Record of Determinations – Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 02/09/2019 - 09/09/2019

Medical Practitioner’s name: Dr Peter JULU

GMC reference number: 5163127

Primary medical qualification: MB ChB 1978 Makerere University

Type of case: New – Misconduct

Outcome on impairment: Not Impaired

Summary of outcome
Case concluded

Tribunal:

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<tr>
<td>Legally Qualified Chair</td>
<td>Ms Chitra Karve</td>
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<tr>
<td>Lay Tribunal Member</td>
<td>Ms Val Evans</td>
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<td>Medical Tribunal Member</td>
<td>Dr Christopher Simpson</td>
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<td>Tribunal Clerk</td>
<td>Ms Keely Crabtree</td>
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Attendance and Representation:

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<td>Medical Practitioner</td>
<td>Present and represented</td>
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<tr>
<td>Medical Practitioner’s Representative</td>
<td>Ms Vivienne Tanchel, Counsel, instructed by CMS Law</td>
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<tr>
<td>GMC Representative</td>
<td>Mr Nick Walker, 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. 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 Application Under Rule 17(2)(g) – 9 September 2019

1. Dr Julu obtained his Bachelor of Medicine and Surgery from the Makerere University, Kampala, Uganda, in 1978. Subsequently, Dr Julu obtained a Masters of Science in Physiology from the University College London in 1984, then a PhD in Neurophysiology at the University College London and Institute of Neurology in 1986. In 2005, Dr Julu gained full registration with the General Medical Council (GMC) and was entered onto the Specialist Register in the area of Autonomic Neurophysiology. He became a Fellow of the Physiological Society of Great Britain in June 2018 and a Fellow of the Royal College of Physicians in January 2019.

2. Since 2013, Dr Julu has been practising as a Specialist Autonomic Neurophysiologist and Senior Research Fellow in the Department of Clinical Pharmacology at Queen Mary University of London. At the time of the alleged events Dr Julu was working on a part-time basis at Breakspear Medical Practice (the Practice) as a Consultant Autonomic Neurophysiologist having commenced this in 2006.

3. The allegation that has led to Dr Julu’s hearing relates to his treatment of Patient A, a minor, in or around February or March 2017 at the Practice. It is alleged that Dr Julu failed to obtain an adequate medical history, failed to adequately assess and examine Patient A and failed to maintain an adequate clinical record. It is further alleged that in February 2017, Dr Julu inappropriately provided oxygen therapy to Patient A, in a home setting, overnight. It is also alleged Dr Julu failed to consider the negative impact of providing overnight oxygen therapy, and failed to adequately monitor the therapy. It is alleged that Dr Julu’s actions in this regard were not clinically indicated.
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The Allegation and the Doctor’s Response

1. In or around February or March 2017 you provided treatment to Patient A, a minor, and you failed to:

   a. obtain an adequate medical history, in that you did not consider:

      i. his history of present illness; **To be determined**
      ii. other medical history; **To be determined**
      iii. his general health; **To be determined**
      iv. his family or social history; **To be determined**
      v. any ongoing treatments; **To be determined**

   b. adequately assess and examine Patient A, in that you did not carry out:

      i. an assessment of Patient A’s general well-being, including the presence or absence of pallor, jaundice, cyanosis, clubbing or lymphadenopathy; **To be determined**
      ii. an examination of Patient A’s respiratory system; **To be determined**
      iii. an examination of Patient A’s cardiovascular system; **To be determined**
      iv. a neurological examination; **To be determined**
      v. an adequate abdominal examination; **To be determined**
      vi. an assessment of Patient A’s known allergies; **To be determined**

   c. maintain an adequate clinical record, in that you did not record:

      i. Patient A’s history of present illness; **To be determined**
      ii. any other medical history; **To be determined**
      iii. Patient A’s general health; **To be determined**
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iv. Patient A’s family or social history; To be determined
v. any known allergies; To be determined
vi. any ongoing treatments; To be determined
vii. any assessments which you had carried out of Patient A; To be determined
viii. any examinations which you had carried out on Patient A. To be determined

2. In February 2017 you:
   a. inappropriately provided oxygen therapy to Patient A:
      i. in a home setting; To be determined
      ii. overnight; To be determined
   b. failed to consider the potential negative impact, emotional and/or physical of providing overnight oxygen therapy to Patient A; To be determined
   c. failed to adequately monitor the oxygen therapy prescribed to Patient A. To be determined

3. Your actions as described at paragraph 2a were not clinically indicated. To be determined

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

Evidence

4. The Tribunal had regard to all the evidence adduced by the GMC, including, but not limited to, the evidence given in person by Dr B and Dr C, their documentary evidence and the exhibits attached to their statements, and the witness statement of Ms F (Patient A’s mother).

5. The Tribunal received an expert report dated 6 March 2018 and a supplemental expert report dated 19 July 2018 prepared by Dr D, expert witness for the GMC. Dr D also gave oral evidence to the Tribunal.

6. Dr Julu provided his own witness statement dated 16 August 2019.
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Application under Rule 17(2)(g)

7. Following the closing of the GMC’s case, Ms Tanchel on behalf of Dr Julu made an application under Rule 17(2) (g) of the GMC’s (Fitness to Practise) Rules 2004, as amended, (the Rules) which states:

‘17(2) The order of proceedings at the hearing before a Medical Practitioners Tribunal shall be as follows—

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

8. Ms Tanchel submitted that the allegations be found not proven because the evidence before the Tribunal is so tenuous, contradictory and/or inadmissible that taken at its highest, a properly directed Tribunal could not properly find the allegations proven.

9. Ms Tanchel referred to the approach set out by Lord Lane in the case of R v Galbraith [1981] 1 WLR 1039 that where there is evidence with some inherent weakness or vagueness then (a) where the judge comes to the conclusion that the evidence, taken at its highest, is not enough for a conviction then it is his duty to stop the case, or (b) where the strength or weakness of the evidence depends on the view to be taken of a witness’s reliability, or other matters within the providence of the jury, upon which the jury could conclude the defendant is guilty then the judge should allow the matter to be tried by the jury.

10. Ms Tanchel also referred the Tribunal to various other legal cases including the case of R v Shippey and Jedynak [1988] Crim LR 767, in that the Tribunal cannot separate the "plums from the duff" when considering these matters.

11. Ms Tanchel stated that the GMC relies on the evidence of Dr B, Dr C, Ms F and Dr D, who is called as an expert witness. Ms Tanchel reminded the Tribunal, that a party calling a witness presents that witness as a witness of truth. Ms Tanchel submitted that in this case there is a direct conflict of evidence between Ms F and Dr D and Dr C and Dr D.

Expert Evidence

12. Ms Tanchel referred the Tribunal to the principles governing expert evidence as set out by Mr Justice Cresswell in the shipping case referred to as the Ikerian Reefer [1993] 2 Lloyds Rep.68. Ms Tanchel stated that similar principles are set out at Part 35 of the Civil Procedure Rules and Part 19 of the Criminal Procedure Rules.
13. Ms Tanchel stated that the first consideration in assessing the expert evidence is whether there are issues on which the Tribunal can be assisted by expertise. That is because expert evidence is by its nature hearsay. The second consideration is whether the relevant individual has the necessary expertise. The third consideration is whether the expert is aware of and has complied with his duties as an expert. Ms Tanchel submitted that in this case, Dr D does not have the necessary expertise and he has not complied with his duties as an expert. Furthermore, the expert must not assume the role of an advocate and, where there is evidence from both sides, must consider both sides of the case.

14. Ms Tanchel submitted that Dr D’s evidence does not satisfy the requirements for expert evidence and as such should be disregarded by the Tribunal.

Dr D’s evidence

15. Ms Tanchel stated that the GMC relies on the evidence of Dr D who is a Paediatric expert to opine on whether Dr Julu’s conduct fell below or far below the standard expected of a reasonable body of Paediatricians. She submitted that Dr D’s evidence was not relevant as Dr Julu is not a Paediatrician. Ms Tanchel stated that Dr D is a Consultant Paediatrician who cannot give evidence on matters of which he has no knowledge.

16. Ms Tanchel further stated that Dr D had conceded that he has no expertise in Autonomic Neurophysiology and cannot comment on whether the medical history obtained by Dr Julu and his assessment and examination of Patient A was adequate when assessed against a responsible body of practising Autonomic Neurophysiologists. Nor could Dr D assist the Tribunal with whether another Autonomic Neurophysiologist would have sufficient information in the clinical records from Dr Julu in order to take over the treatment of Patient A.

17. Ms Tanchel stated that Dr D’s fall-back position was that ‘all’ clinicians treating children would take a more detailed history than that taken by Dr Julu. Ms Tanchel submitted that Dr D does not have the expertise to give an opinion on this. Further, Ms Tanchel submitted that Dr D, both in his written report and in his oral evidence, either failed to consider the clinical notes carefully enough to ascertain that some of the information he asserts is missing is in fact there or he did notice it but did not consider its impact. Ms Tanchel submitted Dr D has failed in his duty as an expert to consider all material in the case irrespective of whether it supported or detracted from his opinion.

18. Ms Tanchel stated that the GMC relies on evidence which falls foul of the well known requirements of an expert, namely that they must have the relevant expertise in order to assist the decision makers.
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19. Ms Tanchel stated that, in oral evidence, Dr D conceded that he had formed “impressions” based on the evidence available to him, including erroneous assumptions about the authorship of certain documents. Ms Tanchel submitted that Dr D has not considered both sides of the evidence as it is incumbent on him to do and has become an advocate in his own cause. Ms Tanchel submitted that Dr D approached the compilation of his report on the basis that there was no clinical need for the prescription of oxygen therapy from his view as a Paediatrician and that this informed his overall view of Dr Julu’s clinical practice.

20. Ms Tanchel submitted that Dr D has also breached the fundamental principles required of an expert witness. He has failed to consider all the evidence, he has been dismissive of Dr Julu’s explanation, and he has failed to consider the other witness evidence in the case. Ms Tanchel further submitted that Dr D failed to consider and/or draw a number of significant points to the attention of the Tribunal, which might have impacted on the strength of his views. For example, the failure to identify the research which, in giving his oral evidence, he said he had conducted on oxygen concentrators.

Allegation 1 (a)

21. Ms Tanchel submitted that a Tribunal could only properly find this allegation proven if it was satisfied that the duty to obtain the particular information as set out at 1 (a) (i)-(v) of this allegation in February or March 2017 existed.

Allegation 1 (b)

22. In relation to Allegation 1 (b)(i), Ms Tanchel stated that Dr D had conceded that the charts showing heart rate and blood pressure coupled with the data on the Tissue Respiration Report was data that he recognised although he had no experience of the numbers as set out because he was unused to these types of measurements containing decimal places. Ms Tanchel submitted that Dr D had reiterated that he cannot opine on the equipment used as he doesn’t have experience of it.

23. In relation to Allegation 1 (b)(ii), Ms Tanchel submitted that Dr D had conceded that the charts showing heart rate and blood pressure coupled with the data on the Tissue Respiration Report were a way in which the cardiovascular system could be measured.

24. In relation to Allegation 1 (b)(vi), Ms Tanchel submitted Dr D had failed to identify that the entire assessment conducted by Dr Julu is a neurological report.

25. In relation to Allegation 1 (b)(v), Ms Tanchel submitted that she had no further submissions to the ones already made in regard to Allegation 1(a).
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26. In relation to Allegation 1(b)(vi), Ms Tanchel submitted that Dr D had conceded that no such assessment was needed and that his report addressed allergies in the context of obtaining a medical history. Therefore, he was of the opinion that whilst it was necessary to obtain information about allergies there was no requirement to assess them. Ms Tanchel submitted that there is no evidence to support this allegation.

Allegation 2 (a)

27. Ms Tanchel stated that it was Dr D’s evidence that in fact if oxygen therapy is to be provided at all, then the best time to provide it is at night because that is when oxygen saturation levels fall and that if the therapy is provided at night then it follows as a matter of logic that it will be done at home. Ms Tanchel submitted that therefore there is no evidence on which the Tribunal could conclude that Dr Julu’s prescription of the oxygen in the home setting and overnight was inappropriate.

Allegation 2 (b)

28. Ms Tanchel stated that in oral evidence, Dr D unequivocally stated that in circumstances where a clinical need is established, the consideration of the potential negative impact is secondary. Further, in response to a question from the Tribunal, Dr D had stated that an oxygen concentrator is more ‘patient friendly’ and less threatening than an oxygen tank.

29. Ms Tanchel submitted Dr D also stated that receiving oxygen for the time prescribed by Dr Julu each day over a period of months would not cause the associated potential problems that Dr D said were linked to administration of high concentrations of oxygen for extended periods of time as set out in his report. Ms Tanchel stated that Dr D also conceded that the risk of facial and upper airways burns caused by exposure to open flames is not relevant in the circumstances of this case.

30. Ms Tanchel stated that the Tissue Respiration Form dated 21 February 2017, indicates that Patient A was relaxed and cooperative. The consent form dated 21 February 2017, sets out that “I have read and understood the potential side-effects below and been made aware of the steps I can take to minimise these.”

31. Ms Tanchel submitted that Dr C’s evidence unequivocally stated that on each occasion Patient A had attended the Practice, Dr Julu carried out an assessment on him as Dr Julu did not trust any other clinicians and he was very thorough in the investigations and enquiries he made.

32. Ms Tanchel submitted that the evidence makes it plain that a Tribunal can reasonably infer that all relevant risks and benefits were considered by Dr Julu. Ms Tanchel submitted the allegation is phrased as a “failure” implicit in which is the
requirement to prove a duty. The duty is to consider “relevant” negative emotional and/or physical impacts not fanciful or speculative matters.

Allegation 2(c)

33. Ms Tanchel submitted that the chronology of events sets out that the final appointment which Dr Julu had with Patient A was on 21 February 2017. The consent form of the appointment which took place on that day states that it was recommended for Patient A to return in 8-12 weeks after the 21 February 2017. Ms Tanchel stated that the treatment however ceased once Dr Julu’s care was called into question. Ms Tanchel stated that Patient A stopped using the oxygen concentrator and no longer attended appointments with Dr Julu. Ms Tanchel stated that Dr D had conceded that treatment which is not being undertaken cannot be monitored.

Allegation 3

34. Ms Tanchel submitted that the GMC have not adduced any evidence in support of the allegation and as such invited the Tribunal to record that there is no evidence in support of this allegation.

Submissions on behalf of the GMC

35. Mr Walker submitted that the GMC does not oppose the application made in relation to Allegations 1(b)(vi), 2 and 3. The application concerning the rest of Allegation 1 is opposed.

Dr D’s Evidence

36. Mr Walker submitted that it is not accepted that Dr D’s evidence ought to be disregarded. Mr Walker stated Dr D is an experienced medical expert across a number of areas of legal dispute and, as he demonstrated in evidence, was aware of his duties as an expert. Mr Walker stated that the criticism of the way in which he approached his task is largely based on the interpretation of his use of the word ‘impression’. Mr Walker submitted Dr D was not offering his opinion, nor was he asserting fact. He was merely recording the way he approached a document. Mr Walker stated in no way could it be said that he was an advocate in the GMC’s cause as Dr D had repeatedly said that he had no interest in the outcome of the case.

37. Mr Walker submitted Dr D did not fail in his duty to consider all evidence as submitted by Ms Tanchel. At worst he was unable to recall which particular section he was being referred to from extensive material which made up his report a year ago. Mr Walker stated this was not a failure of his duty to consider material – it was a demonstration of a witness doing his best, not an expert disregarding that which he well knows.
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Criticism of the use of a Paediatrician

38. Mr Walker stated that the case has been brought against the single expert on the specialist register. Mr Walker submitted that the criticisms made of Dr Julu by Dr D are relevant and applicable and someone in the position of Dr Julu is not beyond scrutiny. At every point where Dr D felt that his expertise prevented him from opining, he has made it clear.

39. Mr Walker submitted that the approach when treating a child ought to be consistent with that contemplated by the evidence of Dr D. As he summarised in his overview Dr D opines on the ‘general paediatric and medical’ issues on the material provided to him with reference to guidance such as Good Medical Practice (GMP). Mr Walker submitted that Dr D’s criticism of the wording of the questions in the Autonomic Assessment Form, the ability for a child to describe unexplained blurring of vision or the type of pain felt by Patient A are examples in support of the validity of his expertise. Mr Walker stated that some of his evidence was not novel – for example the requirement to record in a way that would assist the next clinician.

Allegation 1(a)

40. Mr Walker submitted that the conclusions of Dr D in his report were not subject to the same sorts of concessions that he had made in relation to allegation 2.

41. Mr Walker stated the appointment in late February 2017 took place beyond the 6 month period when Dr C said changes in a patient’s neurophysiology can occur. Mr Walker submitted a doctor ought to be on notice that change can or might occur and ought not rely on evidence that might be out of date as children quickly change. Mr Walker submitted that the evidence of Dr C supports the proposition of Dr D. Mr Walker submitted that the Tribunal can therefore be satisfied that there was a duty to perform the testing at the material time. In discussions with Ms Tanchel after his initial submissions, Mr Walker accepted that Dr C at first had stated changes could occur between 6-9 months but then stated they could occur up to a year.

42. Mr Walker stated it was the view of Dr D that the extent of the questioning by Dr Julu was inadequate for the purposes of treating a child. The questions on the Autonomic Assessment Form were not appropriate for children and it was little more than a tick-box exercise that would not elicit the thorough answers he would expect to see in the examination of a child. Mr Walker stated Dr D had given examples of the questions he would expect to see in relation to pain and bowel movements that went far beyond the questions that appear on the Autonomic Assessment template form. Mr Walker stated Dr D had also given an example of the Presenting Complaint...
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section “has slow growth” that demanded interrogation as to previous heights and weights and the need to chart percentiles. Further, Dr D said “anyone looking after a child” needs to know these things. Mr Walker stated that further examples were given in his report and that Dr D was critical of the questions in relation to the child’s vision.

43. Mr Walker stated there are no records beyond the Autonomic Index: Tissue Respiration (TR) Report (TR Report) results sheet and the Function Test Sheet for May 2016, November 2016 and February 2017.

44. Mr Walker stated that Dr D’s evidence was that “Dr Julu should take his own history and focus and expand on the referral...”. That was his duty. Mr Walker submitted therefore that there is evidence upon which a Tribunal could conclude that there was a duty and that Dr Julu failed in his duty adequately to obtain medical history.

Allegation 1(b)

45. Mr Walker stated, but for the concession made in relation to 1(b)(vi), there is evidence from Dr D that the assessments were inadequate. For the purpose of meeting a submission of no case to answer, that is sufficient. Mr Walker submitted that it is not tenuous or insufficient and should be considered in the round at the end of the case along with all the remaining allegations. In addition, Mr Walker reminded the tribunal of Ms F’s evidence that “After he completed the questionnaire Dr Julu examined Patient A on the bed. I recall that the assessment was not as thorough or as detailed as Dr E’s.”

Allegation 1c

46. Mr Walker submitted in the alternative, even if a Tribunal could not be satisfied that the examination / assessment / history was not carried out, the recording is inadequate. Mr Walker stated that no one looking at the record would know what Patient A or Ms F told Dr Julu in anything approaching a satisfactory level given the number of occasions Patient A was there.

47. Mr Walker submitted that the testing in August, November and February were not purely mechanisms to assist diagnosis: it is not akin to sending a patient for an x-ray. Mr Walker stated that Dr C said that Dr Julu assessed Patient A every time he attended the clinic as he did not trust other clinicians. Mr Walker submitted that the use of the Neuroscope and the Autonomic Tissue Respiration reports that were produced were not simply stand-alone assessment procedures for which an examination was not necessary. Further, on each occasion a suggestion for treatment followed the assessment which was ‘cross-examined’ and signed-off by Dr Julu.
48. Mr Walker submitted that there are no meaningful notes for Patient A and his dealings with Dr Julu in May and November 2016. Moreover, there are no records for his time at the clinic in February 2017 beyond the TR Report and the handwritten record of the data compiled by Dr C. This is a failure and Dr Julu has a case to answer.

49. Mr Walker submitted that the fact that the GMC has not opposed part of the application is not an acceptance that the expert is flawed or that the expertise is wrong. Further, in all the circumstances of this case, the evidence of Dr D with, at times, support from Ms F and Dr C and taken at its highest, a tribunal could find the facts proved. The evidence is not vague, weak or inconsistent, nor is it a case where there is no evidence going to the charges. Mr Walker submitted that there is a case to answer.

**The Tribunal’s Approach and Legal Advice**

50. The Tribunal reminded itself that, at this stage, its purpose was not to make findings of fact but to determine whether sufficient evidence existed such that a Tribunal, correctly advised as to the law, could properly find the relevant paragraph(s) proved to the civil standard. The Tribunal considered Ms Tanchel’s submissions and those of Mr Walker. It also took account of the evidence presented, both oral and documentary, in reaching its decision.

51. The Legally Qualified Chair (LQC) reminded the Tribunal that making a decision that there is no case to answer must be made with great caution, and must be done taking fully into account the tribunal’s overarching statutory duties to protect the public, which are:

   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.

52. The LQC stated that the burden of proof is on the GMC to prove their case, and the standard of proof the civil standard, whether something is more likely than not.

53. The LQC then adopted the Galbraith test as stated by Ms Tanchel and directed the Tribunal to consider this test in its deliberations. However, the LQC also directed the Tribunal to the first limb of the Galbraith test which states:
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‘(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.’

54. The LQC added that the learned judge in the case of R (Tutin) v GMC 2009 EWHC 533 (Admin) agreed the approach that the panel had taken in adopting the Galbraith test and helpfully outlined the questions that that panel had asked itself, as follows:

- The panel should ask itself: was there any evidence before the panel upon which it could find each allegation proved? And/or

- Was there some evidence, but of such unsatisfactory character that a panel, properly directed as to the burden and standard of proof, could not find each allegation proved? And/or

- Was there some evidence, the relative strength or weakness of which was dependent on the panel’s view of the reliability of the witness?

55. The LQC further reminded the Tribunal that the GMC’s case is largely if not entirely based on the evidence of the expert called by the GMC, Dr D. Two broad areas should be considered in relation to Dr D.

56. Firstly, whether or not, considering the Bolam principles (which are outlined below), the Tribunal was in a position of comparing apples and pears. Here, Ms Tanchel, representing Dr Julu, points to Dr D’s own concession that he is commenting as a Paediatrician, and that he cannot comment about the practice of an Autonomic Neurophysiologist. In answer, Mr Walker for the GMC states that since Dr Julu was the only registered expert in his field, the GMC made a decision that there was sufficient ‘read across’ for someone who is a specialist in children to provide an expert opinion, not on the science, but, as the allegations indicate, the taking of history, assessment and recording during appointments.

57. The second broad area is to consider the submissions by Ms Tanchel representing the doctor and rejected by the GMC, that in any event Dr D’s entire approach to his report and his oral evidence was so affected by his negative view of Dr Julu’s area of specialism, that he became unable to be independent and balanced when giving his opinion and therefore all his evidence should be rejected.

*Bolam v Friern Hospital Management Committee 1957 1 WLR. 582*

58. The LQC gave the Tribunal a warning that Bolam was a case of negligence which is not alleged here. The principles however, are relevant. The case of Bolitho v City and Hackney Health Authority 1998 AC further supported this view.
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59. The judge in the case of *Bolam*, summing up for the jury said (among other things not relevant to this case and not repeated here) as follow:

“I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art … putting it another way, a man is not negligent if he is acting in accordance with such a practice merely because there is a body of opinion who would take a contrary view.”

60. The LQC further advised that the Tribunal should consider if:

a) Having considered carefully the nature of the allegations and the concessions made by the GMC in relation to a number of these allegations, whether or not they can rely on – for some or all of the allegations – the expert opinion of Dr D given his specialism and his concession that he has little or no knowledge of Dr Julu’s specialism.

b) If they decide that they cannot so rely, the Tribunal must then consider whether there is any other evidence before it that means that there is a case to answer on any of the allegations.

c) If they cannot find any other evidence as above, then they must accept Ms Tanchel’s submission that there is no case to answer for any of the allegations.

61. If the Tribunal comes to the view that for some or all of the allegations, they can rely on Dr D’s opinion as a Paediatrician then Ms Tanchel’s submission must be considered by the Tribunal, that Dr D’s whole approach is, to use her word, ‘infected’ by his negative view of Dr Julu’s area of specialism and that this has got in the way of his ability to be either independent or impartial. The Tribunal has full submissions by her on this point, and Mr Walker’s rejection of these submissions which the Tribunal will need to consider carefully. Here the Tribunal can rely on the written and oral evidence that has been provided to it to date.

62. The Tribunal accepted the LQC’s advice.

Tribunal Decision

63. The GMC having closed its case, the Tribunal analysed the quality of the evidence that the GMC has adduced to evaluate whether on the balance of probability it could find the facts proved.

64. Taking the LQC’s advice, The Tribunal first considered whether or not it could rely on the opinion for some or all of the allegations given that the expert opinion of
Dr D provided standards for a Specialist Paediatrician and not an Autonomic Neurophysiologist. The Tribunal noted Dr D’s self declared limitations that he could not provide any specialist knowledge of Autonomic Neurophysiology in relation to the matters that he had been asked to opine on. It noted that in his report dated 6 March 2018, Dr D stated:

‘I inform the GMC that I have no specialist knowledge of autonomic neurophysiology and I shall make this clear if addressing such issues in this report.’

The Tribunal had regard to Dr D’s supplemental report dated 19 July 2018 which stated:

‘When I opine that the standard of care was seriously below a reasonable standard, the standard to which I refer is that of a reasonably responsible and competent Paediatrician of any sub-specialty, noting that the “Issues to Address” paragraphs in the Letter of Instruction refer to “a reasonably competent Autonomic Neurophysiologist”.

The Tribunal was of the view that Dr D had done his best to meet the brief set by the GMC and that he had tried to assist it. The Tribunal noted however, under cross examination, Dr D conceded many points with respects to his report and opinion, and that he quite properly continued to assert that the standards he was applying were those of a reasonably competent Paediatrician not an Autonomic Neurophysiologist.

The Tribunal considered whether it could find any evidence for a case to answer if it accepted the submission that Dr D’s evidence ought not to be disregarded as he was an ‘experienced medical expert over a number of areas of legal dispute’. The Tribunal noted on that point that when questioned Dr D indicated that he had provided expert opinion in personal injury and negligence cases and also for the GMC for about 40 years, however, this was as a Paediatrician. He accepted that he was unable to comment on the standard of Dr Julu’s practice as an Autonomic Neurophysiologist.

The Tribunal then considered if there was any other evidence including that of Dr C and Dr B to assist it in its deliberations on whether there was a case to answer and concluded that there was not. Neither of them were medical specialists in Autonomic Neurophysiology and therefore they were unable to comment on the standard of Dr Julu’s practice.

The Tribunal concluded that there is no clear evidence before it, as to what standards are expected of an Autonomic Neurophysiologist. It also concluded that the evidence of Dr D was unable to assist in providing any information on standards that would be appropriate in Autonomic Neurophysiology. The Tribunal therefore
determined that, taking it at its highest, viewing it in the round and as a whole, there was insufficient evidence adduced by the GMC which could enable a properly directed Tribunal to determine if the facts could be found proved.

70. The Tribunal concluded that in these circumstances there was no case to answer.

71. That concludes the case.

Confirmed
Date 09 September 2019

Ms Chitra Karve, Chair