Record of Determinations – Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 01/04/2019 – 05/04/2019 and 17/06/2019 - 18/06/2019

Medical Practitioner’s name: Dr Nabila HANOSH

GMC reference number: 4359715

Primary medical qualification: State Exam 1991 Universita degli Studi di Bologna

Type of case
New - Misconduct

Outcome on impairment
Not impaired

Summary of outcome

Warning not considered

Tribunal:

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<th>Legally Qualified Chair</th>
<th>Mr Nicholas Flanagan</th>
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<td>Medical Tribunal Member:</td>
<td>Professor Robert Mansel</td>
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<td>Dr Kate Thomas</td>
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| Tribunal Clerk: | Ms Keely Crabtree |

Attendance and Representation:

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<td>Medical Practitioner’s Representative:</td>
<td>Mr Richard Smith, Counsel, instructed by MDU</td>
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<td>GMC Representative:</td>
<td>Ms Rebecca Vanstone, Counsel</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 - 05/04/2019

Background

1. Dr Hanosh qualified in 1991 from Bologna University in Italy and obtained her DFSRH and MRCGP in the UK, in February 2006 and October 2011 respectively. Dr Hanosh has worked as a General Practitioner since 2007 and at the time of the events was the sole GP Partner and only permanent practitioner at Belsize Priory Medical Practice ('the Practice').

2. Patient A was undergoing gender transition, initially with the Tavistock Clinic, and subsequently with the Northampton Gender Identity Clinic ('GIC'). A shared care protocol between the Gender Clinic and the Practice had been signed by a previous GP in 2015; although a copy may not have been placed in his GP medical records.

3. Patient A started his treatment plan in April 2017, with the Practice providing Patient A with regular prescriptions from July 2017. Following a consultation between Patient A and the GIC on the 17 November 2017, the Practice received a letter around 4 December 2017. The letter updated the treatment plan for Patient A, providing changes in the regimen of the drugs to be provided: Leuprorelin acetate and specifically, an increase in the dose of Tostran gel. This treatment is highly specialised and these medications are being used outside of the licensed indications.

4. The medical records indicate that between 10 October 2017 and 1 December 2017 three repeat prescription requests for Tostran gel were made, which were duly authorised. Two further requests were made on 5 December 2017 and 7 December 2017, although these were declined and a note was made requesting Patient A to make an appointment to see a GP. On 19 December 2017, Patient A saw a locum doctor at the Practice who prescribed the new dosage of Leuprorelin injection, as recently recommended by the GIC. No new Tostran gel was prescribed and the medical notes are silent as to what was discussed with regards to the gel.

5. On 12 January 2018, a prescription request was made for more Tostran gel. Dr Hanosh declined to authorise a further prescription. Patient A states that on 21 January 2018 he ran out of Tostran Gel, so he contacted the Practice again on 22
January 2018 for a repeat prescription. Patient A spoke with Dr Hanosh by telephone. She did not issue the prescription. The reasons provided at this point were that there was no shared care protocol that Dr Hanosh was aware of and that the medication requested had been issued three times in the previous four months, providing an adequate supply based on the recommended dose. It was, therefore, being requested too soon.

6. Patient A was very upset following Dr Hanosh’s telephone call and felt that the only way he was going to get his medication reinstated was if he made a complaint to the relevant authorities. Patient A made an initial complaint to the Practice on 1 February 2018, as well as several other authorities and to the GMC on 2 February 2018. Around 12 February 2018, the deputy Practice Manager arranged a meeting with Patient A to take place on 15 February 2018 to discuss his complaint regarding Dr Hanosh.

7. The meeting took place at the Practice on the 15 February 2018. Present at the meeting were Dr Hanosh, the Practice Manager, Administration Clerk (taking minutes), Patient A, Patient A’s mother and Patient A’s grandfather. The setting was a clinical room which was arranged so that all parties were sitting in a circle, with the administrator sitting behind on the examination couch, taking minutes.

8. At the end of the meeting on 15 February 2018, an ongoing care plan was agreed, in which Dr Hanosh would be responsible for prescribing and monitoring Patient A’s treatment. This included a set of tests (blood tests, ECG and an x-ray). Subsequently, a consultation was arranged for 27 February 2018, during which Dr Hanosh was to provide request forms for the agreed investigations.

9. The allegation that has led to Dr Hanosh’s hearing can be summarised as: on 15 February 2018, Dr Hanosh attended a meeting with Patient A and his family, during which she was aggressive and confrontational towards the patient. Furthermore, it is alleged that on 27 February 2018, Dr Hanosh entered incorrect information on a request form, which she knew was untrue and was therefore dishonest.

The Outcome of Applications Made during the Facts Stage

10. The Tribunal granted Ms Rebecca Vanstone’s application, on behalf of the GMC, to anonymise Patient A’s grandfather throughout the hearing and refer to him as Mr B. Mr Richard Smith, on behalf of Dr Hanosh, did not object to the application. The Tribunal determined it was reasonable and appropriate to anonymise Patient A’s grandfather, to ensure Patient A’s anonymity and therefore decided to refer to him as Mr B throughout the hearing.

11. At the outset of the hearing, Ms Vanstone informed the Tribunal that sub-paragraphs 1.a, 1.c and 2.a of the allegation were to be withdrawn.
The Allegation and the Doctor’s Response

12. The Allegation made against Dr Hanosh is as follows:

1. On 15 February 2018 you attended a meeting with Patient A where you:
   a. did not inform Patient A in advance that you would be present to discuss his complaint; Withdrawn by GMC
   b. were aggressive and confrontational towards Patient A in that you:
      i. spoke over Patient A; To be determined
      ii. did not speak directly to Patient A; To be determined
      iii. spoke about Patient A in the third person; To be determined
      iv. pointed in Patient A’s face; To be determined
   c. did not offer Patient A a choice of general practitioner to be responsible for his ongoing care. Withdrawn by GMC

2. On 27 February 2018 you:
   a. failed to record the reason for requesting an ECG; Withdrawn by GMC
   b. inappropriately referred Patient A for an x-ray that: Admitted and found proved
      i. would expose Patient A to radiation that should have been avoided; Admitted and found proved
      ii. would cause a colleague to carry out an examination to investigate symptoms that Patient A did not report; To be determined
      iii. was not clinically indicated; Admitted and found proved
   c. entered ‘chesty cough’ on the request form as the reason for requesting an x-ray. Admitted and found proved

3. You knew that Patient A did not have a chesty cough. To be determined
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4. Your action at paragraph 2c was dishonest by reason of paragraph 3. **To be determined**

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

**The Admitted Facts**

13. At the outset of these proceedings, Dr Hanosh, through her counsel, Mr Smith, made admissions to sub-paragraphs 2.b and 2.c 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.

14. During his submissions on the facts, Mr Smith, on behalf of Dr Hanosh, expanded the admissions to include sub-paragraphs 2.b (i) and 2.b (iii) of the allegation. These were therefore found proved.

**The Facts to be Determined**

15. In light of Dr Hanosh’s response to the Allegation made against her, the Tribunal is required to determine the remaining paragraphs of the allegation, namely: whether Dr Hanosh acted in an aggressive, confrontational and inappropriate manner towards Patient A during the meeting on 15 February 2018; and if Dr Hanosh knew Patient A had not presented symptoms of a chesty cough during their consultation on 27 February 2018, thereby acting dishonestly.

**Factual Witness Evidence**

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

- Patient A, in person;
- Mr B, Grandfather of Patient A, in person.

17. Dr Hanosh provided her own witness statement dated 4 March 2019 and also gave oral evidence at the hearing. In addition, the Tribunal received evidence from the following witnesses on Dr Hanosh’s behalf:

- Ms C, Deputy Practice Manager at Belsize Medical Practice, by telephone link (agreed by case management);
- Ms D, Administration Clerk at Belsize Medical Practice, in person;
- Ms E, Practice Manager at Belsize Medical Practice, in person.
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Expert Witness Evidence

18. The Tribunal received an expert report dated 11 May 2018 and supplemental report dated 29 September 2018 prepared by Dr F, expert witness for the GMC.

19. The Tribunal received an expert report dated 12 February 2019 prepared by Dr G on behalf of Dr Hanosh.

20. The Tribunal also had regard to Dr F and Dr G’s two joint reports dated 19 March 2019 and 1 April 2019.

21. Dr F and Dr G assisted the Tribunal in understanding the professional standards to be expected of a General Practitioner.

Documentary Evidence

22. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to, extracts from Patient A’s medical records, x-ray and ECG request forms, minutes of the meeting on 15 February 2018 regarding the complaint at Belsize Priory Medical Practice and Patient A’s online complaint form to the GMC dated 2 February 2018.

23. The Tribunal received a variety of testimonials from Dr Hanosh’s colleagues and patients attesting to her good character, professional manner and commitment to safe patient care. The testimonials made clear that she is a dedicated clinician.

The Tribunal’s Approach

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

The Tribunal’s Analysis of the Evidence and Findings

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

26. The Tribunal noted that at the meeting on 15 February 2018, tensions were high since Patient A’s complaint against Dr Hanosh had already been made, and Dr Hanosh was aware of that. The Tribunal heard five separate accounts of the meeting, with individual recollections and perceptions being provided. In attempting
to reconcile the varying versions of events, the Tribunal considered the relative objectivity of the witnesses and the consistencies in the evidence.

27. The Tribunal determined that there was a significant degree of anxiety on the part of Patient A and his family members, since they were of the view that Dr Hanosh had ceased his medication inappropriately and without justification. The Tribunal considered that the understandable anxiety and stress this would have caused may have clouded their perception of Dr Hanosh and her actions. The Tribunal did not conclude that Patient A and Mr B were in any way misleading in their evidence, but that their recollections may have been influenced by the stress of the situation.

28. Equally, it was clear that Dr Hanosh also felt anxious at the meeting, albeit for different reasons. She was aware that Patient A had made a complaint about her and was attempting to defend her position. Dr Hanosh had significant concerns about prescribing without a full understanding of the agreement and rationale behind administering the specialist medications. Dr Hanosh felt professionally obliged to ensure that the medications were being prescribed appropriately and safely. Indeed, her concerns may have been more pronounced, as she had previously authorised prescriptions without these safeguards being in place.

1. On 15 February 2018 you attended a meeting with Patient A where you:

b. were aggressive and confrontational towards Patient A in that you:

i. spoke over Patient A;

29. The Tribunal compared the evidence of Mr B, who stated that Dr Hanosh had turned away to talk to someone else, with that of Patient A, who stated that Dr Hanosh had spoken when he was speaking. Patient A and Mr B therefore provided different interpretations of what they understood to be ‘speaking over’. Patient A and Mr B did not provide any examples of either what Patient A was saying when he was interrupted or when in the meeting he was being spoken over. Dr Hanosh, Ms D and Ms E were consistent in stating that Dr Hanosh had not spoken at the same time as Patient A. They also stated that she had not been aggressive or confrontational in the meeting. In assessing the evidence, the Tribunal concluded that Patient A said very little during the meeting and there was therefore limited opportunity for the alleged conduct to have occurred. The Tribunal accepted the defence witness evidence, which was consistent and therefore, on the balance of probabilities, it was more likely than not that Dr Hanosh did not speak over Patient A in an aggressive and confrontational manner. It therefore found sub-paragraph 1.b.i of the Allegation not proved.
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ii.  *did not speak directly to Patient A*;

30. The Tribunal accepted the evidence of Dr Hanosh, Ms D and Ms E, that during the meeting Mr B was effectively acting as the family representative and did the vast majority of the talking. A number of queries were discussed, most of which were initiated by Mr B and another family member. During the meeting, Dr Hanosh said that she had directed her responses to the person who had instigated the query, which was mainly Mr B. The Tribunal determined that in these circumstances, it would have been impractical for Dr Hanosh to direct her answers to Patient A at all times and it was therefore likely that she, at times, did not speak directly to Patient A. However, on the basis of the evidence before the Tribunal, and having accepted the evidence of Dr Hanosh, it concluded that it was more likely than not that Dr Hanosh did not do so in an aggressive and confrontational manner. Accordingly, it found sub-paragraph 1.b.ii. of the Allegation not proved.

  

iii.  *spoke about Patient A in the third person*;

31. The Tribunal was given no specific examples in the evidence provided by the GMC of Dr Hanosh speaking about Patient A in the third person. The Tribunal has already concluded that the majority of Dr Hanosh’s responses within the meeting were directed at Mr B as he had initiated the query. She therefore may have spoken about Patient A in the third person since she was responding to Mr B, and that the natural way to respond. Having regard to all of the evidence provided, the Tribunal determined that on the balance of probabilities, it was more likely than not that Dr Hanosh did not speak about Patient A in the third person in an aggressive and confrontational manner. Accordingly, it found sub-paragraph 1.b.iii. of the Allegation not proved.

  

iv.  *pointed in Patient A’s face*;

32. The Tribunal noted the evidence of Patient A, where he stated that Dr Hanosh had been aggressive during the meeting and on a number of occasions gestured towards him and had pointed directly in his face. However, this was not collaborated by Mr B’s evidence, who described Dr Hanosh wagging her finger towards Patient A on a single occasion. Notably, Mr B had not recalled this event in his initial witness statement, raising it for the first time before the Tribunal.

33. The Tribunal observed that when Dr Hanosh gave evidence she spoke in a somewhat animated style which, in the difficult situation of a complaints meeting, where emotions are high, and perceptions accordingly altered, this could be interpreted as confrontational. Dr Hanosh stated that at no point during the meeting had she pointed in Patient A’s face.
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34. The Tribunal also had regard to the evidence of Ms D and Ms E, who were present at the meeting. Both witnesses stated that at no point during the meeting did they witness Dr Hanosh pointing in Patient A’s face.

35. In the Tribunal’s judgment, if Dr Hanosh had pointed directly in Patient A’s face, it would have been very unlikely for Ms D and Ms E to have missed what would have been a dramatic and memorable event.

36. As such, the Tribunal determined that it was more likely than not that Dr Hanosh did not point in Patient A’s face in an aggressive and confrontational manner. Therefore, it found sub-paragraph 1.b.iv. of the Allegation not proved.

2. On 27 February 2018 you:

b. inappropriately referred Patient A for an x-ray that:

   ii  would cause a colleague to carry out an examination to investigate symptoms that Patient A did not report;

3. You knew that Patient A did not have a chesty cough.

37. Having sought representations from the parties, the Tribunal determined the two allegations together as they revolve around the same facts. The Tribunal accepted all of the witness evidence, as well as the minutes prepared at the conclusion of the meeting on 15 February 2018, that all parties were aware that Dr Hanosh would solely be responsible in providing ongoing treatment to Patient A, to ensure continuity in his care. It was also clear that Dr Hanosh considered it necessary to obtain blood tests, an ECG and a chest x-ray, which had been agreed on 15 February 2018. In addition, Patient A signed a consent form to receive off licence medication and also for the Practice to access his gender clinic notes.

38. The Tribunal noted Dr Hanosh’s evidence, in which she stated that she felt the blood tests, ECG and x-ray were necessary due to the medication Patient A was being prescribed. Furthermore, she wanted a baseline for future comparison and also considered him a patient who was contemplating surgery in the future. In her oral evidence she described that at the time, she viewed these as a standard set of tests.

39. Patient A attended an appointment with Dr Hanosh on 27 February 2018, to obtain the relevant investigation forms. Dr Hanosh stated that during the consultation she had asked Patient A how he was doing and that he had replied that he had been coughing, which led her to ask him about his smoking status. Dr Hanosh said that Patient A confirmed he did not smoke and that he had had the cough for approximately 2 days. She had felt concerned about Patient A’s reported
symptoms of a cough due to the medication he was on. Dr Hanosh admitted that she had failed to record that Patient A had complained of a cough or his smoking status in his medical records.

40. Dr Hanosh stated that on the x-ray form she wrote: “chesty cough ? cause” as Patient A had presented with a cough, however her primary reason for her request was due to Patient A’s medication and to get a baseline. She admitted that she should have used the same reasoning as she did on the ECG form i.e “pt on medication that needs monitoring”. It was notable that Patient A was provided with both request forms at the same time, to be performed at the same hospital.

41. Patient A’s evidence was that he attended the appointment on 27 February 2018, and he never mentioned having a cough. He stated that he did not question Dr Hanosh when she advised him that she would put down ‘chesty cough’ on the x-ray form as he did not want to upset her. He stated that Dr Hanosh had asked him if he smoked.

42. The Tribunal considered that Patient A’s credibility was somewhat reduced, since he did not raise the issue of Dr Hanosh writing ‘chesty cough’ on the x-ray form for some time after the consultation, even though he was aware of the ongoing GMC investigation into Dr Hanosh, which he had instigated.

43. The Tribunal accepted Dr Hanosh’s explanation that the 27 February 2018 had been a long and stressful day; one locum doctor had called in sick, requiring Dr Hanosh to cover his patients in addition to her own. She also had to leave the surgery to certify a complicated community death. By the time of seeing Patient A she was 70 minutes behind schedule. She inferred that these factors cumulatively may have led to her writing ‘chesty cough’ on the form as the reason for referring Patient A for an x-ray, when she had intended to use the same rationale as on the ECG form. She had also explained during the meeting of 15 February 2018 the reasoning for the x-ray – because of the medication Patient A was on and wanting a baseline for future comparison, which nobody had questioned. She admitted that now, on reflection, in this situation, she would not request a chest x-ray at all.

44. The Tribunal concluded that on the balance of probabilities, it was more likely than not that Patient A had reported having a chesty cough at the consultation on 27 February 2018. Further, it considered that it would have been illogical and unlikely for Dr Hanosh to have asked Patient A whether he smoked, if he had not reported or presented with symptoms of a chesty cough.

45. For these reasons, the Tribunal concluded that sub-paragraph 2.b (ii) and paragraph 3 of the allegation not proved.
4. Your action at paragraph 2c was dishonest by reason of paragraph 3.

46. The Tribunal had regard to the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67* in which it is indicated that when dishonesty is in question, the Tribunal must first ascertain the actual state of the individual’s knowledge or belief as to the facts. Once his actual state of mind as to the knowledge or belief as to the facts is established, the question as to whether her conduct was honest or dishonest is to be determined by applying the standards of ordinary decent people. There is no requirement that the defendant must appreciate that what she has done is, by those standards, dishonest.

47. The Tribunal has already found that it was more likely than not that Patient A had presented with symptoms of a ‘chesty cough’. As the Tribunal concluded this was Dr Hanosh’s belief, her entering ‘chesty cough’ in the request form cannot be viewed as inaccurate or dishonest.

48. The Tribunal concluded that it would not be regarded as dishonest by the standards of ordinary decent people for ‘chesty cough’ being entered on the form as the reason for requesting a chest x-ray, as this was Dr Hanosh’s belief at the time.

49. The Tribunal took into account the evidence in relation to Dr Hanosh’s good character including the positive testimonials from colleagues and patients. The Tribunal considered that there would have been no benefit to Dr Hanosh writing ‘chesty cough’ on the form without Patient A presenting with symptoms. Also, Patient A would have had the chest x-ray in any case, if the alternative entry of ‘for monitoring medication’ had been entered instead. Indeed, Dr Hanosh was always planning a chest x-ray and Patient A was aware of this.

50. As such the Tribunal found paragraph 4 of the allegation not proved.

**The Tribunal's Overall Determination on the Facts**

51. The Tribunal has determined the facts as follows:

1. On 15 February 2018 you attended a meeting with Patient A where you:
   a. did not inform Patient A in advance that you would be present to discuss his complaint; **Withdrawn by GMC**
   b. were aggressive and confrontational towards Patient A in that you:
      i. spoke over Patient A; **Not proved**
i. did not speak directly to Patient A; **Not proved**

ii. spoke about Patient A in the third person; **Not proved**

iv. pointed in Patient A’s face; **Not proved**

c. did not offer Patient A a choice of general practitioner to be responsible for his ongoing care. **Withdrawn by GMC**

2. On 27 February 2018 you:

a. failed to record the reason for requesting an ECG; **Withdrawn by GMC**

b. inappropriately referred Patient A for an x-ray that: **Admitted and found proved**

   i. would expose Patient A to radiation that should have been avoided; **Admitted and found proved**

   ii. would cause a colleague to carry out an examination to investigate symptoms that Patient A did not report; **Not proved**

   iii. was not clinically indicated; **Admitted and found proved**

c. entered ‘chesty cough’ on the request form as the reason for requesting an x-ray. **Admitted and found proved**

3. You knew that Patient A did not have a chesty cough. **Not proved**

4. Your action at paragraph 2c was dishonest by reason of paragraph 3. **Not proved**

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

**Determination on Impairment - 17/06/2019**

1. The Tribunal now has to decide in accordance with Rule 17(2)(i) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Hanosh’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 a number of testimonials, in support of Dr Hanosh, all of which it has considered carefully.

4. The Tribunal also received a number of Continuing Professional Development Certificates (CPD):

- BMA Practical Skills for Effective Communication dated 16 October 2018
- BMJ Learning Gender Dysphoria: Assessment and management for non-specialists dated 22 February 2019
- BMJ Learning Primary care symptoms: Chronic cough in adult dated 22 February 2019
- Gender Identity Clinic Information Session for GPs dated 25 February 2019
- MPS Medical Records for GPs workshop dated 1 March 2019
- BMJ Learning Complaint Management dated 27 March 2019

Submissions

5. On behalf of the GMC, Ms Vanstone referred to the legal tests in relation to misconduct and impairment, in particular the authority of CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin). She made reference to Dr Hanosh’s departure from Good Medical Practice (2016) (GMP), in relation to paragraph 15:

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

6. Ms Vanstone submitted that Dr Hanosh’s actions fell short of expected standards and referred to the opinions of both experts. She drew the Tribunal’s attention to the joint expert statement dated 1 April 2019 that the standard of care provided by Dr Hanosh was below, but not seriously below, the expected standard of a reasonably competent General Practitioner (GP).

7. Ms Vanstone stated that an x-ray should not be carried out unless there was sufficient benefit due to exposure to radiation. She referred the Tribunal to The Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) in particular paragraphs 10
and 11. Ms Vanstone stated that a referrer shares responsibility for any breach of the radiation exposure regulations.

8. Ms Vanstone submitted that it was for the Tribunal to consider whether the findings of fact amount to misconduct, and therefore if Dr Hanosh’s fitness to practise is impaired. She stated that the Tribunal should have regard to public confidence and the need to uphold proper professional standards, but the GMC did not positively submit that the findings amounted to misconduct.

9. She referred to the principles in Cohen v GMC [2008] EWHC 581 (Admin), urging the Tribunal to consider whether Dr Hanosh’s conduct is remediable, has been remedied and if it is highly unlikely to reoccur. Ms Vanstone accepted that the remediation material provided was targeted and relevant.

10. On behalf of Dr Hanosh, Mr Richard Smith submitted that Dr Hanosh’s fitness to practise is not impaired. Primarily, he stated this is not a case where the departure from GMP is so serious as to amount to misconduct. Mr Smith submitted that, to qualify as misconduct, the departure must be serious and conduct that could be described as ‘deplorable, reprehensible or particularly grave’.

11. Mr Smith stated that this was a single incident and the facts proved are solely following admissions made by Dr Hanosh. He stated that the events took place at the end of a long and stressful day and that Patient A had stated to Dr Hanosh that he had a cough.

12. Mr Smith submitted that both experts found that Dr Hanosh’s actions were below but not seriously below the expected standard. He submitted that the Tribunal should not make a finding of misconduct. However, should the Tribunal go on to consider the question of impairment, Mr Smith submitted that Dr Hanosh has insight into her actions, she has taken steps to remedy her conduct and she has remediated. Mr Smith submitted that Dr Hanosh knows things went wrong, but is now better equipped for the future. He asked the Tribunal to consider the large amount of relevant CPD undertaken by Dr Hanosh and the testimonials from patients and colleagues. Mr Smith stated that Dr Hanosh was a caring, confident and competent GP. Mr Smith submitted that Dr Hanosh’s fitness to practise is not currently impaired.

The Relevant Legal Principles

13. 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.

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

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

The Tribunal’s Determination on Impairment

Misconduct

16. The Tribunal first considered whether Dr Hanosh’s actions amount to misconduct.

17. It has been admitted and found proved that Dr Hanosh inappropriately referred Patient A for an x-ray which would expose Patient A to radiation that should have been avoided, was not clinically indicated, and that Dr Hanosh entered ‘chesty cough’ on the request form as the reason for requesting an x-ray.

18. The Tribunal considered the evidence of Dr F the GMC expert, who had stated in September 2018, that referring Patient A for an x-ray in the circumstances was seriously below the standard of care expected of a reasonably competent GP. However, Dr F’s opinion has since evolved and in the joint expert report dated the 1 April 2019 he concluded that the referral was below, but not seriously below, the expected standards. The evidence of Dr G was that such a referral was not uncommon and, given the relative safety of a chest x-ray, was not below reasonable standards.

19. In the absence of a finding of dishonesty, the Tribunal did not agree with the GMC submission that the referrer and the operator shared a responsibility for radiation exposure under (IR(ME)R). Therefore, the Tribunal did not find this of relevance to its determination on the issue of misconduct.

20. The Tribunal has found that Dr Hanosh acknowledges her shortcomings on the day in question. Dr Hanosh was clearly under pressure after a long and stressful day at work. The Tribunal noted that Dr Hanosh was the sole practitioner at the time and had a difficult day, and that the consultation with Patient A took place at the end of that day. The Tribunal found that these factors mitigated against any suboptimal care that was provided to Patient A.

21. On the basis of the Tribunal having no evidence to indicate that the admitted conduct was seriously below the standards expected of a reasonably competent GP, coupled with the isolated nature of the incident and Dr Hanosh’s extensive
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mitigation, the Tribunal did not conclude that the conduct amounted to misconduct that was serious.

22. The Tribunal acknowledged that the conduct under consideration resulted solely from admissions made by Dr Hanosh. Since the GMC investigation started Dr Hanosh has undertaken extensive targeted and relevant remediation. The Tribunal noted the CPD, in particular that relating to investigations and treatment for chronic cough in adults. The Tribunal also considered the CPD undertaken relating to Gender Dysphoria and its management for non-specialists and learning on how to manage complaints. The Tribunal concluded that Dr Hanosh has demonstrated clear insight into this matter and evidenced how she would act differently in the future. The Tribunal determined that the risk of repetition was so low as to be negligible.

23. In the absence of any evidence to suggest that the misconduct found proved was seriously below that expected of a reasonable competent doctor, the Tribunal does not find that Dr Hanosh’s actions amount to serious misconduct. As such, the Tribunal did therefore not need to consider the question of impairment. In any event, Dr Hanosh’s remediation and her insight is such that the prospect of this conduct being repeated is extremely low.

24. There being no submissions for a warning to be considered that concludes the case.

Confirmed
Date 18 June 2019

Mr Nicholas Flanagan, Chair