PUBLIC RECORD

Dates: 05/09/2023 - 07/09/2023, 13/09/2023
23/10/2023 - 27/10/2023
01/12/2023 – 04/12/2023

Medical Practitioner's name:	Mr Nagy GABRIEL
GMC reference number:	4264532
Primary medical qualification:	MB BCh 1982 Ain Shams University

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 9 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr Simon Bond
Lay Tribunal Member:	Mrs Barbara Larkin
Medical Tribunal Member:	Dr Richard Brighton-Knight

Tribunal Clerk:	Ms Jemine Pemu Miss Emma Saunders - 13/09/2023 only Mr Sewa Singh – 01/12/2023 only

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Amardeep Dhillon, Counsel, instructed by Markel Law LLP
GMC Representative:	Ms Colette Renton, 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 - 26/10/2023

1. This determination will be handed down in private. However, as the case concerns Mr Gabriel's alleged misconduct, a redacted version will be published at the close of the hearing.

Background

2. Mr Nagy Nazeer Grais Gabriel qualified with MB BCh in 1982 from Ain Shams University in Egypt and moved to the United Kingdom in 1993. He initially worked in Obstetrics and Gynaecology and entered General Practice in 2013. In 2017 Mr Gabriel joined the Orchard Practice Dartford ("the Practice") as a Salaried GP. His qualifications are MBBCh DObsRCPI FRCS FRCOG JCPTGP.

3. There is previous fitness to practise history, which commenced on 21 November 2017 and concluded on 19 September 2019 having adjourned part-heard on four occasions (the '2019 Tribunal').

4. The final decision of the 2019 Tribunal was that Mr Gabriel's fitness to practice was impaired by reason of deficient professional performance. The 2019 Tribunal imposed conditions for a period of six months which it considered would allow sufficient time for Mr Gabriel to make further significant steps in remediating the deficiencies identified in his performance. NHSE imposed the same conditions.

5. At a review hearing in April 2020 a Tribunal determined that Mr Gabriel's fitness to practise was no longer impaired. It revoked the substantive sanction of conditions with immediate effect.

6. On 20 May 2020 a Performers List Decision Panel concluded that they would revoke all conditions and that: "*There will be a record and docman audit after 6 months across all settings where Dr Gabriel has worked*".

7. XXX

8. Mr Gabriel was subject to XXX between 30 November 2020 and 5 February 2021, during which time he worked only 30 sessions. He returned to 'normal practice' during week commencing 1 February 2021. Mr Gabriel continued to work for the Practice until he was suspended by NHS England on 13 April 2021.

9. The allegation that has led to Mr Gabriel's hearing relates to concerns about his professional performance in relation to Patients A, B, C, D, E, F, H and I.

10. The NHSE conducted an audit of Mr Gabriel's work, and on 15th April 2021 the GMC received a referral from NHS England and NHS Improvement – Southeast with concerns about Mr Gabriel's performance. Additional concerns were also raised by Dr K a GP at the Practice. These concerns formed the basis of the GMC's investigation and the subsequent allegations before the Tribunal.

The Outcome of Applications Made during the Facts Stage

11. Ms Renton, Counsel for the GMC, raised a preliminary matter for the Allegation to be amended by withdrawing a number of paragraphs under Rule 17(2)(c) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'). Mr Dhillon, Counsel on behalf of Mr Gabriel, did not oppose the application. The Tribunal determined that paragraphs 1a, 1b(iii), 1b(iv)(1), 5a(i), 5a(ii), 5b, 6a and 7 of the Allegation should be withdrawn. The Tribunal's full decision on the application is included at Annex A.

12. On 13 September 2023 Mr Dhillon made an application for Dr N, an expert on behalf of Mr Gabriel, to give evidence by video link. Ms Renton stated that there was no objection from the GMC. The Tribunal granted the application under Rule 34(13) and (14) of the Rules.

The Allegation and the Doctor's Response

13. The Allegation made against Mr Gabriel is as follows:

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

Patient A

1. On 30 December 2020 you had a telephone consultation with Patient A and you failed to:

    a. ~~add a correct diagnostic read code~~; Withdrawn under Rule 17(6)

    b. record:

        i. an adequate history regarding her symptoms; Admitted and Found Proved

ii. an assessment as to whether Patient A's symptoms warranted a face-to-face consultation; **Admitted and Found Proved**

iii. ~~your diagnosis of Patient A~~; **Withdrawn under Rule 17(6)**

iv. that you considered whether Patient A:

1. ~~was acutely unwell requiring immediate hospital admission;~~ **Withdrawn under Rule 17(6)**

2. had been unwell for a prolonged period of time requiring:

a. blood tests; **Admitted and Found Proved**

b. a chest X-ray. **Admitted and Found Proved**

Patient B

2. On 25 January 2021 you had a telephone consultation with Patient B, and you failed to:

a. formulate an adequate treatment plan in that you did not:

i. arrange a future face-to-face consultation in order for Patient B's abdomen to be physically assessed; **Admitted and Found Proved**

ii. either refer Patient B to hospital as a same day acute admission under the urology team for an urgent scan, or recommend Patient B attend Accident and Emergency for an urgent scan; **To be determined**

b. record an adequate history regarding:

i. his symptoms; **Admitted and Found Proved**

ii. urinary output. **Admitted and Found Proved**

Patient C

3. On 25 January 2021 you had a telephone consultation with Patient C and you failed to:

a. formulate an adequate treatment plan in that you did not:

i. obtain blood tests to look for inflammatory causes; **Admitted and Found Proved**

ii. arrange an ultrasound scan to look for tendinopathies; **Admitted and Found Proved**

iii. refer Patient C to a physiotherapist; **Admitted and Found Proved**

b. record:

i. an adequate history regarding his symptoms; **Admitted and Found Proved**

ii. that you requested Patient C:

1. carry out left shoulder and elbow movements to ascertain whether the:

a. range of movement was restricted; **Admitted and Found Proved**

b. movements brought on pain; **Admitted and Found Proved**

2. palpate his arm to determine the site of the pain; **Admitted and Found Proved**

iii. an adequate diagnosis of Patient C. **Admitted and Found Proved**

Patient D

4. On 5 February 2021 you reviewed an advice and guidance letter received from Patient D's cardiologist dated 4 February 2021 and you:

a. inappropriately marked the letter as 'no action required' when in fact the letter requested Patient D be referred back to cardiology; **Admitted and Found Proved**

b. failed to make an urgent referral to cardiology. **Admitted and Found Proved**

Patient E

5. On 19 February 2021 you had a telephone consultation with Patient E and you failed to:

a. formulate an adequate treatment plan in that you did not:

i. ~~either adjust Patient E's dose of statin, or change the brand of statin, in order to achieve a target of less than 5 millimoles per litre;~~ **Withdrawn under Rule 17(6)**

ii. ~~organise an annual recall to re-check Patient E's haemoglobin AC1 ('HBA1c') level;~~ Withdrawn under Rule 17(6)

iii. diagnose non-diabetic hyperglycaemia despite Patient E's raised HBA1c level; To be determined

iv. add a read code diagnosis of non-diabetic hyperglycaemia; Admitted and Found Proved

~~b. record:~~

~~i. either:~~

~~1. an adequate history of Patient E's symptomatic angina; or~~ Withdrawn under Rule 17(6)

~~2. that the reason you noted a limited history taking of Patient E's symptomatic angina was because this information had already been recorded by another general practitioner on 17 February 2021;~~ Withdrawn under Rule 17(6)

~~ii. that you had considered whether Patient E either should have been referred to hospital immediately, or could wait for her forthcoming cardiology appointment;~~ Withdrawn under Rule 17(6)

~~iii. an assessment of Patient E's:~~

~~1. total cholesterol;~~ Withdrawn under Rule 17(6)

~~2. HBA1c;~~ Withdrawn under Rule 17(6)

~~iv. your discussion with Patient E regarding:~~

~~1. her high cholesterol;~~ Withdrawn under Rule 17(6)

~~2. the significance of a raised HBA1c;~~ Withdrawn under Rule 17(6)

~~3. a diagnosis of non-diabetic hyperglycaemia;~~ Withdrawn under Rule 17(6)

~~v. the reason why Patient E's blood pressure medication was switched.~~ Withdrawn under Rule 17(6)

Patient F

6. On 22 February 2021 you had a telephone consultation with Patient F's mother, Ms G ('the Consultation') and you:

   ~~a. inappropriately prescribed Duac (Benzoyl Peroxide 3% / Clindamycin 1% gel) for Patient F's acne in that:~~

      i. ~~Duac medication was not licensed for patients under 12 years of age~~; Withdrawn under Rule 17(6)

      ii. ~~licensed medication preparations were available for Patient F~~; Withdrawn under Rule 17(6)

   b. failed to record that the Consultation had been conducted with Ms G. Admitted and Found Proved

~~7. You made an inappropriate change to the note of the Consultation in Patient F's medical record on one or more of the following dates, in that you did not specify that changes you made on that date were retrospective:~~

   ~~a. 22 February 2021;~~ Withdrawn under Rule 17(6)

   b. ~~26 February 2021~~. Withdrawn under Rule 17(6)

Patient H

8. On 10 March 2021 you had a telephone consultation with Patient H and you failed to formulate an adequate treatment plan in that you did not:

   a. arrange relevant blood tests; Admitted and Found Proved

   b. determine whether Patient H either:

      i. needed to be admitted to hospital immediately; or Admitted and Found Proved

      ii. could be seen at a future face-to-face GP appointment. Admitted and Found Proved

Patient I

9. On 11 March 2021 you reviewed the result of Patient I's dual energy X-ray absorptiometry scan ('DEXA scan') and you:

   a. inappropriately marked Patient I's DEXA scan result as 'tell patient normal' when the DEXA scan was abnormal as it:

      i. confirmed the presence of osteoporosis; Admitted and Found Proved

ii. indicated that treatment was required; Admitted and Found Proved

b. failed to act upon the DEXA scan result in that you did not arrange an appointment with Patient I to discuss:

i. the DEXA scan result; To be determined

ii. management of osteoporosis; To be determined

iii. that Patient I would be high risk for fractures if left untreated; To be determined

iv. the use of calcium, vitamin D and bisphosphonates. To be determined

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

The Admitted Facts

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

Factual Witness Evidence

15. The Tribunal received evidence on behalf of the GMC in the form of witness statements and heard oral evidence, in person, from the following witnesses:

- Ms J, Practice Manager at the Wellcome Practice, formerly known as The Orchard Practice ('the Practice'), witness statement dated, 23 February 2023;
- Dr K, General Practitioner and GP Partner at the Practice, witness statement dated, 26 February 2023;
- Dr L, temporary salaried GP at the Practice, witness statement dated, 06 February 2023.

16. The Tribunal also received evidence on behalf of the GMC in the form of a witness statement from Ms G, Mother to Patient F, dated 10 March 2023. She was not called to give oral evidence.

17. Mr Gabriel provided his own witness statement, dated 25 August 2023 and also gave oral evidence at the hearing.

Expert Witness Evidence

18. The Tribunal also received evidence from two expert witnesses. Both experts specialised in General Practice and their evidence was directed at assisting the Tribunal in understanding the standard of care to be expected of a GP in relation to Patients A-I.

19. Dr M, expert witness for the GMC, gave evidence on 7 September 2023. Dr M prepared an expert report, dated 26 October 2021. He also provided a Supplementary Expert Report, dated 28 March 2022.

20. In his report, Dr M concluded that Mr Gabriel's overall standard of care fell seriously below the standard expected with regard to Patients A-I .

21. Dr M sent two expert clarification emails dated 04 April 2023 and 04 June 2023 to the GMC in relation to his Expert Reports.

22. Dr N, expert witness called on behalf of Mr Gabriel, gave evidence to the Tribunal on 13 September 2023. Dr N prepared an expert report, dated 22 July 2023.

23. Dr N found the standard of GP care provided by Mr Gabriel in relation to Patients A, B, C, D and H to be seriously below the standard expected from a reasonably competent General Practitioner. With regards to Patient E, Dr N agreed that '*the diagnosis of pre-diabetes should [have] been made and coded in the records*.' In relation to Patient F, Dr N agreed that Mr Gabriel had failed to record that the relevant consultation had been conducted with Ms G.

24. In relation to Patient I (DEXA scan result) Dr N's expert report concluded that Mr Gabriel's overall standard of care was reasonable and was therefore not below the standard expected from a reasonably competent General Practitioner.

25. In his expert report, Dr N stated:

> '*My view here is that, whilst I again recognise there are factual matters for the Tribunal, the difference between Dr M and myself is how we would quantify the seriousness of the issue particularly when looking at how average General Practice works. Dr M considers that for Dr Gabriel to spot a file error and correct it, allocate it to the correct GP and arrange for an appointment for the patient to see a GP to discuss the DEXA scan result, to still be below the standard of care required. My view is that this puts the standard far too high and is perhaps more akin to Gold Standard Practice. If this were genuinely the standard expected, then nearly every GP up and down the land would be considered to be operating at below standard. I say this because with the sheer volume of administrative work in General Practice, it is relatively common that an initial file error can be made when marking a letter or result but a double check or failsafe mechanism picks it up and corrects it.*
> *This would be standard care, not below standard care.'*

26. Dr M and Dr N prepared a Joint Expert Report in which they set out their areas of common ground and areas of disagreement by reference to each paragraph of the Allegation. This Joint Expert Report was dated 22 August 2023.

27. Both Dr M and Dr N agreed in regard to Patients A, C, D, F and H that the standard of care provided to these patients was seriously below the standard expected from a reasonably competent General Practitioner.

Documentary Evidence

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

- Email referral from NHS England ('NHSE') to GMC's Employer Liaison Adviser, dated 15 April 2021;
- Audit Report of Mr Gabriel's Medical Record provided by NHSE, dated 15 April 2021;
- First Rule 7 Response from Mr Gabriel's Legal Representatives to GMC & Exhibits, dated 07 February 2022:
    - NG/1 PLDP Outcome Sheet, dated 22 May 2020;
    - NG2/ Mr Gabriel's CV;
    - XXX;
    - XXX
    - NG/6 emails to Ms J.
- Second Rule 7 Response from Mr Gabriel's Legal Representatives to GMC, dated 01 June 2022;
- Email from Patient H to GMC, dated 08 February 2023;
- Telephone Note of call between Patient B and GMC, dated 09 February 2023;
- Telephone Note of call between Patient C and GMC, dated 09 February 2023;
- Mr Gabriel's XXX from w/c 30/11/2020 – 18/01/2021, undated;
- Email correspondence between Mr Gabriel and Ms J regarding online consultation training, dated 30 November 2020;
- Further email correspondence between Mr Gabriel and Ms J regarding VPN log in details, dated 22 April 2020 – 25 January 2021;
- Email correspondence between Ms J and NHSE to conduct a record audit on Mr Gabriel, dated 01 March 2021;
- Screenshot of a Patient record taken from the Orchard Practice System of consultation with Mr Gabriel, dated 08 March 2021;
- Screenshot of a Patient record taken from the Orchard Practice System of consultation with Mr Gabriel, dated 11 January 2021;
- Document of timings produced from Mr Gabriel's consultations, dated 22 January 2021;
- Email correspondence between Mr Gabriel and Dr K in response to COVID pandemic, dated 07 December 2020;

- Minutes of meeting between Mr Gabriel and Dr K, dated 03 February 2021;
- Document containing data of search of Mr Gabriel's Orchard Practice computer system conducted by Ms J, dated 30 November 2020 – 01 May 2021;
- Screenshot of WhatsApp messages sent between Mr Gabriel and Ms J regarding his headset, dated 22 February 2021 – 23 February 2021;
- Email Correspondence from Mr Gabriel to Dr K/Orchard Practice, dated 04 January 2021;
- Email correspondence between Mr Gabriel to Dr K/Orchard Practice regarding the notes from the review meeting held on 01/02/2021, dated 03 February 2021;
- XXX;
- Mr Gabriel's Appraisals; 2021, 2022 & 2023 & PDP 2023, various dates.

29. The Tribunal was also provided with the GP Medical Records of the following Patients which were to be relied upon by the GMC:

- Patient A, dated 03 July 2014 - 30 July 2021;
- Patient B, dated 23 January 1998 - 04 August 2021;
- Patient C, dated - 13 February 2006 - 29 July 2021;
- Patient D, dated 15 February 1990 - 17 August 2021;
- Patient E, dated 20 November 1989 - 20 November 2021;
- Patient F, dated 08 June 2009 - 14 June 2021;
- Patient H, dated 27 September 2004 - 19 August 2021; and
- Patient I, dated 1997 - 09 May 2021.

The Tribunal's Approach

30. 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 Gabriel 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.

Advice from the Legally Qualified Chair

31. Under rule 17(2)(j) Fitness to Practise Rules 2004 the Tribunal must consider and announce its findings of fact and shall give its reasons for those findings.

32. It is for the GMC to satisfy the Tribunal that the alleged facts have been found proved on the balance of probabilities, which is the standard of proof applicable to civil proceedings.

33. In *re H and others (1996) AC 563* Lord Nicholls stated that the balance of probability standard means that a court is satisfied an event occurred if the court considers that, on the evidence, the occurrence of the event was more likely than not.

34. In the case of *Re B [2008] UKHL 35* the Supreme Court clarified that neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The Court said that there was no logical or necessary connection between seriousness and probability. The inherent probabilities were simply something to be taken into account, where relevant, in deciding where the truth lay.

35. In the case of *Roomi, R (on the application of) v GMC [2009] EWHC 2188* Justice Collins said that the practitioner faces an allegation which is contained in the notice of hearing and no other allegation, unless that notice is amended in accordance with rule 17(3). As a result, the Tribunal should not rely on issues not forming part of the allegation made against the practitioner, unless the necessary amendment has been made.

36. The Tribunal should assess and determine each paragraph and sub-paragraph of the Allegation separately. Whilst the Tribunal may draw inferences from the evidence, it must not speculate as to any further evidence that has not come before it.

37. In the case of *Council for the Regulation of Health Care Professionals v GMC and Basiouny (2005) EWHC 68*, The Court stated that whilst specialist Tribunals may have medical expertise of their own, such Tribunals should give clear and compelling reasons if they decide to reject expert medical evidence.

The Tribunal's Analysis of the Evidence and Findings

38. 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.

39. The Tribunal considered the expert evidence in relation to each paragraph of the Allegation and noted the following.

Patient A

Paragraph 1(b)(i)

40. Mr Gabriel admitted that on 30 December 2020 he had a telephone consultation with Patient A and he failed to record an adequate history regarding her symptoms.

41. Both experts were in agreement that Mr Gabriel's record keeping fell seriously below the standards expected of a reasonably competent General Practitioner.

Paragraph 1(b)(ii)

42. Mr Gabriel admitted that on 30 December 2020 Mr Gabriel had a telephone consultation with Patient A and he failed to record an assessment as to whether Patient A's symptoms warranted a face-to-face consultation.

43. Both experts were in agreement that the assessment carried out by Mr Gabriel was seriously below the standard expected of a reasonably competent General Practitioner.

Paragraph 1(b)(iv)(2)(a)

44. Mr Gabriel admitted that on 30 December 2020 he had a telephone consultation with Patient A and failed to record that he considered whether Patient A had been unwell for a prolonged period of time requiring blood tests.

45. In their joint report the experts agreed that if Patient A had red flag symptoms (such as coughing up blood or shortness of breath) then further investigation by way of blood tests would have been necessary. In that event Mr Gabriel's standard of care would have fallen seriously below the standard expected of a reasonably competent General Practitioner. However, if there were no red flag symptoms then blood tests would not have been indicated and Mr Gabriel's actions would have been appropriate.

46. The Tribunal noted from Patient A's medical records that there was no mention of any red flag symptoms in Mr Gabriel's note of his consultation with Patient A. The Tribunal also noted that Patient A had a consultation with Dr P on 31 December 2020, during which there was no discussion of any red flag symptoms. As a result, the Tribunal concluded on the balance of probabilities that there were unlikely to have been any red flag symptoms present during Patient A's consultation with Mr Gabriel on 30 December 2020. The Tribunal therefore concluded that Mr Gabriel's actions as described by paragraph 1(b)(iv)(2)(a) of the Allegation did not fall below the standard expected of a reasonably competent General Practitioner.

Paragraph 1(b)(iv)(2)(b)

47. Mr Gabriel admitted that on 30 December 2020 he had a telephone consultation with Patient A and failed to record that he considered whether Patient A had been unwell for a prolonged period of time requiring a chest X-ray.

48. The experts agreed that if Patient A had red flag symptoms during the consultation with Mr Gabriel, then further investigations by way of a chest X-ray would have been necessary. In that event Mr Gabriel's standard of care would have fallen seriously below the standard expected of a reasonably competent General Practitioner. However, if there were no red flag symptoms then the experts agreed that a chest X-ray would not have been indicated and Mr Gabriel's actions would have been appropriate.

49. For the reasons set out in relation to paragraph 1(b)(iv)(2)(a) of the Allegation, the Tribunal concluded on balance of probabilities that there were unlikely to have been any red flag symptoms during Patient A's consultation with Mr Gabriel on 30 December 2020. The Tribunal therefore concluded that Mr Gabriel's actions as described by paragraph 1(b)(iv)(2)(b) of the Allegation did not fall below the standard expected of a reasonably competent General Practitioner.

Patient B

Paragraph 2(a)(i)

50. Mr Gabriel admitted that on 25 January 2021 he had a telephone consultation with Patient B, and that Mr Gabriel failed to formulate an adequate treatment plan in that he did not arrange a future face-to-face consultation in order for Patient B's abdomen to be physically assessed.

51. The experts agreed that a face to face assessment had been required and that Mr Gabriel's failure to physically assess Patient B fell seriously below the standard expected of a reasonably competent General Practitioner.

Paragraph 2(a)(ii)

52. It is alleged that on 25 January 2021 Mr Gabriel had a telephone consultation with Patient B, and that Mr Gabriel failed to formulate an adequate treatment plan in that he did not either refer Patient B to hospital as a same day acute admission under the urology team for an urgent scan, or recommend Patient B attend Accident and Emergency for an urgent scan.

53. The experts agreed that Mr Gabriel had a duty to get Patient B seen and assessed and that this could either take place within the practice or in a hospital setting. The experts also agreed that to do neither fell seriously below the standard expected of a reasonably competent General Practitioner.

54. The Tribunal considered the evidence given by Mr Gabriel in his witness statement dated 11 August 2023, namely, '*I am unable to accept allegation 2(a)(ii) as it is unclear whether Patient B required emergency admission. It had been recorded previously that the Patient was under the care of the urology department. I understood that an ultrasound was already booked for Patient B, I recorded this. I also recommended to Patent B "if pain ids not hbetter for AE (sic)". I also recorded the correct diagnosis of a Kidney Stone.*'

55. Ms Renton reminded the Tribunal of the oral evidence of Dr M, namely that looking at Patient B's background there was a possibility of kidney stones. She further stated, '*Dr M explained why this was a situation which can deteriorate rapidly and there is a risk of infection. Dr M's evidence is that whilst the Patient record of Dr Gabriel reflected he was considering the issue of kidney stones, the patient needed to be seen on the same day. Dr M referred to the NICE guidance - Renal and ureteric stones: assessment and management, that in the circumstances a scan should take place in 24 hours. It is agreed between the parties these were published on 8th January 2019*.'

56. The Tribunal accepted the experts' evidence that the NICE guidelines applied and should have been followed in this case. Those guidelines state that patients with kidney

stones require a CT scan within 24 hours to mitigate the risk of infection. In his oral evidence Mr Gabriel accepted that *'ideally the patient should have been referred within that time scale*'.

57. The Tribunal determined that although Mr Gabriel did identify the kidney stone during his consultation with Patient B on 25 January 2021, he had not given sufficient consideration to the importance of the patient being referred for an urgent scan in accordance with the NICE guidelines. Although Patient B may have been under the care of the urology department and had a booking for an ultrasound, the Tribunal considered that this did not absolve Mr Gabriel from his responsibility to ensure that Patient B was referred for an urgent scan.

58. In the circumstances, the Tribunal was satisfied that the GMC has proved, on the balance of probabilities, that Mr Gabriel failed to either refer Patient B to hospital as a same day acute admission under the urology team for an urgent scan, or recommend Patient B attend Accident and Emergency for an urgent scan.

59. Paragraph 2a(ii) of the Allegation was therefore found proved.

<u>Paragraph 2(b)(i)</u>

60. Mr Gabriel admitted that on 25 January 2021 he had a telephone consultation with Patient B, and that Mr Gabriel failed to record an adequate history regarding Patient B's symptoms.

61. The Tribunal noted Mr Gabriel's Rule 7 response in which he stated *'It is my recollection that I did ask Patient B about his symptoms and their urinary output. However, while I did make some records, I accept that I did not record the full symptoms asked about or his urinary output.*'

62. The Tribunal considered the First Expert Report of Dr M, dated 26 October 2021, in which he stated that '*Dr Gabriel took a very limited history for a patient who had a past history of renal stones and was already under a urologist and awaiting an ultrasound scan. Dr Gabriel noted that Patient B had been having right sided intermittent flank pain with no blood in the urine or weight loss. There was no information about urine output, urinary frequency, pain on urination, vomiting, temperature and frequency of the intermittent attacks. Therefore, Dr Gabriel's actions in taking an adequate history falls seriously below the standard expected of a reasonably competent General Practitioner. '*

63. The Tribunal took into account the First Expert Report of Dr N, dated 22 July 2023, in which he stated that '*My view on this consultation is that the record is inadequate in that a urinary tract infection needed to be considered here and Dr Gabriel should have been asked about symptoms consistent with infection such as a fever, vomiting, symptoms when urinating and there should have been advice to attend an appointment for a physical assessment and to drop a urine sample in to be tested*.'

64. The Tribunal also noted the comments of Dr N within the joint expert report in which it was stated that '*Dr N considers that [Dr M's opinion] does not encompass the full range of expert opinion on this. Dr N states that it is not usual practice to record all the negatives on questioning but rather the salient negatives. Dr Gabriel did record that there was flank pain and no haematuria and his witness evidence is that he asked more questions about other symptoms. The implication being that he only recorded the salient symptoms. If the Tribunal accepts this evidence then in Dr N's view this was not below the required standard. If the Tribunal considers as fact that there were other important symptoms present but were not recorded then Dr N considers that this would fall seriously below the standard expected of a reasonably competent General Practitioner*. '

65. The Tribunal had regard that Dr N's opinion appeared to have changed from his initial expert's report to the position that he adopted in the joint experts' report. In view of Dr N's initial opinion that Mr Gabriel's record was inadequate together with Dr M's opinion that Mr Gabriel failed to record an adequate history of Patient B's symptoms, the Tribunal concluded that Mr Gabriel's actions, especially with failing to record temperature, fell seriously below the standards expected of a reasonably competent General Practitioner.

Paragraph 2(b)(ii)

66. Mr Gabriel admitted that on 25 January 2021 he had a telephone consultation with Patient B, and Mr Gabriel failed to record an adequate history regarding urinary output.

67. In his Rule 7 Response Mr Gabriel stated that he did ask Patient B to bring a urine sample into the practice, which Patient B did on 26 January 2021 and which was tested on 27 January 2021.

68. The Tribunal noted the comments of Dr M within the joint expert report in which it was stated that, '*Dr M states that irrespective of whether Dr Gabriel asked Patient B about urinary output, there was a failure to record this in the clinical record and therefore the standard of care falls seriously below the standard expected of a reasonably competent General Practitioner*.'

69. The Tribunal also noted the comments of Dr N within the joint expert report in which it was stated that '*Dr N does not agree and considers that there will be a range of reasonable opinion here. He considers that again his answer is contingent on a factual finding by the Tribunal. If urine output was asked about and was normal (as indicated by Dr Gabriel requesting and being supplied with a urine sample) then there was no necessity to record this and the standard of care was not below the standard expected from a reasonably competent General Practitioner. If the Tribunal considers that urine output was abnormal then Dr Gabriel should have recorded this important fact and in that circumstance the standard of care falls seriously below the standard expected of a reasonably competent General Practitioner.'*

70. The Tribunal had regard to the medical records of Patient B in which Mr Gabriel recorded the patient's history of absence of blood in the urine and asked Patient B to provide a urine sample. On that basis the Tribunal considered it more likely than not that Mr Gabriel asked Patient B about urine output. The Tribunal took the view that there were no indicators in Patient B's medical records after their consultation with Mr Gabriel on 25 January 2021 suggesting that urine output was abnormal. On that basis that the Tribunal preferred Dr N's expert evidence and concluded that Mr Gabriel's failure to record an adequate history regarding urinary output did not fall seriously below the standards expected of a reasonably competent General Practitioner.

Patient C

Paragraph 3(a)(i)

71. Mr Gabriel admitted that on 25 January 2021 he had a telephone consultation with Patient C and Mr Gabriel failed to formulate an adequate treatment plan in that he did not obtain blood tests to look for inflammatory causes.

72. Both experts were in agreement that in failing to arrange an assessment, Mr Gabriel did not allow for the possibility that blood tests were required to look for inflammatory causes and therefore Mr Gabriel's actions fell seriously below the standard expected of a reasonably competent General Practitioner.

Paragraph 3(a)(ii)

73. Mr Gabriel admitted that on 25 January 2021 he had a telephone consultation with Patient C and Mr Gabriel failed to formulate an adequate treatment plan in that he did not arrange an ultrasound scan to look for tendinopathies.

74. The experts were both in agreement that in failing to arrange an assessment, Mr Gabriel did not allow for the possibility that an ultrasound scan was required to look for tendinopathies and therefore Mr Gabriel's actions fell seriously below the standard expected of a reasonably competent General Practitioner.

Paragraph 3(a)(iii)

75. Mr Gabriel admitted that on 25 January 2021 he had a telephone consultation with Patient C and Mr Gabriel failed to formulate an adequate treatment plan in that he did not refer Patient C to a physiotherapist.

76. The experts were both in agreement that in failing to arrange an assessment, Mr Gabriel did not allow for the possibility that Patient C should have been referred to a physiotherapist and therefore Mr Gabriel's actions fell seriously below the standard expected of a reasonably competent General Practitioner.

Paragraph 3(b)(i)

77. Mr Gabriel admitted that on 25 January 2021 he had a telephone consultation with Patient C and Mr Gabriel failed to record an adequate history regarding his symptoms.

78. The experts were both in agreement that no adequate history was taken about symptoms and therefore the standard of care fell seriously below the standard expected of a reasonably competent GP.

Paragraph 3(b)(ii)(1)(a)

79. Mr Gabriel admitted that on 25 January 2021 he had a telephone consultation with Patient C and Mr Gabriel failed to record that he requested Patient C carry out left shoulder and elbow movements to ascertain whether the range of movement was restricted.

80. The experts were both in agreement that there was no adequate recording of any assessment of the left shoulder therefore the standard of care fell seriously below the standard expected of a reasonably competent GP.

Paragraph 3(b)(ii)(1)(b)

81. Mr Gabriel admitted that on 25 January 2021 he had a telephone consultation with Patient C and Mr Gabriel failed to record that he requested Patient C carry out left shoulder and elbow movements to ascertain whether the movements brought on pain.

82. The experts were both in agreement that there was no adequate recording of assessment about which movements brought on pain in Patient C's left shoulder and therefore the standard of care fell seriously below the standard expected of a reasonably competent GP.

Paragraph 3(b)(ii)(2)

83. Mr Gabriel admitted that on 25 January 2021 he had a telephone consultation with Patient C and Mr Gabriel failed to record that he requested Patient C palpate his arm to determine the site of the pain.

84. The experts were both in agreement that there was no adequate recording of asking Patient C to palpate the left shoulder to determine the site of pain and therefore the standard of care fell seriously below the standard expected of a reasonably competent GP.

Paragraph 3(b)(iii)

85. Mr Gabriel admitted that on 25 January 2021 he had a telephone consultation with Patient C and Mr Gabriel failed to record an adequate diagnosis of Patient C.

86. The experts were both in agreement that no adequate recording of a working diagnosis was made and therefore the standard of care fell seriously below the standard expected of a reasonably competent GP.

87. On behalf of Mr Gabriel, Mr Dhillon asked the Tribunal to note that no other treating GP had undertaken any of the investigations of Patient C which it is alleged that Mr Gabriel should have undertaken. However, the Tribunal noted from the medical records of Patient C that, unlike Mr Gabriel, other clinicians had made detailed records of their consultations with Patient C. Those records had, for example, summarised Patient C's symptoms, had advised the patient to make a self-referral to physiotherapy and included a text message showing the patient how to make a self-referral.

Patient D

Paragraph 4(a)

88. Mr Gabriel admitted that on 5 February 2021 he reviewed an advice and guidance letter received from Patient D's cardiologist dated 4 February 2021 and Mr Gabriel inappropriately marked the letter as 'no action required' when in fact the letter requested Patient D be referred back to cardiology.

89. The Tribunal had regard to Mr Gabriel's witness statement, dated 11 August 2023, in which he stated, '*I accept that I marked the letter as 'no action required'. I accept I did not make an urgent (or otherwise) referral to cardiology. However, I did attempt to forward a copy of the letter to Dr S (the locum) by trying to change the ownership of the letter, as it was requested by her. I cannot recall if this worked. I also believe I may have tried to call reception to check, but cannot recall*.'

90. The experts were both in agreement that Mr Gabriel's actions as described by paragraph 4(a) of the Allegation fell seriously below the standard expected of a reasonably competent General Practitioner.

91. Mr Dhillon had invited the Tribunal to find that Mr Gabriel changed the owner of the letter to Dr L, that Dr L saw the letter in her "docman" inbox and then actioned the referral. However, the Tribunal took the view that there was no evidence in Patient D's records to support the contention that Mr Gabriel had changed the ownership of the letter. It also considered that the medical records indicated that Dr L had written to a consultant cardiologist on 18 March 2021, which appeared to be inconsistent with the notion that the letter was sent to her inbox on or around 5 February 2021.

92. The Tribunal therefore determined, on balance of probabilities, that Mr Gabriel did not change the owner of the record to Dr L.

Paragraph 4(b)

93. Mr Gabriel admitted that on 5 February 2021 he reviewed an advice and guidance letter received from Patient D's cardiologist dated 4 February 2021 and Mr Gabriel failed to make an urgent referral to cardiology.

94. The experts were both in agreement that Mr Gabriel's actions fell seriously below the standard expected of a reasonably competent General Practitioner.

Patient E

Paragraph 5(a)(iii)

95. It is alleged that on 19 February 2021 Mr Gabriel had a telephone consultation with Patient E and Mr Gabriel failed to formulate an adequate treatment plan in that he did not diagnose non-diabetic hyperglycaemia despite Patient E's raised HBA1c level.

96. The experts were both in agreement that Mr Gabriel was obliged to make a diagnosis of non-diabetic hyperglycaemia to ensure that future recalls could take place. They stated in their joint report, '*We understand within the clinical system that abnormal HbA1c levels cannot be searched and detected unless read coded. If this is the case Dr Gabriel was required to make the diagnosis (and read code it) in order for ongoing /annual monitoring of the patient and his actions in failing to do this fall seriously below the standard expected of a reasonably competent General Practitioner*.'

97. The Tribunal had regard to Mr Gabriel's witness statement in which he stated, '*I do not accept 5(a)(iii). The previous Doctor had considered the HbA1c as 'Just Outside Normal Range – no action required'. I accept that I did not explicitly record that I diagnosed non-diabetic hyperglycaemia; I did not consider this was essential at that time. I had changed her medication, so I had a working diagnosis of non-diabetic hyperglycaemia. I therefore accept I did not add a read-code in those circumstances. There were many to choose from and I didn't want to get it wrong*.'

98. During his submissions Mr Dhillon highlighted comments made by Dr M in his oral evidence. During cross examination Dr M expressed the opinion that Mr Gabriel had made a working diagnosis of pre-diabetic hyperglycaemia when considering the totality of Mr Gabriel's entry in respect of blood sugar, weight loss and in particular, the change of medication from Bendrofluazide to Indepamide. Mr Dhillon submitted that, in light of this evidence, this paragraph of the allegation should be found not proved.

99. The Tribunal noted the evidence of Dr N given during cross examination in which he stated, '*I agreed that there was no record but the inference in the change of medication and from the weight loss advice is consistent with a diagnosis of prediabetic hyperglycaemia but that diagnosis should have been read coded*'.

100. On behalf of the GMC Ms Renton submitted that an *'inferential working diagnosis'* of non-diabetic hyperglycaemia was not sufficient to amount to a proper diagnosis. She stated that in order to have formally diagnosed Patient E Mr Gabriel ought to have

a. recorded that he had made a diagnosis;
b. applied a read code of this to the record; and
c. if not appropriate to apply the read code, refer the case to the nurse practitioner highlighting he had made a formal diagnosis.

101. The Tribunal was conscious that the allegation was not that the doctor did not make a written diagnosis, but had 'failed to diagnose'. It took the view that Mr Gabriel did make the diagnosis, albeit that it was a working diagnosis that he had not confirmed in writing. It considered that the steps taken by Mr Gabriel in changing the patient's medication and giving lifestyle advice were consistent with his working diagnosis and constituted an adequate treatment plan.

102. In the circumstances, the Tribunal was not satisfied that the GMC has proved, on the balance of probabilities, that Mr Gabriel failed to formulate an adequate treatment plan in that he did not diagnose non-diabetic hyperglycaemia despite Patient E's raised HBA1c level.

103. Paragraph 5a (iii) of the Allegation was therefore found not proved.

Paragraph 5(a)(iv)

104. Mr Gabriel admitted that on 19 February 2021 he had a telephone consultation with Patient E and Mr Gabriel failed to formulate an adequate treatment plan in that he did not add a read code diagnosis of non-diabetic hyperglycaemia.

105. The experts were both in agreement that Mr Gabriel was obliged to enter a read code diagnosis of nondiabetic hyperglycaemia in order for future recalls to take place. They stated in their joint report, *'We understand within the clinical system that abnormal HbA1c levels cannot be searched and detected unless read coded by a clinician. If this is the case Dr Gabriel was required to enter a read coded diagnosis in order for ongoing /annual monitoring of the patient and his actions in failing to do this falls seriously below the standard expected of a reasonably competent General Practitioner*.'

106. The Tribunal considered Dr N's first expert report dated, 22 July 2023, in which he stated, '*I agree that the diagnosis of pre-diabetes should have been made and then coded in the records* .'

107. The Tribunal noted that Mr Gabriel, in his oral evidence, stated that the practice had a diabetic nurse who reviewed the blood results that came into the practice and contacted patients with prediabetic results. The Tribunal was also mindful of Mr Gabriel's Rule 7 Response dated 07 February 2021 in which he stated, *'It is the role of the Practice Diabetic Nurse to deal with this*.'

108. The Tribunal accepted that the purpose of a read code is so that the Practice could arrange ongoing and annual monitoring of patients. Mr Gabriel's evidence of the Practice having a diabetic nurse was not challenged. However, his suggestion that the nurse was responsible for read coding patient entries was inconsistent with his admission of paragraph 5(a)(iii) of the Allegation and his oral evidence that he did not read code Patient E's diagnosis because he did not wish to make the wrong selection from the drop-down list. The Tribunal accepted the evidence of the experts that Mr Gabriel had been required to enter a read coded diagnosis and his actions in failing to do so fell seriously below the standard expected of a reasonably competent General Practitioner.

Patient F

Paragraph 6(b)

109. Mr Gabriel admitted that on 22 February 2021 he had a telephone consultation with Patient F's mother, Ms G ('the Consultation') and Mr Gabriel failed to record that the Consultation had been conducted with Ms G.

110. The experts were both in agreement that the clinical notes do not state whether Mr Gabriel spoke to Patient F (who was 11 years old at the relevant time) or to Patient F's mother. The experts further stated in their joint report, *'If Dr Gabriel spoke to Patient F's mother then this should have been recorded but if Dr Gabriel spoke to Patient F alone and without her mother being present, then an assessment of her capacity using the Gillick principles should have been recorded in the notes. Therefore, Dr Gabriel's record keeping regarding who he spoke to at the consultation falls seriously below the standard expected of a reasonably competent general practitioner*.'

Patient H

Paragraph 8(a)

111. Mr Gabriel admitted that on 10 March 2021 he had a telephone consultation with Patient H and Mr Gabriel failed to formulate an adequate treatment plan in that he did not arrange relevant blood tests.

112. The experts were both in agreement that *'if Patient H had features of stable angina, then Dr Gabriel should have arranged an ECG, bloods (full blood count, renal and liver function, lipids, HBA1c and thyroid function tests) and made a referral to a rapid access chest pain service or cardiology service, if such a service did not exist locally*.' They further stated in their joint report, *'Therefore, Dr Gabriel's actions in failing to arrange appropriate blood tests fall seriously below the standard expected of a reasonably competent General Practitioner*.'

Paragraph 8(b)(i)

113. Mr Gabriel admitted that on 10 March 2021 he had a telephone consultation with Patient H and Mr Gabriel failed to formulate an adequate treatment plan in that he did not determine whether Patient H either needed to be admitted to hospital immediately.

114. The experts were both in agreement that if Patient H had features of unstable angina, then Mr Gabriel should have advised immediate admission to hospital. They further stated in their joint report, '*Therefore Dr Gabriel's actions in failing to advise immediate hospital admission falls seriously below the standard expected of a reasonably competent General Practitioner.*'

Paragraph 8(b)(ii)

115. Mr Gabriel admitted that on 10 March 2021 he had a telephone consultation with Patient H and Mr Gabriel failed to formulate an adequate treatment plan in that he did not determine whether Patient H could be seen at a future face-to-face GP appointment.

116. The experts were both in agreement that if Patient H had features of stable angina then Patient H could be seen at a future face-to-face GP appointment. They further stated in their joint report, '*Therefore, Dr Gabriel's actions in failing to arrange this fall seriously below the standard expected of a reasonably competent General Practitioner.*'

117. The Tribunal noted that, during their oral evidence, the experts had expressed different views on whether it could be said that Patient H had stable or unstable Angina. Dr M, in his oral evidence, was of the opinion that Patient H was suffering from stable rather than unstable angina because there was no pain at rest, no shortness of breath and no signs of unstable angina. He considered that Mr Gabriel's decision to refer Patient H for an ECG was entirely appropriate management in the case of stable angina.

118. However, in his evidence Dr N felt unable to express a view as to whether the Patient H was suffering from stable or unstable angina.

119. Given the lack of any definitive view from the experts, the Tribunal was unable to reach a conclusion as to whether Patient H had been displaying signs of stable or unstable angina. However, it concluded that Mr Gabriel's treatment of Patient H fell seriously below the standard expected of a reasonably competent General Practitioner because, if Patient H was suffering from stable angina, then Mr Gabriel should have arranged relevant blood tests and should have determined whether Patient H could be seen at a future face to face GP appointment. On the other hand, if Patient H was displaying symptoms of unstable angina, then they needed to be admitted to hospital immediately and Mr Gabriel's failure to make that determination fell seriously below the standard expected of a reasonably competent GP.

Patient I

Paragraph 9(a)(i) and 9(a)(ii)

120. Mr Gabriel admitted that on 11 March 2021 he reviewed the result of Patient I's dual energy X-ray absorptiometry scan ('DEXA scan') and Mr Gabriel inappropriately marked Patient I's DEXA scan result as 'tell patient normal' when the DEXA scan was abnormal as it confirmed the presence of osteoporosis and indicated that treatment was required.

121. The Tribunal had regard to the joint report prepared by both experts which stated, '*If the Tribunal accepts that Dr Gabriel realised he had incorrectly marked the DEXA scan result as normal but realised this and through reception arranged for Patient I to be seen (as per… Dr Gabriel's statement), then this was appropriate and not below the standard expected of a reasonably competent General Practitioner. If the Tribunal accepts that [Dr L] was the person to identify the error, then Dr Gabriel failed to appreciate the presence of osteoporosis and his actions fall seriously below the standard expected of a reasonably competent General Practitioner*.'

122. The experts further stated in their joint report, '*If the Tribunal accepts that Dr Gabriel realised he had incorrectly marked the DEXA scan result as normal but realised this and through reception arranged for Patient I to be seen to initiate treatment (as per… Dr Gabriel's statement), then this was appropriate and not below the standard expected. If the Tribunal accepts [Dr L] was the person to identify the error, then the experts agree that Dr Gabriel failed to appreciate the presence of osteoporosis which required treatment and his actions fall seriously below the standard expected of a reasonably competent General Practitioner*.'

123. The Tribunal considered the evidence given by Mr Gabriel in his witness statement dated 11 August 2023 in which he stated, '*In error, I then mistakenly entered 'Tell Patient Normal' as the outcome. Realising I had made this mistake, as I was struggling with the IT system, then changed the "owner" of the result to another GP (Dr R) who had been the GP who requested the DEXA scan*.' He further stated, '*On 12 March 2021 I requested that reception make an appointment for Patient I with Dr R. That appointment took place on 18 March 2021. Patient I was informed that DEXA showed osteoporosis and advice was given by Dr L and patient was already on medication*.'

124. The Tribunal was mindful of the oral evidence of Dr L in which she stated that she came across the letter relating to Patient I, but she was unclear on the circumstances of how she did so. Dr L also accepted that she did not remember making the 18 March 2021 appointment in which she spoke to Patient I and that it was possible that Mr Gabriel had arranged that appointment.

125. The Tribunal noted that there was no evidence on the face of the medical records that ownership of the DEXA scan results was changed from Mr Gabriel to Dr L.

126. The Tribunal further noted that Patient I had a telephone consultation with Dr L on 18 March 2021. The Tribunal found that it was more likely than not, on the balance of probabilities, that this consultation was the result of Mr Gabriel's request to reception that an appointment be made. Although Dr L had little recollection of her involvement in Patient I's case she had accepted the possibility that Mr Gabriel had caused the appointment to be

made. Taking into account the experts' evidence, the Tribunal determined that Mr Gabriel's actions in arranging the appointment were appropriate remediation for incorrectly marking the DEXA scan. Therefore, his actions did not fall below the standard of care expected of a reasonably competent General Practitioner.

Paragraph 9(b)(i), 9(b)(ii), 9(b)(iii) and 9(b)(iv)

127. It is alleged that on 11 March 2021 Mr Gabriel reviewed the result of Patient I's DEXA scan and Mr Gabriel failed to act upon the DEXA scan result in that he did not arrange an appointment with Patient I to discuss: the DEXA scan result; management of osteoporosis; that Patient I would be high risk for fractures if left untreated and the use of calcium; and vitamin D and bisphosphonates.

128. In her closing submissions, Ms Renton submitted to the Tribunal that the wording of allegation 9(b) was such that Mr Gabriel had been required to arrange an appointment with Patient I to discuss the four matters in the subparagraphs of allegation 9(b). However, the Tribunal regarded it as self-evident that the appointment Mr Gabriel arranged for Patient I was to discuss the DEXA scan result which he had incorrectly marked. Further, that the concern arising from the DEXA scan result, was the management and treatment of Patient I's osteoporosis and that Patient I would be at high risk of fractures if left untreated.

129. Given the Tribunal's findings in relation to paragraphs 9(a)(i) and 9(a)(ii), namely that Mr Gabriel caused an appointment to be made for Patient I, it found paragraphs 9(b)(i) to (iv) of the Allegation to be not proved.

Other matters

130. The Tribunal went on to consider a number of other submissions made by both representatives.

XXX

131. XXX

132. XXX

133. XXX

134. Ms Renton reminded the Tribunal of the evidence of Dr K that '*many of Dr Gabriel's issues were that he had issues logging in to the systems. She felt that Dr Gabriel would have benefited from some more time in person in the surgery to support him with the systems.XXX. She felt that Dr Gabriel at times put up barriers*.'

135. Mr Dhillon submitted that it was a '*stark and incontrovertible fact*' that the Allegation against Mr Gabriel related to patients that Mr Gabriel had assessed remotely from home. Mr

Dhillon stated that there had been an element of hostility by Dr K towards Mr Gabriel, not least because she considered that Mr Gabriel should have worked from the Practice more often, rather than working from home.

136. The Tribunal had regard to the witness statement of Dr K in which she said that she expected that Mr Gabriel would have IT issues, which could have been resolved more easily and swiftly if Mr Gabriel was working on site. Dr K acknowledged that all the new technology that was put in place during COVID *'was not perfect'* and therefore, '*it was much easier to work on site'*. Dr K's evidence was that Mr Gabriel *'did not want to work on site and insisted that he wanted to work from home',* and as a result it was negotiated that he would work on site at the Practice once a week XXX.

137. The Tribunal found, that having made an agreement with Mr Gabriel, the Practice were reluctant to adhere to the agreed framework.

Training and support for computer systems

138. Mr Dhillon submitted that Mr Gabriel did not have any real experience of the EMIS System before his leave in March 2020. He stated that four software systems had been changed during the time between Mr Gabriel's leave and his suspension and that Mr Gabriel had required full and proper training in all of the IT systems. Mr Dhillon submitted that Mr Gabriel did not receive sufficient training.

139. Ms Renton reminded the Tribunal of the evidence of both Ms J and Dr K, who gave evidence about the training that Doctor Gabriel received. Ms Renton submitted that Mr Gabriel's training had included in house and external training although she accepted that there was a degree of learning 'on the job'.

140. The Tribunal noted Mr Gabriel's description of himself as 'old school' in relation to matters relating to IT. The Tribunal considered that there was evidence that Mr Gabriel had received some IT training from the Practice. However, the Tribunal accepted Mr Gabriel's evidence that the training had been less than satisfactory for him, in that a planned one to one training session had included other individuals and that some scheduled training with a colleague called Ms Q had not in fact taken place. The Tribunal was conscious that the effectiveness of training can be subjective and it found it likely that the training provided to Mr Gabriel had not been sufficient for his needs.

Equipment and XXX

141. XXX

142. XXX

143. XXX

144. The Tribunal took the view that the practice did not fully engage with XXX. It determined that the Practice had given inadequate consideration to what equipment Mr Gabriel required in order to work efficiently from home. For example, XXX

145. In addition, although the Practice had arranged for Dr K to act as Mr Gabriel's supervisor, the was little evidence presented to the Tribunal of any meaningful supervision by her. XXX.

Arranging face to face appointments

146. In his witness statement Mr Gabriel stated that he had been unable to arrange face to face appointments personally. He expressed the view that he had not been provided with clear instructions on how to make any such referral to the partners. However, in relation to Patient B he accepted that the Practice '*might have been able to facilitate*' a face to face appointment.

147. In Dr K's witness statement, she said that if Mr Gabriel determined that a patient may require a face to face appointment, he would make arrangements for the patient to be passed to another doctor at the Practice, who would then conduct a consultation and potentially invite the patient into the Practice for a face to face appointment. Dr K stated that these arrangements had been verbally agreed with Mr Gabriel XXX.

148. The Tribunal considered that the process by which Mr Gabriel could arrange face to face appointments was not made entirely clear by the witnesses. However the Tribunal took the view that as an experienced practitioner Mr Gabriel would have been aware that he could contact his colleagues at the Practice to arrange face to face appointments in the interests of patient care.

The Tribunal's Overall Determination on the Facts

149. The Tribunal has determined the facts as follows:

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

Patient A

1. On 30 December 2020 you had a telephone consultation with Patient A and you failed to:

    a. ~~add a correct diagnostic read code~~; Withdrawn under Rule 17(6)

    b. record:

        i. an adequate history regarding her symptoms; Admitted and Found Proved

ii. an assessment as to whether Patient A's symptoms warranted a face-to-face consultation; **Admitted and Found Proved**

iii. ~~your diagnosis of Patient A~~; **Withdrawn under Rule 17(6)**

iv. that you considered whether Patient A:

1. ~~was acutely unwell requiring immediate hospital admission;~~ **Withdrawn under Rule 17(6)**

2. had been unwell for a prolonged period of time requiring:

a. blood tests; **Admitted and Found Proved**

b. a chest X-ray. **Admitted and Found Proved**

Patient B

2. On 25 January 2021 you had a telephone consultation with Patient B, and you failed to:

a. formulate an adequate treatment plan in that you did not:

i. arrange a future face-to-face consultation in order for Patient B's abdomen to be physically assessed; **Admitted and Found Proved**

ii. either refer Patient B to hospital as a same day acute admission under the urology team for an urgent scan, or recommend Patient B attend Accident and Emergency for an urgent scan; **Determined and Found Proved**

b. record an adequate history regarding:

i. his symptoms; **Admitted and Found Proved**

ii. urinary output. **Admitted and Found Proved**

Patient C

3. On 25 January 2021 you had a telephone consultation with Patient C and you failed to:

a. formulate an adequate treatment plan in that you did not:

i. obtain blood tests to look for inflammatory causes; **Admitted and Found Proved**

ii. arrange an ultrasound scan to look for tendinopathies; **Admitted and Found Proved**

iii. refer Patient C to a physiotherapist; **Admitted and Found Proved**

b. record:

i. an adequate history regarding his symptoms; **Admitted and Found Proved**

ii. that you requested Patient C:

1. carry out left shoulder and elbow movements to ascertain whether the:

a. range of movement was restricted; **Admitted and Found Proved**

b. movements brought on pain; **Admitted and Found Proved**

2. palpate his arm to determine the site of the pain; **Admitted and Found Proved**

iii. an adequate diagnosis of Patient C. **Admitted and Found Proved**

Patient D

4. On 5 February 2021 you reviewed an advice and guidance letter received from Patient D's cardiologist dated 4 February 2021 and you:

a. inappropriately marked the letter as 'no action required' when in fact the letter requested Patient D be referred back to cardiology; **Admitted and Found Proved**

b. failed to make an urgent referral to cardiology. **Admitted and Found Proved**

Patient E

5. On 19 February 2021 you had a telephone consultation with Patient E and you failed to:

a. formulate an adequate treatment plan in that you did not:

i. ~~either adjust Patient E's dose of statin, or change the brand of statin, in order to achieve a target of less than 5 millimoles per litre;~~ **Withdrawn under Rule 17(6)**

ii. ~~organise an annual recall to re-check Patient E's haemoglobin AC1 ('HBA1c') level;~~ Withdrawn under Rule 17(6)

iii. diagnose non-diabetic hyperglycaemia despite Patient E's raised HBA1c level; Not Proved

iv. add a read code diagnosis of non-diabetic hyperglycaemia; Admitted and Found Proved

~~b. record:~~

~~i. either:~~

~~1. an adequate history of Patient E's symptomatic angina; or~~ Withdrawn under Rule 17(6)

~~2. that the reason you noted a limited history taking of Patient E's symptomatic angina was because this information had already been recorded by another general practitioner on 17 February 2021;~~ Withdrawn under Rule 17(6)

~~ii. that you had considered whether Patient E either should have been referred to hospital immediately, or could wait for her forthcoming cardiology appointment;~~ Withdrawn under Rule 17(6)

~~iii. an assessment of Patient E's:~~

~~1. total cholesterol;~~ Withdrawn under Rule 17(6)

~~2. HBA1c;~~ Withdrawn under Rule 17(6)

~~iv. your discussion with Patient E regarding:~~

~~1. her high cholesterol;~~ Withdrawn under Rule 17(6)

~~2. the significance of a raised HBA1c;~~ Withdrawn under Rule 17(6)

~~3. a diagnosis of non-diabetic hyperglycaemia;~~ Withdrawn under Rule 17(6)

~~v. the reason why Patient E's blood pressure medication was switched.~~ Withdrawn under Rule 17(6)

Patient F

6. On 22 February 2021 you had a telephone consultation with Patient F's mother, Ms G ('the Consultation') and you:

~~a. inappropriately prescribed Duac (Benzoyl Peroxide 3% / Clindamycin 1% gel) for Patient F's acne in that:~~

i. ~~Duac medication was not licensed for patients under 12 years of age~~; Withdrawn under Rule 17(6)

ii. ~~licensed medication preparations were available for Patient F~~; Withdrawn under Rule 17(6)

b. failed to record that the Consultation had been conducted with Ms G. Admitted and Found Proved

~~7. You made an inappropriate change to the note of the Consultation in Patient F's medical record on one or more of the following dates, in that you did not specify that changes you made on that date were retrospective:~~

~~a. 22 February 2021;~~ Withdrawn under Rule 17(6)

b. ~~26 February 2021~~. Withdrawn under Rule 17(6)

Patient H

8. On 10 March 2021 you had a telephone consultation with Patient H and you failed to formulate an adequate treatment plan in that you did not:

a. arrange relevant blood tests; Admitted and Found Proved

b. determine whether Patient H either:

i. needed to be admitted to hospital immediately; or Admitted and Found Proved

ii. could be seen at a future face-to-face GP appointment. Admitted and Found Proved

Patient I

9. On 11 March 2021 you reviewed the result of Patient I's dual energy X-ray absorptiometry scan ('DEXA scan') and you:

a. inappropriately marked Patient I's DEXA scan result as 'tell patient normal' when the DEXA scan was abnormal as it:

i. confirmed the presence of osteoporosis; Admitted and Found Proved

ii. indicated that treatment was required; Admitted and Found Proved

b. failed to act upon the DEXA scan result in that you did not arrange an appointment with Patient I to discuss:

i. the DEXA scan result; **Not Proved**

ii. management of osteoporosis; **Not Proved**

iii. that Patient I would be high risk for fractures if left untreated; **Not Proved**

iv. the use of calcium, vitamin D and bisphosphonates **Not Proved**

Determination on Impairment - 01/12/2023

150. This determination will be handed down in private. However, as the case concerns Mr Gabriel's alleged misconduct, a redacted version will be published at the close of the hearing.

151. 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 Gabriel's fitness to practise is impaired by reason of misconduct.

The Evidence

152. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence by way of Mr Gabriel's 2023-2024 appraisal dated 20 October 2023.

Submissions

<u>On behalf of the GMC</u>

153. Ms Renton, Counsel, submitted that the Tribunal are obliged to consider if Mr Gabriel's fitness to practise medicine is currently impaired. She submitted that there is no burden or standard of proof in this regard as it is a matter for the Tribunal's judgement.

154. Ms Renton reminded the Tribunal of its findings of fact, particularly in relation to those parts of the Allegation admitted or found proved and those that the Tribunal determined fell seriously below the standards expected of a reasonably competent General Practitioner. She also reminded the Tribunal of its findings of fact in relation to those parts of the Allegation admitted or found proved that the Tribunal determined did not fall seriously below the standards expected of a reasonably competent General Practitioner.

155. Ms Renton submitted, in summary, that the issues which fall seriously below the standard expected of a reasonably competent General Practitioner can be categorised as: eight incidents of failing to make records (one failure to add a read code, one incorrect

marking of a letter); three incidents of failing to make proper decisions on the referral of patients (Patient B, D and H); and one incident of failing to form an adequate treatment plan in three different ways (Patient C).

156. Ms Renton submitted that the findings of the Tribunal reflect conduct by Mr Gabriel that is serious. She submitted that each of the incidents were not merely trivial or inconsequential, nor a temporary lapse or something excusable or forgivable *(Khan V BSB [2018] EWHC 2184 (Admin)).* She submitted that Mr Gabriel's conduct put patients at risk. She reminded the Tribunal of an example in which Mr Gabriel failed to refer three patients for further care and assessment, including in circumstances which were urgent. Ms Renton submitted that Mr Gabriel accepted that if a detail is not reflected on the face of a patient record, anyone interrogating that record in the future, would be unable to say what was said/considered/done. She submitted that this creates a risk to the patient by poor communication.

157. Ms Renton submitted that Mr Gabriel has not upheld the high standards of the profession by the allegations admitted/found proved and his conduct breached paragraphs 11, 15, 16(d) and 21 (a-d) of *Good Medical Practice (2013) ('GMP'*).

158. Ms Renton noted the findings of the Tribunal in relation to the working environment of Mr Gabriel. She invited the Tribunal to consider the authority of *R(Campbell) v GMC [2005] 1 WLR 3488 CA* and conclude that Mr Gabriel's working conditions should not diminish the seriousness of the conduct.

159. Ms Renton reminded the Tribunal of the test for impairment as set out by Dame Janet Smith in the 5th Shipman report and adopted in *CHRE v NMC and Paula Grant [2011] EWHC 927.* Ms Renton submitted that Mr Gabriel's conduct engaged the first three limbs of that test:

> *'a) Whether the registrant has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;*
>
> *b) Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;*
>
> *c) Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.*
>
> *d) …'*

160. Ms Renton submitted that this case primarily relates to the failure to make referrals or adequate treatment plans. She further submitted that such failures can place patients at risk. Ms Renton submitted that Mr Gabriel has failed to uphold the standards required of a General Practitioner and his actions therefore breach fundamental tenets of the medical profession e.g. pertaining to patient care, patient safety and record keeping.

161. Ms Renton submitted that Mr Gabriel has shown some insight in that he has accepted many parts of the Allegation initially brought before the Tribunal. She submitted that Mr Gabriel is continuing to develop insight.

162. Ms Renton submitted that whilst Mr Gabriel has not specifically stated he is remorseful, he does appear to be remorseful in attitude and somewhat reflective. She submitted that this is cautiously balanced against the lack of specific evidence on the matter of remorse.

163. With regard to remediation, Ms Renton noted Mr Gabriel's personal development plan and appraisals. She submitted that Mr Gabriel is clearly working to improve his skills, including his use of IT which is central to the issues in this case. Ms Renton submitted that the GMC remain concerned that Mr Gabriel must not rely on his skills as an "old school GP" but must keep up to date with modern working practices.

164. Ms Renton submitted that the Tribunal should consider all 3 limbs of the overarching objective in determining impairment. She stated that submissions have already been made regarding the risk to patients. Ms Renton submitted that Mr Gabriel's actions have disturbed the 'natural and expected' public confidence in the medical profession, namely that consultations, even if by telephone, will be sufficiently actioned and recorded. She further submitted that, for the reasons set out previously, Mr Gabriel has not upheld the professional standards and conduct expected of a member of the profession.

165. Ms Renton submitted that whilst the GMC accept that Mr Gabriel has shown some development of insight, a finding of current impairment is necessary in order to uphold the overarching objective.

166. Ms Renton submitted that the Tribunal may wish to consider that Mr Gabriel has a previous history of engagement with his regulator and has previously served a period of suspension.

<u>On behalf of Mr Gabriel</u>

167. Mr Dhillon, Counsel, submitted that Mr Gabriel's admissions and the experts' reports evidenced a number of failures that are seriously below the required standard. He submitted that, if that was the case alone, then Mr Gabriel would accept a finding of impairment; however, given the circumstances surrounding this particular case, Mr Dhillon submitted that the Tribunal should find no impairment.

168. Mr Dhillon invited the Tribunal to consider the circumstances in which these failures by Mr Gabriel occurred. He submitted that Mr Gabriel's failures only occurred in relation to patients treated remotely when he was working from home. Mr Dhillon submitted that this is not a case where there were failings in every setting in which Mr Gabriel was working. He reminded the Tribunal that there is nothing being presented about Mr Gabriel's face to face

practice, which he worked one day a week. Mr Dhillon submitted that this should go some way to reassure the Tribunal that the issues which arose in relation to Mr Gabriel's clinical practice stemmed from the circumstances at the relevant time, including the lack of support he received from the Practice XXX.

169. Mr Dhillon submitted that Mr Gabriel made a number of admissions at the outset of this case. He submitted that Mr Gabriel denied three paragraphs of the Allegation of which the Tribunal found two in his favour. Mr Dhillon reminded the Tribunal that Mr Gabriel was XXX, he did not have the proper equipment, nor did he have proper or sufficient training. Furthermore, Mr Dhillon submitted that the Tribunal have already found that the Practice did not properly engage with Mr Gabriel to support XXX as agreed. He submitted that the Tribunal should find in Mr Gabriel's favour because any employee in his situation would not have been able to perform their work sufficiently.

170. Mr Dhillon submitted that, notwithstanding the seriousness of the Allegation, any member of the public would understand why in this unique case, a finding of no impairment had been made. He submitted that the public would consider that Mr Gabriel is safe to practise as the issues raised relate only to his working conditions at the time. Mr Dhillon reminded the Tribunal of Mr Gabriel's witness statement in which he sets out, '*XXX. I am not longer in the same position I was. Further, I would be able to see patients face to face. I have purchased my own headset to use ….*'

171. Mr Dhillon reminded the Tribunal that, in his evidence, Mr Gabriel offered the Tribunal great detail and tried to explain the wider background of what happened. He submitted that Mr Gabriel has shown a great deal of remorse and insight in the manner in which he gave evidence at the facts stage. He submitted that Mr Gabriel has cooperated with his regulator rather than trying to hide or avoid responsibility for what occurred.

172. Mr Dhillon directed the Tribunal to Mr Gabriel's Appraisal of 2023-2024 and noted that Mr Gabriel had a wide-ranging PDP, which included: avoiding missed or delayed diagnosis; record keeping; EMIS training; and interpretation of lab results by GPs. Mr Dhillon submitted that these aimed to address Mr Gabriel's failures in this case and to prevent the failings from reoccurring.

173. Mr Dhillon submitted that Mr Gabriel has not been able to find a practice to employ him on the conditions to which he is currently subject. He submitted that this prevents Mr Gabriel from being able to offer evidence to show how he has altered his practice and the way in which he treats patients following the incident.

174. Mr Dhillon submitted that none of the patients treated by Mr Gabriel suffered long term issues or serious complications from his failings. He reminded the Tribunal that the failings occurred in a particular context, including Mr Gabriel's location, the lack of support he received from the Practice and against the background of COVID restrictions. He submitted that these factors do not excuse Mr Gabriel's failings, but the Tribunal should bear them in mind. Mr Dhillon submitted that the Tribunal should consider the circumstances of

this case against the backdrop that Mr Gabriel has been unable to work since his suspension and has found it a challenge to remain motivated.

175. Following the parties' submissions on impairment, the Tribunal raised with both representatives Mr Dhillon's submission that the Allegation related only to patients who had a consultation with Mr Gabriel whilst he was working from home. It seemed to the Tribunal that that submission might be contradicted by a printout of log-in and log-out times that was referred to in Ms J's witness statement. However, both representatives agreed that the print out was not reliable evidence as to whether Mr Gabriel had been working from home or working at the Practice at the times of his consultations with Patients A, B, C, D, E, F, H and I.

176. Mr Dhillon clarified that his submission that Mr Gabriel had consulted with those patients whilst working from home derived from paragraph 46 of Mr Gabriel's witness statement, dated 25 August 2023, in which he stated, ' *Further, I had only a laptop with an 11-inch screen to work from. XXX*' Mr Dhillon further stated that his submissions had been reinforced by paragraph 48 of Mr Gabriel's witness statement which states, '*There has been reference made to my forgetting passwords. This is not correct. I kept a secure record of this. However, my room, which is linked to the laptop at home, was used by another locum and due to security changes, they kept changing passwords. This caused me further issues*.'

The Relevant Legal Principles

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

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

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

180. In the case of *Council for the Regulation of Health Care Professionals v GMC & Biswas (2006) EWHC* 464 Justice Jackson held that in considering whether a practitioner's fitness to practise is impaired, a panel must carry out an exercise of judgement or assessment, rather than the issues being one of "proof".

181. When considering misconduct, the Tribunal referred to the case of *Roylance v. The General Medical Council (No.2) [2000] 1 AC 311:*

'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will qualify. The professional misconduct must be serious.'

182. In the case of *Meadow v GMC (2006) EWCA 1390* Auld LJ stated that serious professional misconduct may take the form, not only of acts of bad faith or other moral turpitude, but also of incompetence or negligence of a high degree. The Court stated that whether misconduct can properly be regarded as "serious" professional misconduct, however, must depend on all the circumstances. Auld LJ referred with approval to comments made in the case of *Nandi v General Medical Council [2004] EWHC* in which the court emphasised the need to give the issue of seriousness proper weight and observed that in other contexts serious professional misconduct had been referred to as "*conduct which would be regarded as deplorable by fellow practitioners*".

183. In *Cohen v GMC (2008) EWHC 581* the Court held that the task of the panel, in considering impairment, is to take account of the practitioner's misconduct and then consider it in light of all the other relevant factors known to them. It will be highly relevant in determining if fitness to practise is impaired to consider:

- whether the practitioner's misconduct is easily remediable;
- whether the misconduct has been remedied; and
- whether the misconduct is likely to be repeated.

184. On impairment, the Tribunal had regard to Dame Janet Smith's test in *The Fifth Shipman Report,* cited in *CHRE v NMC and Paula Grant [2011] EWHC 927 (Admin*) as referred to by Ms Renton.

The Tribunal's Determination on Impairment

185. The Tribunal considered whether Mr Gabriel's fitness to practise is currently impaired by reason of his misconduct. In reaching its decision, the Tribunal reminded itself that it must consider whether Mr Gabriel's fitness to practise is impaired today and must therefore look forward. The Tribunal also had regard to all three limbs of the overarching objective and its obligation to give sufficient weight to each limb.

Misconduct

186. The Tribunal reminded itself that Mr Gabriel had admitted, in particular, the following paragraphs of the Allegation:

- Paragraph 1(b)(i) – failing to record an adequate history regarding Patient A's symptoms;
- Paragraph 1(b)(ii) – failing to record an assessment as to whether Patient A's symptoms warranted a face-to-face consultation;
- Paragraph 2(a)(i) – failing to formulate an adequate treatment plan in that Mr Gabriel did not arrange a future face-to-face consultation in order for Patient B's abdomen to be physically assessed;
- Paragraphs 3(a)(i), (ii) and (iii) – failing to formulate an adequate treatment plan in that Mr Gabriel did not obtain blood tests to look for inflammatory causes, arrange an ultrasound scan to look for tendinopathies or refer Patient C to a physiotherapist;
- Paragraph 3(b)(i) - failing to record an adequate history regarding Patient C's symptoms;
- Paragraphs 3(b)(ii)(1) – failing to record that Mr Gabriel requested Patient C carry left shoulder and elbow movements to ascertain whether the range of movement was restricted or movements brought on pain;
- Paragraph 3(b)(ii)(2) - failing to record that Mr Gabriel requested Patient C palpate his arm to determine the site of the pain;
- Paragraph 3(b)(iii) – failing to record an adequate diagnosis of Patient C;
- Paragraph 4(a) – inappropriately marked a letter from Patient D's cardiologist as 'no action required' when in fact the letter requested Patient D be referred back to cardiology;
- Paragraph 4(b) – failing to make an urgent referral to cardiology;
- Paragraph 5(a)(iv) – failing to add a read code diagnosis of non-diabetic hyperglycaemia;
- Paragraph 6(b) – failing to record that the consultation had been conducted with Patient F's mother, Ms G;

187. In relation to each of the above paragraphs of the Allegation both experts agreed that Mr Gabriel's conduct fell seriously below the standards expected of a reasonably competent General Practitioner. The Tribunal accepted that expert evidence.

188. The Tribunal also reminded itself that it determined and found proved paragraph 2(a)(ii) of the Allegation, namely that Mr Gabriel failed to formulate an adequate treatment plan in that he did not either refer Patient B to hospital as a same day acute admission under the urology team for an urgent scan, or recommend that Patient B attend Accident and Emergency for an urgent scan. In finding that paragraph of the Allegation to be proved, the Tribunal accepted the experts' evidence that the NICE guidelines applied and should have been followed and that Mr Gabriel's conduct fell seriously below the standards expected of a reasonably competent General Practitioner.

189. The Tribunal further reminded itself of its findings in relation to the following paragraphs of the Allegation, where there had been some lack of certainty or disagreement between the experts:

- Paragraph 2(b)(i) - the Tribunal accepted that Mr Gabriel's failure to record an adequate history regarding Patient B's symptoms fell seriously below the standards expected of a reasonably competent General Practitioner.
- Paragraphs 8(a) and 8(b)(i) and (ii) - the Tribunal was unable to reach a conclusion as to whether Patient H had been displaying signs of stable or unstable angina. However, it concluded that Mr Gabriel's treatment of Patient H fell seriously below the standard expected of a reasonably competent General Practitioner. If Patient H had been suffering from stable angina, then Mr Gabriel should have arranged relevant blood tests and should have determined whether Patient H could be seen at a future face to face GP appointment. On the other hand, if Patient H had been displaying symptoms of unstable angina, then they needed to be admitted to hospital immediately and Mr Gabriel's failure to make that determination fell seriously below the standard expected of a reasonably competent GP. In summary, whether Patient H was displaying symptoms of stable or unstable angina, Mr Gabriel's treatment of them fell seriously below the expected standard.

190. The Tribunal found that paragraphs 1, 7, 8, 11, 15, 16(d) and 21 (a-d) of GMP had been breached by Mr Gabriel, These state:

> *'1 'Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, ….*
>
> *7 You must be competent in all aspects of your work, ….*
>
> *8 You must keep your professional knowledge and skills up to date.*
>
> *11 You must be familiar with guidelines and developments that affect your work.*
>
> *15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> *a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> *b promptly provide or arrange suitable advice, investigations or*

treatment where necessary

c refer a patient to another practitioner when this serves the patient's needs.

16 In providing clinical care you must:

…

d consult colleagues where appropriate

21 Clinical records should include:

a relevant clinical findings

b the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c the information given to patients

d any drugs prescribed or other investigation or treatment.'

191. The Tribunal considered that these breaches of GMP included fundamental tenets of the profession, including a doctor's obligation to make the care of their patients their first concern and to provide a good standard of practice and care. In breaching GMP, Mr Gabriel had put patients at risk of harm, as well as undermining the public's confidence in the profession and failing to uphold proper professional standards.

192. The Tribunal took the view that Mr Gabriel's actions amounted to misconduct. The Tribunal noted that its determination on facts had identified a significant number of failures in Mr Gabriel's practice that fell seriously below the standards expected of a reasonably competent General Practitioner.

193. The Tribunal considered that its findings of fact in relation to Patients B and H were particularly serious on their own. Whilst the Tribunal noted that a number of the failings related to poor record keeping, Mr Gabriel's misconduct also involved clinical failings of not taking action when there was a clinical need. For example, not referring Patient B for an urgent scan; failing to urgently refer Patient D to cardiology; not read coding Patient E's non diabetic hyperglyceamia; and failing to appropriately assess and formulate an adequate treatment plan for Patient H. The Tribunal considered that these clinical failings went beyond IT issues and poor record keeping and amounted to misconduct whether Mr Gabriel was working at home or from within the Practice setting.

194. The Tribunal therefore concluded that Mr Gabriel's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct that was serious.

The Tribunal's Determination on Impairment

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

196. The Tribunal first considered whether the misconduct was remediable, whether it had been remedied and the likelihood of repetition.

197. The Tribunal took the view that Mr Gabriel had shown some insight, in that he made early admissions to a number of paragraphs of the Allegation. The Tribunal also considered that Mr Gabriel has demonstrated some degree of remorse and reflection. The Tribunal noted Mr Gabriel's appraisals of 2021/2022, 2022/2023 and 2023/2024. Whilst there was evidence that Mr Gabriel had undertaken CPD, some of which was relevant, the Tribunal considered that the evidence was limited and there was a paucity of self-reflection from the training he had done.

198. The Tribunal further noted that it had been presented with limited self-reflection from Mr Gabriel in relation to the Allegation. Whilst his defence placed reliance upon issues with IT systems and equipment and the lack of support and training that Mr Gabriel received from the Practice, there was little evidence of any self-reflection in relation to the clinical failings or what steps he was taking to ensure that they would not reoccur. The Tribunal considered that Mr Gabriel needed to better understand that, even when he was facing IT difficulties or a lack of support, he was under a professional responsibility to ensure that he had taken the appropriate clinical actions to ensure patients' needs were met. Therefore, the Tribunal determined that although Mr Gabriel's behaviour was potentially capable of remediation, it had not been sufficiently remediated.

199. The Tribunal took the view that Mr Gabriel has limited insight, particularly into his clinical failings, and it could not therefore be satisfied that his misconduct would not be repeated. The Tribunal was mindful that Mr Gabriel's registration had previously been subject to conditions in relation to similar concerns. It therefore determined that there was a significant risk of repetition as there is little evidence that Mr Gabriel possesses a sufficient understanding of the causes of his difficulties or what he will do to ensure that they will not occur in the future.

200. The Tribunal had regard to the test set out in case of *Grant* and determined that the first three limbs were engaged in this case. Mr Gabriel's conduct had put patients at risk; Mr Gabriel had failed to uphold proper professional standards and, in so doing, risked bringing the profession into disrepute; Mr Gabriel had failed to put the needs of his patients first thereby breaching one of the fundamental tenets of the medical profession. The Tribunal took the view that there was a risk that these failures could be repeated.

201. Having given full consideration to the serious nature of Mr Gabriel's misconduct, the Tribunal reminded itself of its responsibility to uphold the overarching objective, namely:

- 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.

202. The Tribunal determined that all three limbs of the overarching objective were engaged in this case. It has a duty to maintain public confidence in the profession and to declare and uphold proper standards of conduct and behaviour. Whilst the Tribunal had sympathy for Mr Gabriel with regard to the lack of support from the Practice and the struggles that he had with IT, it felt that he had not put his patients at the centre of his practice and had been insufficiently proactive in ensuring that his patients' needs were met. The Tribunal concluded that the public interest, and the need to uphold all three limbs of the overarching objective, would be undermined if a finding of impairment were not made.

203. The Tribunal has therefore determined that Mr Gabriel's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 04/12/2023

204. This determination will be handed down in private. However, as the case concerns Mr Gabriel's alleged misconduct, a redacted version will be published at the close of the hearing.

205. Having determined that Mr Gabriel's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

206. The Tribunal has taken into account the evidence received during the earlier stages of the hearing, where relevant, to reaching a decision on sanction.

207. The Tribunal was provided with the case of *General Medical Council v Bawa-Garba (British Medical Association and others intervening) [2018] EWCA Civ 1879*.

Submissions for the GMC

208. Ms Renton submitted that the appropriate sanction is a short period of suspension, although she acknowledged that this was a matter for the Tribunal. She took the Tribunal through those paragraphs of the Sanctions Guidance (November 2020 version) (SG) which

she submitted indicated why taking no action or imposing an order of conditions were not the appropriate response in this case. Ms Renton reminded the Tribunal that it had found all three limbs of the overarching objective to be engaged in this case. She further reminded the Tribunal that it should consider the sanctions available, starting with the least restrictive.

209. Ms Renton highlighted the mitigating features in this case which she submitted were: the circumstances surrounding the Allegation, such as Mr Gabriel's difficulties with IT; the lapse of time since those events, which occurred in 2020/21; his attempts to remediate his misconduct; Mr Gabriel's admissions at the outset of these proceedings; and finally, his expressions of remorse.

210. Ms Renton then referred the Tribunal to paragraphs 49 – 51 of its determination on impairment and highlighted the aggravating features in this case which she submitted were: Mr Gabriel's limited reflections in respect of the concerns identified, particularly his clinical failings and the causes of those failings; his limited insight into the concerns identified and the misconduct found; that Mr Gabriel's actions put patients at risk of harm; and that he had breached a number of paragraphs of GMP. Ms Renton submitted that Mr Gabriel failed in his professional responsibility to put patients at the centre of his clinical practice. Further, Ms Renton reminded the Tribunal that Mr Gabriel had a previous finding of impairment against him following concerns of a similar nature which led to conditions being imposed upon his registration. She submitted that given this was a significant aggravating feature, it might be expected that Mr Gabriel would have demonstrated a greater level of remediation and insight on this occasion.

211. Ms Renton submitted that a short period of suspension would have a deterrent effect and send out a message that the type of behaviour found proven was unacceptable. She acknowledged that this case was finely balanced between an order of conditions and suspension. However, Ms Renton submitted that given the findings of the Tribunal, together with the seriousness of the misconduct found, a period of suspension was required to protect the public and maintain public confidence in the medical profession.

212. Ms Renton submitted that, whilst the Tribunal had found that Mr Gabriel presented a significant risk of repeating his behaviour, it was the GMC's submission that his actions were not fundamentally incompatible with his continued registration on the medical register. She submitted that, as a result, erasure would not be appropriate in this case. Ms Renton reminded the Tribunal that Mr Gabriel had admitted a large number of allegations and that of the three contested, the Tribunal found two not proved. She added that there was no evidence that there has been any repetition of similar behaviour since these events.

213. In all the circumstances, Ms Renton invited the Tribunal to suspend Mr Gabriel's registration. She also invited the Tribunal to direct a review hearing.

Submissions on sanction for Mr Gabriel

214. Mr Dhillon submitted that the appropriate sanction was a period of conditional registration. He outlined to the Tribunal a proposed framework of conditions which he submitted would assist to address the concerns identified, as well as protect the public. These included that Mr Gabriel undertake five hours of CPD in each area where his clinical practice was considered inadequate before he was allowed to return to working in a GP practice; that an audit of Mr Gabriel's clinical work be undertaken every six months; that he only be permitted to work from a GP practice and not remotely; that at least one other GP should be present on site during the times that Mr Gabriel worked; and that he be required to have an educational supervisor who would provide a report to the GMC every six months.

215. Mr Dhillon submitted that the real overarching factor in this case was the background and the circumstances which led to the index events. He referred the Tribunal to those paragraphs of its determination on facts where it had made a number of important contextual findings, for example, at paragraphs 137 (reluctance by the Practice to support XXX), 143 (four different software regimes in place and inadequate equipment) and 145 (no meaningful supervision). He reminded the Tribunal that these events occurred during the COVID-19 pandemic.

216. Mr Dhillon submitted that whilst Mr Gabriel was a registrant who had just come out of a previous sanction, it was to be noted that he had passed a formal performance assessment at around the time he stopped working XXX in March 2019. Mr Dhillon stated that, having passed his assessment, Mr Gabriel never had an opportunity to actually work in the manner that he was accustomed to. Mr Dhillon submitted that, at the time of the events, Mr Gabriel was XXX and had not received adequate support from his employer.

217. Mr Dhillon acknowledged the Tribunal's finding that Mr Gabriel had not demonstrated sufficient insight or remediation, and that there was a significant risk of him repeating his behaviour. However, he submitted that the circumstances which prevailed at the time of the index events no longer existed. Mr Dhillon stated that the Tribunal could feel reassured if Mr Gabriel resumed working in a GP practice with at least one other GP on site.

218. Mr Dhillon submitted that Mr Gabriel is not a doctor who was unwilling to work with his colleagues. He referred the Tribunal to Mr Gabriel's email of January 2021 in which he made his employer aware that he was struggling with the clinical IT systems implemented in

December 2020. This, he submitted, demonstrated that Mr Gabriel was able to say when he needed help. Mr Dhillon referred the Tribunal to the case of *Bawa-Garba*, and highlighted that the case involved systemic failings by the employer. He submitted that the Tribunal should take the systemic failings at the Practice into account when considering the issue of sanction in Mr Gabriel's case.

219. Mr Dhillon submitted that Mr Gabriel was an experienced doctor who was able to offer his patients an invaluable service and he asked the Tribunal to afford Mr Gabriel the chance to remediate whilst working under conditions. He submitted that this was not a suspension case. He reminded the Tribunal that it had found Mr Gabriel's misconduct was potentially remediable. He added that the Tribunal should take into account that Mr Gabriel had not worked for almost two years and any further period of suspension would only add to the length of that period and could lead to de-skilling.

220. Referring to the SG, Mr Dhillon submitted that Mr Gabriel will respond to remediation and that conditions would be a suitable sanction. Mr Dhillon added that Mr Gabriel fully understood that should the Tribunal decide to impose a period of conditions, it would likely include a condition requiring supervision. Mr Dhillon submitted that Mr Gabriel was aware that if he resisted supervision, he risked a finding that he lacked insight. However, Mr Dhillon stated that supervision would make it very difficult for Mr Gabriel to secure any suitable employment. Mr Dhillon submitted that Mr Gabriel was therefore 'between a rock and a hard place' in relation to the issue of supervision. Mr Dhillon confirmed that Mr Gabriel was willing to comply with those conditions that the Tribunal considered appropriate.

221. Mr Dhillon invited the Tribunal to impose a period of conditions upon Mr Gabriel's registration.

The Tribunal's Approach

222. The decision as to the appropriate sanction to impose, if any, is a matter for the Tribunal exercising its own judgement, considering any relevant mitigating and aggravating factors. It should apply the principle of proportionality, balancing the doctor's interests with the public interest. The Tribunal took into account that the purpose of sanctions is not to be punitive although the sanction imposed may have a punitive effect.

223. The Tribunal bore in mind that the main reason for imposing sanctions is to protect the public, which includes protecting and promoting the health, safety and wellbeing of the public, maintaining public confidence in the profession, and declaring and upholding proper standards of conduct and behaviour. In making its decision, the Tribunal also had regard to

the principle of proportionality, weighing the interests of the public against those of Mr Gabriel. It also considered and balanced the mitigating and aggravating factors in this case.

224. The Tribunal reminded itself of the requirement in SG to consider the least restrictive sanction first and then, if necessary, consider the other sanctions, taking into account the evidence and submissions that have been heard, including its earlier findings on fact and impairment.

225. The Legally Qualified Chair advised the Tribunal of the case of *Bolton v Law Society (1994) 1 WLR 512*, in which the Court set out the general approach to be adopted when considering sanctions in professional regulatory cases. In particular the Court highlighted that considerations which would normally weigh in mitigation have less effect in this jurisdiction when considering the issue of what sanction, if any, to impose.

226. The Legally Qualified Chair also drew the Tribunal's attention to the case of *General Medical Council and The Professional Standards Authority for Health and Social Care v Bramhall [2021] EWHC 2109* in which the Court held that if a Tribunal departs from SG, it has a duty to state more clear, substantial and specific reasons for the departure, than if the Guidance was being followed.

Aggravating and Mitigating Factors

227. The Tribunal had regard to paragraphs 50 - 55 and 129 of the SG and identified the following aggravating factors:

- there was limited evidence of insight, particularly in relation to the clinical failings;
- there was a lack of reflection by Mr Gabriel into the concerns identified in this case;
- there was little evidence of any substantial remediation;
- patients were put at risk of harm; and
- Mr Gabriel had been subject to a finding of misconduct by a previous Tribunal in relation to similar concerns. The Tribunal regarded this as a substantial aggravating factor given Mr Gabriel's limited insight and remediation.

228. The Tribunal had regard to paragraphs 25(a), 25(c), 31, 42(b) and 46 of the SG, and identified the following mitigating factors:

- Mr Gabriel had some, albeit limited, insight;
- he had demonstrated some remorse;
- he had made some, albeit insufficient, attempts to remediate the misconduct found;

- he had made early admissions to the majority of the paragraphs of the Allegation; and
- he had been unsupported by the Practice and had struggled with IT issues XXX.

229. The Tribunal acknowledged that the index events occurred during Mr Gabriel's XXX and at the time of the COVID-19 pandemic. However, it did not regard these matters as mitigating features in this case. The Tribunal noted that Mr Gabriel is an experienced practitioner and it took the view that the background circumstances of the pandemic did not mitigate his clinical failings or his failures in record keeping. Whilst Mr Gabriel's poor record keeping could, to some extent, be ascribed to his difficulties with IT, the Tribunal was presented with little evidence that the pandemic itself impacted on Mr Gabriel's ability to keep accurate records. Similarly, the Tribunal took the view that the fact that Mr Gabriel was on a XXX at the time of some of the index events was of limited relevance. The Practice had made adjustments to Mr Gabriel's working commitments so that he could ease himself back into the workplace and the fact that he was on XXX did not mitigate his clinical failings.

230. The Tribunal balanced the aggravating and mitigating features. The Tribunal had sympathy for Mr Gabriel with regard to the lack of support he received from the Practice and the struggles that he had with IT. It was to his credit that he made early admissions and had demonstrated some remorse. However, these mitigating features did not in themselves explain Mr Gabriel's clinical failings or his lack of reflection, insight and remediation into those matters. The Tribunal regarded it as concerning that Mr Gabriel's fitness to practise had been found to be impaired on a previous occasion and, despite having attended a previous review hearing, was unable to demonstrate to this Tribunal that he understood what had caused his clinical failings at the Practice or what he would do in the future to prevent a recurrence.

231. The Tribunal found that the circumstances of this case were materially different to those in *Bawa-Garba.* It considered that certain of Mr Gabriel's colleagues at the Practice had taken the (unreasonable) view that he should have worked at the Practice on more than one day per week; that led the Practice to be unsupportive of Mr Gabriel and to be less than sympathetic towards his IT issues. The Tribunal concluded that the lack of support from the Practice resulted from relationship issues rather than the 'systemic failings' identified in *Bawa-Garba*.

The Tribunal's Determination on Sanction

No action

232. In coming to its decision as to the appropriate sanction, if any, to impose in Mr Gabriel's case, the Tribunal first considered whether to conclude the case by taking no action. The Tribunal considered the submissions of both parties. It also considered paragraphs 68-70 of the SG which highlights that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

233. The Tribunal determined that, given the gravity of the facts found proved, and in the absence of any exceptional circumstances in this case, taking no action would be neither appropriate, proportionate nor in the public interest.

Undertakings

234. No undertakings were submitted to the Tribunal.

Conditions

235. The Tribunal next considered whether it would be sufficient to impose conditions on Mr Gabriel's registration.

236. The Tribunal took account of paragraph 80 of SG which highlights that, in many cases, the purpose of conditions is to help the doctor remedy any deficiencies in their practice, while protecting the public. Further, the Tribunal noted paragraph 81 of SG which confirms that conditions might be most appropriate in cases involving issues around the doctor's performance or where there is evidence of shortcomings in areas of the doctor's practice.

237. It also had regard to paragraph 85, which states:

> *'85 Conditions should be appropriate, proportionate, workable and measurable.'*

238. The Tribunal took into account paragraph 82 of SG which advises that:

> *'82 Conditions are likely to workable where:*
>
> *a. the doctor has insight;*
> *b. a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings;*
> *c. the Tribunal is satisfied that the doctor will comply with them;*
> *d. the doctor has the potential to respond positively to remediation or retraining or to their work being supervised.'*

239. The Tribunal also had regard to paragraph 84 of SG which lists the factors that would indicate that conditions may be appropriate.

240. The Tribunal found in its impairment determination that Mr Gabriel had limited insight into his clinical failings. Further, despite an earlier finding that his fitness to practise was impaired, had not presented the Tribunal with any meaningful reflections on why he was again before a Fitness to Practise Tribunal, what had caused his clinical errors and what he would do to prevent a recurrence. The Tribunal reminded itself of its earlier findings that there was a substantial risk of repetition of Mr Gabriel's misconduct and that all three limbs of the overarching objective were engaged.

241. In addition, whilst the Tribunal found that Mr Gabriel's misconduct was potentially remediable, the Tribunal had limited evidence of his attempts at remediation and a paucity of self-reflection arising from the training that had been undertaken. Given his previous experience of fitness to practise proceedings, the Tribunal would have expected much more substantial engagement in attempts at remediation by Mr Gabriel. Despite Mr Dhillon's submission that Mr Gabriel would comply with any conditions that might be imposed, it appeared to the Tribunal that Mr Gabriel was somewhat reluctant to accept clinical supervision on the basis that it might make it more difficult for him to obtain employment.

242. Given these factors, the Tribunal was concerned that any conditions that could be formulated might not be workable.

243. The Tribunal took into account paragraph 130 of SG which states that where a doctor has not acted in a patient's best interests and has failed to provide an adequate level of care it is particularly important that a doctor has developed or has the potential to develop insight into these failures. Paragraph 130 states, '*where insight is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient'.*

244. The Tribunal concluded that, given the gravity of Mr Gabriel's misconduct and his limited insight, the imposition of conditions would not be sufficient to address the Tribunal's findings on impairment.

Suspension

245. The Tribunal then went on to consider whether a period of suspension would be an appropriate and proportionate sanction to impose on Mr Gabriel's registration.

246. The Tribunal had regard to paragraphs 91, 92, 93, 94 and 97 (a), (b), (f) and (g), which state:

'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

93. Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions.

94 Suspension is also likely to be appropriate in a case of deficient performance or lack of knowledge of English in which the doctor currently poses a risk of harm to patients but where there is evidence that they have gained insight into the deficiencies and have the potential to remediate if prepared to undergo a rehabilitation or retraining programme.

97. Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a. A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors."

b In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.

f No evidence of repetition of similar behaviour since incident'.

247. The Tribunal was satisfied that this case fell within the ambit of those paragraphs of the SG as set out above. The Tribunal was mindful of its findings at the impairment stage. It had identified a significant number of failures in Mr Gabriel's practice that fell seriously below the standards expected of a reasonably competent General Practitioner. His conduct was a significant departure from the standards of GMP, his misconduct was serious, and his actions put patients at risk of harm. Whilst the Tribunal noted that a number of the failings related to poor record keeping, Mr Gabriel's misconduct also involved clinical failings of not taking action when there was a clinical need to do so.

248. The Tribunal was mindful of paragraphs 94 and 97(g) of SG which indicate that suspension may be appropriate where the doctor has insight and (in the case of paragraph 97(g)) where the doctor does not pose a significant risk of repeating their behaviour. The Tribunal determined at the impairment stage that Mr Gabriel had limited insight and presented a significant risk of repeating his behaviour. As a result, the Tribunal considered whether suspension was an adequate sanction and had regard to those paragraphs of SG relating to erasure. However (for the reasons set out below) the Tribunal concluded that, whilst Mr Gabriel's conduct was serious and his limited insight was concerning, his misconduct was not fundamentally incompatible with continued registration.

249. For all the above reasons, the Tribunal determined that a period of suspension would be the appropriate and proportionate sanction in this case. It considered that suspension would properly mark the seriousness with which the Tribunal viewed Mr Gabriel's misconduct, and would appropriately protect the public interest and uphold and maintain professional standards in the medical profession. Further, a period of suspension would send out a clear message to the public, the medical profession and Mr Gabriel that this type of behaviour is not acceptable.

Erasure

250. In view of the seriousness of Mr Gabriel's misconduct, the Tribunal considered whether erasure would be an appropriate sanction.

251. The Tribunal considered paragraphs 107 – 109 of the SG, particularly 109 (a), the Tribunal considered the following:

> *'109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> > *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor'*

252. Mr Gabriel's actions were a serious departure from GMP. However, the Tribunal concluded that despite the serious nature of Mr Gabriel's misconduct, and the limited insight he has demonstrated, it was not fundamentally incompatible with his continued registration. It took the view that whilst the misconduct was serious it had not been deliberate or reckless and Mr Gabriel is yet to reach the threshold for a persistent lack of insight. The Tribunal considered that, as an experienced practitioner, it might be possible for Mr Gabriel to remediate his misconduct. It took the view that a period of suspension would afford Mr Gabriel the time to remediate, reflect on his misconduct, gain insight and potentially return to practice; as such a sanction of erasure would be disproportionate.

253. Having weighed the interests of the public against those of Mr Gabriel, the Tribunal determined that a period of suspension was the appropriate and proportionate sanction in this case.

Length of suspension

254. In determining the length of the suspension, the Tribunal had regard to paragraphs 99 – 102 of SG and the table following paragraph 102. It had regard to the following factors set out in that table in light of its previous findings:

- the extent to which the doctor departed from the principles of GMP;
- the extent to which the doctor's actions risked patient safety or public confidence; and
- whether the doctor showed a lack of responsibility toward clinical duties/patient care.

255. The Tribunal considered that the length of suspension should recognise the seriousness of Mr Gabriel's misconduct and be sufficient to maintain public confidence and uphold proper professional standards of behaviour. Further, in a case where only limited insight and remediation had been demonstrated, it was the Tribunal's view that a sufficient

period was required to enable Mr Gabriel to undertake further development of his insight and undertake further remediation, and be able to demonstrate such at any review hearing. The Tribunal considered that, given his current lack of adequate remediation and insight, a period of nine months suspension, was appropriate and proportionate in this case.

Review

256. Paragraphs 163 and 164 of the SG deals with review hearings and states:

> *'163 It is important that no doctor is allowed to resume unrestricted practice following a period of conditional registration or suspension unless the tribunal considers that they are safe to do so.*
>
> *164 In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing.'*

257. The Tribunal has determined to direct a review of Mr Gabriel's case. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that at the review hearing the onus will be on Mr Gabriel to demonstrate that he has developed an appropriate level of insight into his misconduct and has remediated.

258. It therefore may assist the reviewing Tribunal to receive from Mr Gabriel the following:

- Mr Gabriel's personal reflections setting out his insight, particularly in relation to the clinical failings; together with his understanding of how his actions had damaged the reputation of the medical profession;
- Evidence of his reflections on the findings of this Tribunal and any remediation he has undertaken to address the concerns identified in this case;
- His Personal Development Plan (PDP) and evidence of Continued Professional Development (CPD);
- Evidence that he has kept his medical knowledge and skills up to date; and
- Any other evidence which Mr Gabriel considers would be of assistance to the reviewing Tribunal. This may include his learning from any clinical attachments or coaching and/or mentorship.

Determination on Immediate Order - 04/12/2023

259. Having determined that Mr Gabriel's registration should be subject to an order of suspension for a period of nine months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

260. On behalf of the GMC, Ms Renton submitted that an immediate order should be imposed in order to protect the members of the public and that an immediate order is otherwise in the public interest.

261. Ms Renton submitted that the Tribunal has found that Mr Gabriel's conduct put patients at risk and showed poor standards of clinical care. She submitted that the Tribunal should consider the matters that led it to impose the substantive sanction of suspension. Ms Renton submitted that the Tribunal has found that Mr Gabriel's conduct amounted to misconduct, with multiple findings that his actions amounted to serious misconduct.

262. Ms Renton submitted that it would not be appropriate for Mr Gabriel to return to unrestricted practice at this time. She submitted that this view is also reflected in the information that the Tribunal seek from a future review hearing. Ms Renton reminded the Tribunal that Mr Gabriel has had restrictions on his registration and has been out of practice for some time such that it would not be appropriate for him to be able to practice without restrictions before the substantive order takes effect.

263. Ms Renton confirmed that there was an interim order in place for Mr Gabriel which should be revoked by the Tribunal.

264. On behalf of Mr Gabriel, Mr Dhillon submitted that Mr Gabriel did not oppose an immediate order.

The Tribunal's Determination

265. In reaching its decision, the Tribunal considered the relevant paragraphs of the SG and exercised its own independent judgement. In particular, it took account of paragraphs 172, 173 and 178, which state:

'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.

173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.

…

178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'

266. The Tribunal determined that an immediate order was necessary in this case to protect members of the public. It found Mr Gabriel's misconduct to be serious as there were a number of clinical failings which put patients at risk. It also found that there was a substantial risk of repetition. The Tribunal took the view that immediate action must be taken to protect public confidence in the medical professional and determined that imposing an immediate order is in the interests of the public.

267. The Tribunal considered paragraph 178 of the SG and noted that the decision to impose an immediate order is at the discretion of the Tribunal. It concluded that it would not be appropriate for Mr Gabriel to continue in unrestricted practice before the substantive order takes effect.

268. This means that Mr Gabriel's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

269. The interim order is hereby revoked.

270. That concludes this case.

ANNEX A - 05/09/2023

Application to amend the Allegation

271. On day one of the hearing, prior to the opening of the case, Ms Colette Renton, Counsel, on behalf of the GMC, made an application to amend the Allegation, pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise) Rules 2004 ('the Rules') to withdraw some paragraphs and subparagraphs of the Allegation.

Submissions

272. Ms Renton reminded the Tribunal of the joint expert report dated 22 August 2023 and informed it that she did not have sight of that document until 1 September 2023. She submitted that, as such there had been insufficient time to refer the allegations to a case examiner.

273. Ms Renton submitted that the GMC were seeking a number of deletions in accordance with the outcome of the joint expert report. She submitted that the GMC did not seek to introduce a new case at a late stage, but sought to focus the issues; she said it had not been possible for this matter to have been dealt with on an earlier occasion.

274. Ms Renton submitted that there was no injustice to the Defence, in that the amendments are by way of deletion rather than addition and that those deletions accord with the evidence in a report to which their Defence expert was a joint contributor.

275. Ms Renton invited the Tribunal to delete paragraphs 1a, 1b(iii), 1b(iv)(1), 5a(i), 5a(ii), 5b, 6a and 7 of the Allegation from:

Patient A

10. On 30 December 2020 you had a telephone consultation with Patient A and you failed to:

c. add a correct diagnostic read code;

d. record:

i. an adequate history regarding her symptoms;

ii. an assessment as to whether Patient A's symptoms warranted a face-to-face consultation;

iii. your diagnosis of Patient A;

iv. that you considered whether Patient A:

1. was acutely unwell requiring immediate hospital admission;

2. had been unwell for a prolonged period of time requiring:

a. blood tests;

b. a chest X-ray.

Patient E

5. On 19 February 2021 you had a telephone consultation with Patient E and you failed to:

a. formulate an adequate treatment plan in that you did not:

i. either adjust Patient E's dose of statin, or change the brand of statin, in order to achieve a target of less than 5 millimoles per litre;

ii. organise an annual recall to re-check Patient E's haemoglobin AC1 ('HBA1c') level;

iii. diagnose non-diabetic hyperglycaemia despite Patient E's raised HBA1c level;

iv. add a read code diagnosis of non-diabetic hyperglycaemia;

b. record:

i. either:

2. an adequate history of Patient E's symptomatic angina; or

3. that the reason you noted a limited history taking of Patient E's symptomatic angina was because this information had already been

recorded by another general practitioner on 17 February 2021;

vi. that you had considered whether Patient E either should have been referred to hospital immediately, or could wait for her forthcoming cardiology appointment;

vii. an assessment of Patient E's:

1. total cholesterol;

2. HBA1c;

viii. your discussion with Patient E regarding:

4. her high cholesterol;

5. the significance of a raised HBA1c;

6. a diagnosis of non-diabetic hyperglycaemia;

ix. the reason why Patient E's blood pressure medication was switched.

Patient F

6. On 22 February 2021 you had a telephone consultation with Patient F's mother, Ms G ('the Consultation') and you:

a. inappropriately prescribed Duac (Benzoyl Peroxide 3% / Clindamycin 1% gel) for Patient F's acne in that:

i. Duac medication was not licensed for patients under 12 years of age;

ii. licensed medication preparations were available for Patient F;

b. failed to record that the Consultation had been conducted with Ms G.

7. You made an inappropriate change to the note of the Consultation in Patient F's medical record on one or more of the following dates, in that you did not specify that changes you made on that date were retrospective:

a. 22 February 2021;

b. 26 February 2021.

To:

Patient A

1. On 30 December 2020 you had a telephone consultation with Patient A and you failed to:

   a. ~~add a correct diagnostic read code~~; Withdrawn under Rule 17(6)

   b. record:

      i. an adequate history regarding her symptoms; To be determined

      ii. an assessment as to whether Patient A's symptoms warranted a face-to-face consultation; To be determined

      iii. ~~your diagnosis of Patient A~~; Withdrawn under Rule 17(6)

      iv. that you considered whether Patient A:

         1. ~~was acutely unwell requiring immediate hospital admission;~~ Withdrawn under Rule 17(6)

         2. had been unwell for a prolonged period of time requiring:

            a. blood tests; To be determined

            b. a chest X-ray. To be determined

Patient E

5. On 19 February 2021 you had a telephone consultation with Patient E and you failed to:

   a. formulate an adequate treatment plan in that you did not:

      i. ~~either adjust Patient E's dose of statin, or change the brand of statin, in order to achieve a target of less than 5 millimoles per litre;~~ Withdrawn under Rule 17(6)

      ii. ~~organise an annual recall to re-check Patient E's haemoglobin AC1 ('HBA1c') level;~~ Withdrawn under Rule 17(6)

      iii. diagnose non-diabetic hyperglycaemia despite Patient E's raised HBA1c level; To be determined

      iv. add a read code diagnosis of non-diabetic hyperglycaemia; To be determined

   ~~b. record:~~

~~i. either:~~

~~1. an adequate history of Patient E's symptomatic angina; or~~ Withdrawn under Rule 17(6)

~~2. that the reason you noted a limited history taking of Patient E's symptomatic angina was because this information had already been recorded by another general practitioner on 17 February 2021;~~ Withdrawn under Rule 17(6)

~~i. that you had considered whether Patient E either should have been referred to hospital immediately, or could wait for her forthcoming cardiology appointment;~~ Withdrawn under Rule 17(6)

~~ii. an assessment of Patient E's:~~

~~1. total cholesterol;~~ Withdrawn under Rule 17(6)

~~2. HBA1c;~~ Withdrawn under Rule 17(6)

~~iii. your discussion with Patient E regarding:~~

~~1. her high cholesterol;~~ Withdrawn under Rule 17(6)

~~2. the significance of a raised HBA1c;~~ Withdrawn under Rule 17(6)

~~3. a diagnosis of non-diabetic hyperglycaemia;~~ Withdrawn under Rule 17(6)

~~iv. the reason why Patient E's blood pressure medication was switched.~~ Withdrawn under Rule 17(6)

Patient F

6. On 22 February 2021 you had a telephone consultation with Patient F's mother, Ms G ('the Consultation') and you:

~~a. inappropriately prescribed Duac (Benzoyl Peroxide 3% / Clindamycin 1% gel) for Patient F's acne in that:~~

i. ~~Duac medication was not licensed for patients under 12 years of age~~; Withdrawn under Rule 17(6)

ii. ~~licensed medication preparations were available for Patient F~~; Withdrawn under Rule 17(6)

b. failed to record that the Consultation had been conducted with Ms G. To be determined

~~7. You made an inappropriate change to the note of the Consultation in Patient F's medical record on one or more of the following dates, in that you did not specify that changes you made on that date were retrospective:~~

~~a. 22 February 2021;~~ Withdrawn under Rule 17(6)

b. ~~26 February 2021~~. Withdrawn under Rule 17(6)

276. Mr Amardeep Dhillon, Counsel, on behalf of Mr Gabriel, did not oppose the application.

LQC advice to the Tribunal

277. Under Rule 17 (6) of the Fitness to Practise Rules, where it appears to the Medical Practitioners Tribunal at any time that: the particulars of the allegation or the facts upon which it is based, of which notice has been given under rule 15, should be amended; and the amendment can be made without injustice, it may, after hearing the parties, amend the particulars on appropriate terms.

The Tribunal's Approach

278. Paragraph 17(6) of the Rules states:

'17(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.'

279. The Tribunal was satisfied that the proposed amendments reflected the correct position in light of the joint expert report and could be made without injustice to either party. Accordingly, it granted the application.

ANNEX B - 13/09/2023

Application for a witness to give evidence remotely

280. On 13 September 2023, Mr Dhillon made an application for Dr N, an expert on behalf of Mr Gabriel, to give evidence by video link. This application was made under Rule 34(13) and (14) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), which states:

> *"(13) A party may, at any time during a hearing, make an application to the Committee or Tribunal for the oral evidence of a witness to be given by means of a video link or a telephone link.*
>
> *(14) When considering whether to grant an application by a party under paragraph (13), the Committee or Tribunal must—*
>
> *(a) give the other party an opportunity to make representations;*
>
> *(b) have regard to—*
>
> *(i) any agreement between the parties, or*
>
> *(ii) in the case of a Tribunal hearing, any relevant direction given by a Case Manager; and*
>
> *(c) only grant the application if the Committee or Tribunal consider that it is in the interests of justice to do so."*

Submissions

281. On behalf of Mr Gabriel, Mr Dhillon stated that he should have made it clearer to the Tribunal that it was proposed that this witness would give evidence remotely. He stated that he had canvassed this with the GMC and that it appeared impossible to hear Dr N's evidence otherwise.

282. Ms Renton stated that there was no objection from the GMC.

Tribunal's Decision

283. The Tribunal had regard to Rule 34(13) and (14) of the Rules, as set out above. It noted the consent between the parties and concluded that it was in the interests of justice. It therefore determined to grant Mr Gabriel's application for Dr N to give evidence by video link.