**Record of Determinations –**
**Medical Practitioners Tribunal**

**PUBLIC RECORD**

**Dates:**

- 21/11/2017 to 30/11/2017
- 29/01/2018 to 30/01/2017
- 04/07/2018 to 06/07/2017
- 09/09/2019 to 11/09/2019
- 16/09/2019 to 19/09/2019

**Medical Practitioner’s name:** Dr Nagy Nazeer Grais GABRIEL

**GMC reference number:** 4264532

**Primary medical qualification:** MB BCh 1982 Ain Shams University

**Type of case**
New - Misconduct

**Outcome on impairment**
Impaired

**Summary of outcome**
Conditions, 6 months.
Review hearing directed
Immediate order imposed

**Tribunal:**

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<th>Role</th>
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<tr>
<td>Legally Qualified Chair</td>
<td>Mr David Robinson</td>
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<td>Mr Paul Moulder</td>
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<td>Medical Tribunal Members:</td>
<td>Dr Anita Clay</td>
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<td>Dr Nitesh Raithatha</td>
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<td>Tribunal Clerk:</td>
<td>Mr Stuart Peachey</td>
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Attendance and Representation:

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<td>Mr Andrew Kennedy, Counsel, instructed by RadcliffesLeBrasseur</td>
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<td>Mr George Thomas, Counsel, instructed by RadcliffesLeBrasseur</td>
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<td>GMC Representative:</td>
<td>Ms Louise Kitchen, 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 - 30/01/2018

Background

1. Dr Gabriel qualified in 1982 in Egypt and moved to the United Kingdom in 1993. Prior to the events which are the subject of the hearing, Dr Gabriel worked in Obstetrics and Gynaecology. Dr Gabriel entered General Practice in 2013. At the time of the events, Dr Gabriel was practising as a Partner at Dashwood House Surgery, Ramsgate. Dr Gabriel joined Dashwood House Surgery in 2003 and was subsequently appointed as a Partner on 13 October 2003.

2. The Allegations that have led to Dr Gabriel’s hearing can be summarised as deficient professional performance arising from separate and distinct Performance Assessments in 2013 and 2016.

3. The initial concerns were referred to the GMC in February 2012 by NHS Eastern and Coastal Kent PCT (‘the PCT’) following allegations raised regarding Dr
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Gabriel’s performance by a member of staff at Dashwood House Surgery in December 2011. On receipt of a Clinical Advisor’s report in January 2012, Dr Gabriel was suspended from the PCT’s Medical Performers’ List due to his immediate and significant risk to patient safety. Dr Gabriel stopped working at Dashwood House Surgery in January 2012.

4. Dr Gabriel was notified on 21 March 2012 that a Performance Assessment had been directed. However, the Performance Assessment was suspended due to a request of Dr Gabriel’s legal representatives until completion of the local investigation.

5. Dr Gabriel was re-invited to undertake a Performance Assessment on 10 October 2012. Dr Gabriel subsequently undertook the Performance Assessment in June 2013 (‘the 2013 Assessment’).

6. Following that Performance Assessment a recommendation was made for supervision and Dr Gabriel began working as a General Practitioner (‘GP’) Assistant, at Crane Surgery, on 12 December 2013.

7. The 2013 Performance Assessment required a successful reassessment before Dr Gabriel could return to unsupervised work. Dr Gabriel ceased working at Crane Surgery in April 2016 and he was invited to undertake a GMC reassessment in a letter dated 21 April 2016, the 2016 Assessment.

8. In September 2016 Dr Gabriel worked for a single Partner practice in Maidstone, ceasing such work on 12 December 2016. Dr Gabriel did not work until May 2017 when he joined the Orchard Practice in Dartford, where he is understood to currently work.

The Allegation and the Doctor’s Response

9. The Allegation made against Dr Gabriel is as follows:

1. Between 11 September and 12 October 2016 you underwent a General Medical Council assessment of the standard of your professional performance. Admitted and found proved

2. Your professional performance was unacceptable in the following areas:

a. Maintaining Professional Performance; To be determined

b. Relationships with Patients. To be determined
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3. Your professional performance was a cause for concern in the following areas:
   
a. Assessment of Patients; **To be determined**
   
b. Clinical Management; **To be determined**
   
c. Record Keeping. **To be determined**

4. In the Knowledge Test you scored 61.67%. This is below the standard set score of 64.91%. **Admitted and found proved**

The Admitted Facts

10. At the outset of these proceedings, through his Counsel, Mr Kennedy, Dr Gabriel made admissions to some 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'). Pursuant to Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

11. In light of Dr Gabriel's response to the Allegation made against him the Tribunal is required to determine whether Dr Gabriel's professional performance was unacceptable in Maintaining Professional Performance and Relationships with Patients. It also has to determine if Dr Gabriel's professional performance was a cause for concern in Assessment of Patients, Clinical Management and Record Keeping. The Tribunal is required to determine whether or not the disputed Allegations are found proved.

Factual Witness Evidence

12. The Tribunal received evidence on behalf of the GMC from the following witnesses:
   
   - Dr A, Performance Assessment Team Leader, in person;
   - Dr B, Performance Assessment Medical Assessor, in person;
   - Dr C, Performance Assessment Lay Assessor, in person;

13. The Tribunal permitted the oral evidence of Dr A, Dr B and Dr C in the absence of witness statements verified by a statement of truth, pursuant to Rule 34(11) of the Rules. This was on the basis that their documentary evidence was contained in both Performance Assessments (signed by Dr A). The Performance Assessments had been disclosed to both parties prior to the hearing.
14. Dr Gabriel provided his own witness statement, dated 16 November 2017 and also gave oral evidence at this hearing.

**Documentary Evidence**

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

- Performance Assessment, dated 2013;
- Performance Assessment, dated 2016;
- Medical Records Bundle for 2016 Performance Assessment, dated 2016;
- Dr A’s Notes, undated;
- Handbook for Performance Assessors, April 2015; and
- OSCE mark sheet.

**The Tribunal’s Approach**

16. 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 Allegations. Dr Gabriel does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

**The Tribunal’s Analysis of the Evidence and Findings**

**The 2013 Performance Assessment**

17. In summary, in June 2013, Dr Gabriel underwent a Performance Assessment. As part of this between 2–4 June 2013, Dr Gabriel underwent a Peer Review and on 26 June 2013 he underwent a Test of Competence (‘TOC’) at the GMC Clinical Assessment Centre. Dr Gabriel’s overall performance was assessed under eight categories and with reference to the professional standards described in Good Medical Practice (2013 edition) (‘GMP’). The Assessment Team (‘the Assessment Team’) comprised of:

- Dr A, Team Leader;
- Dr D, Medical Assessor;
- Dr C, Lay Assessor;
- Mr E, Performance Assessment Officer;
- Ms F, GMC Observer;
- Ms G, Stenographer.
18. The Assessment Team concluded Dr Gabriel’s performance had been found to be deficient across the majority of categories of GMP. The Assessment Team found multiple examples where patient safety had been compromised. Dr Gabriel’s scores in the TOC reflected these deficiencies. The Assessment Team recommended Dr Gabriel must not work as an unsupervised GP, and must work 12 months under direct supervision at all times. The Assessment Team concluded that Dr Gabriel was fit to practise on a limited basis.

19. The Assessment Team recommended a further GMC Performance Assessment to be carried out before Dr Gabriel could be considered to return to unsupervised General Practice.

**The 2016 Performance Assessment Report**

20. The process of the 2016 Performance Assessment comprised of:

1. A Peer Review which included:
   - First Interview and Site Tour;
   - Medical Record Review;
   - Third Party Interviews;
   - Observation of Practice;
   - Case Based Discussion; and
   - Second and Third Interviews.

2. Tests of Competence (TOCs) with:
   - Knowledge Test;
   - Objective Structured Clinical Examination (OSCE); and
   - Simulated Surgery.

21. The Tribunal considered discrete matters that arose from the documentation, oral evidence and submissions. The Tribunal found this helpful in order to explain its approach prior to referencing specifics from the below matters within its overall findings.

**First Interview**

22. The Assessment Team conducted a First Interview with Dr Gabriel and a Site Tour to allow the Assessment Team to gain an understanding of the context of his practice.

**Medical Record Review**
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23. Medical records were requested from The Crane Surgery where Dr Gabriel worked. The Medical Assessors reviewed 51 sets of records, 49 of the records were supplied as full patient printouts including incoming and outgoing correspondence, past problems and investigation results. Two sets of records were supplied in relation to Dr Gabriel’s home visits.

Third Party Interviews

24. Dr Gabriel was entitled to nominate two people to be interviewed by the Assessment Team. He nominated the Practice Manager and Receptionist at The Crane Surgery.

25. The Assessment Team nominated three individuals to interview; the GP Principal (Dr Gabriel’s Educational and Clinical Supervisor), Practice Nurse and a Healthcare Assistant. A verbatim transcript of all the Third Party Interviews was provided to Dr Gabriel and he was given an opportunity to comment on those.

Observation of Practice

26. The Assessment Team did not conduct an Observation of Practice. However, the Tribunal noted that an Observation of Practice had been considered by the Lead Assessor, Dr A, but Dr Gabriel’s Educational and Clinical Supervisor was unavailable. The Tribunal heard during evidence that Dr Gabriel accepted that he had a choice to delay the Performance Assessment until January 2017 when an Observation of Practice could be conducted. Dr Gabriel had agreed to proceed as arranged in 2016.

27. The Tribunal was referred to GMC ‘Handbook for Performance Assessors’ relevant at the time of the 2016 Performance Assessment, which stated:

   ‘As a performance assessor you will, wherever possible, observe the doctor’s interaction with patients in their clinic, surgery or on a ward round. If the doctor has been suspended from work this may not be possible’.

28. In Dr A’s oral evidence, it was highlighted he had been informed that there had been a discussion with a member of staff of the GMC who was administrating the process and procedure of the assessment in relation to the possibility of a video of an Observation of Practice, thus mitigating against the absence of his Educational and Clinical Supervisor. Although the Tribunal considered this to be a limited discussion, it was considered that Dr A was satisfied to proceed in the absence of an Observation of Practice.

29. The Tribunal noted from Dr A’s oral evidence that it was not a mandatory part of the assessment for an Observation of Practice to take place and from his experience they had not always occurred.
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30. Dr A’s evidence was that from his experience, an Observation of Practice adds little value to the overall assessment and that the OSCEs and Simulated Surgeries presented Dr Gabriel with the opportunity to showcase his skills. In Dr B’s evidence, he agreed that a doctor should be able to evidence skills through the OSCEs and Simulated Surgeries.

31. Dr A explained that the weighting given to Observations of Practice is reduced owing to only one Assessor being in the room with a doctor at any one time. The Tribunal further heard from Dr C, the Lay Assessor, who shared Dr A’s view.

32. In Dr Gabriel’s evidence, he stated that OSCEs and Simulated Surgeries were artificial, and the Tribunal acknowledged that this was the case as role players were used and concluded on the oral evidence of Dr A, Dr C and Dr B that they are a recognised method of assessment.

Case Based Discussion

33. This took place on 13 September 2016. Prior to a discussion on 12 September 2016, Dr Gabriel was provided with 12 sets of notes which would be used in the discussion.

Knowledge Test

34. Dr Gabriel undertook a 2 hour test of 120 single best answer questions. The test was invigilated by a Lay Assessor. Prior to Dr Gabriel starting the test, the Team Leader went through the instructions and an example question to ensure Dr Gabriel was comfortable with the format and proceeding.

35. The Tribunal noted from the 2016 Performance Assessment report that the Angoff method was used to interpret test results, which is described as follows:

'**The Angoff method** is used internationally to set standards in tests of competence in medicine. Under this method, a group of judges begin by looking at each question in the test. They then discuss and agree the characteristics of a hypothetical ‘just passing’ doctor, before each envisages a group of such doctors. Each judge then estimates the percentage of these doctors that would answer each question correctly. They then discuss as a group any significant discrepancies in the estimates to allow them to change their percentage, if they so wish. The final percentages are averaged for each question, and then summed to arrive at an overall standard set mark.’

36. The Tribunal note that the minimum expectation of knowledge in relation to the Knowledge Test for the 2016 Performance Assessment to achieve the level expected for independent medical practice was 64.91%. The Tribunal accept
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admissions made on Dr Gabriel’s behalf that he did not meet this minimum expectation in his scoring of 61.67%.

37. Dr B referred to the minimum expectation as the absolute bar by which a GP must reach or exceed, and not to do so was very significant.

OSCEs

38. The OSCE scenarios were chosen by the Team Leader, in consultation with the Assessment Team and Academic Centre for Medical Education (‘ACME’), to reflect a range of cases in the speciality, including a compulsory Basic Life Support station. The OSCE scenarios for Dr Gabriel were:

- emergency contraception for teenager;
- cot death advice;
- post-menopausal bleeding history via interpreter;
- toddler diarrhoea;
- TIA weakness history;
- deal with complaint against practice nurse;
- explain high PSA result;
- discuss obesity surgery referral;
- depression assessment;
- respiratory examination and management;
- shoulder examination;
- adult basic life support.

39. Dr Gabriel was directly observed by the Assessment Team.

Simulated Surgery

40. The Simulated Surgery consisted of consultations with role-players which were chosen from a list of possible scenarios. The Simulated Surgery scenarios for Dr Gabriel were:

- child with temperature;
- chlamydia treatment discussion;
- request for analgesia;
- alcohol dependency and drink driving;
- headache – worried about cancer;
- dyspepsia assessment;
- asthma and persistent cough;
- counselling re inappropriate contraception;
- explain simvastatin treatment; and
- manage type 2 diabetes.
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41. The Assessment Team observed Dr Gabriel through audio and visual link from a separate monitoring room. Any prescriptions written by Dr Gabriel were seen by the Team.

Second and Third Interviews

42. Dr Gabriel was made aware that he was entitled to have a supporter present during the interviews, but chose not to have one at the Second Interview. Dr Gabriel was accompanied by his Clinical and Educational Supervisor for the Third Interview.

Outcome of the 2016 Performance Assessment

43. Dr Gabriel’s overall performance was assessed under eight categories and with reference to the professional standards described in GMP (2013 edition). The Assessment Team comprised of:

- Dr A, Team Leader;
- Dr B, Medical Assessor;
- Dr C, Lay Assessor;
- Ms H, Performance Assessment Officer; and
- Ms I, Shorthand Writer.

44. The Assessment Team produced a joint report that all agreed as accurate.

45. The report is a compilation of all the evidence gathered during the Performance Assessment process. The Assessors must mark each entry as ‘acceptable’ (A) or ‘unacceptable’ (U), categorising it according to the GMP. The entries are then transcribed in the Performance Assessment database (‘the Database’).

46. The evidence in the Database is then incorporated into the Report and each piece of evidence appears as an individual judgement grouped into those which were ‘acceptable’ or ‘unacceptable’ under each domain. The Assessment Team produce a report on the standard of the practitioner’s professional performance which expresses an opinion as to whether the practitioner is fit to practise either generally or on a limited basis and any recommendations as to the management of the case.

47. The Tribunal noted the Assessment Team gave an overall judgement of Dr Gabriel’s performance in each of the eight categories according to the following scale:

- **Unacceptable** indicates that there is evidence of repeated or persistent failure to comply with the professional standards appropriate to the work being done by the doctor, particularly where this places
patients or members of the public in jeopardy (i.e. deficient professional performance). This grade should be entered either if you have evidence that the criteria for an acceptable level of performance are regularly NOT being met OR if negative criteria are being met.

- **Acceptable** means that the evidence demonstrates that the doctor’s performance is consistently above the standard described above. This grade should only be entered if you are satisfied that all or almost all of the criteria are satisfied in all or almost all of the examples that you have seen or heard reported.

- **Cause for concern** means that there is evidence that the doctor’s performance may not be acceptable but there is not sufficient evidence to suggest deficient professional performance. The grade should be entered if you have evidence of some instances of unacceptable performance but which, in the view of the assessing team, do not amount overall to unacceptable performance. The reasons for using this grade, rather than ‘unacceptable’, for this aspect of performance should be described.

48. The Assessment Team’s overall assessment for each of the eight categories, under the domain of GMP were as follows:

**Domain 1: Knowledge, Skills and Performance**
- Maintaining Professional Performance: **Unacceptable**
- Assessment of Patients’ Condition: **Cause for concern**
- Clinical Management: **Cause for concern**
- Operative/Technical Skills: **No judgement was made**
- Record Keeping: **Cause for concern**

**Domain 2: Safety and Quality**
- Safety and Quality: **No judgement was made**

**Domain 3: Communication, Partnership and Teamwork and Domain 4: Maintaining Trust**
- Relationships with Patients: **Unacceptable**
- Working with Colleagues: **Acceptable**

**Witness Evidence**

49. The Tribunal considered the oral evidence of the individual assessors (Dr A, Dr C and Dr B) on how they conducted the assessment and prepared the 2016 Performance Assessment. The Tribunal does not seek to impose its own opinion in place of the Assessment Team’s opinion; they are appropriately qualified and trained...
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to undertake this task. However, the Tribunal will robustly challenge test and weigh
that evidence appropriately.

Dr A – GMC Lead Assessor (2013 and 2016 Performance Assessment)

50. The Tribunal found Dr A to be a credible, careful and thoughtful witness. The
Tribunal noted from his oral evidence he was balanced in his responses and sought
to assist in answering the questions. Dr A was prepared to give an opinion on
matters relevant to Dr Gabriel’s case. However, the Tribunal noted Dr A recognised
his own limitations on those questions which he could not answer by virtue of
memory or simply because of matters outside of his direct knowledge.

Dr B – GMC Medical Assessor (2016 Performance Assessment)

51. The Tribunal found Dr B to be a credible, focused and direct witness who, in
his oral evidence, relied on his contemporaneous evidence and did not stray from it.
The Tribunal noted that Dr B was measured basing his opinion on what was written
in the Performance Assessment reports.

Dr C – GMC Lay Assessor (2013 and 2016 Performance Assessment)

52. The Tribunal found Dr C to be a credible but not reliable witness namely by
her poor recollection of the 2013 and 2016 Performance Assessments. The Tribunal
considered Dr C’s responses to oral questioning lacked support from the
documentary evidence. The Tribunal was of the view that whilst Dr C contributed to
the Performance Assessment, she allowed her role to be subsidiary and less
significant than the Medical Assessors. The Tribunal regarded Dr C’s evidence to be
of assistance in relation to the factual observations she made of Dr Gabriel during
the assessment process.

Dr Gabriel

53. The Tribunal found Dr Gabriel to be a credible witness who did his best to
assist it by answering honestly to the best of his knowledge and recollection.
However, the Tribunal noted that Dr Gabriel was not able to always give reliable
answers to questions due to the passage of time. The Tribunal made no criticism of
Dr Gabriel in this regard.

Findings

Observation of Practice

54. The Tribunal recognise Dr Gabriel had experience of OSCEs and Simulated
Surgeries from the 2013 Performance Assessment. Furthermore, it is noted that Dr
Gabriel was notified of the 2016 Performance Assessment by letter dated 21 April 2016 and therefore had time to prepare.

55. In the light of the evidence presented from all witnesses, the guidance and its summaries, the Tribunal considered that the absence of an Observation of Practice did not prejudice Dr Gabriel or undermine the validity or accuracy of the 2016 Performance Assessment.

Knowledge Test

56. In light of the documentation, oral evidence and submissions, the Tribunal considered that it would be wrong to seek to judge Dr Gabriel’s performance by reference to anything but the minimum expectation; to do otherwise would be to go behind an approved method of assessment used in the Knowledge Test.

57. However, the Tribunal considered Dr Gabriel’s failure to meet that minimum expectation as serious.

58. The Tribunal determined the Knowledge Test as an exceptionally important standard.

Case Mix

59. The Tribunal had regard to the issue of Dr Gabriel’s case mix at the time of, and leading up to his undertaking of the 2016 Performance Assessment.

60. In the oral evidence of Dr A and Dr B, they regarded Dr Gabriel’s case mix as 'low challenge'. Dr A and Dr B qualified this opinion by explaining that low challenge meant that Dr Gabriel’s case mix involved predominately minor complaints and included only a limited amount of complex conditions and management, such as chronic diseases and mental health. However, Dr A and Dr B both accepted Dr Gabriel had some exposure to chronic disease and mental health management as evidenced in a limited number by the Medical Records Review.

61. It was highlighted to the Tribunal that the issue of the low challenge case mix only appeared as a singular reference within the completed written 2016 Performance Assessment. However, it was raised as a significant issue during oral evidence by both Dr A and Dr B.

62. The Tribunal accepted the evidence before it, that the case mix was 'low challenge'.

Interviews
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63. The Tribunal found that the interviews were less helpful in reaching its
determination owing to an almost ridged question pattern. Whilst the Tribunal
understands the rationale behind this, ensuring consistency in approach, such a rigid
question pattern has the potential to stifle discussion.

64. Accordingly, the Tribunal therefore approached the evidence obtained
through the interview process with caution.

PARAGRAPH 2(a)

65. The Tribunal had regard to GMP, specifically, paragraphs 7, 8, 9, 10, 11, 12,

66. The Tribunal had regard to the numerical scoring and graphical
representations as outlined in the 2016 Performance Assessment reports.

67. The Tribunal considers that knowledge is an integral part of a doctor’s duty in
Maintaining Professional Performance, and weighted it heavily in its determination.
The Tribunal considered that the most accurate method of testing knowledge was
the Knowledge Test, and that whilst the OSCEs, Simulated Surgery, Case Based
Discussions/ Medical Record Review and Interviews are relevant, the Tribunal place
less weight on them in considering this Allegation. The Tribunal found this consistent
with the approach taken by the 2016 Performance Assessment Team.

68. The Tribunal found that OSCEs, Simulated Surgery, Case Based Discussions/
Medical Record Review and Interviews provided limited evidence to discharge the
GMC’s burden of proof in relation to this Allegation.

69. Owing to the cardinal importance of the Knowledge Test, the Tribunal did not
consider it a conducive to outline its views in relation to specific sample cases or
evidence from the material presented, although it considered all evidence in detail.

Overall Findings

70. The Tribunal accepted the evidence that Dr Gabriel had demonstrated a level
of knowledge in the Peer Review, TOC and his motivation to improve the quality of
his work.

71. The overall conclusion by the Assessment Team in the 2016 Performance
Assessment report in relation to Maintaining Professional Performance states:

‘The overall judgement in this category is Unacceptable on the basis of Dr
Gabriel’s score in the Knowledge Test.’
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72. Balancing all the evidence before the Tribunal, it concluded the Knowledge Test (as outlined earlier in this determination) is a fair and robust testing system, and when Dr Gabriel’s knowledge was tested his standards fell short of the minimum standard.

73. The Tribunal concluded the Knowledge Test is an objective and quantitate assessment of knowledge.

74. The Tribunal therefore found Paragraph 2(a) of the Allegation, proved.

**PARAGRAPH 2(b)**

75. The Tribunal had regard to GMP, specifically, paragraphs 16(e), 17, 31, 32, 33, 46, 47, 48, 49(a)(b)(c)(d) 50, 51(a)(b), 52, 54, 55(a)(b)(c), 57, 59, 60, 61, 62, 64, 68, in relation to Relationship with Patients.

76. The Tribunal has noted some positive examples from Dr Gabriel’s practice consistent with GMP, notably:

- the OSCE concerning cot death advice;
- the OSCE concerning respiratory examination and management;
- the OSCE explaining the high PSA result;
- the Simulated Surgery of a child with a temperature;
- the Simulated Surgery of managing type 2 diabetes;
- the Simulated Surgery discussing chlamydia treatment.

77. However, the Tribunal also found some serious concerns and failings of GMP in a number of areas:

- the OSCE concerning emergency contraception for a teenager;
- the OSCE discussing obesity surgery referral;
- the OSCE concerning a depression assessment;
- the Simulated Surgery concerning alcohol dependency and drink driving;
- the Simulated Surgery headache – worried about cancer;
- the Simulated Surgery concerning counselling re-inappropriate contraception,

78. Specific case examples which weigh heavily in the Tribunal’s determination were as follows:

**1. Case Description - OSCE 1 emergency contraception for teenager**

79. The summary in the 2016 Performance Assessment states:
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‘In Station 1, Having established that this patient did not want to discuss her need for emergency contraception with her parents (TOC13-11), Dr Gabriel went on to pressurise this teenager to tell her parents without enquiring as to what her relationship was like with them and why she felt that she couldn’t tell them (TOC13-13, 1-13).

80. In the Database, the Tribunal noted:

Dr C’s comment:

‘We will help you talk to your parents if you wish – supportive and confronts a difficult issue as girl resistant.’
TOC25-14 (acceptable)

Dr B’s comment:

‘Pushes patient about whether her parents will find out which patient respond didn’t want to pursue but wants morning after pill.’
TOC13-13 (unacceptable)

Dr A’s comment:

‘Unduly pressurises patient with regard to tell parents without any enquiry as to what her relationship with parents is like.’
TOC1-13 (unacceptable)

81. The Tribunal has considered all three comments but weighing in the balance, it accepts those of Dr A and Dr B that Dr Gabriel was not listening to his patient. The Tribunal was of the view that consultations should be patient centred. However, it noted this consultation was doctor centred.

82. The Tribunal concluded that Dr Gabriel departed from the guidelines set out in GMP, specifically paragraph 31.

2. Case Description - OSCE 8 discuss obesity surgery referral

83. In the Database, the Tribunal noted:

Dr B’s comments:

‘Asks patient why she wont accept counselling and makes patient say ‘I’m not mad’ and patient becomes irritable.’
TOC20-22 (unacceptable)
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'Tries again to suggest walk program and a dietician when patient insisting she can't exercise and has been to Weight Watchers.’
TOC20-21 (unacceptable)

'Responds to patient pressure about op with distraction by suggesting further investigation - blood tests – mentions checking cortisol which patient doesn't understand.’
TOC20-20 (unacceptable)

Dr A’s comment:

'Doctor does not demonstrate any strategy for dealing with this assertive, demanding patient and doesn't address her concerns or expectations.’
TOC8-17 (unacceptable)

Dr C’s comment:

'Dr G says will help with weight loss by other means if surgery excluded. Not dismissing uncooperative patient.’
TOC32-15 (acceptable)

84. The Tribunal has considered all the comments but weighing in the balance, it accepts those of Dr A and Dr B and considered that there was an issue of poor verbal communication between Dr Gabriel and his patient.

85. The Tribunal concluded that Dr Gabriel departed from the guidelines and fell below the standard set out in GMP, specifically paragraphs 31, 32, 49, 51, 57.

3. Case Description - OSCE 9 depression assessment

86. The summary in the 2016 Performance Assessment states:

'In Station 9, Dr Gabriel started the consultation with a series of closed questions, rather than let the patient tell his story. The impact of this on the quality of the history obtained has been discussed earlier in this report, but this also irritated the patient, as he was not given the opportunity to describe his symptoms in detail (TOC9-10). Dr Gabriel did enquire about family and social factors, and the patient mentioned that he had huge debts, although this cue was not followed up (TOC33-11). Dr Gabriel asked the patient whether he wanted to consider counselling, tablets or group therapy sessions, in an attempt to involve the patient in decisions about management (TOC33-13). Although this may empower the patient with regard to his care, it would have been important for Dr Gabriel to advise what 563 treatment was likely to be the most effective, to allow the patient to make an informed decision.
87. In the Database, the Tribunal noted:

Dr B’s comment:

‘Persists with doctors agenda about alcohol and counselling to patient irritation and repeatedly does not address patients needs.’
TOC21-28 (unacceptable)

Dr A’s comment:

‘Doctor insistent on sending patient for counselling despite his reluctance.’
TOC9-15 (unacceptable)

Dr C’s comment:

‘Non verbal communication is excellent. Dr G looks at the patient. Asks questions at good pace. Uses same descriptions as the patient, eg. feeling low.’
TOC33-10 (acceptable)

88. In the Database, the Tribunal noted Dr B’s comment in Assessment of Patients to which it considered was also relevant to Relationship with Patients:

‘Asks about suicide but doesn't follow up "well yes I do".
TOC21-13 (unacceptable)

89. The Tribunal has considered all the comments but weighing in the balance, it accepts those of Dr A and Dr B that there was an issue of poor verbal communication between Dr Gabriel and his patient.

90. The Tribunal concluded Dr Gabriel missing a suicide risk was a serious departure from the guidelines set out in GMP, specifically paragraphs 31, 32, 49, 51, 57.

4. Case Description – Simulated Surgery 4 alcohol dependency and drink driving

91. The summary in the 2016 Performance Assessment states:
'In Patient 4, Dr Gabriel twice ignored this patient’s request for a letter for court, and diverted to discussion to another topic. Although Dr Gabriel may have been unwilling to write a letter, this should have been addressed directly with the patient (TOC50-13, 40-12). Dr Gabriel went on to advise the patient that he was going to put him into an alcohol counselling programme without seeking the patient’s agreement to this course of action (TOC40-16, 60-14).’

92. In the Database, Dr A states:

‘Doctor tells patient he is going to be put on a program to reduce drinking without any discussion as to whether the patient wants this.’
TOC40-16 (unacceptable)

‘Patient asks doctor twice for a letter for court which he ignored and talked about something else.’
TOC40-12 (unacceptable)

93. The Tribunal accept Dr A’s evidence that Dr Gabriel was not listening or responding to the patient’s needs.

94. The Tribunal concluded that Dr Gabriel’s actions in Simulated Surgery 4 fell significantly short of the standards set out in GMP, specifically paragraph 31.

5. Case Based Discussion and Medical Record Review

95. The Tribunal noted the Case Based Discussion and Medical Record Review when considering Dr Gabriel’s Relationship with Patients.

96. However, the Tribunal concluded that they did not significantly assist it.

6. Interviews

97. The Tribunal places appropriate weight on the interviews in the context earlier outlined in this determination. Relevant weight has been applied accordingly.

Overall Findings

98. Particular threads that were identified by the Tribunal through the above examples was Dr Gabriel’s doctor centred approach rather than a patient centred approach in addition to the risk of potential harm to patients. Dr Gabriel’s evidence did not alleviate the serious concerns.

99. The Tribunal considered that relationships with patients are fundamental to practice as a General Practitioner (which Dr Gabriel practises in).
100. In the overall conclusion by the Assessment Team in the 2016 Performance Assessment report, in relation to Relationships with Patients states:

'GMP states that "you must work in partnership with patients, sharing with them the information they will need to make decisions about their care" (para 49); "you must listen to patients, take account of their views, and respond honestly to their questions" (para 31). In TOC Simulated Surgery patients 5, 6, 7 and 8, Dr Gabriel’s performance clearly departed from this GMP standard. His performance in this category was therefore Unacceptable.'

101. The Tribunal does not take account of Simulated Surgery 6 on the grounds that it considered Dr Gabriel had been unfairly clouded by his previous experience of the 2013 Performance Assessment in this respect.

102. The Tribunal took account of the Simulated Surgeries 5, 7 and 8 referred to in the Assessment Team’s summary and noted that during the Assessment, Dr Gabriel’s actions fell below the standards set out in GMP, which could, on a number of occasions cause potential harm to patients. Notably this was present in his:

- OSCE 1 – went on to pressuring a teenager;
- OSCE 8 – clearly not engaging with the patient; and
- OSCE 9 – missing a suicide risk;

103. The Tribunal noted that Dr Gabriel scored 41.00 in the interpersonal skills performance was notably below the curve of the reference group.

104. The Tribunal concluded that Dr Gabriel’s actions in conjunction with the Assessors’ comments and his performance fell short of the standards set out in GMP, specifically paragraphs 31 and 49, and his performance in this regard was unacceptable.

105. The Tribunal therefore found Paragraph 2(b) of the Allegation, proved.

**PARAGRAPH 3(a)**

106. The Tribunal had regard to GMP, specifically, paragraphs 15(a)(b) and 18 in relation to Assessment of Patients.

107. The Tribunal has noted some positive examples from Dr Gabriel’s practice consistent with GMP, notably the OSCE concerning post menopausal bleeding.

108. However, the Tribunal also found some serious concerns and failings of GMP in a number of areas:
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- OSCE relating to depression assessment;
- OSCE concerning a respiratory examination and management;
- OSCE dealing with a shoulder examination;
- Simulated Surgery with a child with a temperature;
- Simulated Surgery relating to headache – worried about cancer;
- Simulated Surgery concerning asthma and persistent cough;

109. The Tribunal did not take into account the Simulated Surgery relating to dyspepsia assessment on the grounds of fairness to Dr Gabriel given that the Tribunal considered his performance was clouded by his previous experience in the 2013 Performance Assessment.

110. The context of the OSCE relating to the depression assessment has been noted above in relation to a separate allegation (Relationship with Patients), and such context will not be repeated in this section. As well as relating to Relationships with Patients, the Tribunal found that it is inextricably linked to Assessment of Patients and the Tribunal similarly accepted the evidence of Dr A and Dr B in that Dr Gabriel did not adequately assess the patient and that this could potentially pose a risk to the patient’s safety.

111. Furthermore, Dr Gabriel’s failings in the OSCE concerning a respiratory examination, and is subsequent explanation in oral evidence, was considered relevant to the Tribunal’s determination.

112. The specific evidence the Tribunal weighted was as follows:

1. Case Description - OSCE 10 respiratory examination and management

113. The summary in the 2016 Performance Assessment states:

‘In Station 10, examination of respiratory system, Dr Gabriel’s explanation and interpretation of the peak flow rate was acceptable (TOC22-15, 22-16, 22-20, 10-11, 10-12, 10-16). However, his examination of the respiratory system was unstructured and superficial. His auscultation of the chest was limited to once on the front, once on each side and twice on the back (TOC10-10, 22-11). He did not check respiratory rate, inspect for chest wall movement and percussed the chest only twice on each side of the back (TOC22-12, 22-13, 22-14). This superficial and limited examination technique would be unlikely to identify any abnormal physical signs that might have been present’

114. In the database, the Tribunal noted:

Dr A’s comment:
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‘Examination of respirator system unstructured. Auscultation not methodical and did not cover all lung zones.’
TOC10-10 (unacceptable)

115. In Dr Gabriel’s evidence, he stated he didn’t demonstrate sufficient acknowledgement and give any reasonable explanation.

116. The Tribunal accepts the evidence of Dr A that Dr Gabriel’s examination was inadequate.

2. Case Description - OSCE 11 shoulder examination

117. The OSCE relating to a shoulder examination was also identified by the Tribunal as being Cause for Concern in the Assessment of Patients and accepted Dr B’s evidence documented in the database that:

‘Globally this was not a fluent, structured shoulder assessment.’
TOC23-21 (unacceptable)

3. Case Description – Simulated Surgery 5 headache – worried about cancer

118. In relation to the Simulated Surgery concerning the patient worried about cancer, the Tribunal particularly weighted Dr B’s comments from the Database

‘Explores with patient if COC is cause of headache despite patient saying on it for five years and only recent headache.
TOC51-12 (unacceptable)

‘Does not ask about red flags - night pain, vomiting, neuro symptoms.’
TOC51-11 (unacceptable)

‘Globally doctor fails to address concern about brain tumour and persists in advice to stop the pill.’
TOC51-19 (unacceptable)

‘Asks patient what her main concern is, which elicits concern about brain tumour and request for a scan.’
TOC51-15 (acceptable)

4. Case Description – Simulated Surgery 7 asthma and persistent cough

119. The Simulated Surgery addressing asthma and persistent cough was also considered important by the Tribunal.
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120. The summary in the 2016 Performance Assessment states:

"In Patient 7, Dr Gabriel took only a limited history with regard to the cough, and did not ask questions which would have suggested a deterioration in the control of asthma, such as wheeze, diurnal variation, frequency of inhaler use, effect of exercise (TOC53-10, 43-11). He was therefore unable to assess whether the asthma was less well controlled and therefore whether his medication should be increased (TOC43-12). Dr Gabriel’s examination of this patient’s chest was cursory and carried out with the patient clothed and consisted only of auscultation (TOC53-14). Dr Gabriel advised that this patient had a chest X-ray, but the patient was a non-smoker with symptoms of asthma - chest X-ray was not indicated at this time as it would not have helped with diagnosis (TOC53-18)."

121. In the Database, the Tribunal noted:

Dr B’s comment:

‘Cursory examined chest with patient standing, clothes on, auscultation only.’
TOC53-14 (unacceptable)

Dr A’s comments:

‘Doctor does not take a focused history to assess whether the asthma is deteriorating and whether his inhaler therapy should be stepped up, i.e. inhaled corticosteroids added. He is already using occasional salbutamol.’
TOC43-12 (unacceptable)

‘Doctor takes a very limited history pertaining to this patient’s cough - not asking about diurnal variation, sputum or how frequently he is currently using inhaler.’
TOC43-11 (unacceptable)

122. The Tribunal accepted the evidence of both Dr A and Dr B that Dr Gabriel failed to adequately assess the patient’s condition, thus falling below the standards set out in GMP, and as referenced collectively at the outset of this section.

5. Case Description – Case Based Discussion 25

123. This Case Based Discussion goes to the core foundation of GMP and the Tribunal found that Dr Gabriel fell short of the standards expected.

124. The summary in the 2016 Performance Assessment states:
'In Case 25, a 59 year old lady with multiple sclerosis (MS) and presenting with dizziness, Dr Gabriel was asked at Case Based Discussion what issues he had considered when assessing her presenting problem. He replied that he had considered other co-morbidities and that she suffered from MS (CBD18-11, 6-11). He stated that he had considered what medication she was currently taking, whether she had suffered from this symptom previously and what her expectations were from the consultation (CBD18-12, 18-14, 18-31). He said that he clarified what she meant by dizziness (CBD6-10). However, whilst he had recognised that she suffered from multiple sclerosis, he did not attribute her current dizziness to this underlying condition that would be the most likely cause of her current symptoms (MRR77-10, CBD18-13, 6-14). As a result of this he was not in a position to give appropriate management advice."

125. In the Database, the Tribunal noted:

Dr B’s comment:

'Does not recognise that vertigo can be symptom of MS relapse. 
CBD18-13 (unacceptable)

126. The Tribunal concluded that Dr Gabriel fell below the standards set out in GMP, specifically paragraph 15(a)(b).

6. Case Description – Case Based Discussion 51

127. In the database, the Tribunal noted:

Dr A’s comment:

'Tried to exclude high BP and malignancy but doesn’t mention cardiovascular examination - a more likely cause of this symptom.’
CBD12-25 (unacceptable)

‘No mention of possible renal function tests before giving furosemide in this age.’
CBD12-16 (unacceptable)

128. The Tribunal accepted Dr A’s evidence that Dr Gabriel failed to take into account the patients history.

129. The Tribunal concluded that Dr Gabriel fell below the standards set out in GMP, specifically paragraph 15(a).
7. Interviews

130. The Tribunal places appropriate weight on the interviews in the context earlier outlined in this determination. Relevant weight has been applied accordingly.

Overall Findings

131. The Tribunal noted the conclusion by the Assessment Team in the 2016 Performance Assessment report, in relation to Assessment of Patients which states:

‘Although there were a number of examples of unacceptable assessment, patients were not put at significant risk as a result, for the reasons explained above.

The overall judgement in this category was therefore Cause for Concern.’

132. The Tribunal notes that Dr Gabriel’s score compared to a reference group of GPs in these Simulated Surgeries in this area was at the tail end of the distribution curve thus embedding such Cause for Concern further.

133. The Tribunal were concerned that on occasions, Dr Gabriel:

- Case Based Discussion 25 – did not take account of patient history;
- Simulated Surgery 7, OSCE 10, OSCE 11 – performed inadequate physical examinations; and
- Simulated Surgery 5 and 7 – asked close and unstructured questions to patients.

134. The Tribunal found and accepted the Assessment Team’s conclusion that Dr Gabriel’s Assessment of Patients was a cause for concern, and based on the evidence before it, his professional performance fell short of the standards as outlined in GMP.

135. The Tribunal therefore found Paragraph 3(a) of the Allegation, proved.

PARAGRAPH 3(b)

136. The Tribunal had regard to GMP, specifically, paragraphs 14, 15(a)(b)(c), 16(a)(b)(c)(f)(g), 18, 26, in relation to Clinical Management.

137. The specific evidence the Tribunal weighted was as follows:

1. Case Description - OSCE 5 TIA weakness history

138. The summary in the 2016 Performance Assessment states:
'In Station 5, although Dr Gabriel appropriately advised that this patient needed to be assessed by the stroke unit and that she may need to be on medication to prevent a recurrence (TOC5-13, 5-14), he advised an immediate ambulance to admit this patient to hospital. As her TIA was the previous day, and she was now asymptomatic, it would be usual to arrange urgent referral to a stroke/TIA outpatient clinic rather than immediate admission – she is unlikely to be admitted anyway, as her symptoms were over 24 hours ago (TOC17-15, 5-16, 5-15).’

139. In the database, the Tribunal noted:

Dr A’s comment:

‘Urgent referral to TIA / stroke clinic in next 24-48 hours would be more appropriate management.’
TOC5-16 (unacceptable)

Dr B’s comment:

‘Wants to transfer patient immediately by ambulance – not appropriate as TIA the day before, needs TIA clinic appointment.’
TOC17-15 (unacceptable)

140. The Tribunal considered that Dr Gabriel’s advice was not suitable in referring Accident and Emergency which was contrary to and does not serve the patient’s needs.

141. The Tribunal concluded that Dr Gabriel fell below the standards set out in GMP, specifically paragraphs 15(a)(b)(c) and 18.

2. Case Description - **OSCE 9 depression assessment**

142. The context of this assessment has been outlined above and has not been repeated. However in the Database, the Tribunal noted:

Dr B’s comment:

‘Dr insists on counselling and then that counsellor will advise if patient needs to go on antidepressants.’
TOC21-22 (acceptable)

‘Suggests to patient he needs AA or cut down on alcohol and wants to do blood test for alcohol.’
TOC21-26 (acceptable)
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Dr A’s comment:

‘Acknowledges patient wishes that he would prefer medication than having counselling.’
TOC9-13 (acceptable)

3. Case Description - **OSCE 10** respiratory examination and management

143. The summary in the 2016 Performance Assessment states:

*In Station 10, although Dr Gabriel acceptably advised smoking cessation in this patient with shortness of breath (TOC22-19, 10-14), he also recommended a course of antibiotics and steroids with no evidence of infection or any other signs to suggest that steroid tablets were indicated (TOC22-23, 10-18).*

144. In the Database, the Tribunal noted:

Dr B’s comments:

‘Advises smoking cessation and establishes patient is willing to try.’
TOC22-19 (acceptable)

‘At end of consultation suddenly suggests course of steroids - unclear why, and then mentions antibiotics.’
TOC22-23 (unacceptable)

145. The Tribunal was unable to identify any objective assessment by Dr Gabriel therefore falling below the standards expected in GMP.

4. Case Description – **Simulated Surgery 5** headache – worried about cancer

146. In the Database, the Tribunal noted:

Dr A’s comment:

‘Doctors only management plan is to stop her contraception and see her again. Still doesn’t address her stated concern.’
TOC41-16 (unacceptable)

147. The Tribunal accepted Dr A’s evidence in that Dr Gabriel failed to arrange treatment for the patient and offered no strategy.
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148. The Tribunal concluded that Dr Gabriel fell below the standards set out in GMP, specifically paragraph 15(a).

5. Case Description – Simulated Surgery 7 headache – asthma and persistent cough

149. The summary in the 2016 Performance Assessment states:

‘In Patient 7, Dr Gabriel told this patient that he was going to treat him for worsening asthma, however he did not clarify how frequently he was using his inhaler, how effective this was or whether he was using it correctly. He advised the patient he was going to give him a blue inhaler, however as he had not clarified what inhaler the patient had been using, it isn’t clear whether Dr Gabriel was prescribing the same treatment that the patient was already using (TOC53-15, 53-17, 43-13). He also advised the patient that he was going to ask the nurse to give him an asthma management plan without any explanation as to what that was (TOC53-20). Dr Gabriel was unable to follow the asthma step guidelines as he had not established the patient’s current treatment.’

150. The Tribunal concluded that Dr Gabriel fell below the standards set out in GMC, specifically paragraphs 15(b) and 18.

6. Case Description – Case Based Discussion 9 noisy breathing child

151. The summary in the 2016 Performance Assessment states:

‘In Case 9, Dr Gabriel suggested to this child’s parent that the child could be referred to hospital for sleep investigation, but gives no justification as to why this might be appropriate for a child whose symptom was of noisy breathing (CBD11-13, 23-14).’

152. In the Database, the Tribunal noted:

Dr B’s comments:

‘I said he could be referred to sleep clinic at Great Ormond Street - no justification as to why this would be appropriate for noisy breathing.’

CBD11-13 (unacceptable)

153. The Tribunal accepted Dr B’s evidence and considered Dr Gabriel made an inappropriate referral. Dr Gabriel offered nothing further in his evidence which provided a satisfactory explanation.
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154. The Tribunal concluded that Dr Gabriel fell below the standards set out in GMP, specifically paragraphs 15(c) and 18

7. Interviews

155. The Tribunal places appropriate weight on the interviews in the context earlier outlined in this determination. Relevant weight has been applied accordingly.

Overall Findings

156. The Tribunal noted the conclusion by the Assessment Team in the 2016 Performance Assessment report, in relation to Clinical Management which states:

‘Whilst patients were not put at significant risk, the above are examples of where Dr Gabriel’s management fell below the standard expected of an independent general practitioner. For this reason, the overall judgement in this category was Cause for Concern.’

157. The Tribunal were concerned that on occasions Dr Gabriel:

- OSCE 5, 10, Simulated Surgery 5 – had poor management planning which was confusing to patients;
- OSCE 9 – referred a patient to a non-clinician for a clinical decisions; and
- OSCE 5, Case Based Discussion 9 – inappropriate use of resources available to him.

158. However, the Tribunal also balanced the above with evidence from Dr Gabriel’s good prescribing to patients, and his professional colleagues’ perception that he is doing a good job.

159. The Tribunal found that Dr Gabriel’s Clinical Management was a cause for concern in that his providing treatment to patients, safety netting and follow-up fell below the standards outlined in GMP.

160. The Tribunal therefore found Paragraph 3(b) of the Allegation, proved.

PARAGRAPH 3(c)

161. The Tribunal had regard to GMP, specifically, paragraphs 19, 20 and 21 in relation to Record Keeping.

162. The Tribunal considered all the evidence presented, orally and in written form, and concluded the following were of particular weight and importance to its
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decision (noting that the most accurate and reliable evidence for Record Keeping emanates from Dr Gabriel’s actual recorded notes):

1. Case Description – Case Based Discussion/Medical Record Review 7

163. The summary in the 2016 Performance Assessment states:

‘In Case 7, Dr Gabriel did not record his reason for undertaking prostate specific antigen blood test or what discussion he had had with the patient prior to undertaking this test (MRR59-90).’

164. In the Database, the Tribunal noted:

Dr B’s comment:

‘27/6/16 Dr G arranged PSA but has not documented reasons for doing so or if pt counselled.’
MRR59-90 (unacceptable)

165. The Tribunal accepted Dr B’s evidence and found it was not clear if Dr Gabriel had the discussion with the patient and simply did not documented the reasons for arranging PSA or not.

166. The Tribunal concluded that Dr Gabriel fell below the standard set out in GMP, specifically paragraph 21(a)(b).

2. Case Description – Case Based Discussion/Medical Record Review 17

167. The summary in the 2016 Performance Assessment states:

‘In Case 17, Dr Gabriel recorded “no neuro deficit”, without recording any detail as to exactly what part of the neurological system he had examined (MRR69-90).’

168. In the Database, the Tribunal noted:

Dr B’s comment:

20/6/16 Dr G recorded “no neuro deficit” - this doesn’t detail what he examined.’
MRR69-90 (unacceptable)

169. The Tribunal considered that this failed to explain the detail of the examination undertaken.
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3. Interviews

170. The Tribunal places appropriate weight on the interviews in the context earlier outlined in this determination. Relevant weight has been applied accordingly.

Third Party Interview

171. The summary in the 2016 Performance Assessment states:

‘Dr Gabriel’s colleagues said that his notes were understandable and straightforward and his referral letters were similar to Dr J’s (TPI8-80, 12-80, 10-191).’

172. The Tribunal noted there were no unacceptable in the Third Party Interview in regard to Record Keeping

Overall Findings

173. The Tribunal noted the conclusion by the Assessment Team in the 2016 Performance Assessment report, in relation to Record Keeping, which states:

‘Those elements of Dr Gabriel’s Record Keeping that were unacceptable did not, however, put patients at risk, and the overall judgement in this category was therefore Cause for Concern.’

174. The Tribunal were concerned that, on occasions, Dr Gabriel:

- lacked expanded notes, rather than an absence of Record Keeping;
- Case Based Discussion 7 – did not write the full content of discussions between patient; and
- Case Based Discussion 17 – used abbreviations which caused ambiguity as to the detail of examinations.

175. Based on the evidence before the Tribunal it was concerned that Dr Gabriel had not fully recorded what was discussed with the patients. The Tribunal considered that other clinicians looking at Dr Gabriel’s notes could have difficulty extrapolating information.

176. The Tribunal found that Dr Gabriel fell below the standards set out in GMP, specifically paragraph 21(a)(b)(c).

177. The Tribunal therefore found Paragraph 3(c) of the Allegation, proved.

The Tribunal’s Overall Determination on the Facts
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178. The Tribunal has determined the facts as follows:

1. Between 11 September and 12 October 2016 you underwent a General Medical Council assessment of the standard of your professional performance. **Admitted and found proved**

2. Your professional performance was unacceptable in the following areas:
   a. Maintaining Professional Performance; **Disputed and found proved**
   b. Relationships with Patients. **Disputed and found proved**

3. Your professional performance was a cause for concern in the following areas:
   a. Assessment of Patients; **Disputed and found proved**
   b. Clinical Management; **Disputed and found proved**
   c. Record Keeping. **Disputed and found proved**

4. In the Knowledge Test you scored 61.67%. This is below the standard set score of 64.91%. **Admitted and found proved**

**Determination on Impairment - 17/09/2019**

1. Having given its determination on the facts in this case, in accordance with Rule 17(2)(k) of the Rules, the Tribunal has considered whether, on the basis of the facts which it has found proved, Dr Gabriel’s fitness to practise is impaired by reason of deficient professional performance

**The Outcome of Application Made during the Impairment Stage**

2. The Tribunal granted the GMC’s application under Rule 34(14) of the Rules for Dr K to give his evidence via Telephone Link. This application was not opposed by Mr George Thomas, Counsel, on behalf of Dr Gabriel.

3. The Tribunal considered whether pursuant to rule Rule 35(5) of the Rules, it should recall Dr L to give further evidence either in person, or via Telephone Link. It was considered that at stage two, the decision as to whether Dr Gabriel’s fitness to practise is a matter for it to determine under its own independent judgement. It considered that it would be relevant for Dr L to give further evidence as she continues to be Dr Gabriel’s Clinical Supervisor and works with him on a day to day
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basis. The Tribunal noted that in the 2019 Performance Assessment there was reference to a number of statements by Dr L which led the Tribunal to have concerns upon which it would be assisted by her further evidence. This course was not opposed by either Counsel and the Tribunal determined it was in the interests of justice and in the public interest to recall Dr L. On the basis that Dr L was in practice in Kent and the call was at short notice the Tribunal determined to hear her evidence by telephone.

The Evidence

July 2018

4. On 4 July 2018, the Tribunal reconvened at stage two to continue its consideration of Dr Gabriel’s case. The following is a summary of evidence adduced at that stage:

Oral evidence from the following GMC witnesses:

• Dr M, General Practitioner at Butchery Surgery, via Telephone Link; and
• Dr N, Clinical Adviser to NHS England – South East, via Telephone Link.

Oral evidence from the following witnesses, called on Dr Gabriel’s behalf:

• Dr L, Dr Gabriel’s Clinical Supervisor, in person; and
• Dr J, Dr Gabriel’s Educational Supervisor, via Telephone Link.

Documentary evidence, which included, but was not limited to:

• Witness statement of Dr M, dated 27 February 2018 enclosing various exhibits;
• Witness statement of Dr N, dated 26 February 2018 enclosing various exhibits;
• Clinical Supervisor Reports from Dr L, dated 28 February 2018; and Dr O, undated;
• Dr Gabriel’s Personal Development Plan (‘PDP’);
• Dr Gabriel’s appraisals, in the period between 2014 to 2018;
• Audit of patient records;
• GP Self-test Certificate, dated 10 June 2018; and
• Various testimonials attesting to Dr Gabriel’s good character.

5. On 6 July 2018, the Tribunal adjourned and directed that Dr Gabriel undertake a further PA. A separate determination is annexed.

September 2019
6. On 9 September 2019, the Tribunal reconvened again at stage two to continue its consideration of Dr Gabriel’s case and the directed performance assessment was placed before the Tribunal and further witnesses were called. The following is a summary of evidence adduced at this stage:

Oral evidence from the following GMC witnesses:

- Dr P, the 2019 Performance Assessment Team Leader, in person; and
- Dr K, the 2019 Performance Assessment Medical Assessor, via Telephone Link.

Documentary evidence, which included, but was not limited to:

- The 2019 Performance Assessment;
- Dr Gabriel’s Appraisal for 2019 – 2020;
- Various confirmations of patient consent with respect to procedures;
- Testimonial from Ms Q, Receptionist / Administration at The Orchard Practice, dated 24 August 2019; and
- Draft ‘Further Personal Development Plan’ (‘PDP’).

7. The Tribunal requested further evidence from Dr L, who remains Dr Gabriel’s Clinical Supervisor. Dr L gave her evidence via Telephone Link.

The 2019 Performance Assessment Report

8. The process of the 2019 Performance Assessment comprised of:

2. A Peer Review which included:

   - First Interview and Site Tour;
   - Medical Record Review;
   - Third Party Interviews;
   - Observation of Practice;
   - Case Based Discussion; and
   - Second and Third Interviews.

2. Tests of Competence (TOCs) with:

   - Knowledge Test;
   - Objective Structured Clinical Examination (OSCE); and
   - Simulated Surgery.

First Interview and Site Tour
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9. The Assessment Team conducted a First Interview with Dr Gabriel and a Site Tour of The Orchard Practice, to allow the Assessment Team to gain an understanding of the context of his practice.

Medical Record Review

10. The Assessment Team requested the records of 50 consecutive patient encounters working backwards from 1 September 2018. Those records were supplied as ‘at least’ two years’ worth of consultations and full patient printouts including:

- incoming and outgoing correspondence;
- past problems; and
- Investigation results.

11. Some of the Medical Records were found to contain no data entry from Dr Gabriel, and one was missing altogether so an extra 10 patient records were requested. Of these 6 were judged making a total of 50 records judged overall.

12. The Team Leader and Medical Assessor independently reviewed the same 50 records.

Third Party Interviews

13. Dr Gabriel was entitled to nominated two people to be interviewed by the team.

   Dr Gabriel nominated:

   - Ms R, an Assistant Practice Manager; and
   - Ms S, a Receptionist.

   The Assessment Team nominated:

   - Dr L, Senior Partner at The Orchard Practice and Dr Gabriel’s Clinical Supervisor;
   - Ms T, a Practice Nurse; and
   - Dr J, Dr Gabriel’s Educational Supervisor.

Observation of Practice

14. On 7 January 2019, an Observation of Practice took place at The Orchard Practice. The Assessment Team each observed Dr Gabriel consulting with eleven patients.
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Case Based Discussion

15. On 7 January 2019, Dr Gabriel was given the 12 sets of notes to be used in the Case Based Discussion to enable him to read over them prior to the discussion, which took place on 8 January 2019.

Knowledge Test

16. On 7 January 2019, Dr Gabriel undertook a 2 hour Knowledge Test comprising of 120 single best answer questions.

17. It was reported that during the test, Dr Gabriel was disturbed several times by practice staff members entering the room. In light of the interruptions, Dr Gabriel undertook a new 2 hour knowledge test on 16 June 2019. The results of the initial Knowledge Test were discarded and did not form part of the Assessment Team’s findings.

OSCE

18. The OSCE scenarios were chosen by the Team Leader, in consultation with the Assessment Team and the Assessment Development Team (‘ADT’) to reflect a range of cases in the speciality, including a compulsory Basic Life Support station. The OSCE scenarios chosen for Dr Gabriel were:

- Advise mother on feverish child with meningococcal rash;
- Basic life support adult;
- Child respiratory system examination;
- Confidentiality and the Fraser guidelines;
- Dealing with worries colleague;
- Discuss emergency contraception request with a teenager;
- Discuss end of life decisions;
- History and management of a patient who has had a TIA;
- History and management of post-menopausal bleeding via an interpreter; and
- Recognition of bowel cancer symptoms.

19. The Medical Assessor and Team Leader took it in turns to observe directly or observe over an audio and visual link. Dr Gabriel was directly observed by the Lay Assessor.

Simulated Surgery

20. The Simulated Surgery consisted of consultations with role-players which were chosen from a list of possible scenarios by the Team Leader. The Simulated Surgery scenarios for Dr Gabriel were:
• Deal with request for painkillers from newly registered patient;
• Recognise and manage abnormal blood results;
• History and management of lower back pain;
• Plantar fasciitis explanation;
• Asthma and persistent cough assessment and management;
• Depression assessment;
• Management of dementia assessment with daughter and mum;
• Shoulder pain assessment;
• Review of new presentation of type 1 diabetes; and
• Addressing prostate cancer concerns of patient.

21. The Assessment Team observed Dr Gabriel through an audio and visual link from a separate monitoring room. Any prescriptions written by Dr Gabriel were seen by the Team.

Second and Third Interviews

22. Dr Gabriel opted to have Dr U from the MPS as a supporter who participated via speakerphone telephone calls during the second and third interview. Dr Gabriel was aware that he was entitled to have a supporter present during these interviews.

Outcome of the 2019 Performance Assessment

23. Dr Gabriel’s overall performance was assessed under eight categories and with reference to the professional standards described in Good Medical Practice (2013 edition) (‘GMP’). The Assessment Team comprised of:

• Dr P, Team Leader;
• Dr K, Medical Assessor;
• Ms V, Lay Assessor; and
• Mr X, Performance Assessment Officer.

24. The Assessment Team produced a joint report that all agreed as accurate.

25. The Assessment Team’s overall assessment for each of the eight categories, under the domain of GMP were as follows:

Domain 1: Knowledge, Skills and Performance

Maintaining Professional Performance: Acceptable
Assessment of Patients’ Condition: Acceptable
Clinical Management: Cause for concern
Operative/Technical Skills: No judgement was made
Record Keeping: Cause for concern
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Domain 2: Safety and Quality
Safety and Quality: No judgement was made

Domain 3: Communication, Partnership and Teamwork and
Domain 4: Maintaining Trust
Relationships with Patients: Acceptable
Working with Colleagues: Acceptable

Summary of Oral Evidence

Dr P

26. Dr P’s evidence focused on one of the causes for concern which was ‘Safety-Netting’. She said that Dr Gabriel was not as clear or thoughtful as he could be and felt he could be more specific, but this had to be put in the context of the patients he was seeing being, on the whole, responsible adults. These patients were not very unwell and were able to monitor and manage their own health. They did not particularly consider more vulnerable patients. In the broader context of Risk Management, Dr P did not feel that Dr Gabriel put patient safety at risk.

27. Dr P then went on to consider Dr Gabriel’s Record Keeping, which was variable in quality. There was clear room for improvement which the team balanced against the limitations on being able to record everything. Dr P said there had been considerable discussion amongst the team on ‘Record Keeping’. She said Dr Gabriel was a ‘work in progress’ and ‘improving’. Dr P was mindful she was working to the standard of GMP. On the whole Dr P thought Dr Gabriel was ‘safe’ and did not see any evidence that he was not safe.

Dr K

28. Dr K was aware that the decision on whether Dr Gabriel should return to unrestricted practice was for the Tribunal. He undertook a holistic assessment and had aligned his decisions to GMP. From his recollection, Dr Gabriel had not been documenting Safety Netting ‘at the level of a jobbing GP’ but at the level of GMP. He was not saying that as a matter of fact any patient had been put at risk. On questioning he stated that he could not say that patients were not put at risk.

29. Dr K noted comments of concern regarding Clinical Management made by Dr L in her Third Party Interview with the Assessment Team, but regarded these as ‘isolated comments’. He said that he had been concerned at the structure of Dr Gabriel’s records and they needed to improve. He said that they were ‘sparse’. On questioning, he stated that he regarded the potential for Dr Gabriel to work as a locum as a hypothetical situation but stated that Dr Gabriel’s Record Keeping could present difficulties for colleagues following on. He referred the Tribunal to the
Recommendations in the Performance Assessment at paragraph 2.9 but said the Performance Assessment Team’s opinion of Dr Gabriel being 'generally fit to practise’ was independent of these recommendations. He was somewhat ambiguous when questioned as to whether Dr Gabriel was fit to practise in any scenario including ‘out of hours’ and as a locum.

30. When asked whether Dr Gabriel could improve his Record Keeping on his own and unsupervised he said it was ‘tricky to comment’ and depended on Dr Gabriel’s motivation and insight.

Dr L

31. Dr L said that Dr Gabriel had continued to work on improvements, since the 2019 Performance Assessment and she no longer regarded him as working at the level of an ‘early registrar’ in relation to more complex cases, which she had stated at the 2019 Performance Assessment. Dr L advised that she still had a ‘few concerns’ relating to Dr Gabriel engaging in independent practice and was concerned as to how he dealt with pathology results and hospital letters. In her opinion she needed to see further improvement. The practice was organising further training for Dr Gabriel on computer systems and Record Keeping and his Record Keeping required further work. Dr L was not concerned about Dr Gabriel’s management planning concerning chronic cases. However, Dr L was unable to provide assurances that Dr Gabriel could be considered fit to practise independently at this stage, stating that further supervision and assistance is required in relation to Record Keeping and clinical administration (pathology results and hospital letters).

Submissions

32. The submissions made by both Counsel at the close of the impairment stage are a matter of record and the following is a non-exhaustive synopsis of those submissions.

Submissions on behalf of the GMC

33. Ms Kitchin, Counsel, submitted that Dr Gabriel’s fitness to practise is impaired by reason of deficient professional performance. She directed the Tribunal to the relevant guidance in GMP and the following case law when making its determination:

- Cohen v GMC [2008] EWHC 581 (Admin);
- Cheatle v GMC [2009] EWHC 645 (Admin);
- Zygmunt v GMC [2008] EWHC 2643 (Admin);
- Yeong v GMC [2009] EWHC 1923 (Admin); and
- The Fifth Shipman Report by Dame Janet Smith.
Ms Kitchin submitted that the current shortcomings in Dr Gabriel’s Record Keeping and administration outlined by Dr L during her recent oral evidence to the Tribunal amount to deficient professional performance and provide evidence contrary to the findings of the 2019 Performance Assessment.

Ms Kitchin submitted that this continued deficient professional performance in areas highlighted as concerns in the 2013 and 2016 Performance Assessments demonstrates the original concerns around Dr Gabriel’s practice remain valid and have not been satisfactorily remediated, in contrast to what is implied by the Assessment Team in the 2019 Performance Assessment.

Ms Kitchin submitted that whilst it is the case that there was no evidence of immediate risk of harm to patients, Dr Gabriel’s performance still fell below the standards expected of a registered practitioner, as outlined in Dr L’s evidence in that she was unable to provide assurance that Dr Gabriel is safe to practise independently without some form of conditions or supervision remaining in place.

Submissions on behalf of Dr Gabriel

Mr Thomas, Counsel, submitted that Dr Gabriel’s fitness to practise is not currently impaired by reason of deficient professional performance.

Mr Thomas submitted that it is the unanimous view of the Assessment Team in the 2019 Performance Assessment that Dr Gabriel is fit to practise generally, and as this is on the basis of a holistic assessment of his performance using standards and methodologies applied to all doctors undertaking such a Performance Assessment, the conclusions of the assessment the Assessment Team should be considered both calibrated and reliable, and the most cogent and weighted evidence as to Dr Gabriel’s status.

Mr Thomas submitted that for the Tribunal to find Dr Gabriel’s fitness to practise to be currently impaired, would be to impose a higher standard than that which is required of the general GP population.

Mr Thomas went on to submit that whilst there are areas of Dr Gabriel’s performance that were identified as areas of concern and requiring improvement, these findings are considered and included within the panel’s overall assessment of Dr Gabriel’s fitness to practise. Further to this, Mr Thomas submitted that Dr K explicitly confirmed in his verbal testimony that those areas identified as concerns or requiring improvement do not amount to impairment.

Mr Thomas submitted that the overall conclusion of the Assessment Team in the 2019 Performance Assessment is that there are no concerns relating to patient safety, and to consider individual components of this Performance Assessment in isolation in order to undermine the unanimous findings would not be fair or
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appropriate. He stated that to do so would be to circumvent the approved process of assessment and hold Dr Gabriel to a different standard than his peers, and the Tribunal should be minded not to reinterpret the findings of the assessors for this reason.

42. Mr Thomas submitted that in relation to Dr L’s evidence and the areas requiring further improvement identified within Dr Gabriel’s Record Keeping and clinical administration, the evidence provided by Dr Gabriel in the form of assessments and draft PDPs, supported by Dr L, demonstrates that Dr Gabriel has been pro-actively addressing these concerns and activities have been or are in the process of being undertaken to remediate appropriately.

43. Mr Thomas submitted that by Dr L’s own admission, she had been unable to assess Dr Gabriel’s current progress in the areas of documentation and clinical administration due to internal computer system issues currently being experienced by their practice. He stated that even if there are areas of improvement in Dr Gabriel’s practise which require further work to remediate, such ongoing development and performance matters do not constitute material evidence contradicting the 2019 Performance Assessment.

44. Whilst Dr Gabriel’s performance in these areas may be below that of his colleagues at the practice in the opinion of Dr L, this is not the measure by which his fitness to practise should be assessed.

The Relevant Legal Principles

45. The Tribunal had regard to the advice given by the Legally Qualified Chair as a matter of record. It was reminded that at this stage of proceedings, there is no formal burden or standard of proof and the decision on impairment is a matter for the Tribunal’s judgment alone.

46. In approaching its decision, the Tribunal was mindful of the two-stage process to be adopted: first, whether the facts as found proved amounted to serious deficient professional performance. If so, it must then consider whether Dr Gabriel’s fitness to practise is currently impaired by reason of such deficient professional performance.

47. At both stages of the process, the Tribunal was mindful of the overarching objective of the GMC set out in section 1 of the Medical Act 1983 (as amended) which requires the Tribunal to:

- Protect, promote and maintain the health, safety and well-being of the public,
- Promote and maintain public confidence in the medical profession, and
c. Promote and maintain proper professional standards and conduct for members of that profession.

48. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as adopted by the High Court in CHRE v NMC and Paula Grant [2011] EWHC 297 Admin. In particular, the Tribunal considered whether its findings of fact showed that Dr Gabriel’s fitness to practise is impaired in the sense that he:

   a. ‘Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

   b. Has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

   c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; [...]’

49. The Tribunal bore in mind that it must determine whether Dr Gabriel’s fitness to practise is currently impaired by reason of deficient professional performance, taking into account his conduct at the time of the events and any other relevant factors such as any development of insight, whether the matters are remediable or have been remedied and the likelihood of repetition.

The Tribunal’s Determination on Impairment

50. In considering the question of impairment, the Tribunal has taken account of all the evidence, both oral and documentary, and the submissions of Ms Kitchin, on behalf of the GMC, and Mr Thomas, on behalf of Dr Gabriel. It also took into account the other documentary evidence provided including Dr Gabriel’s PDP, appraisals from 2014 to 2019, audit of patient records and various testimonials, and in particular the evidence of Dr L.

Deficient Professional Performance

51. The Tribunal first considered whether Dr Gabriel’s actions amounted to deficient professional performance. It had regard to its findings of fact and the 2013 and 2016 Performance Assessment.

52. The Tribunal considered the paragraphs of GMP which set out the standards that a doctor must continue to meet throughout their professional career.

53. The Tribunal considered that the 2016 Performance Assessment Report was a complete and full assessment of a fair sample of Dr Gabriel’s practice. It accepted
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the conclusion of the Performance Assessment that Dr Gabriel’s performance was significantly deficient in a number of important areas of practice. In particular he had received unacceptable performance ratings in Maintaining Professional Performance, Relationships with Patients and the Performance Assessment had found cause for concern in the following areas: Assessment of Patient’s Condition; Clinical Management; and Record Keeping. In addition, the Tribunal noted that Dr Gabriel had failed to meet the appropriate standard score in the Knowledge Test.

54. The 2016 Assessment Team unanimously stated that Dr Gabriel ‘is not fit to practise’. Further, the 2016 Assessment Team stated that not only did Dr Gabriel fail the 2016 Performance Assessment, they stipulated that he was not going to be able to meet the standard because this was his second attempt at undertaking a GMC Performance Assessment and that his performance was so far below the standards expected of a GP that he would not reach independent practice in the future.

55. The Tribunal took the 2016 Performance Assessment as a definitive and fair assessment of Dr Gabriel’s working practise at that time. It accepted the 2016 Assessment Team’s conclusions, and Dr Gabriel’s own admissions that his professional performance was deficient.

56. Taking into account all of the above, the Tribunal was satisfied that Dr Gabriel’s professional performance was deficient at the time of the 2016 Performance Assessment.

Impairment by reason of Deficient Professional Performance

57. Having found that the facts found proved amounted to deficient professional performance, the Tribunal went on to consider whether, as a result of this, Dr Gabriel’s fitness to practise is currently impaired by reason of his deficient professional performance.

58. Dr Gabriel’s performance in the categories of Maintaining Professional Performance and Relationships with Patients was found to be unacceptable in the 2016 Performance Assessment, and Assessment of Patients Condition was found to be a cause for concern. All of these were found to be acceptable by the 2019 Performance Assessment. The Tribunal had concerns that no improvement in Dr Gabriel’s performance in the areas of Clinical Management and Record Keeping had had been demonstrated over the period.

59. In the results of the 2019 Performance Assessment, in particular the Tribunal noted the following objective assessments:

- In the Knowledge Test, Dr Gabriel had recorded a score which was just over the hypothetical ‘just passing’ doctor.
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• Out of the twelve OSCE stations, Dr Gabriel was below the median in five stations and in two stations was below the 25th percentile.

• Out of the ten simulated surgeries, Dr Gabriel was below the median in four stations and in four stations was below the 25th percentile.

60. The Tribunal noted the findings of the 2019 Performance Assessors that there remains ‘cause for concern’ in terms of Dr Gabriel’s Record Keeping and Clinical Management. The definition of ‘cause for concern’ is that there is evidence that Dr Gabriel’s performance may not be acceptable in these areas but in the view of the Performance Assessors there is not sufficient evidence to suggest deficient professional performance.

61. The Tribunal, in reaching its decision as to current impairment took into account the findings of the 2019 Performance Assessment but set these into the context of the background history relating to the 2013 and 2016 Performance Assessments and in particular the finding of facts in relation to the 2016 Performance Assessment. The Tribunal took into account that the 2019 Performance Assessment did not consider or address historic concerns or the long-term context of Dr Gabriel’s Performance Assessments.

62. The Tribunal, having heard evidence from Dr P and Dr K considered that the 2019 Performance Assessment had focused particularly on Dr Gabriel and his practice within his current position at The Orchard Practice. It was mindful that a finding of no impairment would mean that Dr Gabriel would be regarded as fit to practise without restriction in any context, including ‘out of hours’ and as a locum. Having heard from the Performance Assessors, the Tribunal was not satisfied that this had been fully considered.

63. In addition to the existing documentation and evidence, the Tribunal was mindful of further oral evidence provided by Dr L, which highlighted Dr Gabriel’s Record Keeping and clinical administration as outstanding areas of concern or requiring further work to address.

64. The Tribunal noted the concerns that there had been at the time of the 2019 Performance Assessment in relation to Dr Gabriel’s Clinical Management. This was corroborated by Dr L’s non-verbatim recorded responses in the interview conducted by Dr K:

‘Dr L stated that he [Dr Gabriel] needs work on his chronic disease management likening this to early stage registrars.’

‘Dr L indicated Dr Gabriel would be suitable for on-going supervision with conditions while he continues to make improvements, which can be seen as an
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assessment from a colleague that he is not ready for independent unsupervised practice.’

65. In the Third Party Interview during the 2019 Performance Assessment, Dr L provided the following (non-verbatim recorded) response about Dr Gabriel’s performance regarding chronic disease management:

Dr K’s question:

‘So you think it is still work in progress?’

Dr L’s response:

‘I personally do, yes, yes.’

Dr K’s question:

‘I am sorry. Can you just expand on the last bit about work in progress?’

Dr L’s response:

‘Well, I think he’s continuing to improve, yes, and assuming he stays under clinical supervision, you know, we will continue to work on it.’

66. In her oral evidence, Dr L stated that she no longer has concerns about Dr Gabriel’s Clinical Management in view of the improvements he had demonstrated since the 2019 Performance Assessment.

67. The Tribunal placed significant weight on the evidence of Dr L, who is Dr Gabriel’s Clinical Supervisor and has worked with him closely over a two-year period.

68. The Tribunal noted that Dr L stated that Dr Gabriel’s Record Keeping requires further development and his clinical notes are not always sufficiently clear to his colleagues when handing over patients or picking up follow-on activities. The Tribunal was concerned that there could still remain a residual risk to patient safety as a result of inadequate Record Keeping and clinical administration on the part of Dr Gabriel.

69. In reference to Record Keeping the Summary of the 2019 Performance Assessment states:

‘There were repeated instances of medical records where the medical assessors could not understand the working diagnosis or the management plan due to brief or poorly structured entries in the medical records. There were further records where the clinical findings were unclear.’
In MRR 42, a patient who came for a mole check, the record contained mention of the '7 point checkpoint’ but didn’t actually give any information about the size or character of the mole, and so it would be impossible for a clinician subsequently seeing the patient to know if the mole had changed.’

In relation to this, Dr P stated:

‘This entry doesn’t record any of the necessary information such as size and character of the lesion. It would make it impossible for a subsequent clinician to know if the lesion had changed.’

Further, the Record Keeping summary also states:

'The documentation of management plans was sparse in MRR 05, 19, 34 and 40, and was judged to be unacceptable (MRR61-20, MRR90-20, MRR96-24).

Many of the records lacked a standard structure such as using headings of history, examination, impression and plan. Examples of this were found in MRR 01, 02, 24 and MRR 36 (MRR57-100, MRR58-100, MRR80-100, MRR92-100). These were judged to be unacceptable.’

70. Taking the above into account, the Tribunal considered these ongoing inadequacies in Dr Gabriel’s Record Keeping in light of the GMP guidance on the expected requirements of a practitioner, namely paragraphs 19 and 21:

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

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

c. the information given to patients

d. any drugs prescribed or other investigation or treatment

e. who is making the record and when.’
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71. Dr Gabriel’s Record Keeping and clinical administration remain areas of concern for the Tribunal. The area of Record Keeping was initially identified back in 2013 and remains a concern in 2019, and there is a lack of demonstrable steps on Dr Gabriel’s behalf to address this. The Tribunal noted that no meaningful remediation activities or development courses were undertaken by Dr Gabriel in relation to Record Keeping.

72. The Tribunal concluded that whilst the Performance Assessors did not find unacceptable performance, it is for the Tribunal to make its judgement in the context of all the available information. The Tribunal noted that these concerns have been going on for a substantial period of time and appear to only just be being addressed by Dr Gabriel within his Personal Development Plan which was submitted to this hearing as an exhibit.

73. The Tribunal was mindful that these assessments have been going on for a number of years, with evidence that Dr Gabriel has been making progress only on a reactive basis over a very extended period.

74. In the view of the Tribunal an independent practitioner is expected to be a self-directed learner. The Tribunal was minded of paragraphs 8 and 13 of the GMP, which state:

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

13 ‘You must take steps to monitor and improve the quality of your work.’

75. The Tribunal was of the view that Dr Gabriel appears to be a largely reactive learner based on the feedback of his educational and clinical supervisors rather than a self-directed learner who would independently develop and maintain professional performance.

76. The Tribunal considered that the public expects to be treated properly by doctors with their cases assessed adequately. They expect doctors dealing with their cases to adhere to the principles set out in GMP. Where doctors fail to do that it undermines public trust in the profession. The Tribunal throughout these matters had applied the standards applicable to all doctors as set out within GMP. In the Tribunal’s view Dr Gabriel is not yet fit for unrestricted practise in all circumstances, including ‘out of hours’ and as a peripatetic locum.

77. The Tribunal was of the view that whilst the areas of Dr Gabriel’s practice found to be unacceptable had improved by the 2019 Performance Assessment, the Tribunal had to judge whether Dr Gabriel was liable in the future to either put patients at unwarranted risk of harm, bring the profession into disrepute or breach any of its fundamental tenets. On the evidence provided, in view of his past failings recorded in the 2016 Performance Assessment and the causes for concern noted in
the 2019 Performance Assessment, the Tribunal judged that there remained a likelihood of continued failings in the areas of Record Keeping, and as raised by Dr L, clinical administration. Such failings risked undermining public confidence in the profession and its standards, leading to a risk that the profession may be brought into disrepute.

78. Therefore, in all the circumstances of this case, the Tribunal determined that in order to:

a. Protect, promote and maintain the health, safety and well-being of the public,

b. Promote and maintain public confidence in the medical profession, and

c. Promote and maintain proper professional standards and conduct for members of that profession.

it found that Dr Gabriel’s fitness to practise is currently impaired by reason of deficient professional performance.

**Determination on Sanction - 19/09/2019**

1. Having determined that Dr Gabriel’s fitness to practise is impaired by reason of his deficient professional performance, the Tribunal moved to consider what sanction, if any, it should impose with regard to Dr Gabriel’s registration.

**The Evidence**

2. The Tribunal had regard to all of the evidence, both oral and documentary adduced during the course of these proceedings.

**Submissions**

3. The submissions made by both Counsel at the close of the sanction stage are a matter of record and the following is a summary of those submissions.

**Submissions on behalf of the GMC**

4. Ms Kitchin submitted that it would be necessary and proportionate to impose an order of conditions on Dr Gabriel’s registration, given the circumstances of this case. She directed the Tribunal’s attention to the Sanctions Guidance (February 2018 edition)("SG") when making its determination. She submitted that no lesser sanction would adequately meet all three limbs of the statutory overarching objective.
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5. Ms Kitchin reminded the Tribunal of its findings of the two areas of Dr Gabriel’s practice which remain areas of concern: Record Keeping and clinical administration. She stated that those are key skills and areas of competency that are required and expected of a registered practitioner. It is therefore necessary that a period of conditions be imposed in order to protect public safety, maintain public confidence in the profession and ensure suitable standards of professional conduct are maintained.

6. Ms Kitchin submitted that progress has been made by Dr Gabriel and his actions so far demonstrate that he does have some understanding of insight into the issues and has made attempts at remediation. Whilst this engagement by Dr Gabriel is acknowledged, it is the position of the GMC that further remediation is clearly necessary before Dr Gabriel can be considered fit to practise independently and without supervision.

7. Ms Kitchin submitted that there are no exceptional circumstances in this case and that whilst the 2019 Performance Assessment considered Dr Gabriel fit to practise, a finding of impairment due to his Clinical Supervisor contradicting this conclusion is appropriate and not exceptional. Therefore, the least restrictive and most appropriate sanction would be a period of conditions as outlined.

Submissions on behalf of Dr Gabriel

8. Mr Thomas submitted that taking no action would be the appropriate and proportionate course of action in these specific circumstances and reminded the Tribunal that they are not compelled to impose a sanction even where impairment has been determined, referring them to the relevant guidance outlined in the SG.

9. Mr Thomas further submitted that the Tribunal should not just consider whether imposing conditions would be appropriate, but rather whether they are necessary, submitting that in this case they are not.

10. Mr Thomas stated that undertakings have been in place for five years and that Dr Gabriel has adhered to these and has delivered against the requirements established through these undertakings and prior Performance Assessments. These undertakings have been demonstrated as effective and, given that there are only remaining residual issues in two specific areas, it would be pragmatic to continue with this course of action. However, he said, the GMC have now changed their stance on Dr Gabriel’s case and seek the imposition of conditions as opposed to maintaining the existing and effective undertakings. The failure of the GMC to accept undertakings, he said, was an exceptional circumstance which would justify taking no action.

11. It was the submission of Mr Thomas that the evidence provided support for the view that no action is necessary, given that the areas of Dr Gabriel’s practice
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identified as ‘Unacceptable’ in the 2013 and 2016 Performance Assessments have been addressed such that the Performance Assessors have unanimously rated Dr Gabriel as generally fit to practise. Dr Gabriel’s performance in the areas of Record Keeping and Clinical Management were assessed as being a ‘Cause for Concern’ within the 2019 Performance Assessment and Dr L confirmed in her verbal evidence that she no longer has concerns regarding Dr Gabriel’s performance in relation to Clinical Management.

12. Mr Thomas reminded the Tribunal that the 2019 Performance Assessment concluded that there was no evidence of patients being placed at risk of harm and importantly they did not find patterns of poor performance that would place patients at risk.

13. Mr Thomas then submitted that Dr K considered Dr Gabriel’s performance as falling just within the category of fit to practise. On this basis, Mr Thomas argued, if the Tribunal deemed Dr Gabriel’s fitness to practise is impaired it should be considered as falling just outside the threshold of fit to practise.

14. Mr Thomas stated that development plans are in place and remediation is well underway in relation to both Record Keeping and clinical administration. He said that the latter was not an issue raised by any of the Performance Assessments and only came to the Tribunal’s attention as a result of Dr L’s verbal evidence. Nonetheless, Dr Gabriel is already in the process of working with Dr L to remediate any shortcomings in this area. It is the view of Dr L, as stated in her verbal evidence, that both these aspects will be addressed in the short-term through the plans and activities currently in place and that a further period of 3 months supervision and support should be sufficient to do so.

15. Mr Thomas submitted that the two areas of concern identified are distinct and specific areas of practice as opposed to broader, global issues relating to Dr Gabriel’s fitness to practice. There is no evidence that these remaining concerns are not fully remediable and activities to do so are well underway. Further to this, Dr Gabriel’s insight, engagement and improvement to date demonstrate that he will continue this course even without the imposition of a sanction.

16. Mr Thomas further submitted that it would not be expected that any medical practitioner would have no gaps whatsoever in their knowledge or performance. To restrict Dr Gabriel’s practice on the basis of the remaining concerns would therefore not be proportionate, particularly given that remediation is well underway.

17. Mr Thomas went on to submit that there are exceptional circumstances in this case, namely that the Tribunal’s finding of impairment was not in agreement with the conclusions of the 2019 Performance Assessment that Dr Gabriel is generally fit to practise. Further, the concerns only relate to two specific areas of his performance and are not considered unacceptable, and that Dr Gabriel is well along
an established pathway of remediation. He further submitted that these circumstances justified the Tribunal taking no action in relation to Dr Gabriel’s registration.

18. Mr Thomas stated that the issue of Dr Gabriel’s competency regarding computer systems is being addressed within his PDP and that Dr L stated the Orchard Practice is currently experiencing issues with its computer systems. This, while not excusing any shortcomings on Dr Gabriel’s part clearly exacerbated the issue. It was Dr L’s evidence that these performance issues may have already been remediated but due to the computer issues she has not been able to formally assess Dr Gabriel’s current position and performance.

19. Mr Thomas maintained that whilst Dr L has been supportive of Dr Gabriel and the undertakings agreed between him and the GMC, the requirements on her as Dr Gabriel’s Clinical Supervisor are nonetheless a burden and that to impose unnecessary conditions would further impact her time management, efficiency and availability. This would continue to impact the wider Orchard Practice, both in terms of fellow colleagues and patients.

20. Mr Thomas submitted that Dr Gabriel has been working to agreed undertakings for five years, and whilst this has been stressful and challenging Dr Gabriel has engaged positively and continues to do so, but the imposition of a sanction would unnecessarily compound this. Further, whilst sanctions may in effect be punitive, where the imposition of a sanction is neither necessary or proportionate this would be an unreasonable determination and not in the best interests of either the public or Dr Gabriel.

21. In the alternative Mr Thomas said that if his primary submission as to taking no action was not accepted, the Tribunal could consider conditions and he took the Tribunal through the current undertakings, suggesting that there should be some adaptation of these. He said that if the Tribunal imposed conditions a period of three months would be sufficient.

The Relevant Legal Principles

22. The Tribunal took into account all of the submissions, its findings and the documentary evidence adduced during the course of these proceedings.

23. The Tribunal accepted the advice given by the Legally Qualified Chair.

24. The decision as to the appropriate sanction is a matter for this Tribunal’s own independent judgement. In reaching its decision the Tribunal took into account the SG and the statutory overarching objective, which includes the need to:
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a. Protect, promote and maintain the health, safety and well-being of the public,

b. Promote and maintain public confidence in the medical profession, and

c. Promote and maintain proper professional standards and conduct for members of that profession.

25. The Tribunal recognised that the purpose of a sanction is not to be punitive, although it may have a punitive effect. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Gabriel’s interests with the public interest.

The Tribunal’s Determination on Sanction

Aggravating and Mitigating Factors

Mitigating Factors

26. The Tribunal has identified the following mitigating factors:

- Evidence that when issues have been raised, Dr Gabriel has responded positively to feedback and a willingness to engage with professional development and colleagues to improve his clinical practice;
- Evidence that Dr Gabriel has been keeping up-to-date with his clinical skills and clinical practice;
- Dr Gabriel’s 2019 Performance Assessment was an improvement from the 2013 and 2016 Performance Assessment, where his scores have predominantly moved from ‘Unacceptable’ to ‘Acceptable’ and/or ‘Cause for concern’;
- Dr Gabriel has remediated some areas in his practice where deficiencies had been identified by previous Performance Assessments; and
- No direct evidence of patient safety issues.

Aggravating Factors

27. The Tribunal balanced those mitigating factors with the following aggravating factors:

- Identified failings in areas of Dr Gabriel’s practice which have remained a live issue throughout these proceedings and which he has failed to remediate, as outlined in the 2013, 2016 and 2019 Performance Assessments;
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- Dr Gabriel’s Record Keeping and clinical administration created a potential risk to patient safety; and
- Dr Gabriel’s failings in regard to Record Keeping and clinical administration are both fundamental areas of a GP clinical practise and are serious failings of the standards outlined in GMP, specifically paragraphs 8, 13, 19 and 21 as set out above;
- The length of time which it has taken Dr Gabriel to remediate deficiencies in his professional performance; and
- In her evidence at stage two of these proceedings, Dr L raised new issues of failings in Dr Gabriel’s clinical practice.

The Tribunal’s Decision

28. In deciding what sanction, if any, to impose, the Tribunal reminded itself that it must consider each of the sanctions available, starting with the least restrictive, to establish which is appropriate and proportionate in this case.

No Action

29. The Tribunal first considered whether to conclude the case by taking no action.

30. The Tribunal determined that there were no exceptional circumstances in this case which would justify taking no action. It did not accept the submission that there was an exceptional circumstance in its having not accepted the findings of the 2019 Performance Assessment that Dr Gabriel was generally fit to practise. In the Tribunal’s view any exceptional circumstance had to relate to its findings regarding Dr Gabriel’s fitness to practise, rather than any difference between those findings and any other evidence.

31. The Tribunal determined that given its findings at the impairment stage of the proceedings it would not be appropriate to conclude the case by taking no action, there being no exceptional circumstances. The Tribunal had identified failings, which whilst limited to two areas were serious and involved the public interests in patient protection and maintaining public confidence in the profession. To take no action would not adequately address these public interests.

Undertakings

32. The Tribunal noted that undertakings were agreed with Dr Gabriel some years ago and he has been subject to those undertakings to-date. It was told that Dr Gabriel has not breached those undertakings and continues to adhere to them in their entirety. The Tribunal was informed that Dr Gabriel had offered undertakings at this stage of the proceedings, but these have not been agreed to by the GMC following the finding of impairment.
33. In the course of hearing submissions, the Tribunal was provided with a copy of the current undertakings. The Tribunal considered that the undertakings on Dr Gabriel’s registration appeared to be appropriate. However, according to the Rules since there had been no agreement between the GMC and the doctor, the matter of undertakings was not something that the Tribunal could take into account further in the proceedings in relation to the matter of taking no action.

34. Given that the current undertakings appear to be relevant, it was a matter of regret that there had not been an agreement on behalf of the GMC for the undertakings to remain in place and/or new specific undertakings being formulated. However, this was not a matter for further consideration by the Tribunal. It had to proceed further on the basis of the facts found and to consider imposing any appropriate sanction in order to satisfy the statutory overarching objective.

35. The Tribunal did not consider that the lack of an agreement reached as to undertakings could be an exceptional circumstance justifying it taking no action.

36. The Tribunal was mindful of para 68 and 69 of the Sanctions Guidance:

   68 ‘Where a doctor’s fitness to practise is impaired, it will usually be necessary to take action to protect the public (see paragraphs 14–16). But there may be exceptional circumstances to justify a tribunal taking no action.’

   69 ‘To find that a doctor’s fitness to practise is impaired, the tribunal will have taken account of the doctor’s level of insight and any remediation, and therefore these mitigating factors are unlikely on their own to justify a tribunal taking no action.’

It had found it was not appropriate to take no action and had identified at the impairment stage failings which involved the public interest as set out above. It therefore concluded it was necessary to take action in respect of Dr Gabriel’s registration and therefore moved on to consider the next available sanction of imposing conditions.

Conditions

37. The Tribunal then considered whether imposing an order of conditions on Dr Gabriel’s registration would be appropriate. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable. The Tribunal had regard to paragraphs 81, 82, 83 and 84 of the SG, that state:

   81 'Conditions might be most appropriate in cases:

   […]
b. involving issues around the doctor’s performance

c. where there is evidence of shortcomings in a specific area or areas of the doctor’s practice’

82 ‘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.’

83 ‘When deciding whether remedial training is possible, the tribunal needs to consider any objective evidence that has been submitted. For example, assessments of the doctor’s performance […]’

84 ‘Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:

a. a no evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor’s unwillingness to engage

b. identifiable areas of their practice are in need of assessment or retraining

c. willing to respond positively to retraining, with evidence that they are committed to keeping their knowledge and skills up to date throughout their working life, improving the quality of their work and promoting patient safety (Good medical practice, paragraphs 7–13 on knowledge, skills and performance and paragraphs 22–23 on safety and quality)

[…]’

The Tribunal applied the above extracts of the SG to the facts found in this case.

38. In its impairment determination, the Tribunal had stated that Dr Gabriel’s engagement has been reactive rather than proactive and still requires encouragement with his professional development. The Tribunal found that Dr
Gabriel has demonstrated a degree of insight into his clinical failings and continues to engage in remediation of his practice and with the regulatory process.

39. The Tribunal had regard to Dr L’s evidence that Dr Gabriel’s remediation was a ‘work in progress’ and was continuing. She stated that she would expect there to be further improvements in Dr Gabriel’s clinical practice within 3 months and that he has already remedied a number of deficiencies outlined within the 2019 Performance Assessment.

40. The Tribunal accepted that this shows that Dr Gabriel has the potential to respond positively to further re-training and comply with conditions imposed on his registration, as demonstrated by his continued adherence to the undertakings currently in place on his registration.

41. Whilst Dr Gabriel’s deficiencies in Record Keeping and clinical administration remain a live issue in this case, the Tribunal considered that imposition of conditions would adequately protect the public from risk of harm and maintain public confidence in the profession whilst Dr Gabriel continues to improve his clinical practice. The Tribunal took into account that undertakings had allowed Dr Gabriel to continue in practice and there had been no issues about his adherence to them over the past years.

42. General Practitioners working as locums and out of hours may well come across different computer systems and working practices. As there remains cause for concern with respect to Dr Gabriel’s Record Keeping and clinical administration the Tribunal considered restriction in these areas of practice was necessary.

43. In all the circumstances of this case, the Tribunal determined that placing conditions on Dr Gabriel’s registration was an appropriate, necessary and proportionate sanction which would adequately:

   a. Protect, promote and maintain the health, safety and well-being of the public,

   b. Promote and maintain public confidence in the medical profession, and

   c. Promote and maintain proper professional standards and conduct for members of that profession.

44. In determining the duration of Dr Gabriel’s conditions the Tribunal took into account its earlier findings and the guidance set out in the SG. Having done so, it determined that a period of 6 months would be an appropriate period in all the circumstances of this case.
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45. The Tribunal considered that a period of 6 months would allow sufficient time for Dr Gabriel to have made further significant steps in remediating his performance. It understood Dr L’s evidence to be that Dr Gabriel would continue to display further improvement over the next 3 months.

46. Further, the Tribunal determined that an imposed period of conditional registration for 6 months would reflect the gravity of his conduct and send out a clear signal to Dr Gabriel, the profession and the wider public. At the same time it would allow Dr Gabriel sufficient time to further reflect and learn from his failings. On balance the Tribunal felt that any longer period would not be proportionate.

47. The following conditions are not confidential and will be published:

1. He must personally ensure the GMC is notified of the following information within seven calendar days of the date these conditions become effective:
   a. The details of his current post, including:
      i his job title
      ii his job location
      iii his responsible officer (or their nominated deputy)
   b. the contact details of his employer and any contracting body, including his direct line manager
   c. any organisation where he has practising privileges and/or admitting rights
   d. any training programmes he is in
   e. of the organisation on whose medical performers list he is included

2. He must personally ensure the GMC is notified:
   a. of any post he accepts, before starting it
   b. that all relevant people have been notified of his conditions, in accordance with condition 9.
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1. Dr GABRIEL shall:
   c if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings
   d if any of his posts, practising privileges, or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination
   e if he applies for a post outside the UK.

3. He must allow the GMC to exchange information with any person involved in monitoring his compliance with his conditions.

4. a. He must have a workplace reporter appointed by his responsible officer (or their nominated deputy).
   b. He must not work until:
      i. his responsible officer (or their nominated deputy) has appointed his workplace reporter
      ii. he has personally ensured that the GMC has been notified of the name and contact details of his workplace reporter.

5. a He must design a Personal Development Plan (PDP), with specific aims to address the deficiencies in the following areas of his practice:
   Record Keeping
   Clinical Administration (Hospital letters, reports and Pathology results)
   b His PDP must be approved by his responsible officer (or their nominated deputy).
   c He must give the GMC a copy of his approved PDP within three months of these substantive conditions becoming effective.
   d He must give the GMC a copy of his approved PDP on request.
   e. He must meet with his responsible officer (or their nominated deputy), as required, to discuss his achievements against the aims of his PDP.

6. a He must have an educational supervisor appointed by his responsible officer (or their nominated deputy)
7. a He must be supervised in all of his posts by a clinical supervisor, as defined in the Glossary for undertakings and conditions. His clinical supervisor must be appointed by his responsible officer (or their nominated deputy).

b He must not work until:

   i his responsible officer (or their nominated deputy) has appointed his clinical supervisor and approved his supervision arrangements.

   ii he has personally ensured that the GMC has been notified of the name and contact details of his clinical supervisor and his supervision arrangements.

8. He must not work:

   a as a locum

   b out-of-hours

   c on-call.

9. He must personally ensure the following persons are notified of the conditions listed at 1 to 8:

   a his responsible officer (or their nominated deputy)

   b the responsible officer of the following organisations:

      i his place(s) of work, and any prospective place of work (at the time of application)

      ii all of his contracting bodies and any prospective contracting body (prior to entering a contract)

      iii any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application)

      iv if any of the organisations listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within that
organisation. If he is unable to identify that person, he must contact the GMC for advice before working for that organisation.

c the responsible officer for the medical performers list on which he is included or seeking inclusion (at the time of application)

d his immediate line manager and senior clinician (where there is one) at his place of work, at least 24 hours before starting work (for current and new posts, including locum posts).

48. In relation to conditions 6 and 7. In the Tribunal’s view there was no reason that the Educational Supervisor and Clinical Supervisor could not be the same individual. However, this is a matter for Dr Gabriel’s Responsible Officer.

49. The Tribunal considered whether it was necessary to go on to consider suspending Dr Gabriel’s registration, noting that neither Counsel submitted it was necessary. It considered that the imposition of conditional registration would satisfy all three limbs of the statutory overarching objective. It would also allow Dr Gabriel to continue in practise. Therefore, an order of conditions was the proportionate order and it was unnecessary to go further and consider suspension.

Review Hearing

50. The Tribunal has directed that, shortly before the end of the period of Dr Gabriel’s conditional registration, his case will be reviewed by a Medical Practitioners Tribunal. This Tribunal considered that a future reviewing Tribunal would be assisted by:

- An audit of Dr Gabriel’s Medical Records;
- A report from Dr Gabriel’s nominated Clinical Supervisor specifically commenting on Dr Gabriel’s Record Keeping and clinical administration and any other matters he/she feels are appropriate;
- A copy of Dr Gabriel’s Personal Development Programme;
- Any evidence of Dr Gabriel’s engagement in reflective practice; and
- Up-to-date testimonials from medical peers.

It is also open to Dr Gabriel’s to provide any other evidence he considers helpful.

**Determination on Immediate Order - 19/09/2019**

1. Having determined to impose an order of conditions on Dr Gabriel’s registration for a period of 6 months, the Tribunal considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.
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Submissions

2. Ms Kitchin submitted that an immediate order of conditions would be appropriate in this case to protect patients and is in the public interest. She stated that the imposition of an immediate order could be supported by the Tribunal’s findings in that it has concluded that ongoing supervision is required.

3. Mr Thomas submitted that an immediate order would be appropriate in the circumstances of this case. However, he stated that it is not necessary to protect the public and that it would be in the public interest and the wider interest of Dr Gabriel. He stated that substantive conditions would effectively replace Dr Gabriel’s undertakings and are appropriate.

The Tribunal’s Decision

4. In reaching its decision, the Tribunal has exercised its own judgment, and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public or otherwise in the public interest, or is in the best interests of the practitioner. It has also borne in mind the guidance given in the relevant paragraphs of the SG relating to immediate orders.

5. The Tribunal determined that in light of its findings and the particular circumstances of this case, an immediate order of conditions was appropriate and necessary. It determined that this was necessary to protect the health, safety and wellbeing of the public; maintain public confidence in the profession; and to uphold and maintain proper professional standards.

6. In relation the immediate order only, his employment at The Orchard Practice only, and conditions 4bi and ii, and 7bi and ii, the Tribunal deemed these conditions to have been satisfied by the current arrangement of Dr L acting as Dr Gabriel’s Clinical Supervisor, in respect to his employment at The Orchard Practice.

7. The effect of this order is that Dr Gabriel’s registration will be subject to an order of conditions from the date when written notice of this decision is deemed to have been served upon him.

8. That concludes this case.

Confirmed
Date 19 September 2019

Mr Paul Moulder, Chair
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Determination on Adjournment – 30/11/2017

Dr Gabriel:

1. The Tribunal is adjourning this case part heard today on the grounds of insufficient time to conclude the proceedings during the in camera consideration of facts.

2. At this stage, recognising that Dr Gabriel has admitted allegations 1 and 4, and have therefore been found proved by the Tribunal, and noting the date for handing down the determination, and acting pursuant to Rule 16(1A)(b), this Tribunal made the following directions:

   1. The parties shall provide to the MPTS and exchange between themselves the following by 5 March 2018:

      • Copies of any documentation it seeks to rely upon in relation to any potential further stages of the hearing;
      • Copies of any witness statements of witnesses it intends to rely upon in relation to any potential further stages of the hearing;
      • Details of any agreement, or alternative skeleton arguments, concerning any application for evidence by Video Link or Telephone Link or any witnesses;
      • Skeleton arguments on any other preliminary issue.

3. The hearing is now adjourned and the Tribunal will resume in camera on Monday 29 January 2018 at 9.30am to continue its consideration of the facts. Parties are asked to attend from 12pm on Tuesday 30 January 2018.

Determination under Rule 17(7) – Whether to Adjourn and Direct a Further Performance Assessment – 06/07/2018

1. The Tribunal convened to consider whether Dr Gabriel’s fitness to practise is currently impaired by reason of his deficient professional performance, and had previously made its determination on the Facts of this case.

2. At the impairment stage of these proceedings, before making a determination, the Tribunal indicated to parties that it was contemplating using its power to adjourn the hearing under Rule 17(7) of the Rules. Rule 17(7) states:

   'At any stage in the proceedings, before making a determination that a practitioner's fitness to practise is impaired, the Medical Practitioners Tribunal may, having regard to the nature of the allegation under consideration, adjourn and direct that -
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(a) an assessment of the practitioner’s performance or health be
carried out in accordance with Schedule 1 or 2; or...

3. The Tribunal invited submissions from both Ms Kitchin, Counsel, on behalf of the GMC and Mr Kennedy, Counsel, on behalf of Dr Gabriel, on the issue of whether to adjourn and direct a further Performance Assessment (‘PA’).

Submissions

Submissions on behalf of the GMC

4. Ms Kitchin opposed any adjournment of the hearing. However, she submitted that it is a matter for the Tribunal to determine and reminded it that Dr Gabriel has admitted that he is currently impaired by reason of deficient professional performance.

5. Ms Kitchin submitted that Dr Gabriel is not capable of remediating further and a direction for him to undertake another PA is unnecessary.

Submissions on behalf of Dr Gabriel

6. Mr Kennedy submitted that Dr Gabriel is not adverse in principle to undertake a further performance assessment. However, he submitted that if the Tribunal was to reach the Sanction stage of these proceedings, his submission would likely be to invite the Tribunal to impose conditions on Dr Gabriel’s registration (equivalent to his current undertakings) and direct a further PA as part of any such conditions.

7. Mr Kennedy directed the Tribunal’s attention to paragraph 19(a) of Guidance for Medical Practitioners Tribunals on adjourning to direct an assessment or for further information or reports to be obtained’ (May 2018), that states:

19 'The tribunal should always consider whether there are any reasons that a performance assessment is not appropriate or necessary, and these reasons may include:

   a. the doctor has completed a GMC performance assessment and there is no reason to believe that the doctor’s performance has changed;...

8. Mr Kennedy submitted that the evidence the Tribunal has received from Dr L, current Clinical Supervisor, indicated that Dr Gabriel is a ‘work in progress’.

9. Mr Kennedy submitted that to direct a further PA now could lead to it being undertaken in 6 months which he submitted was potentially ‘too tight’ and may limit Dr Gabriel’s chance of success at that PA. If the matter were to progress to the
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Sanction stage, the imposition of a PA through conditions on Dr Gabriel’s registration could mean that he would undertake it in approximately 18 months’ time, as opposed to 6 months. His submission was to postpone a consideration of a further PA to the Sanction stage if the hearing proceeds to that stage.

The Tribunal’s Decision

10. The Tribunal then considered whether it should adjourn and direct a further assessment of Dr Gabriel’s professional performance. This was a matter for the Tribunal’s own judgement.

11. In doing so, it took into account ‘Guidance for Medical Practitioners Tribunals on adjourning to direct an assessment or for further information or reports to be obtained’ (May 2018) and ‘Guidance for decision makers on directing a performance assessment’.

12. The Tribunal has borne in mind the statutory over-arching objective, which includes to:

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

13. The Tribunal noted the admission on Dr Gabriel’s behalf, during the impairment stage submissions, that he is currently impaired by reason of his deficient professional performance.

14. The Tribunal considered that a PA is the standard assessment when there is a concern regarding the competency of a Medical Practitioner. It was of the view that, in conjunction with the statutory over-arching objective, the public requires a doctor to have the requisite skills to practise medicine. It noted that Dr Gabriel has been involved in regulatory proceedings regarding his deficient professional performance for approximately 4 years. The Tribunal noted that Dr J, his Educational Supervisor, stated that Dr Gabriel was fit to practice independently, yet Dr L did not.

15. The Tribunal noted contradictory evidence as between the objective PA of 2016 and the recent observations of colleagues and feedback from patients.

16. The Tribunal notes it is for the Tribunal alone to determine the issue of impairment. The test of impairment is a two stage test, first determining whether the facts as found proved amount to deficient professional performance and
secondly, whether that deficient professional performance could lead to a finding of impairment. The Tribunal considered if it was to make a determination on impairment, it should take into account relevant factors such as whether the matters are remediable, have been remedied, and any likelihood of repetition.

17. The Tribunal considered that a further PA could provide it with the evidence it requires for it to make a decision on whether Dr Gabriel’s fitness to practice is currently impaired. No evidence has been provided that should limit his ability to prepare for or focus upon a PA.

18. The Tribunal cannot be satisfied that any alleged deficiencies in Dr Gabriel’s current professional performance have been addressed so as to obviate the need for a further PA and would assist a future determination on impairment.

19. The Tribunal considered that members of the medical profession would expect colleagues to have the requisite levels of performance and knowledge demonstrating a sufficient professional standard, and that a doctor should be able to remediate over the period Dr Gabriel has had to date, and will have leading up to any further assessment. In absence of such objective assessment as a PA, there could be a potential impact on health, safety and wellbeing of the public, although the Tribunal notes that there has been no indication of a risk to the public to date, given the supervision in place.

20. Furthermore, it considered public confidence in the profession could be diminished if a determination on impairment was made now without an up to date indication of performance, particularly in light of the contradictory evidence as indicated above.

21. In all the circumstances and having borne in mind the statutory over-arching objective, the Tribunal is satisfied that it is appropriate and necessary for this hearing to be adjourned and it directs that a new PA of Dr Gabriel’s professional performance should be undertaken.

**Determination on: (1) Performance Assessment Directions; and (2) Directions under Rule 16(1A)(b) – 06/07/2018**

1. The Tribunal has already determined that this hearing should be adjourned to allow for a further assessment of Dr Gabriel’s professional performance to be carried out.

**Performance Assessment Directions**

2. After receiving submissions from both Counsel, the Tribunal has made the directions in the form below.
**Tribunal directions**

### Hearing details

<table>
<thead>
<tr>
<th>Hearing</th>
<th>Dr Nagy GABRIEL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing Dates</strong></td>
<td>21 November 2017 to 30 November 2017 (Adjourned)</td>
</tr>
<tr>
<td></td>
<td>29 January 2018 to 30 January 2018 (Adjourned)</td>
</tr>
<tr>
<td></td>
<td>4 July 2018 to 10 July 2018 (Adjourned)</td>
</tr>
<tr>
<td><strong>Adjourned on</strong></td>
<td>6 July 2018</td>
</tr>
<tr>
<td><strong>Reconvene date(s)</strong></td>
<td>17 June 2019 to 28 June 2019</td>
</tr>
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### Parties details

<table>
<thead>
<tr>
<th><strong>GMC Details</strong></th>
<th>Represented by Ms Louise Kitchin, Counsel, instructed by GMC Legal Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor Details</strong></td>
<td>Dr Gabriel is present and represented by Mr Andrew Kennedy, Counsel, instructed by RadcliffesLeBrasseur</td>
</tr>
</tbody>
</table>
Directions

Performance assessment

<table>
<thead>
<tr>
<th>Direction</th>
<th>GMC due date</th>
<th>Doctor due date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 GMC to issue the doctor with a Performance Assessment Portfolio</td>
<td>6 August 2018</td>
<td></td>
</tr>
<tr>
<td>2 Doctor to return fully completed Performance Assessment Portfolio</td>
<td></td>
<td>14 September 2018</td>
</tr>
<tr>
<td>3 GMC to appoint Performance Assessment Team</td>
<td>5 October 2018</td>
<td></td>
</tr>
<tr>
<td>4 Assessment dates scheduled and confirmed</td>
<td>26 October 2018</td>
<td>26 October 2018</td>
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<tr>
<td>5 Assessment to be completed by</td>
<td>16 January 2019</td>
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</tr>
<tr>
<td>6 Report review date</td>
<td>20 February 2019</td>
<td></td>
</tr>
<tr>
<td>7 Report finalised by</td>
<td>20 March 2019</td>
<td></td>
</tr>
<tr>
<td>8 GMC to disclose assessment report to the doctor</td>
<td>3 April 2019</td>
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</tbody>
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3. The Tribunal has directed that the parties will attend a MPTS Listings telephone conference on 24 April 2019, detailing:

- Witness scheduling;
- Evidence; and
- Any other matter considered material to the issues of this case.

Directions under Rule 16(1A)(b)

4. Acting pursuant to Rule 16(1A)(b), this Tribunal made the following directions:

1. The parties shall provide to the MPTS and exchange between themselves the following by 8 May 2019 any updated evidence including:

- Witness statements; and
• Reports of Educational and Clinical Supervisors.

2. Any updated evidence to be provided by the party relying upon it, in a paginated and indexed bundle in hard copy to the MPTS by 22 May 2019.

5. Should either party fail to comply with the above directions, they must provide evidence as to why it has failed to comply not less than 7 days prior to the reconvened hearing so that the Tribunal can consider on its own initiative, after receiving evidence and submissions, whether a cost award should be made under the Rules.

6. The Tribunal will reconvene for 10 days from 17 June 2019 to 28 June 2019.

7. This hearing has now adjourned.