Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

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Dates: 21/11/2016 – 16/12/2016
Reconvened: 19/04/2017 – 21/04/2017

Medical Practitioner's name: Mr Pradeep AGARWAL

GMC reference number: 2394503

Primary medical qualification: MB BS 1973 Lucknow University

Type of case	**Outcome on impairment**
New - Misconduct	Impaired
New - Deficient professional performance	Impaired

Summary of outcome
Erasure

Immediate order imposed

Tribunal:

Medical Tribunal Member (Chair)	Dr Priya Iyer
Lay Tribunal Member:	Mrs Sue Wadham
Medical Tribunal Member:	Dr Vivek Sen

Legal Assessor:	Mr Angus MacPherson
Tribunal Clerk:	Ms Corina Seymour – 21/11/2016 – 16/12/2016 Miss Miriam Bonabana – 19/04/2017 – 21/04/2017

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Alun Jones, Counsel, instructed by RadcliffeLeBrasseur Solicitors
GMC Representative:	Mr Simon Jackson QC – 21/11/2016 – 16/12/2017 Mr Terence Rigby, Counsel – 20/04/2017 – 21/04/2017

Record of Determinations – Medical Practitioners Tribunal

Allegation and Findings of Fact

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

Patient A (Fitzwilliam Hospital)

1. Between 18 September and 6 November 2013 you were contracted as a Consultant Colorectal Surgeon at the Fitzwilliam Hospital. **Admitted and found proved**

2. During a consultation with Patient A on 18 September 2013 you failed to:

    a. explain the type of examinations you intended to undertake on Patient A; **Found not proved**

    b. explain your intention to use a sigmoidoscope (or similar probe) during the examination you intended to undertake on Patient A; **Found proved**

    c. gain informed consent from Patient A regarding the rectal examination you undertook using:

        i. your finger; **Found not proved**

        ii. a sigmoidosope (or similar probe); **Found proved**

    d. gain informed consent from Patient A to start the examination in the absence of a chaperone; **Found not proved**

    e. discuss alternative non-surgical conservative treatments with Patient A. **Found proved**

3. Within your medical record of the consultation with Patient A on 18 September 2013 you failed to:

    a. comment on the size of Patient A's haemorrhoids; **Found proved**

    b. comment on whether the haemorrhoids were prolapsing; **Found proved**

    c. comment on how chronic the fissure was; **Found proved**

    d. record your findings on your digital examination; **Found not proved**

e. record the sigmoidoscopy examination; **Found not proved**

f. record your findings on undertaking a sigmoidoscopy; **Found proved**

g. record Patient A's symptoms (apart from anal pain). **Found proved**

4. Prior to carrying out surgery on Patient A on 21 October 2013 you failed to:

   a. notify Patient A you intended to carry out a lateral sphincterectomy operation; **Found proved**

   b. obtain consent from Patient A for a lateral sphincterectomy operation. **Found proved**

5. You proceeded to surgery on 21 October 2013:

   a. without first identifying and recording the appropriate indications for a haemorrhoidectomy or a lateral sphincterectomy; **Found proved**

   b. before establishing non-surgical conservative treatments for an anal fissure had failed, or were likely to fail, such as one or more of the following:

      i. 8-12 week course of GTN; **Found proved**

      ii. Diltiazem cream; **Found proved**

      iii. Clostridium Botulinum Toxin ('Botox') injections; **Found proved**

   c. without taking sufficient account of the fact that Patient A had had one course of GTN prescribed by her GP which:

      i. did have some beneficial effect; **Found proved**

      ii. should have been repeated; **Found proved**

   d. before establishing non-surgical conservative treatments for the symptoms of haemorrhoids had failed, or were likely to fail, such as one of more of the following:

      i. phenol injections; **Found proved**

      ii. banding; **Found proved**

iii. advice about diet; **Found proved**

e. which was unnecessary. **Found proved**

6. Within your operation note of 21 October 2013 relating to Patient A you failed to record:

a. an accurate description of the haemorrhoids; **Found proved**

b. whether the haemorrhoids were prolapsing; **Found not proved**

c. clearly whether Patient A had an acute or chronic fissure; **Found proved**

d. clearly your findings from the examination under anaesthetic; **Found not proved**

e. clearly the indications for undertaking a lateral sphincterotomy, as well as a haemorrhoidectomy; **Admitted and found proved**

f. any post-operative instructions about:

i. pain control; and/or **Found proved**

ii. laxatives. **Found proved**

7. Subsequent to the surgery carried out by you on Patient A on 21 October 2013 and prior to Patient A's discharge on 22 October 2013 you failed to:

a. personally inform Patient A that you had in fact carried out a lateral sphincterotomy, which differed from the fissurectomy procedure originally consented to by Patient A; **Found proved**

b. explain the reasoning for the change in operation, (referred to in paragraph 7a above), to Patient A; **Found proved**

c. discuss with Patient A, or to arrange for someone else to explain the nature and the outcome of her operation on the 21 October 2013; **Found proved**

d. provide adequate post-operative care such as:

i. to warn Patient A about the pain she might experience when having her bowels open in the first week after surgery; **Found proved**

ii. to explain to Patient A how to cope with the pain; **Found proved**

iii. to make clear the importance of taking laxatives to prevent post-operative constipation. **Found proved**

8. During a post-operative consultation with Patient A on 4 November 2013 you:

a. failed to:

i. explain the type of examination you then intended to undertake on Patient A; **Found proved**

ii. warn Patient A of the level of pain that an examination of this type would cause as a result of her recent surgery; **Found proved**

iii. await the arrival of a chaperone before gesturing for Patient A to move to the examination table; **Found proved**

iv. allow Patient A an appropriate period of time to make an informed decision regarding the use of a chaperone; **Found not proved**

v. gain informed consent from Patient A for the rectal examination you subsequently undertook with your finger; **Found proved**

vi. pull a curtain round Patient A whilst she undressed; **Found proved**

vii. provide Patient A with a blanket whilst she undressed; **Found proved**

viii. halt the examination when:

1. Patient A became distressed; **Found proved**

2. Patient A indicated by her actions that she wished you to stop; **Found proved**

3. Nurse B first informed you Patient A wished to stop; **Found not proved**

ix. offer to halt the examination at any time, when you knew or ought to have realised that Patient A was in severe pain; **Found proved**

x. at any time during the examination check on Patient A's:

1. wellbeing; **Found not proved**

2. pain levels; **Found not proved**

3. willingness to continue with the examination; **Found not proved**

xi. reassure Patient A that her continued discomfort was usual after a haemorrhoidectomy; **Found proved**

xii. provide advice on bowel function; **Found proved**

b. incorrectly recorded within the medical record that you had performed a fissurectomy rather than a lateral sphincterotomy. **Admitted and found proved**

9. During a post-operative consultation with Patient A on 4 November 2013 you undertook a rectal examination which:

a. was unnecessary in light of the severe pain that Patient A would experience as a result of the planned examination; and **Found proved**

b. caused unnecessary pain to Patient A. **Found proved**

Patient C (Pilgrim Hospital)

10. Between 14 November 2013 and 26 March 2014 you were employed as a Consultant Colorectal and General Surgeon at the Pilgrim Hospital by the United Lincolnshire Hospitals NHS Trust. **Admitted and found proved**

11. On 14 November 2013 prior to commencing a flexible sigmoidoscopy procedure on Patient C you undertook a digital rectal examination. **Admitted and found proved**

12. On 14 November 2013 whilst performing a flexible sigmoidoscopy procedure on Patient C you:

    a. held the scope in a clinically unusual manner and/or in a different manner to the way you held it for a subsequent male patient; **Found proved**

    b. inserted your outstretched right index finger into the vagina of Patient C:

        i. whilst simultaneously inserting the scope into the anus of Patient C; **Found proved**

        ii. on more than one occasion. **Found not proved**

13. Your conduct as alleged in paragraphs 11 and 12 was sexually motivated.

In relation to paragraph 11 Found not proved
In relation to paragraph 12 Found not proved

Restrictions

14. Restrictions were imposed upon your clinical practice by the Pilgrim Hospital, which you were informed of:

    a. verbally during a meeting held with you on 20 November 2013; **Admitted and found proved**

    b. by letter dated 21 November 2013. **Admitted and found proved**

15. You failed to notify the Fitzwilliam Hospital of the restrictions imposed upon your clinical practice on 20 November 2013 by the Pilgrim Hospital. **Admitted and found proved**

Request to Ms D

16. On or around 26 March 2014 you approached Ms D and requested that she 'have a word with Ms E and ask her to drop the allegation', (in respect of Patient C) or words to that effect. **Found proved**

Deficient Professional Performance

17. You underwent a General Medical Council assessment of the standard of your professional performance on:

    a. 30 November – 3 December 2015 (peer review); **Admitted and found proved**

    b. 4 December 2015 (tests of competence). **Admitted and found proved**

18. Your professional performance was unacceptable in the area of Relationships with Patients. **Admitted and found proved**

19. Your professional performance was a cause for concern in the area of Assessment. **Admitted and found proved**

Patient F (Medico Legal Report)

20. Between 23 January 2014 and April 2015 you were acting as an Expert General Surgeon on behalf of Capita Medical Reporting. **Admitted and found proved**

21. Prior to a consultation with Patient F you failed to familiarise yourself with Patient F's:

    a. case instructions; **Found not proved**

    b. medical records. **Admitted and found proved**

22. On 8 April 2014 you held the consultation ('the consultation') with Patient F:

    a. within the kitchen area of a domestic flat; **Found not proved**

    b. with no other medical staff present. **Admitted and found proved**

23. During the consultation with Patient F you failed to:

    a. arrange a setting which:

        i. was appropriate for a consultation; **Admitted and found proved**

ii. would have been appropriate for a patient examination; **Admitted and found proved**

b. have Patient F's medical records available to you; **Admitted and found proved**

c. have Patient F's case instructions available to you; **Found not proved**

d. conduct a physical examination of Patient F's:

i. chest; **Found proved**

ii. abdomen. **Found proved**

24. Subsequent to the consultation with Patient F you produced a medico legal report, dated 20 April 2014 which:

a. contained one or more of the inaccuracies outlined within Schedule 1; **Admitted and found proved**

b. referred to an examination of Patient F which:

i. did not take place; **Found proved**

ii. you knew did not take place; **Found proved**

c. contained a prognosis and opinion which was based on incorrect information. **Admitted and found proved**

25. Subsequent to a telephone conversation with Patient F which took place between 30 April 2014 and 24 October 2014 you produced an amended version of the medico legal report, dated 20 April 2014 which:

a. still contained one of more of the inaccuracies outlined within Schedule 2; **Admitted and found proved**

b. referred within paragraph 12 to an examination of Patient F which:

i. did not take place; **Found proved**

ii. you knew did not take place; **Found proved**

c. contained a prognosis and opinion which was based on incorrect information. **Found not proved**

26. Your conduct as described at paragraphs:

a. 24 and 25 was misleading;

Admitted and found proved in relation to 24(a), 24(c) and 25(a)
Found proved in relation to 24(b)(i), 24(b)(ii), 25(b)(i) and 25(b)(ii)
Falls in relation to 25(c)

b. 24(b) and 25(b) was dishonest. **Found proved in relation to 24(b) and 25(c)**

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

a. misconduct in respect of paragraphs 1-16 and 20-26;

b. deficient professional performance in respect of paragraphs 17-19.

Attendance of Press / Public

The hearing was all heard in public

Determination on Facts - 14/12/2016

Mr Agarwal:

Admissions

1. At the outset of the proceedings you made a number of admissions in relation to paragraphs 1, 6(e), 8(b), 10, 11, 14(a), 14(b), 15, 17(a), 17(b), 18, 19, 20, 21(b), 22(b), 23(a)(i), 23(a)(ii), 23(b), 24(a), 24(c), 25(a) and 26(a), in relation to 24(a), 24(c) and 25(a). These are set out below.

Amendments

2. During in camera discussions, the tribunal, of its motion, determined to make amendments to correct typographical errors which it found in the allegation. The procedure set out in paragraphs 4a, 4b and 5a of the allegation is "*lateral sphincterectomy*". The tribunal amended those references to lateral sphincterotomy to be consistent with the actual operation that you undertook and the relevant evidence.

Application to admit evidence

3. Prior to submissions, Mr Jackson, on behalf of the GMC, made an application under Rule 34(1) to admit an email from Ms G, in relation to the availability of Botox at Fitzwilliam Hospital during the period in which the incident with Patient A occurred. Mr Jones, on your behalf, opposed the application submitting that it was neither relevant nor fair. He submitted that it was not relevant as the use of Botox identified by Ms G in the hospital during this period was for a different condition, namely fistula-in-ano and therefore to admit the email would also be unfair. The tribunal determined that the availability or otherwise of Botox within the same department as you was relevant, and that although the information attained by Ms G was based on hearsay it would accede to the application from Mr Jackson and it would attach what weight, if any, it considered appropriate during its deliberations on the facts.

Background to the case

4. At the time of the allegations against you, you worked as a Consultant Colorectal and General Surgeon at the Pilgrim Hospital, (United Lincolnshire Hospitals NHS Trust), having been appointed in March 2001. Alongside your NHS practice, you also had private practising privileges at Fitzwilliam Hospital, Peterborough (Ramsay Healthcare Group). You also provided professional medical services to Capita Reporting as a medico-legal expert.

Witnesses and Evidence

5. The tribunal has given consideration to all of the oral and documentary evidence adduced in this case. It has also taken account of the submissions made by Mr Jackson and Mr Jones. These are a matter of record and the tribunal has not rehearsed them in this determination.

6. The tribunal received a Performance Assessment Report dated 2 February 2016. It has also heard the oral evidence of:

- Dr A, (GMC Assessor, (team leader) and retired General Practitioner);
- Mr B, (GMC Assessor and Consultant Colorectal Surgeon and Clinical Lecturer, University Hospital).

7. The tribunal has also received expert reports from Mr C, Consultant Surgeon in relation to:

- Patient A, dated 11 February 2016 and supplementary report dated 15 November 2016;
- Patient C, dated 11 December 2015;

- Patient F, dated 16 February 2016 and supplementary report dated 17 February 2016.

8. The tribunal has also received witness statements from the following GMC witnesses:

- Mr D, (Medical Director, Ramsay Health Care);
- Dr E, (Medical Director, Capita) ;
- Ms F, (Projects Co-ordinator, Capita).

9. These witness statements had been served upon you in accordance with the Case Management Directions. Neither you, nor the tribunal required these witnesses to attend for cross examination/tribunal questions. Accordingly the attendance of these witnesses at the hearing was not required and the tribunal accepted their witness statements as their evidence in chief pursuant to Rule 34 (11).

10. The tribunal has received witness statements, and heard oral evidence from the following witnesses:

- Patient A;
- Nurse B, (Sister, Outpatients Department, Fitzwilliam Hospital);
- Ms G, (Matron, Fitzwilliam Hospital);
- Ms E, (Assistant Practitioner, Endoscopy Department, Pilgrim Hospital);
- Ms H, (Senior Human Resources, Pilgrim Hospital) ;
- Ms D, (Staff Nurse, Endoscopy Department, Pilgrim Hospital);
- Patient F;
- Patient F's Partner;

11. The tribunal has also received a witness statement from you. You also gave oral evidence to the tribunal.

12. The tribunal was provided by you with a bundle of testimonials, the content of which it accepted. However, this evidence was not of great assistance to the tribunal in determining the facts.

Tribunal's approach

13. The tribunal gave careful consideration to all the oral and documentary evidence adduced in this case and has taken account of the submissions made by Mr Jackson and those made by Mr Jones.

14. The tribunal accepted the Legal Assessor's advice that the burden of proof lies upon the GMC. The required standard of proof is the civil standard, that is the balance of probabilities. The tribunal also accepted the advice of the Legal Assessor in relation to good character. He explained that this is relevant in two respects.

First it goes to your propensity to behave as alleged by the GMC; secondly, it goes to the credibility of your own testimony. It accepted that good character is not, in itself, determinative of the issues before it.

15. Accordingly, the tribunal has made the following findings on the outstanding facts:

Patient A (Fitzwilliam Hospital)

Paragraph 1 Between 18 September and 6 November 2013 you were contracted as a Consultant Colorectal Surgeon at the Fitzwilliam Hospital. **Admitted and found proved**

Paragraph 2 During a consultation with Patient A on 18 September 2013 you failed to:

16. The tribunal had regard to the following evidence in relation to paragraph 2: Patient A's witness statement, dated 10 July 2015; Patient A's complaint letter to the Fitzwilliam Hospital, copied to the GMC, dated 14 February 2014; Patient A's oral evidence; your witness statement and oral evidence; the expert report of Mr C in relation to Patient A, dated 11 February 2016; and a supplementary report dated 15 November 2016. It also had regard to the relevant paragraphs of GMP.

a. explain the type of examinations you intended to undertake on Patient A; **Found not proved**

17. In approaching this sub-paragraph, the tribunal construed the allegation as referring to the examinations which you discussed with Patient A before you examined her, rather than the instruments which you would use to conduct those examinations. It had regard to your witness statement, in which you stated that you would "*first examine the abdomen and then the back passage, initially with my finger…*". The tribunal also had regard to Patient A's complaint letter in which she stated, "*he then very quickly said he wanted to examine me, I presumed it would be examining me using a finger, which was what my Dr had previously done*". The tribunal considered that it was more likely than not that you explained that you were going to conduct an abdominal and a digital rectal examination. It therefore finds this sub-paragraph not proved.

b. explain your intention to use a sigmoidoscope (or similar probe) during the examination you intended to undertake on Patient A; **Found proved**

18. In approaching this paragraph, the tribunal considered that this should be construed as referring to the instrument by which you would conduct the

examination of the anal canal, after you had examined Patient A with your finger. The tribunal had regard to your witness statement in which you said that "*you would examine her with an instrument …called a sigmoidoscope to view inside the anal canal with the camera*." In your oral evidence you stated that you would have said "*I'm now going to use the scope*". The tribunal also had regard to Patient A's complaint letter, witness statement and oral evidence. She consistently stated that all you said was "*probe going in*" and that you did not explain what that meant. In all her evidence, Patient A consistently used words such as "*shock*", "*surprise*", and "*entirely by surprise* and "*I did not expect that*" to explain how she had felt when the sigmoidoscope was inserted into her anus. The tribunal is of the opinion that Patient A was credible on this issue; it therefore accepted her evidence. The tribunal went on to consider whether you had a duty to explain your intention to use a sigmoidoscope. It was of the view that a doctor must give information to patients so they understand what is going to happen. This is especially so in an intimate examination. It therefore determined that you did have a duty to explain your intention to use the sigmoidoscope and on balance concluded that you did not discharge that duty. The tribunal therefore found this sub-paragraph proved.

c. gain informed consent from Patient A regarding the rectal examination you undertook using:

i. your finger; **Found not proved**

19. The tribunal had regard to Patient A's evidence in which she explained that she went to the treatment table and curled up and adopted the foetal position the same way that she had done at her GP Surgery. The tribunal is of the view that Patient A would have only done this if she was expecting a digital rectal examination. The tribunal have accepted your evidence that you had explained that you would be undertaking a digital rectal examination and had regard to your evidence that you would have informed her that it may be uncomfortable. In these circumstances the tribunal considered that you did gain consent from Patient A and therefore found this sub-paragraph not proved.

ii. a sigmoidoscope (or similar probe); **Found proved**

20. The tribunal had regard to the evidence of Patient A. It has already found that you did not explain your intention to use a sigmoidoscope. Patient A consistently stated that when she heard you saying "*probe going in*", and when you inserted something into her anus, she had no idea what was happening and that it took her completely by surprise (or words to that effect). The tribunal also had regard to your evidence that you would "*always warn the patient*", and "*would normally show the scope to the patient as well*". The tribunal preferred the evidence of Patient A to your evidence. In these circumstances, the tribunal found this sub-paragraph proved.

d. gain informed consent from Patient A to start the examination in the absence of a chaperone; **Found not proved**

21. The tribunal had regard to the evidence of Patient A. She stated that when the nurse arrived she pulled the curtain around her, told her to lower her clothing, and gave her a blanket to cover herself. She said that she got on to the treatment table and curled up. She stated that "*Mr Agarwal was outside of the curtain*". The tribunal is of the view that given Patient A's evidence, you did not start the examination in the absence of a chaperone and therefore determined that this sub-paragraph is not proved.

e. discuss alternative non-surgical conservative treatments with Patient A. **Found proved**

22. The tribunal noted that Patient A had undertaken some conservative treatments to relieve her symptoms, namely laxatives, soothing ointment and GTN ointment. The tribunal had regard to your evidence that you believed that Patient A would not benefit from any further non-surgical treatments. The tribunal also noted the evidence of Patient A that you did not discuss any alternative treatments with her. The tribunal had regard to the evidence of Mr C who explained his opinion that further non-surgical conservative treatments were available and should have been discussed with Patient A.

23. The tribunal had regard to Good Medical Practice (2013), (GMP) paragraph 49a which states:

> 49. You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:
>
> a. their condition, its likely progression and the options for treatment, including associated risks and uncertainties"

24. The tribunal is of the view that regardless of your opinion that non-surgical conservative treatments would not benefit Patient A, they were still available, and that you should have discussed options for treatment with her, so as to discharge your duty as above. Therefore it determined that this sub-paragraph is proved.

Paragraph 3 Within your medical record of the consultation with Patient A on 18 September 2013 you failed to:

25. In relation to this paragraph, the tribunal had regard to the medical records of the consultation you had with Patient A on 18 September 2013, including the letter

sent to her GP of the same date. It also had regard to your evidence and that of Mr C.

26. The tribunal accepted the evidence of the Legal Assessor, who advised that the words "*you failed*", had the following general meaning, that is a "*duty*; *not discharged*".

27. The tribunal had regard to GMP paragraph 21a which states:

> "21. Clinical records should include:
>
> a. relevant clinical findings"

c. comment on the size of Patient A's haemorrhoids; **Found proved**

28. The tribunal noted your medical records of Patient A, in which you did not comment on the size of Patient A's haemorrhoids. The tribunal had regard to the totality of the evidence of Mr C. He stated that size of haemorrhoids and whether they are prolapsing should be recorded as it can determine the modality of treatment. The tribunal accepted the evidence of Mr C that the size of haemorrhoids and whether they were prolapsing were relevant clinical findings, and therefore should have been recorded in Patient A's medical records. Therefore the tribunal found this sub-paragraph proved.

d. comment on whether the haemorrhoids were prolapsing; **Found proved**

29. For the same reasons as given above the tribunal also found this paragraph proved.

e. comment on how chronic the fissure was; **Found proved**

30. The tribunal noted your medical record of Patient A. You did not state whether her fissure was acute or chronic; you made no comment. The tribunal accepted the evidence of Mr C that this was a relevant clinical finding as it goes to type of treatment offered. It therefore was of the view that you had a duty to record how chronic Patient A's fissure was. The tribunal therefore determined that this sub-paragraph is proved.

f. record your findings on your digital examination; **Found not proved**

31. The tribunal had regard to your medical record of Patient A, in which you recorded P/R → very tender. It also noted that in your letter to Patient A's GP, you

stated that "*on rectal examination she was very tender*." The tribunal is of the view that this, albeit brief notation constituted a record of your findings of your digital rectal examination. It therefore found this sub-paragraph not proved.

g. record the sigmoidoscopy examination; **Found not proved**

32. The tribunal had regard to your medical record of Patient A. You recorded that you had undertaken a sigmoidoscopy examination. It also had regard to your letter to Patient A's GP in which you stated that you "*performed a sigmoidoscopy*". The tribunal is of the view that you had recorded that you had undertaken a sigmoidoscopy examination. It therefore found this sub-paragraph not proved.

h. record your findings on undertaking a sigmoidoscopy; **Found proved**

33. The tribunal had regard to your medical record of Patient A, in which you recorded sigmoidoscopy with an arrow pointing to the same findings as the digital examination: "*very tender*". In response to tribunal questions, you stated that when you undertook the sigmoidoscopy, you saw a fissure and a round haemorrhoid 2cm in the anal canal. You make no mention of this on the medical record or the letter to Patient A's GP. The tribunal is of the view that these would be relevant clinical findings and therefore should have been recorded. Therefore it determined that this sub-paragraph proved.

i. record Patient A's symptoms (apart from anal pain). **Found proved**

34. The tribunal noted in your medical record of Patient A's "*Anal pain*". It also noted the letter to Patient A's GP in which you stated: "*with anal pain for more than 3½ months, in particular when she passes a motion*." The tribunal accepted the evidence of Mr C who stated that there should have been a note of Patient A's pain levels, frequency, nature of the anal pain and whether it was intermittent and whether it was associated with defecation. Mr C said these were important characteristics pertinent to the condition and modalities of treatment and therefore clinically relevant. Whilst the tribunal acknowledged your record of the particular circumstances in which Patient A experienced anal pain, it determined that this was insufficient in the light of Mr C's expert evidence. The tribunal therefore determined this sub-paragraph proved.

Paragraph 4 Prior to carrying out surgery on Patient A on 21 October 2013 you failed to:

35. The tribunal had regard to the following evidence in relation to this paragraph; Patient A's witness statement, dated 10 July 2015; Patient A's complaint

letter to the Fitzwilliam Hospital, copied to the GMC, dated 14 February 2014; Patient A's oral evidence; your witness statement and oral evidence; the expert report of Mr C in relation to Patient A, dated 11 February 2016; and a supplementary report dated 15 November 2016. It also had regard to the relevant paragraphs of GMP.

a. notify Patient A you intended to carry out a lateral sphincterotomy operation; **Found proved**

36. The tribunal had regard to the consent form completed and signed by you and Patient A on the 21 October 2013. The tribunal had regard to the evidence of Patient A that when she left the consultation, she researched the procedures on the internet that were named on the consent form; namely fissurectomy and haemorrhoidectomy. She stated in oral evidence, in her complaint letter and witness statement that the first she had heard of a lateral sphincterotomy was after the procedure had been undertaken.

37. The tribunal also had regard to your evidence in which you stated that you would have talked to Patient A about a lateral sphincterotomy, but could not explain the omission of lateral sphincterotomy on the consent form.

38. The tribunal noted Patient A's evidence that she did not notice the abbreviation EUA on the consent form. However, the tribunal accepted Patient A's explanation as it is of the view that she would have been focussed on the substantive procedures, fissurectomy and haemorrhoidectomy.

39. The tribunal preferred Patient A's evidence to yours on this issue, it therefore found this sub-paragraph proved.

b. obtain consent from Patient A for a lateral sphincterotomy operation. **Found proved**

40. The tribunal has already determined that you did not notify Patient A that you intended to undertake a lateral sphincterotomy operation. It also noted that you did not write that you intended to undertake a lateral sphincterotomy operation on the consent form. In these circumstances, the tribunal is of the view that you did not obtain Patient A's consent for a lateral sphincterotomy operation and therefore this sub-paragraph is proved.

Paragraph 5 You proceeded to surgery on 21 October 2013:

41. The tribunal had regard to the following evidence in relation to paragraph 5; Patient A's witness statement, dated 10 July 2015; Patient A's complaint letter to the Fitzwilliam Hospital, copied to the GMC, dated 14 February 2014; Patient A's oral evidence; your witness statement and oral evidence; the expert report of Mr C in relation to Patient A, dated 11 February 2016; and a supplementary report dated 15 November 2016. It also had regard to the medical records of 18 September 2013.

a. without first identifying and recording the appropriate indications for a haemorrhoidectomy or a lateral sphincterotomy; **Found proved**

42. In considering this paragraph, the tribunal determined that the stem refers to your performance prior to Patient A being anaesthetised and therefore prior to you undertaking the EUA. Therefore it only took account of the medical records of the 18 September 2013 and the findings you recorded in them. The tribunal has already determined that you failed to record relevant clinical findings. In your letter to the GP you stated "*I suspected that she had some haemorrhoids*" and "*I could not see the fissure clearly*".

43. The tribunal noted your evidence that you had seen Patient A prior to the surgery and she confirmed that her symptoms had not resolved.

44. The tribunal had regard to the evidence of Mr C who confirmed in oral evidence that you proceeded to surgery without appropriate indications. He also informed the tribunal that standard practice would have been to undertake a EUA and then wake up the patient and, at a further consultation, discuss what you had found in the examination and discuss options for treatment.

45. The tribunal is of the view that, although you may have suspected certain indications, you did not identify or record them in Patient A's record prior to the anaesthetic; nor in fact did you identify or record them in that record after the EUA. The tribunal therefore found that you proceeded to carry out the haemorrhoidectomy and lateral sphincterotomy operations without having first identified and recorded appropriate indications. In these circumstances, it found this sub-paragraph proved.

b. before establishing non-surgical conservative treatments for an anal fissure had failed, or were likely to fail, such as one or more of the following:

i. 8-12 week course of GTN; **Found proved**

46. It is your evidence that by the time of the procedure Patient A had taken a course of GTN and that her symptoms had not resolved. You added that, in your opinion, if GTN doesn't work in the first two to three weeks, it will never work.

47. Mr C gave evidence to the tribunal that the findings made by you and Patient A's GP suggest that she had recurrent anal fissure with small piles, which can be managed by non-surgical conservative treatments. He informed the tribunal that recurrent anal fissures are initially treated with 8-12 week courses of GTN. He reminded the tribunal that there had been some beneficial effect to Patient A with the course of GTN prescribed to her by her GP, and stated that this should have been repeated.

48. The tribunal preferred the evidence of Mr C to yours and therefore found this sub-paragraph proved.

ii. Diltiazem cream; **Found proved**

49. It was your evidence that this was not tried as, if GTN had not worked, Diltiazem cream would not work and therefore you never use it. The tribunal heard evidence from Mr C that if GTN is not tolerated, Diltiazem cream should be tried. The tribunal preferred the evidence of Mr C, and therefore found this paragraph proved.

iii. Clostridium Botulinum Toxin ('Botox') injections; **Found proved**

50. Mr C gave evidence to the tribunal that if Diltiazem cream fails then you try Botox injections. You gave evidence to the tribunal that Botox injections for this procedure were not available at the Fitzwilliam Hospital. The tribunal accepted the evidence of Mr C that Botox injections should have been tried. It was of the view that if Botox was not available at the hospital, then you should have referred Patient A elsewhere. It therefore finds the sub-paragraph proved.

c. without taking sufficient account of the fact that Patient A had had one course of GTN prescribed by her GP which:

i. did have some beneficial effect; **Found proved**

ii. should have been repeated; **Found proved**

51. In relation to both sub-paragraphs 5(c)(i) and 5(c)(ii) the tribunal accepted the opinion of Mr C that as Patient A had had one course of GTN prescribed by her

GP which did have some beneficial effect, it should have been repeated. It therefore found these sub-paragraphs proved.

d. before establishing non-surgical conservative treatments for the symptoms of haemorrhoids had failed, or were likely to fail, such as one of more of the following:

i. phenol injections; **Found proved.**

ii. banding; **Found proved**

iii. advice about diet; **Found proved**

52. Mr C gave evidence to the tribunal that piles that are not prolapsing are always treated by phenol injection or banding, which together with advice about diet to soften the stool nearly always controls simple pile symptoms.

53. In your evidence you stated that you do not offer phenol injections. In oral evidence you added that they are not used for external haemorrhoids. The tribunal noted that, in Patient A's medical records, you identified haemorrhoids and did not record whether the haemorrhoids were internal or external. In oral evidence you stated that if the haemorrhoids were prolapsing you would record that. In evidence you stated that you do not offer phenol injections and did not consider banding appropriate treatment for Patient A as she was in such acute pain. You further gave evidence that Patient A's condition was beyond advice about diet. However you also acknowledged that most colorectal surgeons would favour banding treatment.

54. Mr C gave evidence to the tribunal that piles that are not prolapsing are always treated by phenol injection or banding, which together with advice about diet to soften the stool nearly always controls simple pile symptoms.

55. The tribunal has already noted that there is no note of acute anal pain in your medical records. The tribunal was therefore not disposed to accept your explanation for not carrying out these conservative measures. It is of the view that regardless of your opinion about such measures, in view of the fact that such treatments were routinely offered, you should have established that they had failed and/or were likely to fail before proceeding to surgery. The tribunal therefore found this sub-paragraph proved.

e. which was unnecessary. **Found proved**

56. It was your evidence to the tribunal that you proceeded to undertake the procedures you did because of your findings at EUA. You did not think it was necessary to awaken the patient and offer her these choices.

57. Mr C gave evidence to the tribunal that, once you had undertaken the EUA, you should have awoken Patient A, and then, at a further consultation, explained your findings to her and discussed treatment options. Further, he stated that if Patient A was offered and treated with conservative treatments, it is likely that her anal fissure would have healed, and that any symptoms she may have from her piles would have been simply controlled. He added that this means it is likely that Patient A had two unnecessary operations.

58. The tribunal preferred the evidence of Mr C, and therefore found this sub-paragraph proved.

Paragraph 6 Within your operation note of 21 October 2013 relating to Patient A you failed to record:

59. The tribunal had regard to the following evidence; your witness statement and oral evidence; the expert report of Mr C in relation to Patient A, dated 11 February 2016; and a supplementary report dated 15 November 2016. It also had regard to the operation note of 21 October 2013 relating to Patient A.

60. The tribunal accepted the evidence of the Legal Assessor, who advised that the words "*you failed*", had the following general meaning, that is a "*duty; not discharged*".

61. The tribunal had regard to GMP paragraph 21a which states:

> "21. Clinical records should include:
>
> a. relevant clinical findings"

a. an accurate description of the haemorrhoids; **Found proved**

62. In the operation note you record: '*circumferential haemorrhoids, external component mainly.*' The tribunal noted that this is not consistent with the GP's description that the external component was small, nor does it accurately detail your description of the haemorrhoids given in evidence that the presence of internal haemorrhoid which were small. The tribunal heard oral evidence from Mr C that it was unlikely in the 3½ months between the GP seeing Patient A and the operation, the haemorrhoids would have changed to such an extent. The tribunal considers

that in these circumstances, your operation notes did not record an accurate description of the haemorrhoids. It therefore found this sub-paragraph proved.

b. whether the haemorrhoids were prolapsing; **Found not proved**

63. In your oral evidence you stated that you did not write down negative findings, and therefore would not record that the haemorrhoids were not prolapsing. The tribunal accepts your evidence, and therefore found this sub-paragraph not proved.

c. clearly whether Patient A had an acute or chronic fissure; **Found proved**

64. The tribunal had regard to the operation note in which you record small posterior anal fissure. You do not record whether the fissure was acute or chronic. In oral evidence, you stated that the fissure was chronic.

65. The tribunal had regard to Mr C's evidence that if a fissure is not chronic, it should be treated conservatively. It therefore considers that you had a duty to record whether the fissure was acute or chronic, which you failed to do. In these circumstances, the tribunal found this sub-paragraph proved.

d. clearly your findings from the examination under anaesthetic; **Found not proved**

66. In the operation note, you record; '*circumferential haemorrhoids, external component mainly, small post anal fissure, sphincter spasm ++.'* Elsewhere in this determination the tribunal has made observations about the adequacy of your findings under anaesthetic.

67. The tribunal has noted your evidence that you only recorded positive findings. Notwithstanding its concerns about the adequacy of those findings, it did accept that these were noted in your record of the EUA. It therefore determined that this sub-paragraph is not proved.

e. clearly the indications for undertaking a lateral sphincterotomy, as well as a haemorrhoidectomy; **Admitted and found proved**

f. any post-operative instructions about:

i. pain control; and/or **Found proved**

ii. laxatives. **Found proved**

68. The tribunal had regard to the operation note, in which you had written the following post-operative care instructions; "*fluid and food after 6pm and home tomorrow*". It also noted that you had written "*co-codomol*", which had been crossed out as Patient A is allergic to codeine. It is therefore of the view that you had not provided post-operative instructions about either pain control or laxatives. The tribunal therefore found these sub-paragraphs proved.

Paragraph 7 Subsequent to the surgery carried out by you on Patient A on 21 October 2013 and prior to Patient A's discharge on 22 October 2013 you failed to:

69. The tribunal had regard to the following evidence in relation to paragraph 2; Patient A's witness statement, dated 10 July 2015; Patient A's complaint letter to the Fitzwilliam Hospital, copied to the GMC, dated 14 February 2014; Patient A's oral evidence; your witness statement and oral evidence; the expert report of Mr C in relation to Patient A, dated 11 February 2016; and a supplementary report dated 15 November 2016. The tribunal also had regard to the GP Summary Discharge Letter, the nurses notes, and the Discharge Day checklist.

a. personally inform Patient A that you had in fact carried out a lateral sphincterotomy, which differed from the fissurectomy procedure originally consented to by Patient A; **Found proved**

70. You informed the tribunal that you spoke to Patient A in the recovery room, after the operation. The tribunal was not disposed to discount this, but it was of the view that Patient A would have been groggy from the anaesthetic at that time and may not have comprehended it.

71. Patient A informed the tribunal you did not come to see her at any point after the surgery on 21 October or before she was discharged the next day. She stated that she had to ask the Ward Sister to contact you to find out what operation you carried out and what to expect regarding recovery. The tribunal had regard to the nurses notes which state "*Mr Agarwal phoned to say he would not be able to see the pt today and would review in clinic in 2 weeks*".

72. The tribunal has accepted that you may have spoken to Patient A in recovery. However, it is of the view that you had a duty to speak to Patient A personally when she was awake and orientated, particularly when you had consented her for a fissurectomy procedure and carried out a lateral sphincterotomy. In these circumstances, the tribunal finds this sub-paragraph proved.

b. explain the reasoning for the change in operation, (referred to in paragraph 7a above), to Patient A; **Found proved**

73. As above the tribunal is of the view that you should have spoken to Patient A personally to inform her that you had changed the operation for which she was consented. You did not. Therefore it follows that you did not explain your reasoning to her prior to her leaving hospital on 22 October 2013. The tribunal is of the view that you had a duty to do so which you failed to discharge. It therefore finds this sub-paragraph proved.

c. discuss with Patient A, or to arrange for someone else to explain the nature and the outcome of her operation on the 21 October 2013; **Found proved**

74. The tribunal is of the view that your discussion with Patient A in recovery was not sufficient given that you had undertaken a different surgery to that for which Patient A gave her consent. You informed the tribunal that the nurses could have explained to her the nature and outcome of her operation, and they are trained to do so. However, the tribunal is of the view that it was your duty as the consultant operating surgeon to explain the findings of the EUA and the nature of the operation which you performed including the reasons for them. This should have been done when Patient A was alert and orientated and before she was discharged. You did not do this. Further there was no evidence that you delegated this duty. Therefore the tribunal finds this sub-paragraph proved.

d. provide adequate post-operative care such as:

i. to warn Patient A about the pain she might experience when having her bowels open in the first week after surgery; **Found proved**

ii. to explain to Patient A how to cope with the pain; **Found proved**

iii. to make clear the importance of taking laxatives to prevent post-operative constipation. **Found proved**

75. You gave evidence to the tribunal that discharge was a nurse led approach. The tribunal considered the submission of Mr Jones that this duty could be delegated. However, it did not accept this given that you undertook a different surgery to that for which Patient A gave her consent.

76. The tribunal accepts the evidence of Mr C who stated that, by not seeing Patient A after surgery, you were not able to warn Patient A about the pain she might experience when opening her bowels, and how to cope with the pain, and the importance of taking laxatives.

77. In these circumstances, the tribunal has found proved sub-paragraphs 7(d)(i), 7(d)(ii) and 7(d)(iii).

Paragraph 8 During a post-operative consultation with Patient A on 4 November 2013 you:

78. The tribunal had regard to the following evidence in relation to paragraph 2; Patient A's witness statement, dated 10 July 2015; Patient A's complaint letter to the Fitzwilliam Hospital, copied to the GMC, dated 14 February 2014; Patient A's oral evidence; your witness statement and oral evidence; the expert report of Mr C in relation to Patient A, dated 11 February 2016; and a supplementary report dated 15 November 2016. The tribunal also had regard to the written statement and oral evidence of Nurse B and Ms G.

a. failed to:

i. explain the type of examination you then intended to undertake on Patient A; **Found proved**

79. The tribunal had regard to the evidence of Patient A. She stated that she tried to inform you of the pain that she had been in since the operation. She stated that she did not expect a digital rectal examination two weeks post-operatively and only expected you to visually examine her bottom when she was undressed and in the foetal position. She informed the tribunal that the first time she understood the nature of this examination was when you stated "*finger going in*" as you "*simultaneously inserted a finger into her anus*."

80. You stated that you did a digital rectal examination as you were concerned that Patient A was suffering from faecal impaction as she had reported on-going pain.

81. Mr C informed the tribunal that a digital rectal examination was inappropriate two weeks post-operatively, due to the pain from unhealed wounds.

82. The tribunal preferred Patient A's evidence to your evidence. It also noted Mr C's evidence that it was inappropriate to undertake a digital rectal examination. In these circumstances, the tribunal finds this sub-paragraph proved.

ii. warn Patient A of the level of pain that an examination of this type would cause as a result of her recent surgery; **Found proved**

83. Patient A's evidence was clear that you did not offer her a local anaesthetic before the examination. The tribunal has already determined that you did not explain the type of examination you intended to undertake on Patient A. It therefore follows that you would not have warned Patient A of the level of pain such an examination would cause and that you would not have suggested a local anaesthetic at that time, as you contended in your written statement. In these circumstances, the tribunal finds this sub-paragraph proved.

iii. await the arrival of a chaperone before gesturing for Patient A to move to the examination table; **Found proved**

84. Patient A informed the tribunal that you gestured with your hands for her to move to the examination table before the chaperone was present. The tribunal accepted this, and therefore finds this sub-paragraph proved.

iv. allow Patient A an appropriate period of time to make an informed decision regarding the use of a chaperone; **Found not proved**

85. Patient A informed the tribunal that you asked her if she wanted a chaperone, and that she had responded yes. She also stated that you rang the buzzer to summon a chaperone. In these circumstances, the tribunal is of the view that you discharged your duty and therefore this paragraph is not proved.

v. gain informed consent from Patient A for the rectal examination you subsequently undertook with your finger; **Found proved**

86. Given that the tribunal has already determined that you did not explain that you were going to undertake a digital rectal examination, nor the level of pain that such an examination might cause two weeks after surgery, it follows that you did not gain informed consent from Patient A before you undertook the examination. In these circumstances, the tribunal finds this allegation proved.

vi. pull a curtain round Patient A whilst she undressed; **Found proved**

87. Patient A gave evidence to the tribunal that she began to undress when she was at the treatment table, she informed the tribunal that you were standing near her and the curtains were not drawn.

88. You told the tribunal that you would never ask a patient to undress, or start an examination without a chaperone being present.

89. In relation to this sub-paragraph, the tribunal had regard to the submission of Mr Jones on the credibility and reliability of two of the GMC witnesses, namely Ms G and Nurse B, who gave conflicting evidence on this and the next sub-paragraph.

90. In Nurse B's contemporaneous statement, (which was undated) she stated that you rang the nurse call bell, and she went in to chaperone. She stated that she was uncertain if the curtain was opened or closed. In oral evidence Nurse B gave evidence as to what her standard practice would be. She suggested to the tribunal that, if the curtains had been open when she came into the room, she would have closed them, and would have mentioned it to you, remembered it and would have referred to it in her contemporaneous statement. She also stated that she never spoke to Ms G about the incident.

91. In contrast, Ms G, in a letter written to you dated 11 November 2013, stated, "*The nurse on duty has confirmed to me that on entering the room the patient was exposed from waist down, no curtain was pulled to maintain dignity and there was no blanket or cover over the patient and her bottom was fully exposed on entering the room*." Ms G was adamant that the nurse on duty was Nurse B and that this was an accurate record of what was discussed in her office.

92. The tribunal noted that Nurse B was a reluctant witness, and had to be reminded of her duty to give evidence before the regulator. Nurse B did give evidence, but most of it concerned her standard practice. There was little recollection of the detail of the incident. In contrast, Ms G who was conducting the inquiry into the incident, was quite sure that what was recorded in her letter to you was an accurate reflection of what Nurse B had told her. The tribunal preferred the evidence of Ms G.

93. The tribunal next considered whether it was a delegated duty to pull the curtains around Patient A. The tribunal is of the view that normally it would be. However, you had gestured that Patient A should move to the treatment area and there was no chaperone present. When Patient A started undressing the duty to maintain her dignity remained with you. You did not discharge that duty.

vii. provide Patient A with a blanket whilst she undressed; **Found proved**

94. The tribunal has already determined that it favours the evidence of Ms G to Nurse B. In her letter Ms G stated that "*The nurse on duty has confirmed to me that*

on entering the room the patient was exposed from waist down, no curtain was pulled to maintain dignity and there was no blanket or cover over the patient and her bottom was fully exposed on entering the room."

95. In her evidence Patient A stated that you stood near her, that she had nothing to cover her, that she felt very vulnerable, and when the nurse came in she remembered that she retrieved a blanket from a nearby cabinet.

96. In these circumstances, the tribunal is of the view that you should have provided Patient A with a blanket whilst she undressed. By not doing so, you did not discharge your duty to maintain Patient A's dignity.

viii. halt the examination when:

1. Patient A became distressed; **Found proved**

97. In her evidence to the tribunal, Patient A remembered screaming out, "*ow*", "*that hurts*" and "*stop it*".

98. Nurse B in her contemporaneous statement (which was not dated) stated that Patient A was uncomfortable and that it was very painful.

99. You stated it became clear quite quickly that Patient A was in a lot of pain and could not tolerate it. You also stated that you asked Patient A whether you should stop, but she said to carry on. This is not corroborated by either Patient A or Nurse B.

100. In these circumstances, the tribunal determined that you did not stop the examination when Patient A became distressed, and therefore finds this sub-paragraph proved.

2. Patient A indicated by her actions that she wished you to stop; **Found proved**

101. Patient A gave consistent evidence that she gestured to you by putting her hands behind her bottom to get you to stop. The tribunal accepts her evidence, and therefore finds this sub-paragraph proved.

3. Nurse B first informed you Patient A wished to stop; **Found not proved**

102. The tribunal had regard to the contemporaneous statement of Nurse B. She stated in it that she told you that Patient A wished to stop the procedure and you asked if she would like a local anaesthetic, to which she said no. In your evidence you stated that once Patient A declined the local anaesthetic, you did not continue with your examination. In these circumstances, the tribunal found this sub-paragraph not proved.

> ix. offer to halt the examination at any time, when you knew or ought to have realised that Patient A was in severe pain; **Found proved**

103. The tribunal has considered the evidence as above. It is of the view that you did not halt the examination when Patient A was in distress, as observed by Nurse B; you did not offer to do so when Patient A gestured to you, nor when she "*shouted out in agony*". In these circumstances, the tribunal is of the view that you ought to have known that Patient A was in severe pain, and offered to halt the examination prior to being asked by Nurse B to do so. It therefore finds this sub-paragraph proved.

> x. at any time during the examination check on Patient A's:
>
> > 1. wellbeing; **Found not proved**
> >
> > 2. pain levels; **Found not proved**
> >
> > 3. willingness to continue with the examination; **Found not proved**

104. The tribunal noted above that you did ask Patient A if she would like a local anaesthetic. In the tribunal's view this constituted a check on her wellbeing, pain levels, and willingness to continue with the examination. It does not consider that this was timely. However it did occur, and therefore the tribunal has found these sub-paragraphs not proved.

> xi. reassure Patient A that her continued discomfort was usual after a haemorrhoidectomy; **Found proved**
>
> xii. provide advice on bowel function; **Found proved**

105. The tribunal had regard to Patient A's witness statement in which she stated that, prior to the examination, she had tried to talk to you about her symptoms, but that you cut her off. It also had regard to her evidence that after the examination

she tried to ask you whether or not it was normal for her to go to the toilet so often with solid stools, at which point she stated that you picked up your Dictaphone and started talking to it.

106. The tribunal also had regard to Patient A's complaint letter, in which she stated, "*due to the rushed nature and the way the examination went I do not believe I had a thorough consultation so again do not believe I got the relevant information and potential medication to support my recovery*."

107. In your evidence you stated that you reassured Patient A that pain was normal so soon after surgery but that she would need to continue with analgesics and laxatives.

108. The tribunal preferred the evidence of Patient A to yours and therefore finds these sub-paragraphs proved.

b. incorrectly recorded within the medical record that you had performed a fissurectomy rather than a lateral sphincterotomy. **Admitted and found proved**

Paragraph 9 During a post-operative consultation with Patient A on 4 November 2013 you undertook a rectal examination which:

a. was unnecessary in light of the severe pain that Patient A would experience as a result of the planned examination; and **Found proved**

109. You stated that you undertook a digital rectal examination as you were concerned that Patient A had faecal impaction. The tribunal noted that this is not recorded in the medical notes of 4 November 2013.

110. The tribunal accepted the evidence of Mr C who stated that a digital rectal examination two weeks after surgery should have been undertaken under local anaesthetic due to the pain it would cause because of unhealed wounds. Therefore it found this sub-paragraph proved.

b. caused unnecessary pain to Patient A. **Found proved**

111. Having found that the digital examination should have been undertaken under local anaesthetic, and having heard that Patient A was in severe pain, the tribunal is of the view that the procedure caused unnecessary pain to Patient A. It therefore finds this sub-paragraph proved.

Patient C (Pilgrim Hospital)

Paragraph 10 Between 14 November 2013 and 26 March 2014 you were employed as a Consultant Colorectal and General Surgeon at the Pilgrim Hospital by the United Lincolnshire Hospitals NHS Trust. **Admitted and found proved**

Paragraph 11 On 14 November 2013 prior to commencing a flexible sigmoidoscopy procedure on Patient C you undertook a digital rectal examination. **Admitted and found proved**

Paragraph 12 On 14 November 2013 whilst performing a flexible sigmoidoscopy procedure on Patient C you:

112. In relation to this paragraph, the tribunal had regard to the following evidence, your witness statement and oral evidence, the witness statements and oral evidence of Ms C and Ms D. It also had regard to the expert report and oral evidence of Mr C in relation to Patient C, dated 11 December 2015

a. held the scope in a clinically unusual manner and/or in a different manner to the way you held it for a subsequent male patient; **Found proved**

113. In her contemporaneous statement to the trust, dated 16 November 2013, Ms E stated that a few seconds into the flexible sigmoidoscopy procedure on Patient C, she noticed the positioning of your right index finger; it was outstretched along the scope and not wrapped around it like she had seen other doctors grasp it. She added that later on, on the endoscopy list, in a subsequent male patient, she observed your hand positioning which was completely different to that of Patient C.

114. In her evidence to the tribunal, Ms D stated that she saw you hold the scope with your index finger extended and move it towards Patient C's anus.

115. Mr C gave evidence to the tribunal that the scope could be held in a variety of ways. You also stated that you had been taught to hold the scope in a variety of ways.

116. The tribunal was of the view that holding the scope in the way you did, with your finger extended, was not a clinically unusual manner. However, you held it in a different manner to the way you held it for a subsequent male patient. It therefore finds this sub-paragraph proved in this respect.

b. inserted your outstretched right index finger into the vagina of Patient C:

i. whilst simultaneously inserting the scope into the anus of Patient C; **Found proved**

117. In Ms E's contemporaneous statement to the trust, dated 16 November 2013, she stated that "*to my surprise his outstretched index finger first made contact with the patient's rectum as the scope was guided forward… on the next advance of the scope I witnessed PKA's outstretched index finger slip completely into the patient's body (vaginal area*)". Ms D could not see this incident from her position at the top of the treatment table. The tribunal found that Ms E's evidence was compelling and powerful, and does not consider that she had any motivation to make a false allegation.

118. Much was made about the lighting in the treatment room. However the tribunal accepted the evidence that there would have been enough ambient lighting for Ms E to have observed the sigmoidoscope procedure.

119. You stated that you do not recall the incident, however if it had occurred, it would have been accidental. The tribunal had regard to Mr C's evidence, wherein he stated that it is possible to accidently enter the vaginal area when using a scope with an outstretched finger.

120. The tribunal accepted the evidence as set out above, and determined that your finger could have entered Patient C's vaginal area unintentionally. It therefore finds this sub-paragraph proved.

ii. on more than one occasion. **Found not proved**

121. Ms E in her contemporaneous statement to the Trust, dated 16 November 2013, stated that "*throughout the procedure this advancing of the scope and slipping into the patient incident happened on more than one occasion, 2-3 times possibly more.*"

122. The tribunal had regard to your evidence and the evidence of Mr C. You both explained to the tribunal that it was necessary to rotate the scope for this procedure. You clarified to the tribunal that the scope used in this procedure was a colonoscope which is heavier and more difficult to manoeuvre. In these circumstances, the tribunal was not satisfied that Ms E saw anything other than your attempts to manoeuvre this scope into an appropriate position to conduct the procedure.

Paragraph 13 Your conduct as alleged in paragraphs 11 and 12 was sexually motivated.

Paragraph 13 in relation to paragraph 11 Found not proved

123. The tribunal has heard evidence from both you and Mr C that it is common practice to do a digital rectal examination prior to this procedure. It noted the GMC led no other evidence about this paragraph and Mr C made no adverse comment. The tribunal therefore determined that your action in conducting a rectal examination on Patient C was not sexually motivated.

Paragraph 13 in relation to paragraph 12 Found not proved

124. The tribunal had regard to Ms E in her contemporaneous statement to the trust, dated 16 November 2013. In which she stated that you were "engrossed in watching the TV monitor to proceed with the procedure". She also stated that "*I looked at PKA's face but he was oblivious to the fact that I was watching his hands*". The tribunal also had regard to Ms E's oral evidence that she observed no facial changes.

125. The tribunal had regard to Mr C's evidence in which he stated that you could accidently insert your finger into the vagina whilst advancing a scope into the rectum of a patient when you were using the outstretched finger technique.

126. In these circumstances, the tribunal determined that your action was unintentional and not sexually motivated.

Restrictions

Paragraph 14 Restrictions were imposed upon your clinical practice by the Pilgrim Hospital, which you were informed of:

a. verbally during a meeting held with you on 20 November 2013; **Admitted and found proved**

b. by letter dated 21 November 2013. **Admitted and found proved**

Paragraph 15 You failed to notify the Fitzwilliam Hospital of the restrictions imposed upon your clinical practice on 20 November 2013 by the Pilgrim Hospital. **Admitted and found proved**

Request to Ms D

Paragraph 16 On or around 26 March 2014 you approached Ms D and requested that she 'have a word with Ms E and ask her to drop the allegation', (in respect of Patient C) or words to that effect. **Found proved**

127. The tribunal had regard to the evidence of Ms D and your evidence, including trust statements. It is not disputed that on 26 March 2014, you asked if Ms D had a minute to spare so that you could talk to her, nor that you asked if you could go somewhere private to do so.

128. It is your evidence that by the time you spoke to Ms D the trust investigation into the allegations about Patient C had effectively been concluded. You state that you approached Ms D as you had been frustrated that Ms E had not approached you directly about her concerns, and wanted to see what Ms D would have done if she had been in similar circumstances. You informed the tribunal that Ms D stated that she would have stopped or alerted you. At that point you asked her if she thought there could be a misunderstanding on the part of Ms E. You said that the conversation was left with Ms D stating that she would see what she could do, but it would be difficult to speak with Ms E. You informed the tribunal that you had reflected upon the conversation, and cannot explain why Ms D had thought you had asked her to speak to Ms E, and are sorry if anything you said was misinterpreted. You also stated it was not your intention that Ms D influenced Ms E in any way and you were sorry if somehow you had implied that.

129. Ms D told the tribunal that you had informed her about the incident with Patient C, and acknowledged that she had been in the room. She stated that you then proceeded to ask if she could have a word with Ms E. In her incident statement, which is not dated, she reported that you had told her, "*it had gone to the GNC (sic) and that it wasn't instigated by this hospital, but thought that it was from Peterborough Hospital where he occasionally works because he had had to tell them an investigation was going on from here*". In oral evidence, Ms D was adamant that you had asked her to have a word with Ms E to drop the allegation.

130. The tribunal regarded Ms D as a credible witness with no motivation to make a false allegation. The tribunal considers that you would have known that you had recently been referred to the GMC, and that this triggered your conversation with Ms D, and amounts to a motivation, even if subconscious, and therefore on the balance of probabilities has found this paragraph proved.

Deficient Professional Performance

Paragraph 17 You underwent a General Medical Council assessment of the standard of your professional performance on:

a. 30 November – 3 December 2015 (peer review); **Admitted and found proved**

b. 4 December 2015 (tests of competence). **Admitted and found proved**

Paragraph 18 Your professional performance was unacceptable in the area of Relationships with Patients. **Admitted and found proved**

Paragraph 19 Your professional performance was a cause for concern in the area of Assessment. **Admitted and found proved**

Patient F (Medico Legal Report)

Paragraph 20 Between 23 January 2014 and April 2015 you were acting as an Expert General Surgeon on behalf of Capita Medical Reporting. **Admitted and found proved**

131. For the remaining paragraphs, the tribunal had regard to the witness statements and oral evidence of Ms F and her partner. It also had regard to your oral evidence and witness statement. The tribunal also had regard to the witness statements of Mr E, and Ms F. The tribunal has also had regard to the medico legal report, dated 20 April 2014, and the amended medico legal report, dated 20 April 2014. The tribunal also had regard to the expert report of Mr C, dated 15 February 2016 and supplementary expert report, dated 17 February 2016.

Paragraph 21 Prior to a consultation with Patient F you failed to familiarise yourself with Patient F's:

a. case instructions; **Found not proved**

132. Patient F and her partner both attended Patient F's consultation with you at your private residence in Sutton. Patient F and her partner gave evidence to the tribunal that you were shuffling papers at the beginning of the consultation.

133. You stated that you have no specific recollection of Patient F's case, but it would be your usual practice to review case instructions, together with medical records, if they had been provided, before seeing a patient.

134. The tribunal accepted your evidence, and on the balance of probabilities found this sub-paragraph not proved.

b. medical records. **Admitted and found proved**

Paragraph 22 On 8 April 2014 you held the consultation ('the consultation') with Patient F:

a. within the kitchen area of a domestic flat; **Found not proved**

135. The tribunal had regard to the evidence of Patient F and her partner. They both told the tribunal that Patient F sat at a table within a kitchen / lounge area, whilst Patient F's partner sat on a couch within the same kitchen / lounge area. You told the tribunal, that whilst you accept that a domestic residence was not an appropriate setting for a consultation and patient examination, that the consultation took place in the lounge area of the open plan apartment.

136. The tribunal noted the evidence concerning the position of a "*sofa*" / "*couch*" in the room and determined that it was more likely than not that the table at which Patient F sat during the consultation was in an open plan room, and not perhaps specifically within the kitchen area. It therefore found this sub-paragraph not proved

b. with no other medical staff present. **Admitted and found proved**

Paragraph 23 During the consultation with Patient F you failed to:

a. arrange a setting which:

i. was appropriate for a consultation; **Admitted and found proved**

ii. would have been appropriate for a patient examination; **Admitted and found proved**

b. have Patient F's medical records available to you; **Admitted and found proved**

c. have Patient F's case instructions available to you; **Found not proved**

137. The tribunal has already accepted that you had familiarised yourself with Patient F's case instructions. It therefore follows that you would have had them available to you. The tribunal therefore finds this sub-paragraph not proved.

d. conduct a physical examination of Patient F's:

i. chest; **Found proved**

ii. abdomen. **Found proved**

138. In your oral evidence you confirmed that you did not recall the specifics of the consultation with Patient F. However, you stated that you would have done a physical examination of Patient F. It was required of you. You stated that "*if it is in my report I would have done the examination*". You stated that your normal practice if you were conducting an examination would be to palpate the abdomen from the side whilst she was sitting and that you would have examined her chest in the same way.

139. Patient F accepted in cross-examination that it was possible that an examination did take place, but that, if it did, it was only of her neck and back. She and her partner were adamant that you did not examine her chest or abdomen.

140. The tribunal had regard to the catalogue of errors in the first report, which Patient F had annotated and returned to you. These include, "*There were four small scars which were consistent to the laparoscopic cholecystectomy that she had.*" Patient F indicated in her written annotations that this was not her. In her oral evidence she also indicated to the tribunal that the finding, "*There was mild tenderness in the lower part of her chest*" was also inaccurate. She told the tribunal, that there were so many errors in the report, that she did not annotate, or even see some of them.

141. The tribunal had regard to Mr Jones' submission that Patient F was meticulous and would have spotted the error above in relation to the chest examination when she first asked for the report to be amended. Likewise he submitted that if there was no examination of Patient F's chest and abdomen that she would have recorded it at the time when she sent back her annotated report. The tribunal accepts Patient F's evidence that she missed some of the errors in the report.

142. The tribunal is of the view that, even if you had conducted the examination you said that you did by palpating Patient F's abdomen from the side, that this would be inadequate. However, it found that Patient F and her partner were

credible and consistent in their evidence that such an examination did not take place. The tribunal therefore finds these sub-paragraphs proved.

Paragraph 24 Subsequent to the consultation with Patient F you produced a medico legal report, dated 20 April 2014 which:

a. contained one or more of the inaccuracies outlined within Schedule 1; **Admitted and found proved**

b. referred to an examination of Patient F which:

i. did not take place; **Found proved**

143. The tribunal has already found that you did not undertake an examination of Patient F's chest and abdomen. The tribunal notes that this is in the medico legal report dated 20 April 2014. It therefore follows that the examination recorded did not take place. The tribunal therefore finds this sub-paragraph proved.

ii. you knew did not take place; **Found proved**

144. You informed the tribunal of your usual practice which included using a Dictaphone to record your findings based on the notes you have taken during the consultation. These are then sent to be typed up. You stated that you did not use a template, and each report was written from "*scratch*". You then receive typed report and check for errors before submitting it to Capita. You could not account for the number of errors made in the report, especially the comment about four small scars on the abdomen.

145. The tribunal considered whether you could have mistakenly confused Patient F with another patient, or got your medical notes mixed up or if you had accidently copied information from a template. However, this does not sit with your evidence that you use your notes to record your findings on a Dictaphone which are then typed up from "*scratch*". You were unable to explain how you came to record in your report abdominal scars on Patient F when she had none.

146. Therefore, the tribunal concluded, that on the balance of probabilities, you did not undertake the examination, and you knew that it had not taken place. The tribunal therefore finds this sub-paragraph proved.

c. contained a prognosis and opinion which was based on incorrect information. **Admitted and found proved**

Paragraph 25 Subsequent to a telephone conversation with Patient F which took place between 30 April 2014 and 24 October 2014 you produced an amended version of the medico legal report, dated 20 April 2014 which:

a. still contained one of more of the inaccuracies outlined within Schedule 2; **Admitted and found proved**

b. referred within paragraph 12 to an examination of Patient F which:

i. did not take place; **Found proved**

147. The tribunal has already determined that you did not undertake an examination of Patient F's chest and abdomen on 8 April 2014. There were no further appointments. Your findings on examination remain in the amended version of the medico legal report. Therefore it follows that this sub-paragraph is proved.

ii. you knew did not take place; **Found proved**

148. The tribunal had regard to a letter from Carpenters (instructing solicitors) dated 3 June 2014. You informed the tribunal that you had seen this letter prior to amending the medico legal report. In the letter, it states, "*At paragraph 12 of the examination section our client disputes that she has mild tenderness in the lower part of her chest and would like the word "mild" removed. Furthermore, at paragraph 2.2 it details an examination of our clients abdomen and that there were four small scars etc. Our client's abdomen was not examined and she has no scars as she has not had the surgery the Expert refers to.*"

149. In these circumstances it was apparent that you had been reminded that you had not undertaken an examination of her abdomen or chest and therefore the tribunal finds this sub-paragraph proved.

c. contained a prognosis and opinion which was based on incorrect information. **Found not proved**

150. The tribunal had regard to the prognosis and opinion as recorded in the medico legal report as amended. It was of the view that this was not based on inaccurate findings, but rather Patient F's medical records at the time, together with the orthopaedic surgeon's report. Other inaccuracies, including the examination findings did not affect your prognosis and opinion in this report. The tribunal therefore finds this sub-paragraph not proved.

Paragraph 26 Your conduct as described at paragraphs:

a. 24 and 25 was misleading; **Admitted and found proved in relation to 24(a), 24(c) and 25(a)**

Found proved in relation to 24(b)(i), 24(b)(ii), 25(b)(i) and 25(b)(ii)

Falls in relation to 25(c)

151. The tribunal has found that you recorded findings on an examination of Patient F's chest and abdomen, which it has determined had not occurred. The very fact that you recorded an examination which did not take place is misleading. Therefore the tribunal finds sub-paragraphs 24(b)(i), 24(b)(ii), 25(b)(i) and 25(b)(ii) proved.

b. 24(b) and 25(b) was dishonest. **Found proved in relation to 24(b) and 25(b)**

152. In considering dishonesty, the tribunal considered Lavis v Nursing and Midwifery Council [2014] EWGC 4083 (Admin), in particular:

> "While not considering that the difference is material ("*those standards*" refers to "*the ordinary standards of reasonable and honest people*") nonetheless in grappling with the 'second stage' test, the Panel did not seem to consider any explanation for the entries which did not involve dishonesty, being drawn to only one conclusion having regard to the "*nature, number and significance*" of the entries. I note that it was not the Appellant's case that the entries in the records had, for instance, been made by mistake (indeed, the Appellant conceded that there was no room for a mistake or error; her case was that her notes reflected the true account of events which in the material respects described above had been rejected by the Panel). But I consider that the Panel could or should more conscientiously have considered the mental element of the alleged dishonesty before reaching its ultimate conclusion on this issue. While dishonesty was plainly one of the possible explanations, it was not the only one: it would have been appropriate, and in my judgment proper, for the Panel to have explicitly considered in respect of each of the entries whether the Appellant had acted in an unthinking way, out of habit, in a 'slapdash' manner or while '*distracted*".

153. The tribunal found that you had indeed made a false declaration. It therefore considered whether that false declaration was made with intent, or whether there could be some other explanation.

154. In relation to the first report dated 21 April 2014. You were adamant in your evidence that you would have only reported an examination if you had undertaken it. Further you stated that your medico legal reports were dictated, written from scratch and then checked. The tribunal noted that the medico legal report was written 12 days after the consultation. The tribunal considered whether your conduct could be explained as accidental, unthinking, slapdash, out of habit, careless or automatic. In particular it noted that there were significant errors in the report which related a history and certain medical conditions and procedures which did not pertain to Patient F, as referenced in Schedule 1. It therefore considered whether you had muddled Patient F with another patient, you denied doing so. You offer no explanation as to how these multiple errors were included in your report about Patient F. You merely repeated that if there was a report of a particular examination you would have carried out that examination. You confirmed in your evidence that you saw no other patient in your home for a medico legal report that day and that you had only ever conducted a few such examinations at that venue.

155. Your second report which bears the same date was received by Capita by 24 October 2014. By this time you had the amendments on the first report made by Patient F; you also had the letter from the instructing solicitor highlighting that you had not conducted an examination of the abdomen and highlighting a significant number of other errors. In the amended version of your medico legal report you again referred to your examination of Patient F, and reported the following findings:

"*Chest: There was mild tenderness in the lower part of the chest.*

No other abnormalities present.

Abdomen: No lump or tenderness present in the abdomen.

No abnormalities present."

The tribunal observed that you had removed reference to the four small scars which were consistent with a laparoscopic cholecystectomy.

156. The tribunal noted that there was only a short period between the examination of Patient F and your first report and that, by the time you came to prepare the amended version, you had been informed about the inaccuracies that were in your first report including those concerning your alleged examination.

157. In all the circumstances the tribunal concluded that your conduct in producing these medico legal reports which recorded examination findings of Patient F's abdomen and chest, when you knew these examinations had not taken place was dishonest. The tribunal therefore finds paragraphs 26 in relation to 24(b) and 25(b) proved.

Determination on Impairment - 21/04/2017

Dr Agarwal:

1. The tribunal must now consider, on the basis of the facts found proved, whether your fitness to practise is impaired by reason of misconduct and deficient professional performance. In doing so, it has taken account of all the evidence adduced, together with Mr Jones submissions on your behalf and those of Mr Jackson on behalf of the GMC.

Submissions

2. Mr Jackson took the tribunal through the relevant case law regarding impairment. He also referred to Good Medical Practice (2013) (GMP), the edition in place at the time of these events.

3. In relation to misconduct, Mr Jackson submitted that your misconduct was serious, persistent, involved both patients and colleagues and dishonesty. He reminded the tribunal of its findings of fact.

4. In turning to impairment, Mr Jackson submitted that you have demonstrated a lack of insight during these proceedings into your serious failings. He submitted that the appropriate decision for the tribunal would be to find your fitness to practise to be currently impaired by both your misconduct and your deficient professional performance.

5. Mr Jones informed the tribunal that you accept that there has been misconduct and deficient professional performance and that you are currently impaired. However, he invited the tribunal to consider each of the paragraphs of the allegation and determine whether each of them, on their own, amounts to serious misconduct. Mr Jones also invited the tribunal to consider the report of Mr C, and submitted that, if it were to depart from his opinion on whether your standard of care was below the standard of a competent colorectal surgeon, and still find misconduct that was serious, it should give reasons.

6. In relation to deficient professional performance, Mr Jones reminded the tribunal of the positive findings of the Performance Assessment Team, and invited the tribunal to consider the totality of the report.

7. Whilst the tribunal has borne in mind the submissions made, it has exercised its own judgement in deciding whether your fitness to practise is impaired.

Tribunal's approach

8. The tribunal has already given a detailed determination in respect of its findings of fact, and it has taken those findings into account during its deliberations on impairment.

9. The issue of impairment is one for the tribunal to determine exercising its own judgement. It has carefully considered the evidence adduced and the facts found proved. It has had regard to the relevant edition of GMP and the principles contained therein. Throughout its deliberations, the tribunal has been mindful of the overarching objective as set out in the Medical Act 1983 (as amended). That objective is the protection of the public and involves the pursuit of the following objectives:

a. to protect, promote and maintain the health, safety and wellbeing of the public
b. to maintain public confidence in the profession
c. to promote and maintain proper professional standards and conduct for members of the profession.

10. In considering impairment by reason of deficient professional performance, the tribunal this in two stages. It first considered whether the facts found proved amount to performance which is sufficiently serious to constitute deficient professional performance. If so, it would then go on to consider whether your fitness to practice is currently impaired.

11. With regards to impairment by reason of misconduct, the tribunal again engaged in a two-stage process. It first considered at stage one whether the facts found proved amounted to misconduct. It was aware that misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice so that it can be properly described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful nature, which prejudices the reputation of the profession. It then considered at stage two whether the misconduct was sufficiently serious to warrant a finding of impairment.

12. The tribunal also took account of the comments of Beatson LJ in Schodlok v General Medical Council [2015] EWCA Civ 769 in relation to *'accumulated non-serious misconduct'*. It recognised that only facts which amounted to serious misconduct should be taken into account when considering whether your fitness to practise is currently impaired.

Misconduct

13. The tribunal had regard to that part of the allegation which charges that your fitness to practise is impaired by reason of misconduct. It accepted Mr Jones' submission that it should consider whether each of paragraphs 1-16 and 20-26 amounted to serious misconduct.
14. The tribunal determined that the following paragraphs of the allegation amounted to mere narrative and did not allege culpable behaviour and therefore did not amount to misconduct: Paragraphs 1, 10, 14(a) and 14(b) and 20.

Patient A

15. In relation to the facts found proved at 2(b) and 2(c)(ii), the tribunal departed from Mr C who opined that your care of Patient A was below the standards expected of a competent colorectal surgeon, but not seriously below. The tribunal considered the nature of the sigmoidoscope examination. This was an intrusive, intimate examination, in which Patient A was in a vulnerable position, curled up, with her bottom exposed. In these circumstances, the tribunal considered that you should have taken extra precautions to ensure Patient A was aware of the examination.

16. The tribunal has noted that GMP states that:

> ***5*** *If patients have capacity to make decisions for themselves, a basic model applies:*
>
> > ***a*** *The doctor and patient make an assessment of the patient's condition, taking into account the patient's medical history, views, experience and knowledge.*
> >
> > ***b*** *The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.*

17. In these circumstance the tribunal determined that your conduct in relation to paragraphs 2(b) and 2(c)(ii) amounted to misconduct which was serious.

18. In relation to paragraph 2(e), the tribunal accepted Mr C's expert opinion, "*if Patient A had been offered and accepted conservative treatment she would not have needed a lateral sphincterotomy and haemorrhoidectomy*". It concluded that this

was seriously below the standards expected of a competent colorectal surgeon and determined that your failure to discuss such conservative treatments with her breached GMP, as stated above, and amounted to misconduct which was serious.

19. The tribunal considered the facts found proved at paragraph 3 in their totality. It had regard to Mr C who opined that in relation to these paragraphs, your care of Patient A was below the standards expected of a competent colorectal surgeon, but not seriously below. The tribunal found that you had made some notes but that these were not sufficient and departed from GMP. The tribunal is of the view that this was misconduct, but did not cross the threshold to amount to misconduct which was serious.

20. In relation to paragraph 4(a) and 4(b), the tribunal accepted Mr C's expert opinion that by consenting Patient A for a fissurectomy and then doing a lateral sphincterotomy without fully informed consent, your care to Patient A was seriously below the standards expected of a competent colorectal surgeon and determined that your failure amounted to misconduct which was serious.

21. The tribunal had regard to the totality of paragraph 5. It accepted Mr C's expert opinion that to proceed to surgery before establishing conservative treatments had failed and without the appropriate indications for haemorrhoidectomy or lateral sphincterotomy, your care of Patient A was seriously below the standards expected of a competent colorectal surgeon and determined that your failure amounted to misconduct which was serious.

22. The tribunal considered the facts found proved at paragraph 6 in their totality. It had regard to Mr C who opined that in relation to these paragraphs that your care of Patient A was below the standards expected of a competent colorectal surgeon, but not seriously below. The tribunal found that you had made some notes but that these were not sufficient and departed from GMP. The tribunal is of the view that this was misconduct, but did not cross the threshold to amount to misconduct which was serious.

23. In relation to paragraph 7(a), (b) and (c), the tribunal noted that Mr C found your care to be below the standards expected of a competent colorectal surgeon, but not seriously below. On your evidence Patient A would have been consented for three procedures and not known which one (or more) you had undertaken. The tribunal considered that, in these circumstances, as you were the responsible surgeon and the only person who knew what you had done and why, you had a responsibility to explain to Patient A the operation you had performed and why you had performed it. Also, the tribunal has found that you undertook a procedure that you did not consent Patient A for, namely a lateral sphincterotomy. It determined that in these circumstances, your duty was even greater, and therefore your actions amounted to misconduct which was serious.

24. In the circumstances explained above the tribunal determined that by not providing post-operative care as found proved at paragraph 7(d), your actions amounted to misconduct which was serious.

25. In relation to the following paragraph at 8(a) (i), (ii), (vi), (viii) and (ix), the tribunal considered the nature of the digital rectal examination which you performed. It was an intrusive, intimate examination, carried out while Patient A was in a vulnerable position and when she had wounds which were healing. The tribunal considered that you should have taken extra precautions to ensure Patient A was aware of the examination and that you should have halted the examination as soon as she indicated that she was in severe pain. In all of these circumstances, the tribunal determined that your failures amounted to misconduct which were serious.

26. With regards to paragraphs 8(a) (iii), (xi) and (xii), the tribunal is of the view that this was misconduct, but did not cross the threshold to amount to misconduct which was serious.

27. The tribunal reminded itself of its findings at paragraph 9 "*Having found that the digital examination should have been undertaken under local anaesthetic, and having heard that Patient A was in severe pain, the tribunal is of the view that the procedure caused unnecessary pain to Patient A."* The tribunal determined that causing unnecessary pain to Patient A amounted to misconduct which was serious.

28. The tribunal has therefore found misconduct relating to Patient A in paragraphs 2(b), 2(c)(ii), 2(e), 4(a), 4(b), 5, 7(a), 7(b), 7(c), 7(d), 8(a)(i), 8(a)(ii), 8(a)(vi), 8(viii), 8(a)(ix) and 9.

Patient C

29. The tribunal had regard to its findings of fact in relation to Patient C. Your conduct at paragraph 11 and paragraph 12(a), was accepted as common practice, and therefore did not cross the threshold for misconduct. The tribunal also considered that your conduct at paragraph 12(b) in inserting your finger into the vagina of Patient C whilst performing a flexible sigmoidoscopy was not deliberate and was in fact more likely to be accidental and therefore did not cross the threshold for misconduct.

Restrictions

30. The tribunal noted the restriction which was placed on your practice by the Pilgrim Hospital, "*immediate restriction of your duties with regard to endoscopy procedures of female patients"*, as found proved at paragraph 15, was done with patient safety in mind. It determined that your failure to notify Fitzwilliam Hospital would be considered deplorable by other medical practitioners, and was sufficient to amount to misconduct which was serious.

Request to Ms D

31. In relation to paragraph 16 the tribunal had regard to GMP paragraph 36 which states:

> "36. *You must treat colleagues fairly and with respect*."

32. The tribunal had regard to Ms D's evidence and the impact your conduct had on her. The tribunal is also of the view that attempting to interfere with an investigation, even if your motivation was subconscious, amounted to misconduct which was serious.

Patient F

33. The tribunal had regard to its findings at paragraphs 21(b) and 23(b). It has heard evidence that it is possible to undertake a consultation without medical records and therefore it determined that this did not amount to misconduct.

34. In relation to paragraphs 23(a)(i) and 23(a)(ii) you accepted that a domestic residence was not an appropriate setting for a consultation and patient examination. Mr C opined that this was "*less than ideal circumstances and without an independent chaperone*" and "*done with inadequate facilities*". In these circumstances, the tribunal is of the view that for a female patient to attend at your domestic residence for a consultation with you, without an independent chaperone, amounted to misconduct which was serious.

35. With regard to paragraphs 24(a) and 25(a), the tribunal accepted the opinion of Mr C who stated, *"Mr Agarwal's initial Medico-Legal report contained 10 errors including a record of incorrectly seeing four abdominal scars. This was deleted from the final report only after Patient F had told him that she had not had a cholecystectomy. The standard of the initial Medico-Legal report prepared by Mr Agarwal was not acceptable and was seriously below the standard expected of a reasonably competent medical expert colorectal surgeon…The amended version of the Medico-Legal report prepared by Mr Agarwal remained below that expected of a reasonably experienced expert witness"*.

36. The tribunal also had regard to GMP paragraphs 19 and 21a which state:

> *"19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards."*
>
> *"21. Clinical records should include:*

a. relevant clinical findings"

37. Your first report contained some serious inaccuracies, which you could not explain. Even after these were pointed out to you by Patient F and you had the opportunity to re-check your report, errors still remained. The tribunal considered that this amounted to misconduct which was serious.

38. In relation to paragraph 26(a), the tribunal has found that you did not undertake an examination of Patient F's chest and abdomen. You signed a statement of truth. This was misleading and the tribunal considered that it amounted to misconduct which was serious.

39. At paragraph 26(b) the tribunal has determined that your conduct was dishonest. It had regard to the following paragraphs of GMP:

> *"65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession."*
>
> *"68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate."*
>
> *"71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.[22] You must make sure that any documents you write or sign are not false or misleading.*
>
> *a. You must take reasonable steps to check the information is correct.*
>
> *b. You must not deliberately leave out relevant information."*

40. The tribunal is of the view that your conduct departed from these standards, and therefore amounted to misconduct which was serious.

41. Doctors are expected to uphold proper standards of conduct. The tribunal has explained above where your conduct departs from the standards it would expect from a reasonably competent colorectal surgeon. Cumulatively, these demonstrated conduct that fell seriously below the standards expected of all registered medical practitioners.

42. The tribunal has therefore found misconduct relating to Patient F in paragraphs 23(a)(i), 23(a)(ii), 24(a), 25(a), 26(a) and 26(b).

Impairment by reason of misconduct

43. The tribunal went on to consider whether your fitness to practise is impaired. The tribunal has been referred to several authorities that gave assistance with the issues that have a bearing on impairment. The issues were:

- Whether the misconduct can be remedied and, if so, whether it has been remedied
- Whether the doctor has insight into their misconduct
- Whether there is any risk of repetition

44. The tribunal recognised that you have started to display some insight into your misconduct, and accepts that this is an iterative process which will develop. It also accepts that you have fully engaged with the GMC investigation and the MPTS proceedings.

45. The tribunal had regard to your reflective statement, dated 14 December 2016, which it considered as a step towards remediation, and a response to its determination on the facts. However, it remained concerned over a number of the statements that you made; "*the patient should be notified if alternative procedures are done at the operation*" and "*should have been informed that there was no more place for conservative treatment as it failed*". It is of the view that these statements do not acknowledge the need for patient participation in decision making. You also state, "*I would keep my handwritten notes for longer period in future*" in response to the tribunal's findings in relation to Patient F and you state "*I would say that I never been dishonest in report writing but accept the blame for the inaccuracies I have made*". The tribunal find that you have not properly accepted your dishonesty nor reflected upon it.

46. In these circumstances that tribunal is not reassured that you will not repeat your actions.

47. The tribunal therefore considers that you have in the past acted and are liable in the future to act so as to present a risk of harm to patients, bring the medical profession into disrepute, breach fundamental tenets of the medical profession; and act dishonestly.

48. In all the circumstances the tribunal has concluded that your fitness to practise is currently impaired by reason of your misconduct.

Deficient Professional Performance

49. In considering whether the facts found proved amount to performance which is sufficiently serious to constitute deficient professional performance, the tribunal first considered whether the evidence before it represented a fair sample of your work. The

tribunal had regard to the elements of the Performance Assessment. These comprised a review of the 45 and 30 cases where you had been identified as having carried out a procedure or was significantly involved in a procedure; a case based discussion involving 12 sets of notes; third party interviews; a knowledge test comprising 120 questions and a 12 station OSCE. The tribunal regarded this assessment to be a fair sample of your work.

50. The Tribunal had regard to Mr Jones submission that you were out of work at the time of the assessment. The tribunal noted that you were excluded from the Trust between 1 April 2014 and 14 May 2014, worked at a different hospital site between May 2014 and 2 January 2015, and retired on 5 June 2015. It also noted that you had been working as a colorectal surgeon for a substantial period prior to being out work.

51. The tribunal then went on to consider whether the findings of the Performance Assessors were sufficiently serious so as to amount to deficient professional performance. Your performance was found to be unacceptable in the area of "*Relationships with Patients*" and a cause for concern in the area of "*Assessmen*t". You were found to be acceptable in the areas of "*Clinical Management*", "*Operative/Technical Skills*", "*Record Keeping*" and "*Working with Colleagues*". When considered overall, the various findings were considered by the tribunal as sufficiently serious to constitute deficient professional performance.

Impairment by reason of Deficient Professional Performance

52. Having determined that the facts admitted and found proved amount to unacceptable performance which was sufficiently serious to constitute deficient professional performance, the tribunal then went on to consider whether your fitness to practise is currently impaired by reason of that deficient professional performance. In doing so, the tribunal considered whether your deficient professional performance is easily remediable, whether it has been remedied, and whether it would be safe to conclude that your deficient professional performance is highly unlikely to be repeated.

53. The tribunal had regard to the recommendations of the performance assessment team as follows:

1. *The doctor should address his difficulties in relationships with patients by attending an appropriate course and subsequently demonstrating an acceptable ability to communicate with patients, explain options, and to involve patients in management decisions.*

2. *In light of the fact that that doctor has not worked since January 2015, and from May 2014 until January 2015 he worked in a supervised capacity, we recommend that the doctor should engage in a period of refresher training in a unit approved for this purpose by the GMC, with an educational and clinical supervisor.*

54. The tribunal has noted the courses that you have undertaken this year in relation to communicating with patients and effective consent. However it has concerns about your reflective statement as described in paragraph 45 of this determination. The tribunal also noted that you have not engaged in a period of refresher trainer.

55. The tribunal considered that the deficiencies highlighted are capable of being remedied. However, the tribunal was provided with no evidence that you have addressed these deficiencies. Without such evidence of remediation, nor a remediation plan, the tribunal concluded that there remains a high risk of repetition of the deficient professional performance.

56. In all the circumstances the tribunal has concluded that your fitness to practise is currently impaired by reason of your deficient professional performance.

Determination on Sanction - 21/04/2017

Dr Agarwal:

1. Having determined that your fitness to practise is currently impaired both by reason of your misconduct and deficient professional performance, the tribunal has considered the submissions made by Mr Rigby, Counsel on behalf of the GMC, and those made by Mr Jones, Counsel on your behalf, regarding the appropriate sanction, if any, that should be imposed on your registration.

2. The tribunal received further documentation from you which comprised:

- Document entitled 'Update' signed by you and dated 20 April 2017
- List of Continuing Professional Development (CPD) undertaken
- Document listing your voluntary clinical observership sessions

GMC submissions

3. Mr Rigby submitted that the appropriate sanction to impose in this case is erasure and drew the tribunal's attention to relevant sections of the Sanctions Guidance (SG) July 2016.

4. In summary, Mr Rigby reminded the tribunal of its determination on impairment, in which it accepted the opinion of Mr C in relation to those matters he considered serious failures. In relation to your misconduct, Mr Rigby submitted that there had been a catalogue of failures by you, and that, your conduct overall could be described as cavalier. In relation to Patient A, he submitted that there was a lack of any real explanation of what you intended to achieve, and what you intended to do to achieve it. Further, he reminded the tribunal that you failed to obtain informed consent from Patient A and, most seriously, you embarked upon an operation

despite not having assured yourself that conservative treatments had failed and not observing appropriate pre-operative procedures. Mr Rigby also referred the tribunal to paragraph 46 of Good Medical Practice (GMP) (2013 Edition).

5. In respect of Patient C, Mr Rigby reminded the tribunal that although it found your actions did not amount to misconduct, aspects of your conduct related to your lack of integrity and trustworthiness. In particular, he referred to your attempting to influence a witness. Further, he reminded the tribunal of your failure to disclose the restrictions imposed on your practice by the Pilgrim Hospital to the Fitzwilliam Hospital. With regards to your dishonesty, Mr Rigby referred to your writing in a report and a supplementary report that you had examined Patient F, when you had not.

6. In respect of your deficient professional performance, Mr Rigby reminded the tribunal of the concerns identified which related to your relationships with patients and that these chime with the deficiencies and failures which led to your misconduct. Mr Rigby submitted therefore that a sanction of suspension or conditions would not be sufficient to satisfy the public interest in this regard.

7. Mr Jones invited the tribunal to consider imposing a sanction of suspension and reminded the tribunal that you have remained fully engaged with the process.

8. In summary, Mr Jones submitted that the tribunal must always have in mind that each case is different and there is no particular sanction for specified misconduct. He reminded the tribunal to consider the protection of the public, the public interest, and your own interest. He also reminded the tribunal that it has found there remains a risk of repetition in respect of your misconduct and deficient professional performance, and that one way of reducing that risk would be for you to demonstrate insight or future insight. A period of suspension would provide the necessary protection to the public whilst your insight was developing. He submitted that it is difficult for a registrant who has previously denied allegations to demonstrate remediation, and that denial alone should not result in an automatic finding of a future risk of repetition. Mr Jones reminded the tribunal that you have attended a number of courses and accept that patient care is vital and you are currently undertaking a voluntary observership.

9. With regards to your clinical shortcoming in assessments of patients, Mr Jones submitted that your deficient professional performance is capable of being remediated. He submitted that whilst the tribunal found limited insight, it cannot be said that greater insight could not be gained over the passage of time. Mr Jones submitted that the tribunal is entitled to consider what a reasonable and well informed member of the public would think. He submitted that it would be in the public interest to allow a doctor of your experience to return to practice, even if that does not happen immediately or was subject to restrictions. Mr Jones invited the tribunal to take account of the references and testimonials, provided on your behalf,

and submitted that it is important to consider personal mitigation. He also invited the tribunal to consider your document entitled 'Update' dated 20 April 2017. Mr Jones reminded the tribunal of your desire to address the failings identified and submitted that you are committed to medicine.

10. Mr Jones submitted these events occurred three and a half years ago and that the time elapsed since your misconduct is important. He told the tribunal that you have been subject to an Interim Order of Conditions on your registration since 2014 and that you continued to work until you left XXX. Further, he told the tribunal that you were unable to find any employment under the strict terms of those conditions, explaining that very few units in the UK employ solely colorectal surgeons. Mr Jones submitted that the length of time you have been unable to work should be taken into account by this tribunal when considering proportionality. He invited the tribunal to consider that the misconduct found in this case is not fundamentally incompatible with continued registration, and he maintained that complete removal from the register would not be in the public interest. Further, he submitted that it was clear from the performance assessment that you are capable of working to an acceptable standard and that, in the context of a career as a colorectal/general surgeon of some 40 years, a sanction of suspension would be appropriate.

Tribunal's decision

11. The decision as to the appropriate sanction, if any, is a matter for this tribunal exercising its own judgement. In reaching its decision, the tribunal has taken account of the SG and the statutory over-arching objective, which includes protecting the health, safety and wellbeing of the public, maintaining public confidence in the profession, and promoting and maintaining proper professional standards and conduct for the members of the profession. The tribunal recognises that the purpose of a sanction is not to be punitive, although it may have a punitive effect. Throughout its deliberations, the tribunal has applied the principle of proportionality, balancing your interests with the public interest.

No Action

12. The tribunal first considered whether to conclude this case by taking no further action on your registration. It determined that, given the serious nature of your misconduct, and your deficient professional performance, and in the absence of any exceptional circumstances, it would be wholly inappropriate to conclude this case by taking no action. Furthermore, the Tribunal determined that concluding the case with no further action would be insufficient to protect patients and would not be in the wider public interest.

Conditions

13. The tribunal next considered whether to impose conditions on your registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable, measurable and sufficient to address the public interest. It took into account the circumstances and criteria for conditions outlined in the relevant paragraphs of the SG and noted in particular paragraph 76 which states:

> *76. Conditions are likely to be 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 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.*

14. The tribunal accepts that the deficiencies identified in your clinical practice are in principle amenable to remediation or retraining. It notes that, prior to the commencement of these proceedings, you had attended courses specifically relating to communicating with patients and effective consent and it took account of the document entitled 'Update' dated 20 April 2017. The tribunal considers that the deficient professional performance aspects of your case could be managed by the imposition of a set of robust conditions. However, the tribunal has had regard to the very serious nature of your misconduct. The tribunal considered that you have demonstrated limited insight into your overall misconduct and it is of the opinion that it would be difficult to formulate conditions that would adequately address those concerns identified in this case.

15. The tribunal has therefore determined that conditions would neither be sufficient, appropriate nor proportionate to protect the public interest, nor would it maintain public confidence in the profession.

Suspension

16. The tribunal then went on to consider whether a period of suspension would be an appropriate and proportionate sanction to impose on your registration. In so doing, it noted paragraph 91 of the SG which state:

> *91. 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…*
>
> *…*
>
> *e.	No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage…*
>
> *…*
>
> *g.	The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

17. The tribunal has taken account of the mitigating factors in this case which are as follows:

- You have demonstrated some insight into your behaviour
- You have made attempts to keep your medical knowledge up to date
- You are of previous good character
- You have engaged fully with the GMC and these proceedings
- You made admissions at the outset of this hearing

18. It also noted that the aggravating factors in your case are as follows:

- You have demonstrated limited insight
- There has been only a partial apology to Patient A in respect of those parts of the allegation which concern her
- There has been a distinct lack of apology to Ms D in your witness statement, reflection statement and your update document
- You showed a lack of responsibility towards patient care in respect of Patient A and failed to take prompt action when Patient A's comfort and dignity were compromised

- Your fitness to practise was found to be impaired by reason of both your misconduct and deficient professional performance
- The tribunal has made several findings of misconduct in your practice and these include instances of dishonesty and lack of integrity

19. The tribunal has already determined that your misconduct and deficient professional performance involved serious breaches of fundamental elements of GMP as detailed in its determination on impairment, and that there is a risk of your repeating your actions. Given the seriousness of your misconduct, your limited insight and remediation into that misconduct, and your deficient professional performance, and recognising its duty to act with proportionality, the tribunal considers that it would not be discharging its duty to protect the public if it imposed a period of suspension. Furthermore, suspension would be insufficient to maintain public confidence in the profession in the particular and serious circumstances of this case.

20. Therefore, the only appropriate and proportionate sanction in this case is one of erasure.

<u>Erasure</u>

21. In reaching this conclusion the tribunal has had regard to paragraphs 103 (a), (b), (h), (j) and 114 of the SG, which state:

> *'103. 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.*
> >
> > *b. A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
> >
> > *…*
> >
> > *h. Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 114–122).*
> >
> > *…*
> >
> > *j. Persistent lack of insight into the seriousness of their actions or the consequences.*

> *114. Good medical practice states that registered doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession.'*

The tribunal has balanced your interests with the public interest and considered the above factors.

22. The tribunal has already concluded that your actions represented serious departures from GMP and a disregard for fundamental principles set out in GMP and that they put patient safety at risk. There were several instances of dishonesty and/or lack of integrity and you have shown a persistent lack of insight into the seriousness of your actions. Further there is insufficient evidence of remediation. The tribunal considered that, taking all the above matters into account, your actions reveal a doctor whose mind is cast in a certain mould, namely that your decisions are correct and not to be challenged. Furthermore, your actions resulted in a catalogue of failures including the following:

- pressing ahead with an operation not consented for and without undertaking appropriate conservative measures
- not disclosing to a patient the procedure which you had undertaken
- examining a patient with a sigmoidoscope without forewarning her and thereby causing her to experience significant pain
- failing to disclose restrictions on your practice imposed by the Pilgrim Hospital to the Fitzwilliam Hospital
- attempting to influence a witness
- not examining a patient prior to preparing a medicolegal report and dishonestly contending in reports that you had done so

23. The tribunal determined that no lesser sanction than erasure from the medical register would protect the health, safety and wellbeing of the public, maintain public confidence in the profession, and promote and maintain proper professional standards. The tribunal is, therefore, satisfied that erasure is the proportionate and appropriate sanction in the public interest. In all of the circumstances of the case, the tribunal has determined to erase your name from the medical register.

24. Mr Jones drew to the tribunal's attention that you offered an apology to Patient A in your reflection statement, introduced at stage two in December 2016. He also noted two paragraphs in your Update document. The tribunal did not consider that the two latter paragraphs represented an apology to Patient A on your part. The apology in the reflection statement was contained in a section which dealt with paragraph four of the allegation and therefore related to your failures to notify Patient A that you intended to carry out a lateral sphincterotomy operation and to obtain her consent for that operation. You denied both of these matters and they were found proved. In your wording of the relevant passage, the tribunal did not

understand that it reflected your apology to Patient A in respect of what happened to her rather than in respect of your failures as alleged. No apology was offered in respect of the other matters set out in the allegation relating to Patient A. As it is possible that the tribunal has misconstrued the offer of apology in your reflection document, and it recognises that it may have done, it has withdrawn the broad proposition that *'there has been a distinct lack of apology to Patient A'*. It has substituted the following: '*There has been only a partial apology to Patient A in respect of those parts of the allegation which concern her*'. This revision of the determination made no difference to the decision on sanction which the tribunal has reached.

25. The effect of the foregoing direction is that, unless you exercise your right of appeal, your name will be erased from the Medical Register 28 days from the date on which written notice of this decision is deemed to have been served upon you.

Determination on Immediate Order - 21/04/2017

Dr Agarwal:

1. Having determined that your name be erased from the Medical Register the tribunal has now considered, in accordance with Section 38 of the Medical Act 1983 as amended, whether to impose an immediate order on your registration. The tribunal has considered all of the circumstances of the case and the submissions made by Mr Rigby.

2. Mr Rigby referred the tribunal to paragraphs 166, 167 and 172 contained within the SG and submitted that an immediate order is necessary in this case.

3. Mr Jones made no submissions on your behalf

4. In reaching its decision, the tribunal has had regard to the relevant paragraphs in the SG and has balanced your interests with the public interest. It determined that given the serious nature of your misconduct and deficient professional performance, an immediate order of suspension is necessary in order to protect patients and is otherwise in the public interest.

5. The substantive direction for erasure, as already announced, will take effect 28 days from when notice is deemed to have been served upon you. The immediate order of suspension will take effect forthwith. If you lodge an appeal, the immediate order for suspension will remain in force until the appeal is determined.

6. The interim order currently imposed on your registration is hereby revoked.

7. That concludes this case.

Confirmed
Date 21 April 2017 Dr Priya Iyer, Chair

Schedule 1

1. Paragraph 3.1:

   Reads: had a gastroscopy 10 years ago;
   Should read: had a gastroscopy 3 years ago;

2. Paragraph 3.3:
   This section contains information which is not the Patient's;

3. Paragraph 4.4:
   Reads: her husband;

   Should read: her partner;

4. Paragraph 5.1:
   Reads: She consulted a Gastroenterologist who prescribed her Lansoprazole;

   Should read: 2 ½ years after the accident she was prescribed Lansoprazole;

5. Paragraph 5.4:

   This section contains information which is not the Patient's;

6. Paragraph 6.1:

   Reads: her abdominal pain has completely resolved;

   Should read: her abdominal pain has not completely resolved;

7. Paragraph 9.1

   Reads: She is still stressed when drove especially with traffic coming from behind at a roundabout. She feels that somebody is hitting in the rear of her car;
   Should read: She is mildly anxious on occasions when driving especially if the traffic is coming from behind at a roundabout. She feels that somebody may hit the rear of her car, but this is improving with time';

8. Paragraph 12.2:

   This section contains information which is not the Patient's;

9. Paragraph 13.1:

   This section contains information which is not the Patient's;

10. Paragraph 13.3:

    This section contains information which is not the Patient's.

Schedule 2

1. Paragraph 3.1:

   Reads: had a gastroscopy 10 years ago;
   Should read: had a gastroscopy 3 years ago;

2. Paragraph 4.4:
   Reads: her husband;

   Should read: her partner;

3. Paragraph 6.1:

   Reads: her abdominal pain has completely resolved;

   Should read: her abdominal pain has not completely resolved.