillance until age 75 years and thereafter continue depending on relative cancer risk and comorbidity. Colonoscopy is likely to be less successful and more risky at older ages. Further, the average lead time for progression of an adenoma to cancer is 10 years which is of the same order as the average life expectancy of an individual aged 75 years or older, suggesting that most will not benefit from surveillance.'*

74. The Tribunal rejected Mr G's assertion that these guidelines were only relevant where a patient was polyp free, because the guidance specifically applied following detection of colorectal adenomas.

75. The Tribunal concluded that Mr Desai had treated Patient A appropriately based on the 'British Society of Gastroenterology/ Association of Coloproctologists of Great Britain and Ireland guidelines'. Mr Desai had done what was expected given Patient A's age, history and health condition and importantly her understandable stance that she wished to avoid faecal incontinence or surgery which would inevitably result in her having to live with a stoma. Mr Desai was also aware of Patient A's background of wanting to avoid incontinence or a colostomy operation. Notwithstanding that another professional could have taken a different approach which may or may not have reached a different conclusion.

76. The Tribunal noted that while Mr G stated that other tests may have been appropriate, it would be a matter of pure speculation to second guess what the results of those tests would have been in 2016, 2017 and 2019 when Mr Desai consulted with Patient A. It therefore follows that it would been similarly speculative to conclude that the extent of the risk of the polyp becoming a cancer at the time of those consultations would have been anything other than the risk identified by Mr Desai.

77. The Tribunal therefore concluded that the GMC has failed to discharge its burden of proof that Mr Desai did not recognise the extent of the risk the polyp would become cancer.

78. In the circumstances, the Tribunal did not find that Mr Desai failed to provide good clinical care to Patient A.

79. Accordingly, the Tribunal found paragraph 2(a) of the Allegation not proved.

Paragraph 2(b)

80. Patient A told the Tribunal in her documentary and oral evidence that from her very first consultation with Mr Desai, and at nearly every consultation after that, Mr Desai would recommend that she had what she understood to be a big operation to remove a large part of her bowel and that she would be left with a colostomy bag.

81. Patient A said that she did not want the operation and had terrible anxiety of having a stoma appliance. Patient A said that she did not recall Mr Desai ever asking her why she did not want the operation and that she did not remember him ever going through the detail of the operation as in the positives and negatives.

82. Patient A said that when she had told Mr Desai that she did not want the operation she thought that he had said something like *'Okay, we'll keep an eye on it'*. Patient A said that the alternative seemed to be the treatment plan that they both used which was that she would go annually, at least, for an examination to check if the polyps had changed at all and then Mr Desai would excise any suspicious or large polyps.

83. Mr B told the Tribunal in evidence, and the Tribunal accepted, that at nearly every follow-up appointment Mr Desai would mention the full colorectal surgery, to remove part of Patient A's bowel. Mr Desai kept saying that the only way for Patient A not to have the recurring visits was to have the major operation, but they accepted that her condition could be managed by these repeated examinations and removal surgeries.

84. Mr B said that he recalled that when Mr Desai referred to the colorectal surgery as an option, he did not really fully explain what the outcomes of the operation would be, although, to his recollection, he remembers him mentioning that Patient A would need to have a stoma bag for the rest of her life.

85. Mr B said that it was his understanding from attending the follow-up appointments that Mr Desai was not removing the whole area of polyp. Both he and Patient A had thought that maybe there was an issue with removing all of the area, maybe it would affect her bowel. Mr B said that Mr Desai would say to Patient A at most of her consultations '*you don't want the big operation, do you?'* or words to that effect, but Patient A really did not want that major surgery.

86. Mr B said that when the radiotherapy was not successful, they had been very low and Patient A had really struggled and talked about making enquiries with Dignitas. She had felt very much at the end of her options and felt strongly about not having the colorectal surgery to remove her bowel. It was only after she went for a consultation at the King Edward VII Hospital in Windsor, and the options were fully explained to her and Patient A agreed to the surgery.

87. Mr Desai told the Tribunal in evidence that he was sincerely sorry that he did not maintain adequate medical records to reflect the discussions he had with Patient A about having an abdomino-perineal resection with permanent stoma and her refusal to consider the procedure. Mr Desai said that there had been a loss of data for the period between 1999 and 2006 which had also exacerbated the situation. However, he reiterated that such discussions had taken place.

88. Mr Desai said that he fully accepted that he should have maintained adequate clinical records to reflect his discussions with Patient A and that he was now more careful and recorded full details of all his discussions, particularly conversations with patients.

89. In determining whether or not Mr Desai discussed the extent of the risk of the polyp becoming cancer. The Tribunal repeats the contents of paragraphs 51 to 55 and 60 to 61 evidencing that he did have relevant discussions.

90. Mr Desai said that on 30 January 2017 he saw Patient A for a routine review. She reported that her episodes of rectal bleeding had significantly decreased over the preceding twelve months. He said that he took her history and carried out a digital rectal examination and would also have undertaken a proctoscopy as his standard practice.

91. Mr Desai said that on examination, the right-sided polyp, which he and Patient A had agreed to keep under observation in 2016, had not increased in size and felt entirely benign. Therefore, they had decided to continue with a conservative approach, and he had planned to review her again in 12 months. Following this consultation, Mr Desai said that he had written a letter to Patient A's GP, dated 30 January 2017, which briefly summarised his examination findings and management plan.

92. The Tribunal accepted Mr Desai's evidence which was consistent with what Patient A said she was told during her consultations. The Tribunal was satisfied that Mr Desai had given

Patient A an explanation of the extent of the risks as he perceived them to be that her polyp could turn cancerous.

93. For the reasons set out above at paragraph 76 the Tribunal concluded that it had no evidence to suggest that the extent of the risk at the time of the examinations was anything other than the risk that Mr Desai had identified, that the polyp could become a cancer. The Tribunal noted that the polyp had become cancerous at some point between March 2015 and November 2019. It concluded that there was an absence of evidence on which it could rely to demonstrate when the polyp became cancerous or when there would have been a sufficient marker to indicate that the cancer would turn malignant.

94. Given that, the Tribunal also concluded that any view expressed by Mr Desai or Mr G as to when the polyp became cancerous was based on supposition rather than medical evidence.

95. Given its rationale at paragraph 76, the Tribunal concluded that the GMC had not discharged its burden of establishing that Mr Desai had not discussed with Patient A the extent of the risk that the polyp may become a cancer.

96. In the circumstances, the Tribunal did not find that Mr Desai failed to provide good clinical care to Patient A.

97. Accordingly, the Tribunal found paragraph 2(b) of the Allegation not proved.

Paragraph 2(c)

98. The Tribunal had regard to Mr Desai's Rule 7 response dated 22 October 2021, as follows:

> *' Mr Desai has received referrals from his surgical and gastroenterology colleagues to manage large rectal polyps for some 25 years. He estimates that he has undertaken thousands of colonoscopies since 1985 and scores of transrectal open excisions of large polyps as endoscopic removals of large polyps. As such he considers that he had the skill and expertise to manage Patient A's treatment without seeking the opinion of another endoscopist.*

*In Patient A's case it was Mr Desai's opinion that there was no clinical need to refer Patient A for a second opinion given that her polyps were all low rectal polyps, and he was satisfied that he could successfully manage her condition.*

*…*
*Mr Desai denies this allegation in that there was no clinical need to refer Patient A for a second opinion from an endoscopist experienced in complex polyp removal. Mr Desai was satisfied that the polyp that he was keeping under review was soft and benign. Biopsies from this polyp on the right side had shown mild/ low grade dysplasia only and that it was within his clinical competence to appropriately manage Patient A's care…'.*

99. The Tribunal noted Mr G's expert report dated 16 June 2021, as follows:

*'Dr Desai failed to arrange the necessary referral of Patient A to an endoscopist experienced in complex polyp removal or to a surgeon with experience of complex polyp management.'*

100. The Tribunal had regard to the 'British Society of Gastroenterology/ Association of Coloproctologists of Great Britain and Ireland guidelines for the management of large non-pedunculated colorectal polyps', as follows:

*'We suggest that clinicians involved in the management of LNPCPs should have access to a multidisciplinary network such as a multidisciplinary meeting (MDM) to discuss complex cases (complex as defined in these guidelines).'*

101. The Tribunal had regard to Mr G's expert report, as follows:

*'Mr Desai denies that he should have sort [sic] the opinion from a colorectal MDT or a complex polyp MDT. Strictly speaking, until the polyp became a cancer, there was no requirement for him to do so but if as he claims he was not treating the residual polyp in a radical way because did not want major surgery then he should have either sort a second opinion from a colorectal surgeon or the support of an MDT in this decision.'*

102. The Tribunal concluded that the wording of the guidance was advisory rather than mandatory. The Tribunal was therefore satisfied that there was no requirement for Mr Desai to ask for an expert in complex polyp removal to assess Patient A. The Tribunal accepted that

Mr Desai is a highly experienced surgeon and was satisfied with his diagnosis and treatment of Patient A. The Tribunal was of the view whilst it may have been best practice to ask for an expert in complex polyp removal to assess Patient A, it was not a requirement to do so and therefore Mr Desai's actions do not amount to a failure on his part.

103. In addition for the reasons set out earlier in this determination, the Tribunal has concluded that there is insufficient evidence to establish when the polyp became cancerous and therefore when a referral was required.

104. In the circumstances, the Tribunal did not find that Mr Desai failed to provide good clinical care to Patient A.

105. Accordingly, the Tribunal found paragraph 2(c) of the Allegation not proved.

Paragraph 2(d)

106. The Tribunal had regard to the paragraph of Mr G's report reproduced at paragraph 101 as above. The Tribunal was therefore satisfied that there was no requirement for Mr Desai to advise Patient A to seek a second opinion unless he had known that Patient A's rectal polyp was cancerous at the time which he did not. For the reasons set out earlier in this determination in relation to paragraph 2(c) of the Allegation, the Tribunal has concluded that there is insufficient evidence to establish when the polyp became cancerous and therefore when a referral was required.

107. In the circumstances, the Tribunal did not find that Mr Desai failed to provide good clinical care to Patient A.

108. Accordingly, the Tribunal found paragraph 2(d) of the Allegation not proved.

Paragraph 2(e)

109. The Tribunal accepted Mr Desai's explanation as to why he had not attempted to remove the rectal polyp because of Patient A's age as referred to in the guidelines, the risks associated with sedation of a patient of her age, the risk of a perforated bowel and location and the risk of damage to the anal sphincter potentially resulting in faecal incontinence.

110. The Tribunal acknowledged that Patient A had wanted to avoid incontinence or a colostomy at all costs

111. There was no evidence on which the Tribunal could conclude that the rectal polyp had turned cancerous as at March 2019 which would have necessitated the need to remove it.

112. The Tribunal had regard to Mr G's expert report dated 8 August 2022, as follows:

> *'From 2016 to 2019 Dr Desai stopped trying to control the polyp and therefore I can only assume that he failed to recognise the risk of malignancy. Not to have recognised the risk was seriously below the standard expected of a reasonably competent consultant surgeon. Not to have attempted to remove the known polyp or arranged for someone else to do so was seriously below the standard of a reasonably competent surgeon. Not to have discussed this risk with Patient A and advised a second opinion because he was unable to control the polyp or because Patient A did not want the suggested treatment was seriously below the standard expected of a reasonably competent consultant surgeon.'*

113. The Tribunal concluded that Mr G's opinion was based on the premise that the rectal polyp was malignant at that time. For the reasons set out above, the Tribunal repeats its finding that there is insufficient evidence to establish when that was the case and therefore when an attempt to remove the polyp should have been made.

114. In the circumstances, the Tribunal did not find that Mr Desai failed to provide good clinical care to Patient A.

115. Accordingly, the Tribunal found paragraph 2(e) of the Allegation not proved.

Paragraph 2(f)

116. Given its finding in relation to paragraph 2(e) the Tribunal considered that it would have been similarly inappropriate to refer Patient A to arrange for someone else to remove the polyp as this would have involved the same risks for Patient A that Mr Desai had identified. The Tribunal also concluded that a referral was not required unless and until it was established that the polyp had become a cancer. For the reasons set out above the Tribunal repeats its rationale for concluding that there is insufficient evidence of when this was the case.

117. In the circumstances, the Tribunal did not find that Mr Desai failed to provide good clinical care to Patient A.

118. Accordingly, the Tribunal found paragraph 2(f) of the Allegation not proved.

Paragraph 2(g)

119. The Tribunal had regard to Mr G's supplemental report dated 8 August 2022, as above.

120. The Tribunal also had regard to Mr G's supplemental report dated 13 December 2021, as follows:

> *'Mr Desai denies that he should have sort [sic] the opinion from a colorectal MDT or a complex polyp MDT. Strictly speaking, until the polyp became a cancer, there was no requirement for him to do so but if as he claims he was not treating the residual polyp in a radical way because Patient A did not want major surgery then he should have either sort a second opinion from a colorectal surgeon or the support of an MDT in this decision.'*

121. The Tribunal was therefore satisfied that there was no requirement for Mr Desai to refer Patient A to the local colorectal cancer MDT unless he had known that the rectal polyp was cancerous at the time, which he did not. The Tribunal concluded that a referral was not required unless and until it was established that the polyp had become a cancer. For the reasons set out above the Tribunal repeats its rationale for concluding that there is insufficient evidence of when this was the case.

122. The Tribunal also accepted Mr Desai's evidence that there was not a local colorectal polyp MDT to refer Patient A to in any event. Mr Hamlet conceded that if that were the case then Mr Desai could not be criticised for not referring Patient A to such a clinic. The Tribunal concluded that the GMC has not provided sufficient evidence to enable the Tribunal to conclude that such a clinic was available to Mr Desai.

123. In the circumstances, the Tribunal did not find that Mr Desai failed to provide good clinical care to Patient A.

124. Accordingly, the Tribunal found paragraph 2(g) of the Allegation not proved.

## The Tribunal's Overall Determination on the Facts

125. The Tribunal has determined the facts as follows:

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

1. Between July 2004 to November 2019 you treated Patient A for a recurring rectal polyp and you failed to maintain adequate clinical records, in that you did not record that on one or more occasion you had suggested to Patient A that she should have an AP (abdomino-perineal resection with permanent stoma). **Admitted and found proved**

2. Between February 2016 to March 2019, you failed to provide good clinical care to Patient A in that you did not:

    a. recognise the extent of the risk that the polyp may become a cancer; **Not proved**

    b. discuss the extent of the risk described in paragraph 2a with Patient A (in the alternative to paragraph 2a); **Not proved**

    c. ask for an expert in complex polyp removal to assess Patient A; **Not proved**

    d. advise Patient A to seek a second opinion; **Not proved**

    e. attempt to remove the polyp; **Not proved**

    f. arrange for someone else to remove the polyp; **Not proved**

    g. refer Patient A to the local colorectal cancer MDT. **Not proved**

3. In a letter dated 21 November 2017, you asked Patient A's GP to perform a CEA and Ca19-9 blood test to help decide if further resection was required, which was inappropriate as those tests are used are for diagnosing advanced metastatic cancer and monitoring cancer treatment. **Admitted and found 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 – 23/09/2023

126. 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, Mr Desai's fitness to practise is impaired by reason of misconduct.

## Submissions

127. On behalf of the GMC, Mr Hamlet stated that in this case, the facts are based entirely on the two admissions that have been made and it is the Tribunal's decision whether, on the basis of those admitted facts, Mr Desai's fitness to practise is impaired. Mr Hamlet stated that firstly, the Tribunal has to decide before it gets to the issue of impairment, whether those admitted facts amount to misconduct and if they do not, the Tribunal does not need to go on to consider the issue of impairment. However, if it does find misconduct, it will then need to consider the issue of whether Mr Desai's fitness to practise is currently impaired.

128. Mr Hamlet stated that the GMC's position is that what has been admitted and found proved, and what remains of the Allegation, on that basis the GMC does not advance a positive case of misconduct.

129. Mr Hamlet referred the Tribunal to the case of *Roylance v GMC (no.2) [2000] 1 A.C. 311* which makes reference to the to the fact and emphasises that it is not just any professional misconduct which qualifies as misconduct, it must be serious professional misconduct. Mr Hamlet also referred the Tribunal to the case of *R (on the application of) Remedy UK v GMC [2010] EWHC 1245 and Nandi v GMC [2004] EWHC 2317 (Admin).*

130. Mr Hamlet submitted that the threshold which the Tribunal is invited to consider conduct which would be regarded as deplorable by fellow practitioners. Mr Hamlet referred the Tribunal to the case of *R (*Calhaem*) v General Medical Council [*2007*] EWHC 2606 (Admin)* which highlights that a single negligent act or omission is less likely to cross the threshold of misconduct than multiple acts or omissions. Nevertheless, depending on the circumstances, a single act or omission, if particularly grave, could be characterised as misconduct. He stated that the Tribunal is not just looking for a breach of proper standards or a falling below of what are the accepted standards, but a serious departure from the accepted standards based on the admitted facts of this case.

131. Mr Hamlet stated that the admitted heads of charge concern a failure by Mr Desai to maintain adequate clinical records regarding his advice to Patient A and referred the Tribunal to the GMC expert report and oral evidence of Mr G. In his report Mr G gave criticism that Mr Desai's failure was seriously below the standards expected of a reasonably competent consultant surgeon. Mr G's criticism was made in the context of an understanding that Mr Desai was unaware or unconcerned with the risk of the polyp becoming malignant and that was the backbone of his concerns. Mr Hamlet said that the failure of record keeping must now be read in the context of the fact that none of the other criticisms, which formed the backbone of the GMC case, were found proved by the Tribunal. It did not find that Mr Desai failed to provide good clinical care. The Tribunal concluded that this was an isolated failure in relation to record keeping only which was divorced from the overall quality of the care provided by Mr Desai to Patient A.

132. Mr Hamlet referred the Tribunal to the admitted charge that in a letter dated 21 November 2017, Mr Desai asked Patient A's GP to perform a CEA and Ca19-9 blood test to help decide if further resection was required. He stated that those tests are used for diagnosing advanced metastatic cancer and monitoring cancer treatment which was inappropriate in the context of the GMC's case. Mr Hamlet referred the Tribunal to Mr G's expert report in which he had deemed that this was seriously below the standard expected of a reasonably competent consultant surgeon. In his second expert report he clarified that the reason he considered this serious was because it implies a complete misunderstanding of the purpose of these tests. It was in the context of a wider position that this was all part of a failure by Mr Desai to appreciate what he was dealing with in terms of this cancer and to treat it appropriately and on the evidence given by Mr Desai. Mr G essentially asserted that it was not that Mr Desai did not understand the role of those tests but has accepted that the efficiency of those tests was, in essence, limited and for that reason was inappropriate.

133. Mr Hamlet stated that in that regard there is an absence of any attendant finding by the Tribunal that Mr Desai had failed to appropriately treat the cancer such that the referral to the to the GP might have been might have reflected a failure by him to appreciate what he was dealing with. Further, the initial allegations against Mr Desai related to him referring Patient A for tests because he was struggling to understand how to deal with the central concern and so the referral was inappropriate. However, the Tribunal should regard Mr Desai's conduct in isolation of his otherwise appropriate management of Patient A. Mr Hamlet submitted that it is the GMC's position that it is a matter for the Tribunal and that the GMC does not advance a positive case that either one of those acts is sufficiently serious to amount to misconduct for the purpose of consideration of impairment. Mr Hamlet stated

that therefore he did not have any submissions on the issue of impairment unless and until the Tribunal were to find misconduct proven.

134. On behalf of Mr Desai, Mr Colman stated that the admitted facts consist of a failure over time to record conversations with the patient that did in fact take place. He stated that Patient A had given evidence that those conversations took place but that they were not fully recorded. Mr Colman stated that Patient A has not suffered any harm as a result of that recording failure and that in any event, the extent of the failure cannot be accurately assessed in this case as some of the records have been lost.

135. Mr Colman stated that the Tribunal is aware that this charge relates to a single patient and that it should consider very carefully whether this amounts to misconduct in the course of what it already knows from all of the testimonial evidence of Mr Desai's otherwise highly distinguished career.

136. Mr Colman stated that the GMC does not suggest that the admitted facts amount to misconduct and submitted that it was a failure of record keeping that caused no harm because there was no discontinuity of treatment. He stated that Mr Desai continued to treat Patient A for a substantial period.

137. Mr Colman referred the Tribunal to the authority of *Calhaem* which states that a single act or omission may amount to misconduct if it is particularly grave but is less likely to amount to misconduct than multiple acts or omissions. Mr Colman stated that this was a case in which there was a single act of requesting two blood tests, which were not specifically appropriate for deciding whether further resection of the patient's polyp was required. He submitted that it was not particularly grave to request too many blood tests and is clearly less serious than not requesting enough because there is no possibility of a patient suffering harm.

## The Relevant Legal Principles

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

139. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted. Firstly, whether the facts admitted and found proved amounted to misconduct. Secondly, and only if those facts were found to amount to misconduct, the Tribunal would go on

to consider whether Mr Desai's fitness to practise is currently impaired as a result of that misconduct.

140. The Tribunal must determine whether Mr Desai's fitness to practise is impaired today, taking into account Mr Desai'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 the likelihood of repetition.

## The Tribunal's Determination on Impairment

Misconduct

141. The Tribunal carefully considered all the evidence and submissions presented to it and considered the facts in the round.

142. It has been admitted and found proved that between July 2004 to November 2019 Mr Desai treated Patient A for a recurring rectal polyp and failed to maintain adequate clinical records, in that he did not record that on one or more occasion that he had suggested to Patient A that she should have an AP (abdomino-perineal resection with permanent stoma). It has also been admitted and found proved that in a letter dated 21 November 2017, Mr Desai asked Patient A's GP to perform a CEA and Ca19-9 blood test to help decide if further resection was required, which was inappropriate as those tests are used are for diagnosing advanced metastatic cancer and monitoring cancer treatment.

143. In relation to paragraph 1 of the Allegation, the Tribunal was mindful of the need, as set out in Good medical practice (GMP) for effective and accurate record keeping and the Tribunal has noted Mr Desai's acceptance of his failing in this regard.

144. However, the Tribunal was mindful that a finding of misconduct does not necessarily follow as a result of a breach of GMP.

145. The Tribunal has carefully considered the seriousness of Mr Desai's failings. In doing so it has identified the following:

- This was an isolated failure to keep accurate records and there was no evidence that this shortcoming was typical of Mr Desai's conduct;

- Mr Desai stated and Patient A accepted that she was repeatedly told and was aware that Patient A should have an abdomino-perineal resection with permanent stoma. However, Patient A wished to avoid such life changing surgery;
- Mr Desai's failing did not result in any harm to Patient A;
- The Tribunal has had regard to Mr G's conclusion regarding the seriousness of Mr Desai's failure to keep accurate records but noted that this was in the context of the alleged failings as set out in paragraph 2 of the Allegation which have been found not proved;
- As set out earlier in its determination of the facts the Tribunal did not find that Mr Desai failed to provide good clinical care to Patient A.

146. Given these factors the Tribunal is satisfied that Mr Desai's failings in respect of paragraph 1 of the Allegation were isolated and were not demonstrative of a deliberate disregard for his professional obligations. The Tribunal has therefore concluded that in all the circumstances to the extent that his conduct does amount to a breach of GMP, it did not consider that his conduct would be considered deplorable by fellow members of the profession. It concluded that in all the circumstances his conduct did not fall so seriously so far below the standards expected of him that it could amount to misconduct.

147. The Tribunal therefore concluded Mr Desai's conduct in relation to paragraph 1 of the Allegation does not amount to misconduct.

148. The Tribunal then considered the seriousness of Mr Desai's failings in relation to paragraph 3 of the Allegation. In doing so it has identified the following:

- No actual harm or risk of harm was posed to Patient A as a result of requesting unnecessary blood tests;
- The Tribunal has had regard to Mr G's conclusion regarding the seriousness of Mr Desai's failure but noted that this was in the context of the alleged failings as set out in paragraph 2 of the Allegation which have been found not proved;
- As set out above, the Tribunal has already concluded that Mr Desai did not fail to provide adequate clinical care to Patient A.

149. Given these factors the Tribunal is satisfied that Mr Desai's failings in respect of paragraph 3 of the Allegation were isolated and were not demonstrative of a deliberate disregard for his professional obligations. The Tribunal has therefore concluded that in all the circumstances to the extent that his conduct does amount to a breach of GMP, it did not

consider that his conduct would be considered deplorable by fellow members of the profession. It concluded that in all the circumstances his conduct did not fall so seriously so far below the standards expected of him that it could amount to misconduct.

150. The Tribunal therefore concluded Mr Desai's conduct in relation to paragraph 3 of the Allegation does not amount to misconduct.

151. Given the above conclusions the Tribunal has concluded that Mr Desai's conduct neither individually or collectively amounts to misconduct.

Impairment

152. In light of the Tribunal's findings in relation to misconduct the Tribunal found Mr Desai's fitness to practise is therefore not impaired by reason of misconduct.

Warning

153. As the Tribunal determined that Mr Desai's conduct did not amount to misconduct and that his fitness to practise is not impaired, it determined that consideration of a warning was not necessary.

154. Mr Hamlet on behalf of the GMC submitted that given his submissions in relation to misconduct and the GMC's guidance on warnings, it was not appropriate for a warning to be imposed in any event.

155. Mr Colman was in agreement with that position. He stated that in theory that it falls to the Tribunal to consider whether a warning is appropriate but then there would have to be the weighing up of whether it is possible to meet the threshold for a warning if misconduct itself was not found.

156. In the circumstances, the Tribunal does not impose a warning.

ANNEX A – 22/03/2023
Application to admit hearsay evidence

157. Mr Colman, on behalf of Mr Desai, made an application pursuant to Rule 34(1) of the Rules, to admit hearsay evidence.

158. Mr Colman stated that he sought to admit the written evidence of Dr F, contained in his witness statement dated 19 March 2023. Dr F is the Consultant Oncologist who treated Patient A and is a witness of relevance and importance on the issue of the location of her cancer.

159. Mr Colman said it ill behoves the GMC to complain about the late service of Dr F's statement, since it was prompted by the GMC's own late and partial disclosure of Patient A's scans. He said that Dr F is not available to give evidence because he has clinical commitments and requires six weeks notice to change them. Mr Colman said that he would have preferred to call him to give evidence but cannot do so for these reasons.

160. Mr Colman stated that Dr F's evidence is relatively simple and factual. It is supported by the contemporaneous documentation of the Multidisciplinary Colorectal Cancer Meeting, which assists in assessing its reliability. Dr F expressly says that this document supports his recollection. He goes on to cite other documentary support for his recollection that would appear to address the GMC's caveat about wishing to test his evidence as to the basis of his recollection. Dr F is a senior, independent practitioner with no motive to do anything but tell the truth.

161. Mr Colman stated that the GMC would not be prejudiced by the admission of Dr F's evidence in written form. If any party is prejudiced by the absence of Dr F it is Mr Desai, because of the possibility that less weight might be attached to his evidence in the absence of the opportunity to question him. Nevertheless, such prejudice is minor compared to that which would be occasioned by not considering Dr F's evidence at all. Mr Colman stated that without it, the Tribunal would have an incomplete basis on which to decide the allegations. This would not be fair to either side or to the Tribunal itself.

162. Mr Colman stated that the High Court extensively reviewed the principles underlying the admission of hearsay evidence in disciplinary proceedings in the well-known cases of *Ogbonna v NMC [2010] EWCA Civ 1216* and *Bonhoeffer v GMC [2011] EWHC 1585 (Admin).* Mr Colman stated that Rule 34(2), which contained a proviso in relation to evidence that

would be inadmissible in criminal proceedings, has since been repealed, so that much of the discussion of criminal admissibility in those cases is no longer relevant.

163. Mr Colman stated that while laying down general principles, the facts of the authorities on hearsay are very different to this case, so they are of limited assistance. The overriding requirement is to consider whether it would be fair to admit or exclude the evidence. Mr Colman submitted that there is nothing unfair about considering the totality of the evidence.

164. Mr Colman stated that Dr F's statement provides evidence of significant probative value which is valuable for the understanding of the other evidence in the case. The location of Patient A's cancer is an important matter in the context of the case as a whole. Dr F and his statement both appear to be reliable. Mr Colman said that these are some of the factors to which the criminal courts are directed when considering the admissibility of evidence under section 114(2) of the Criminal Justice Act 2003. While that Act does not apply to these proceedings, the Tribunal may find those factors helpful to consider on the issue of fairness.

165. Mr Hamlet, on behalf of the GMC stated that the central issue disputed in this case is where the cancerous polyp originated from. Was it from an area that Mr Desai had been monitoring for many years and which was essentially missed, or did it arise from an entirely different area? Mr Hamlet stated that the statement of Dr F is produced by the defence with its purpose of going directly to this issue.

166. Mr Hamlet stated that because it goes to the controversial issue between the parties, the statement can only be received in one of three ways. Firstly, when the contents of the witness statement are confirmed by a witness who attends and gives live evidence. Secondly, that it is admitted to the Tribunal on an agreed basis or thirdly, the Tribunal exercises its discretion to receive it under Rule 34(1).

167. Mr Hamlet stated that option one and two are out of the question because Dr F is not available at all and therefore the only option available is that the Tribunal uses its own discretion to admit it.

168. Mr Hamlet submitted that it would be unfair and wrong to admit this written statement. He said that the account given by Dr F goes to the heart of the issues which the GMC are entitled to challenge. However, the GMC cannot challenge it if it is admitted in statement form. He said that as the defence highlight, this is a witness who has relevance and

importance to the case. However, the witness has not been called to give evidence and his availability should have been secured in advance.

169. Mr Hamlet stated that the defence blame this late disclosure on an unnamed scan disclosed to them by the GMC. However, what Dr F comments upon is essentially his recollection of the position of the polyp drawn by him from a personal recollection of his involvement in the case as an oncologist back in December 2019. Mr Hamlet said that this had nothing to do with any scans that have been served on the defence. Further, Dr F's statement makes reference to the content of the notes of the MDT meeting of 27 December 2019 which forms the basis of his recollection. It also makes reference to material that already appears in the GMC bundle including the CT, MRI and Histology reports that have been in the possession of the defence for some time.

170. Mr Hamlet stated that even if Dr F could not have been asked until the very last moment, and that is now the reason for him being unavailable, this is not a reason to admit this evidence now if it is otherwise inadmissible. However, his objection was not because it has been served late but because the evidence itself is controversial and the GMC are entitled to challenge it.

171. Mr Hamlet stated that the statement in the form the Tribunal has been invited to receive it raises a number of insurmountable issues as regards its reliability. Mr Hamlet said that it is a statement that expresses a view on the central issue of from where this polyp originated, without explaining how that recollection was established. Furthermore, it is not clear whether it is based on a direct personal recollection or whether it is based on a discussion with others or even a paper review. Mr Hamlet said that we simply do not know the answer to these questions.

172. Mr Hamlet stated that he would wish to challenge the strength of any recollection given that appears to be drawn upon a recollection which is now many months after the event. Mr Hamlet said that alternatively, if it is a recollection derived from a review of the clinical history based upon the MDT summary, then it is tantamount to an expert opinion or quasi expert opinion on the proper interpretation of the materials before the Tribunal which should be confined to expert evidence only.

173. Mr Hamlet stated that Dr F is not an expert, but is a witness of fact. He should therefore not be entitled to write an opinion on the content of the reports. Mr Hamlet submitted that Dr F expresses a recollection of unclear provenance and an opinion on the

MRI report and allowing this statement on such an important issue on an uncontested basis would be prejudicial to the GMC.

174. Mr Hamlet stated that the statement is of questionable reliability which cannot be resolved by inviting the Tribunal to simply to attach less weight to it. If the document is considered inadmissible, it is inadmissible.

175. Mr Hamlet submitted that the Tribunal should not exercise its discretion under the rules to allow the statement.

## Tribunal Decision

176. In considering the application the Tribunal had regard to Rule 34(1) of the Rules which states:

> *'The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'*

177. The Tribunal determined to allow the application. It considered that the content of Dr F's statement was relevant to the facts which it had to determine because it related to the site of the cancerous polyp and potentially whether it was the same polyp that Mr Desai had been monitoring. It was accepted by both parties that Dr F's statement was relevant to the facts in dispute.

178. The Tribunal then went on to consider whether it was fair to admit Dr F's statement by way of his hearsay evidence. In doing so it has considered those factors identified in the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*. Having done so it has identified the following:

- Dr F's statement does not represent the sole and decisive evidence in relation to the issue of the location of the cancerous polyp as Mr Desai specifically addresses this issue;
- There is no suggestion that Dr F has any reason to fabricate his evidence;
- The Tribunal accepted that the late service of Dr F's statement was due to the late and partial disclosure by the GMC to the doctor's legal representative;

- It accepted that Dr F had provided a genuine and valid reason for his unavailability to attend this hearing to give live evidence.

179. The Tribunal rejected Mr Hamlet's submission that Dr F's evidence in effect amounted to expert opinion evidence. Having read Dr F's statement he stated that he confirmed his recollection of events and made reference to the MDT meeting notes which he stated supported his recollection and as such did not amount to opinion evidence.

180. The Tribunal accepted that in allowing the admission of Dr F's statement in the absence of his attendance the GMC would be deprived of the opportunity of cross-examining Dr F in relation to those matters referred to in Mr Hamlet's submissions. However, it considered that this could be addressed by the Tribunal by assessing the weight to be attached to his statement when considering its determination on facts.

181. The Tribunal determined that the admission of Dr F's statement was relevant and fair and that there would no unfairness or injustice to the GMC in allowing its admission.

182. The Tribunal therefore granted Mr Colman's application.

ANNEX B – 22/03/2023
Application to amend the Allegation

183. Mr Hamlet, on behalf of the GMC, made an application pursuant to Rule 17(6) of the Rules, to amend sub paragraphs 2(a) and 2(b) of the Allegation as follows:

> 2. Between February 2016 to March 2019, you failed to provide good clinical care to Patient A in that you did not:
>
> a. recognise the extent of the risk that the polyp may become a cancer;
>
> b. discuss the extent of the risk described in paragraph 2a with Patient A (in the alternative to paragraph 2a);

184. Mr Hamlet stated that the application arises in the light of the way that Mr Desai has responded in his witness statement to paragraphs 2(a) and 2(b) of the Allegation. It is also, to a lesser extent, following the evidence of Patient A and Mr B because what emerges from Mr Desai's statement is a recognition that the Allegation has been interpreted in a binary way that was not intended by the GMC and does not accord with the way the case is being pursued or put by him during his opening.

185. Mr Hamlet referred the Tribunal to paragraphs 94 to 103 of Mr Desai's witness statement in which he deals specifically with his response to Allegation 2(a) and 2(b). Mr Desai denies these allegations on the basis that he did recognise there was some risk that the polyp could become a cancer and that he did then discuss that risk with Patient A.

186. Mr Hamlet said that by that binary approach, it was known that Patient A and Mr B would come to these proceedings and say that there had been some discussion. Mr Hamlet stated that it was known that this would be their position but the case is not put in that way. It was not that there was no recognition at all of the risks and no discussion of the risks. The case that is brought is not of recognition but of generalised risk of cancer developing and the evident risk arising from the growth of polyps in the area under observation by Mr Desai that were likely to turn malignant.

187. He stated that Mr Desai failed to properly monitor Patient A's condition resulting in his failure to recognise the likelihood of the malignancy occurring. As such he submitted that Mr Desai failed to take the steps as set out in paragraphs 2(c) to 2(g) of the Allegation. This

case is about the failure to conduct examinations specifically using sigmoidoscopies that would put Mr Desai in a position to understand that there was a growth.

188. Mr Hamlet stated that Patient A was being monitored by Mr Desai but her condition was not identified by digital palpation alone. It was a failure by virtue of the change of approach that Mr Desai took from 2016 in switching to digital or primarily the digital examination of the area that led him to miss the growing polyp.

189. Mr Hamlet said that the words *'recognise the risk'* and *'discuss the risk'* are reference not simply to whether any risk was recognised and discussed but the specific risk of a cancer arising from a growing polyp. Mr Desai had not identified this because he had not examined Patient A as comprehensively as he should have done in the post February 2016 period. Mr Hamlet stated that given that this is the basis on which he has put the case and how he has directed the Tribunal to the evidence that is a criticism that has already been made clear and also the criticism of Mr G. Therefore, one may think that there is no need to amend the charges. However, given that Mr Desai's response is based on a binary appreciation of the way that the charges are put, it is better to amend them to make it absolutely clear how the GMC is pursuing the case.

190. Mr Hamlet submitted that the amendment does not represent a shift in the case but serves to underline the existing case, and specifically that it is about the extent of the risk that Mr Desai should have recognised.

191. Mr Colman, on behalf of Mr Desai stated that the GMC's case as currently pleaded is based on the evidence of the GMC expert Mr G. His position is as follows:

- *"There is no evidence in the bundle provided that Mr Desai ever discussed the possibility that leaving the polyp in situ was running the risk that it might become a cancer."*

- "*There is no documentation to suggest that Mr Desai was concerned about a risk of malignancy or that he advised Patient A that there was a risk."*

- *"From 2016 to 2019 Mr Desai stopped trying to control the polyp and therefore I can only assume that he failed to recognize the risk of malignancy. Not to have recognized the risk was seriously below the standard of a reasonably competent consultant surgeon."*

192. Mr Colman submitted that these assertions are in absolute terms and do not reflect the amendment now sought.

193. Mr Colman said that following the service of Mr Desai's witness statement on Monday (20 March 2023), the case for the GMC was opened on the basis that Mr Desai did not put himself in a position to assess the extent of the risk. However, they now seek to amend the allegation to align with this gloss.

194. Mr Colman stated that after Patient A and her husband gave evidence to the effect that everyone was aware of the risk of cancer developing and that this was discussed at each appointment, the defence enquired of the GMC whether they were going to consider their position on paragraphs 2(a) and 2(b) of the Allegation. This application is their response.

195. Mr Colman stated that although Mr Desai's witness statement was only served on Monday, the GMC have long known the nature of his defence from his Rule 7 response dated 22 October 2021. It is their duty to give the Registrant and his legal representatives notice of the allegation against him and the facts upon which it is based under Rule 15, drafting the charge accordingly.

196. Mr Colman stated that the amendment does not accord with the evidence relied on by the GMC. There is no evidence about what the extent of the risk was at any particular point during the period of February 2016 to March 2019, nor of how its level could be sensibly assessed.

197. Mr Colman stated that the proposed amendments amount to a narrowing of the case for the GMC, meaning they have less to prove to establish the charge. It is a result of the belated realisation that they cannot prove the wider charge, as pleaded.

198. Mr Colman stated that the suggestion that this is not a shift in the GMC's position is untenable. Allegation 2(a) is now said to represent the failure to conduct sigmoidoscopy. This could have been specifically charged and has not been.

199. Mr Colman submitted that to allow the amendment could deprive Mr Desai of an effectual answer to paragraphs 2(a) and 2(b) after evidence has been established in his favour. Mr Colman further submitted that the GMC should not be allowed to trim their case to make it more likely that an allegation would be found proved. This amendment cannot be made without injustice.

## Tribunal Decision

200. In considering the application the Tribunal had regard to Rule 17(6) of the Rules which states:

> *(6) Where, at any time, it appears to the Medical Practitioners Tribunal that—*
>
> *(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and*
>
> *(b) the amendment can be made without injustice, it may, after hearing the parties, amend the allegation in appropriate terms.*

201. The Tribunal was mindful that the nature of the changes do not alter the substance of the Allegation but required the Tribunal to consider the extent of a risk rather than an assessment of the risk itself. The Tribunal concluded that there was no material difference between the existing wording of the Allegation and the proposed amendments. Both versions required an assessment as to whether Mr Desai recognised the possibility of the polyp becoming a cancer and whether he discussed that risk with Patient A. The Tribunal was mindful that reference to 'the polyp' could only logically be interpretated with reference to the 'recurring rectal polyp' referred to in paragraph 1 of the Allegation, in the absence of being defined as any other polyp. That assessment would necessarily require consideration of all surrounding factors.

202. The Tribunal considered whether by allowing the amendments there was any unfairness or injustice to Mr Desai. It concluded that the proposed amendments did not change the substance of the Allegation of which Mr Desai had notice, nor did it introduce a new allegation that Mr Desai had not had the opportunity to answer. As such the Tribunal concluded that the amendments could be made without injustice.

203. The Tribunal therefore granted Mr Hamlet's application to amend the Allegation as proposed.