Record of Determinations – Medical Practitioners Tribunal

PUBLIC RECORD

**Dates:** 30/09/2019 - 07/10/2019

**Medical Practitioner’s name:** Dr Manish HEGDE

**GMC reference number:** 5198821

**Primary medical qualification:** MB BS 1997 Poona

**Type of case**
New - Misconduct

**Outcome on impairment**
Not Impaired

**Summary of outcome**
No warning

**Tribunal:**

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<th>Role</th>
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<tr>
<td>Legally Qualified Chair</td>
<td>Mrs Claire Sharp</td>
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<tr>
<td>Lay Tribunal Member:</td>
<td>Mrs Cindy Mackie</td>
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<tr>
<td>Medical Tribunal Member:</td>
<td>Dr Damian McDermott</td>
</tr>
<tr>
<td>Tribunal Clerk:</td>
<td>Mr Edward Kelly (30th September – 3rd October 2019 am)</td>
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<td>Ms Jacqueline Kramer (3rd October 2019 pm)</td>
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<td>Ms Lorraine Curry (4th – 7th October 2019)</td>
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**Attendance and Representation:**

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<td>Medical Practitioner:</td>
<td>Present and represented</td>
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<td>Medical Practitioner’s Representative:</td>
<td>Mr Christopher Gillespie, Counsel, instructed by MDU.</td>
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<tr>
<td>GMC Representative:</td>
<td>Mr Tim Grey, Counsel, instructed by GMC Legal.</td>
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Attendance of Press / Public
In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

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

Determination on Facts - 03/10/2019

Background

1. Prior to the events which are the subject of the hearing, Dr Hegde worked in a number of hospitals around the UK before obtaining membership to the Royal College of Physicians in 2002. He completed specialist training in Gastroenterology and General Medicine in 2008 and was appointed Consultant Gastroenterologist at Great Western Hospital NHS Foundation Trust (‘the Trust’) in July 2009. Dr Hegde has worked in this capacity from 2009 to date, including at the time of the alleged events. He also maintains a private practice at the Berkshire Independent Hospital (‘the Hospital’).

2. The allegation that has led to Dr Hegde’s hearing arise out of his diagnosis and treatment of Patient A, with whom he conducted three consultations at the Hospital, following referral from her GP, for the first time in July 2013 and for the last time in December 2013. In February 2014, Patient A’s condition worsened and she was subsequently diagnosed with cancer of the colon by a different consultant and successfully treated for this.

3. In January 2018 during consultation with Mr B, a Consultant Colorectal Surgeon, Patient A became aware of the contents of a letter dated 23 May 2014 from Ms C, a Matron at the Hospital. The letter asserted that Patient A declined to have a colonoscopy when offered by Dr Hegde on 5 September 2013. It was this assertion that prompted Patient A to complain to both the Trust and the GMC. Patient A complained that Dr Hegde had advised her not to have a colonoscopy and was "too young to have cancer", or words to that effect.

The Outcome of Applications Made during the Facts Stage

4. The Tribunal determined to grant the application from Mr Gillespie, on behalf of Dr Hegde, made pursuant to Rule 17(2)(g) of the Rules, of no case to answer in
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relation to paragraph 1(d)(ii) of the Allegation. However, it refused the application in relation to paragraph 1(d)(i) of the Allegation. The Tribunal’s full determination on this application is included at Annex A.

The Allegation and the Doctor’s Response

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

1. Between 11 July 2013 and 9 December 2013 you were involved in the care and treatment of Patient A and you:

   a. failed to adequately investigate Patient A’s lower gastrointestinal tract in that you did not undertake a:

      i. colonoscopy; or Admitted and found proved

      ii. CT colonography; Admitted and found proved

   b. failed to diagnose Patient A’s condition; Admitted and found proved

   c. failed to adequately discuss with Patient A the:

      i. level of her risk of colonic cancer; Admitted and found proved

      ii. risks and benefits of lower gastrointestinal investigations. Admitted and found proved

   d. told Patient A that:

      i. she was too young to have cancer or words to that effect; To Be Determined following an unsuccessful Rule 17(2)(g) application

      ii. a colonoscopy was not:

         1. appropriate; Withdrawn following a successful Rule 17(2)(g) application

         2. necessary. Withdrawn following a successful Rule 17(2)(g) application
And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. **To Be Determined**

**The Admitted Facts**

6. At the outset of these proceedings, through his counsel, Mr Gillespie, Dr Hegde made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved. It confirmed though that it would consider whether the risks and benefits of a colonoscopy were adequately explained to Patient A by Dr Hegde during the consultations. This is because while Dr Hegde has admitted paragraph 1(c)(ii), this was only in respect of his failure to adequately explain the risks and benefits of CT colonography, not colonoscopy. In the Tribunal’s view, it was important to fully establish the position in order to properly consider Dr Hegde’s fitness to practice.

**The Facts to be Determined**

7. In light of Dr Hegde’s response to the Allegation made against him, the Tribunal is required to determine the remaining paragraphs.

**Witness Evidence**

8. The Tribunal received oral evidence on behalf of the GMC from Patient A, who also provided a written statement, dated 16 May 2019.

9. The Tribunal also received evidence from an expert witness called by the GMC, Dr D, Consultant Gastroenterologist, in the form of an expert report, dated 9 August 2018, who gave oral evidence to the Tribunal.

10. Dr Hegde provided his own witness statement, dated 25 July 2019 and gave oral evidence at the hearing.

**Documentary Evidence**

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

- Patient A’s medical records from her GP and the Hospital, various dates;
- Letters from Dr Hegde to Patient A’s GP, various dates;
- Correspondence from Dr Hegde to Patient A, between 5 September 2013 – 21 February 2014;
- Patient A’s complaint to the Hospital, dated 25 January 2018;
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- Patient A’s complaint to the GMC, dated 5 February 2018;
- Letters between Mr B and the Hospital, dated 6 March 2014 and 23 May 2014; and
- Letters between Dr Hegde and Ms C, Matron at the Hospital, dated 30 April 2014 and 19 May 2014.

The Tribunal’s Approach

12. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC. Dr Hegde does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

13. The Tribunal reminded itself that it must form its own judgment about the witness evidence heard before it, and the reliability of such witnesses, including Dr Hegde. It noted that it must decide whether to accept or reject part or all of such evidence, and what weight to attach to it.

14. The Tribunal also bore in mind that it should assess and determine each paragraph and sub-paragraph of the Allegation separately. It reminded itself that while it could draw inferences from the evidence, it must not speculate as to any further evidence that has not come before it.

15. The Tribunal accepted the advice of the Legally Qualified Chair who directed its attention to relevant paragraphs of the judgment of Leggatt J in Gestmin SGPS SA v Credit Suisse (UK) Ltd [2013] EWHC 3560 (Comm), which deals with how to approach the recollections of witnesses. Mr Justice Leggatt opined that “the best approach ... is ... to base factual findings on inferences drawn from the documentary evidence and known or probable facts.” The Legally Qualified Chair also noted factors such as inherent believability, contemporaneous evidence, and internal consistency were relevant.

16. The Tribunal took account of submissions from Mr Grey, on behalf of the GMC and those of Mr Gillespie on behalf of Dr Hegde.

The Tribunal’s Analysis of the Evidence and Findings

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

Paragraph 1(c)(ii)

18. The Tribunal firstly considered paragraph 1(c)(ii) of the Allegation. Dr Hegde admitted this paragraph in respect of his failure to discuss, or offer, CT colonography to Patient A. However, the issue of whether he adequately discussed the risks and benefits of colonoscopy remains in dispute.
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19. The Tribunal determined that there was no doubt as to whether a colonoscopy investigation was discussed because the documentary evidence (letters) and oral evidence from both Patient A and Dr Hegde mentioned the discussions in relation to colonoscopy. The Tribunal noted Patient A’s GP medical notes from 11 March 2014, which state: "Discussed with pt & husband Dr Hegde’s decision not to proceed to colonoscopy & the fact that patient had decided that she did not want one.” This is a clear indication that the discussion regarding colonoscopy had occurred. Patient A, in her oral evidence, was vague as to whether she discussed risks and benefits with Dr Hegde or her GP.

20. The Tribunal determined that even though there is evidence that colonoscopy was discussed, it concluded that Dr Hegde failed to adequately discuss the potential benefits to Patient A. He told her about the main risk of the procedure (perforation), but miscategorised her risk of cancer as low. Dr Hegde accepted that he did not "push" colonoscopy as the recommended way forward as much as he should have. The Tribunal considered Dr Hegde’s incorrect assessment of Patient A’s risk of cancer, combined with his failure to adequately discuss the benefits of colonoscopy, led to Patient A indicating that she would "leave it" for the time being.

21. The Tribunal noted Dr Hegde’s letter to Patient A’s GP, on 11 July 2013, following his first consultation with Patient A. It states: “On examination, apart from being extremely pale, there is nothing else significant to find". It also states: "I have suggested that Patient A should have a gastroscopy, which I have organised ... In a lady of Patient A’s age, it is likely to be nutrition or blood loss related to periods as a cause for iron deficiency but it would be worthwhile to rule out coeliac disease or any other malabsorption as a cause of her symptoms.”. This is evidence that Dr Hegde had overlooked the fact that Patient A had a Mirena coil fitted and was, therefore, not menstruating. That resulted in Dr Hegde underestimating the risk of cancer (despite the 2011 guidelines by the British Society of Gastroenterology for the management of iron deficiency anaemia which makes it clear such patients should have either colonoscopy or radiological imaging). He did not, therefore, adequately discuss the risks and benefits of appropriate treatment options with her. A significant benefit of colonoscopy is to detect cancer. The Tribunal considered it was also relevant that Dr Hegde completely failed to discuss CT colonography with Patient A as an alternative to colonoscopy; this showed he did not adequately discuss all available options as he accepts.

22. The Tribunal, by virtue of Dr Hegde’s admission, finds paragraph 1(c)(ii) proved and concludes due to the evidence before it that Dr Hegde also failed to adequately discuss the risks and benefits of colonoscopy with Patient A.
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Paragraph 1(d)(i)

23. The Tribunal was of the view that both Patient A and Dr Hegde were honest witnesses who made efforts to assist the Tribunal in its deliberations. Both, when unsure of an answer or when they did not remember, would say so accordingly. Patient A was credible, but her oral evidence at times was internally inconsistent with her other evidence. Dr Hegde was frank and the Tribunal also took into account that, to his credit, that Dr Hegde admitted many of the allegations made against him and has not sought to hide from his failings.

24. In relation to paragraph 1(d)(i), the Tribunal took particular account of the oral evidence of Patient A in which she stated before the Tribunal, when asked regarding the exact wording used during the consultation in relation to risk of colonic cancer occurring, that Dr Hegde had told her that her risk of cancer was “very slim”. In his oral evidence, Dr Hegde was adamant that, despite not remembering the wording of the discussions in the consultation, he "would never inform any patient” that there was no risk of colonic cancer, due to a patient’s age. Dr Hegde gave evidence that he has treated patients of all ages, including teenagers, for cancer, and that it would be entirely wrong for a doctor to make such a statement.

25. The Tribunal noted that there were some inconsistencies in Patient A’s memory of the consultations with Dr Hegde. Of particular importance is that, there is no evidence or record, prior to the complaint in 2018, of Dr Hegde advising Patient A that "she was too young to have cancer”. The Tribunal noted references to risks of colonic cancer in relation to her age in Patient A’s GP records and in correspondence from Dr Hegde in 2013/2014. The complaint was made several years after the consultations and memories are known to change over time. It is easy to see how a reference for example of "low risk” due to age could be honestly, but incorrectly, be recalled as "too young”. An example of similar changes is shown by Patient A’s description of Ms C saying in a letter that Patient A "refused”a colonoscopy, when in fact the word “declined” was used.

26. The Tribunal does not suggest that Patient A has sought to mislead the Tribunal, only that the evidence taken in the round is not entirely consistent and that the statement "she was too young to have cancer” only arose a significant time after events. The Tribunal believes it is just as likely that Dr Hegde could have advised Patient A that there was a “low risk”, as he stated in his oral evidence. Patient A in the Tribunal’s judgment was on this point an honest, but mistaken, witness.

27. Taking into account all evidence, documentary and oral, the Tribunal determined that it is inherently improbable for a Consultant Gastroenterologist, of considerable experience, to make the statement that a patient was "too young to have cancer”. It accepted the evidence from Dr Hegde that he would never say this and the oral evidence of Patient A that Dr Hegde said "very slim”risk. The Tribunal
determined that the GMC has not done enough to persuade it to find proved that Dr Hegde made the statement alleged.

28. Therefore, on the balance of probabilities, the Tribunal finds paragraph 1(d)(ii) of the Allegation not proved.

The Tribunal’s Overall Determination on the Facts

29. The Tribunal has determined the facts as follows:

1. Between 11 July 2013 and 9 December 2013 you were involved in the care and treatment of Patient A and you:
   a. failed to adequately investigate Patient A’s lower gastrointestinal tract in that you did not undertake a:
      i. colonoscopy; or **Admitted and found proved**
      ii. CT colonography; **Admitted and found proved**
   b. failed to diagnose Patient A’s condition; **Admitted and found proved**
   c. failed to adequately discuss with Patient A the:
      i. level of her risk of colonic cancer; **Admitted and found proved**
      ii. risks and benefits of lower gastrointestinal investigations. **Admitted and found proved**
   d. told Patient A that:
      i. she was too young to have cancer or words to that effect; **Not Proved**
      ii. a colonoscopy was not:
         1. appropriate; **Withdrawn following a successful Rule 17(2)(g) application**
         2. necessary; **Withdrawn following a successful Rule 17(2)(g) application**
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And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. To Be Determined

Determination on Impairment - 07/10/2019

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Hegde’s fitness to practise is impaired by reason of misconduct.

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence. Dr Hegde provided a further bundle of documents and also gave oral evidence at the hearing. The bundle contained various documents including:

- Reflection document
- CPD Certificates including:
  - Mastering your risk (July 2018)
  - Shared decision making (February 2019)
  - Conversations on Consent (July 2019)
- Testimonials from various colleagues across a range of roles and seniority levels
- Feedback from patients

Submissions on behalf of the GMC

3. In summary, Mr Grey submitted that Dr Hegde had demonstrated a failure to follow the fundamental principles set out in Good Medical Practice (2013) (‘GMP’). He submitted that the following paragraphs GMP are relevant.

'8. You must keep your professional knowledge and skills up to date.

11. You must be familiar with guidelines and developments that affect your work.

15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

... 

b. promptly provide or arrange suitable advice, investigations or treatment where necessary

32. You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients’ language and communication needs.
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

4. Mr Grey stated that Dr Hegde has demonstrated serious and basic failures in respect of Patient A. He stated that Patient A was undiagnosed for a period of around 4 months, which was a serious and profound failing, and constituted serious misconduct.

5. In respect of impairment, Mr Grey stated that Dr Hegde’s fitness to practise was currently impaired. Mr Grey referred to the test set out by Dame Janet Smith in her Fifth Shipman Report and stated that while Dr Hegde’s actions can be remedied, there is an issue whether there has been a substantial change in his practice. He stated that the Tribunal has not heard sufficient evidence to demonstrate that there will be no repetition. He further acknowledged that Dr Hegde had some insight.

6. Mr Grey stated that there had been a serious falling below of the standards expected of a competent Consultant Gastroenterologist; the mistakes made by Dr Hegde related to basic knowledge and this directly impacts public confidence in the profession and the upholding of proper standards of conduct. He submitted that the Tribunal should find Dr Hegde’s fitness to practise is currently impaired.

**Submissions on behalf of Dr Hegde**

7. Mr Gillespie reminded the Tribunal not to speculate on what have might have been, but to consider the facts as found.

8. Mr Gillespie submitted that the Tribunal will have to consider whether Dr Hegde’s admitted failures amount to serious misconduct. Mr Gillespie stated that Patient A was a rare case, particularly in 2013, due to her age. He submitted that Dr Hegde accepts that he should have known, given her personal circumstances that she was at significant risk of cancer. He had accepted that this was a mischaracterisation of risk and admitted his mistake. Mr Gillespie then drew the Tribunal’s attention to parts of Dr Hegde’s reflective statement and oral evidence and submitted that Dr Hegde had a full appreciation of the errors he made.

9. In relation to serious misconduct, Mr Gillespie referred the Tribunal to various relevant authorities, including:

   - Roylance v GMC [2001] 1 AC 311
   - Nandi v GMC [2004] EWHC 2317 (Admin)
   - Spencer v General Osteopathic Council [2012] EWHC 3146 (Admin) [2013]
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• Calhaem v GMC [2007] EWHC 2606

10. Mr Gillespie noted the circumstances of this case and the fact that it was a single, isolated incident which occurred 6 years ago; he told the Tribunal that there has not been a repetition of the conduct since the allegation. Mr Gillespie submitted that this one incident was not reflective of Dr Hegde’s practice and a single act of negligence does not always amount to misconduct. He further stated that Dr Hegde accepted that there had been breaches of GMP, but they were not so serious as to amount to misconduct.

11. Mr Gillespie referred to the testimonials attesting to Dr Hegde’s skills and experience; he submitted that these demonstrated Dr Hegde’s clinical skills and there are no issues or concerns in relation to his practice. He stated that there have been no further incidents or complaints against Dr Hegde since these events.

12. Mr Gillespie stated that Dr Hegde had outlined that it has only been in recent years that there has been an increase in younger patients who have been presenting with similar symptoms as Patient A; Dr Hegde recognises this and has reviewed relevant guidelines and taken steps to ensure that his failures will not be repeated.

13. Mr Gillespie referred the Tribunal to the over-arching objective and submitted that there is no requirement for Dr Hegde’s conduct to be marked with a finding of impairment.

The Relevant Legal Principles

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

15. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first, whether the facts as found proved amounted to serious misconduct. It must then consider whether Dr Hegde’s fitness to practise is impaired by reason of any serious misconduct found.

16. The Tribunal must determine whether Dr Hegde’s fitness to practise is impaired today, taking into account Dr Hegde’s conduct at the time of the events and relevant factors such as whether he has insight, whether the matters are remediable, whether they have been remediated and any likelihood of repetition.

17. Throughout its consideration of the issue of impairment, the Tribunal has borne in mind the overarching objective as set out in section 1 of the Medical Act 1983.
The Tribunal’s Determination on Impairment

Misconduct

18. The Tribunal found that Dr Hegde did not adequately discuss the risks and benefits of various treatment options with Patient A. Nor did he discuss a CT Colonography as an alternative to colonoscopy. Dr Hegde failed to adequately identify Patient A’s risk of cancer and act as recommended by the guidelines. However, the Tribunal was satisfied that this was a single incident of negligence covering a three month period. It was of the view that his actions breached the following paragraphs of GMP:

15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

   a. adequately assess the patient’s conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

   b. promptly provide or arrange suitable advice, investigations or treatment where necessary.

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

19. The Tribunal was not persuaded that there were any other breaches of GMP and felt that the quoted paragraphs above best fitted what had happened in this case. Dr Hegde had failed to take account the absence of menstruation by Patient A due to her having a Mirena coil fitted and to bear that in mind when advising her about the investigations which should have been carried out in September 2013. In addition, his failure to accurately identify Patient A’s condition and her likely risk of cancer was why he had failed to “push” Patient A sufficiently to have a colonoscopy, or to offer a CT colonography.

20. The Tribunal had regard to the evident remorse that Dr Hegde has shown throughout. It found his expressions of remorse in his evidence to the Tribunal to be clear and sincere. The Tribunal also had regard to Dr Hegde’s insight. The Tribunal accepts that Dr Hegde has reflected since the incident, that this process started in 2014 as soon as he was notified of Patient A’s cancer diagnosis. Dr Hegde’s evidence was that he immediately took steps to change his practice, and the letter he wrote to Ms C dated 19 May 2014 supports this. In his reflective statement, Dr Hegde states that he has changed his practice in more detail:
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"In March 2014, when this case was first brought to my attention, I changed my practice to offer patients fitting the BSG guidelines for Iron Deficiency Guidelines (2011) a Gastroscopy and Colonoscopy in the same sitting or CT Colonography.

Since being made aware of the GMC complaint, I have discussed this case with colleagues, revisited the British Society of Gastroenterology Guidelines for the Management of Iron Deficiency Anaemia and the GMC guidance on consent to refresh my knowledge."

21. Dr Hegde acknowledged in his evidence to the Tribunal that his actions brought the profession into disrepute, and that public confidence in the profession could be undermined by his conduct.

22. On the question of remediation, the Tribunal found that Dr Hegde has taken material steps to ensure that no further incidents of this nature occur. He told the Tribunal that he “takes extra care” with patients similar to Patient A, and follows relevant guidelines to explore every investigative option to ensure patients receive the best care. The Tribunal determined that based on the information it has received from Dr Hegde he has taken adequate steps to reflect on his practice and undertaken relevant courses to improve his knowledge and skills. The range of testimonials provided show that he is a good, conscientious doctor who has not been subjected to a complaint or incident report at the Trust since these events. In the view of the Tribunal, it was highly unlikely that Dr Hegde would repeat his act of negligence.

23. The Tribunal accepts that Dr Hegde was negligent, but concluded that his negligence was not gross. It was a single incident, and even Patient A in her oral testimony said “I know it wasn’t malicious”. The Tribunal was satisfied that Dr Hegde had acted in good faith, albeit that his actions were ill judged on the basis of the evidence available to him in the consultations with Patient A, but no moral opprobrium could be attached to his actions. Fellow medical practitioners would not consider Dr Hegde’s actions to be deplorable, as he offered Patient A a colonoscopy, (but failed to adequately to explain why it was to her benefit).

24. Having taken into account the full context of the case, the Tribunal determined that this single act of negligence on Dr Hegde’s part did not meet the threshold of misconduct.

25. In conclusion, the Tribunal determined that Dr Hegde’s conduct did not fall so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct. It follows therefore that his fitness to practise is not impaired.
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**Determination on Warning** - 07/10/2019

1. The Tribunal determined that the facts found proved did not amount to misconduct and, as such, Dr Hegde’s fitness to practise was not impaired. The Tribunal invited submissions from the parties as to whether a warning was required, in accordance with s35D (3) of the Medical Act 1983.

**GMC Submissions**

2. Mr Grey submitted that although there has been a breach of the standards in this case, given the circumstances, including the passage of time since the index event, a warning is not necessary.

**Submissions on Dr Hegde’s behalf**

3. Mr Gillespie referred the Tribunal to the ‘Guidance on Warnings’ document (February 2018) (‘the Guidance’), particularly paragraph 33. He stated that the Tribunal had reflected the points raised in this paragraph already in its Impairment determination. He submitted that therefore, a warning is not necessary.

**The Tribunal’s Determination on Warning**

4. In making its decision the Tribunal exercised its own judgment. It took account of the specific circumstances of this case and had regard to the submissions provided by both parties.

5. The Tribunal had regard to the warnings Guidance including the test at paragraph 16:

‘A warning will be appropriate if there is evidence to suggest that the practitioner’s behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:

- there has been a significant departure from Good medical practice...’

6. The Tribunal took account of the fact that warnings are a serious response for concerns that approach but falls short of the threshold for a finding of impaired fitness to practise. Warnings may have the effect of highlighting to the wider profession that such conduct or behaviour is unacceptable.

7. The Tribunal noted that there has been clear and specific breaches of GMP, as identified in the Tribunal’s findings on impairment. The misconduct is sufficiently serious that, if there were a repetition, it would be likely to result in a finding of impaired fitness
to practise. The Tribunal bears in mind its findings on impairment as regards the impact on patient care, public confidence in the profession and the reputation of the profession.

8. The Tribunal then had regard to paragraph 33 of the warnings Guidance which states:

'33  However, if the decision makers are satisfied that the doctor’s fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate. These might include:

The level of insight into the failings:
  a.  A genuine expression of regret/ apology.
  b.  Previous good history.
  c.  Whether the incident was isolated or whether there has been any repetition.
  d.  Any indicators as to the likelihood of the concerns being repeated.
  e.  Any rehabilitative/corrective steps taken
  f.  Relevant and appropriate references and testimonials.’

9. The Tribunal took account of the fact that Dr Hegde’s misconduct was one single incident of negligence in respect of a single patient and occurred over six years ago, in the context of a long and distinguished career.

10. The Tribunal reminded itself that its decision that Dr Hegde’s fitness to practise was not currently impaired and had noted the existence of the mitigating factors set out above, including his insight and full remediation since the index event.

11. The Tribunal has already determined that Dr Hegde has insight into his behaviour and is very unlikely to repeat it. It was apparent to the Tribunal that he understood at an early stage the need to reflect and change his practice and had taken action; the Tribunal also noted the range of relevant CPD courses that Dr Hegde had completed.

12. It had regard to the various testimonials from various colleagues across a range of roles and seniority levels which attest to Dr Hegde’s good character and competency as a Consultant Gastroenterologist.

13. In its determination on impairment, the Tribunal found that all six of the mitigating factors in paragraph 33 of the Guidance, set out above, had been satisfied. The Tribunal considered that there is no need to record formally the concerns raised in this case and has therefore determined not to impose a warning on Dr Hegde’s registration.
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14. That concludes this case.

Confirmed
Date 07 October 2019 Mrs Claire Sharp, Chair

ANNEX A – 03/10/2019

Application under Rule 17(2)(g)

1. On behalf of Dr Hegde, Mr Gillespie made an application under Rule 17(2)(g) in relation to paragraphs 1d(i) and 1d(ii) of the allegation. The Rule states:

"the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld."

Submissions

2. Mr Gillespie directed the Tribunal’s attention to the authority of R v Galbraith [1981] 2 All ER 1060, which sets out the test for an application of no case to answer as follows:

"1. If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.

2. The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.

a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.

b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness’s reliability, or other matters which are generally speaking within the province of the jury and where, on one possible view of the facts, there is evidence upon which a jury can properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury."
3. In relation to paragraph 1(d)(i), Mr Gillespie submitted that, in accordance with the second limb of the Galbraith test, the evidence adduced by the GMC in support of that allegation was too tenuous for the Tribunal, properly directed, to find it proved.

4. In relation to paragraph 1d(ii,) Mr Gillespie submitted that, in accordance with the first limb of the Galbraith test, no evidence had been submitted by the GMC in support of that allegation and there was, therefore, no case to answer. He submitted that the GMC had adduced no evidence that Dr Hegde had stated that a colonoscopy would be neither ‘appropriate’ nor ‘necessary’. In an alternative submission, Mr Gillespie submitted that if the Tribunal found that the GMC had adduced some evidence in support of that allegation, then that evidence was too tenuous for the Tribunal to find it proved.

5. On behalf of the GMC, Mr Grey submitted that sufficient evidence had been adduced to support a finding in relation to both paragraphs, 1d(i) and 1d(ii). He reminded the Tribunal that its task was to consider Mr Gillespie’s application of no case to answer and that it was not, at this stage, determining whether the allegation was found proved. He also reminded the Tribunal that, under this application, it must determine whether it could find each of those paragraphs proved, not whether it should find them proved.

The Tribunal’s Decision

Paragraph 1(d)(i)

6. The Tribunal determined that there is a case to answer in relation to this paragraph. It took account of Patient A’s complaints to the Berkshire Independent Hospital, dated 25 January 2018 and to the GMC dated 5 February 2018. In both complaints, Patient A stated that Dr Hegde had told her that she was ‘too young’ to have cancer.

7. The Tribunal accepted Mr Gillespie’s submission that the evidence adduced by the GMC in support of this allegation was limited. It noted that both complaints were made five years after Patient A’s conversations with Dr Hegde and, in those circumstances, it concluded that the weight it could attach to that evidence was weak. The Tribunal also took account of Dr Hegde’s letter dated September 2013 which made no mention of Patient A being ‘too young’ to have cancer. The Tribunal took the view though that Patient A’s evidence had been inconsistent. It determined that the appropriate stage at which to assess the reliability of Patient A’s evidence was during its deliberation of the facts. In conclusion, it would determine whether paragraph 1(d)(i) is found proved at the facts stage of the proceedings as the
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strength of the GMC’s case depended on the weight to be placed on Patient A’s evidence.

Paragraph 1(d)(ii)(1) and (2)

8. The Tribunal determined that there was no case to answer in relation to this paragraph. It noted that the GMC had adduced no significant evidence to support the allegation that Dr Hegde had stated that a colonoscopy was neither appropriate nor necessary as he discussed it with Patient A in September 2013.

9. The only evidence before the Tribunal which could support this allegation were the two written complaints made by Patient A (referred to above) in which she referred to Dr Hegde stating that a colonoscopy would not be ‘appropriate’, and in her witness statement. She did not use the term ‘necessary’ in either complaint. In her oral evidence before the Tribunal, Patient A could not recall Dr Hegde stating either that a colonoscopy was not ‘appropriate’ or that it was not ‘necessary’.

10. The Tribunal bore in mind that the burden of proof rests with the GMC. It determined that, even taking the GMC’s case at its highest, that there is insufficient evidence to enable a properly directed Tribunal to find this paragraph proved.