Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 10/06/2019 - 26/06/2019

Medical Practitioner’s name: Mr Chandrakant SHAH

GMC reference number: 3362116

Primary medical qualification: MB BS 1976 Gujarat

Type of case
New - Misconduct

Outcome on impairment
Not Impaired

Summary of outcome
No warning

Tribunal:

<table>
<thead>
<tr>
<th>Legally Qualified Chair</th>
<th>Mrs Julia Oakford</th>
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<tr>
<td>Lay Tribunal Member:</td>
<td>Mr Darren Shenton</td>
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<td>Medical Tribunal Member:</td>
<td>Dr Joanne Topping</td>
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Tribunal Clerk: Ms D Montgomery

Attendance and Representation:

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<tr>
<th>Medical Practitioner:</th>
<th>Present and represented</th>
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<tbody>
<tr>
<td>Medical Practitioner’s Representative:</td>
<td>Mr Matthew McDonagh, Counsel, instructed by Carson McDowell Solicitors</td>
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<tr>
<td>GMC Representative:</td>
<td>Mr Robin Kitching, 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.
Record of Determinations –
Medical Practitioners Tribunal

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 - 24/06/2019

Background

1. Mr Shah qualified in 1976 and prior to the events which are the subject of the hearing he worked as a Consultant Ear Nose and Throat (ENT) Surgeon. At the time of the events Mr Shah was practising as a Consultant ENT Surgeon at the Western Health and Social Care Trust (the Trust), a position that he has held since 2005.

2. The allegation that has led to Mr Shah’s hearing can be summarised as concerns arising in relation to the ‘conduct of Mr Shah when treating Patient A’. Following the conclusion of a local investigation conducted in line with the Maintaining High Professional Standards Framework, the Trust raised concerns with the General Medical Council (GMC) regarding the assessment and management of Patient A over the course of a weekend.

3. Patient A was a 91 year old man who, in or around May 2012, had been diagnosed with laryngeal cancer. At the time of diagnosis Patient A was found to have a laryngeal tumour and he remained under the care of the ENT department at the Altnagelvin Area Hospital (AAH).

4. On Saturday 27 October 2012, at approximately 11.55, Patient A attended the Emergency Department at AAH. He was noted to have stridor (noisy breathing) and had been experiencing breathing difficulties over the previous days. Mr Shah was the ENT Consultant on call on 27 and 28 October 2012 and was assisted by Dr B, a Foundation Year (FY) 2 doctor and Dr C, a Trust Assistant Surgeon. Patient A was seen by Dr B who arranged for him to be admitted to the ENT ward.

5. Patient A was reviewed by Mr Shah and Dr C at approximately 15.05. The intended plan was for a full assessment of Patient A to be followed by monitoring and conservative treatment, if this was appropriate, until Monday when the head and neck surgeon who had previously treated Patient A was available.

6. On 29 October 2012, in the early hours of the morning, Patient A’s condition deteriorated and he was transferred to theatre where an emergency tracheostomy was performed.
The Outcome of Applications made during the Facts Stage

7. The Tribunal granted the GMC’s unopposed application, made pursuant to Rule 17(6) of the GMC (Fitness to Practise) Rules 2004 (the Rules), to amend paragraph 2 of the Allegation for the purposes of clarification, as set out below. The Tribunal was satisfied that there would be no injustice to Dr Shah in making the amendment.

8. The Tribunal also granted the GMC’s unopposed applications, made pursuant to Rule 34(13) of the Rules, to hear the evidence of a number of the GMC witnesses, as set out below, by telephone rather than delay the hearing while attempts were made to establish a viable Skype connection. The Tribunal determined that it was in the interests of justice to accede to the applications.

9. The Tribunal upheld, in part, submissions made by Mr McDonagh, Counsel on behalf of Mr Shah, pursuant to Rule 17(2)(g) of the Rules. The Tribunal’s full decision is included at Annex A.

The Allegation and the Doctor’s Response

10. The Allegation made against Dr Shah is as follows:

   1. On 27 October 2012 you failed to perform or direct a flexible nasal endoscopy on Patient A. **Deleted following Rule 17(2)(g) submissions**

   2. On one or more occasions between 28 to 29 on 28 October 2012 you consulted with Patient A and you failed to keep adequate and appropriate records. **To be determined as amended**

   3. On 28 October 2012 you were requested to attend on Patient A and you failed to do so. **To be determined**

The Facts to be Determined

11. Following Mr McDonagh’s successful submission under Rule 17(2)(g), the Tribunal is required to determine whether Mr Shah consulted with Patient A on one or more occasion on 28 October 2012 and whether he failed to keep adequate records. The Tribunal is also required to determine whether, on 28 October 2012, Mr Shah was asked to attend on Patient A and failed to do so.

Factual Witness Evidence

12. The Tribunal received evidence on behalf of the GMC from the following witnesses:
Record of Determinations –
Medical Practitioners Tribunal

- Dr B, FY2 Doctor at the Trust, at the time of events, by Skype link
- Dr C, Trust Assistant Surgeon, ENT, in person
- Ms D, Acting Sister, ENT, at the time of events, by telephone
- Ms E, Ward Sister, ENT, by telephone
- Ms F, Band 6 Ward Nurse, ENT, by telephone
- Ms G, Staff Nurse, ENT, by telephone
- Ms H, Staff Nurse, ENT, by telephone.

13. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Dr I, Consultant Anaesthetist and Divisional Clinical Director for Surgery and Anaesthetics at the Trust.

14. Dr Shah provided his own witness statement, dated 11 November 2015, and also gave oral evidence at the hearing.

15. The Tribunal also received in support of Mr Shah a number of testimonials from colleagues, all of which it has read.

Expert Witness Evidence

16. The Tribunal received evidence from the GMC expert witness, Mr J, Consultant Otolaryngologist, Head and Neck Surgeon, who provided an expert report, dated 22 December 2017 and a supplemental report, dated 16 January 2018. He also gave oral evidence in person. Mr J was instructed to comment on the clinical care provided by Mr Shah to Patient A and to assist the Tribunal in understanding the professional standards to be expected of a reasonably competent Consultant ENT. Mr J was also asked to provide an opinion on whether Mr Shah met those standards.

17. The Tribunal found Mr J to be a credible and helpful witness and it was satisfied that he had the appropriate experience and qualifications to enable him to provide an opinion on the care provided to Patient A by Mr Shah. The Tribunal recognised that Mr J had been asked to comment on matters, most of which, this Tribunal was not required to determine.

Documentary Evidence

18. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included the following:

- Extracts from Patient A’s medical records
Record of Determinations – Medical Practitioners Tribunal

- Telephone logs
- Dr C’s witness statement to the Trust, dated 15 November 2012
- Trust Investigatory meeting notes, 2013.

The Tribunal’s Approach

19. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Mr Shah 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.

20. The Tribunal has borne in mind that Mr Shah’s good character, in the sense that he has no previous findings against him, is a relevant factor in its assessment of both the likelihood of him behaving as alleged and of his credibility.

The Tribunal’s Analysis of the Evidence and Findings

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

Paragraph 2

22. The Tribunal first considered whether Mr Shah had consulted with Patient A on one or more occasions on 28 October 2012.

23. The Tribunal had regard to Mr Shah’s witness statement to the Trust, dated 14 November 2015. In it Mr Shah stated that when he was on the on-call rota at the weekend, it was his normal practice to attend the ward at some stage during a Sunday morning to briefly review each of the ENT patients. Mr Shah recalled that on 28 October 2012, he arrived on the ward after Dr C had completed the formal ward round and he estimated that he was on the ward for about 20 minutes. He recalled that Patient A was stable and seemed normal when he saw him with an oxygen saturation of 97% and respiratory rate of about 16. Mr Shah accepted that he did not make any notes during his review of the patients, including Patient A.

24. On behalf of the GMC, Mr Kitching, Counsel, invited the Tribunal to find that Mr Shah did not attend the ward on 28 October 2012. He stated that Patient A was undoubtedly the focus of care that weekend yet Mr Shah did not speak to any of the nursing staff or make enquiries about the episode of breathlessness that Patient A had suffered overnight. Mr Kitching submitted that Mr Shah’s account was inherently implausible.

25. The Tribunal noted that throughout the local investigation, and in his evidence before this Tribunal, Mr Shah has been consistent regarding his attendance
Record of Determinations –
Medical Practitioners Tribunal

on the ward. The Tribunal had regard to Mr Shah’s evidence, given during cross-
examination, that Patient A had told him that he had been ‘a bit breathless but then
settled down’. The Tribunal was satisfied that this accorded with what had happened
in the early hours and was terminology that a patient would use.

26. The Tribunal considered whether it was plausible that Mr Shah had attended
the ward on 28 October 2012 and not been seen. It had regard to the evidence of
the nursing staff, and Dr B, all of whom accepted that staff would be busy with their
own tasks and might not necessarily notice if Mr Shah was present or not. The
Tribunal noted that Mr Shah was not actually required to attend the ward as part of
his on-call duties.

27. Taking Mr Shah’s good character into account, the Tribunal was not satisfied
that there was sufficient cogent evidence to enable it to find that Mr Shah had lied
about his attendance on the ward. Accordingly, it was satisfied that he did attend.

28. The Tribunal next considered the nature of Mr Shah’s interaction with Patient
A and if it amounted to a ‘consultation’ which needed to be recorded in Patient A’s
medical records.

29. The Tribunal accepted that not all interactions with patients amount to
consultations and that there are instances when there will not be a duty to make
clinical records. Mr Shah maintained that he had conducted an informal review,
following which he was satisfied that the clinical picture had not changed and that
there was therefore no need for him to make a note.

30. The Tribunal had regard to Mr Shah’s oral evidence that Patient A had
reported breathlessness during the night, although it had resolved by the time of Mr
Shah’s review. The Tribunal also had regard to the confirmed Minutes of the
Preliminary/informal meeting held between Mr Shah and Dr I on 19 November 2012
which record that on attending Patient A on 28 October 2012, Mr Shah had noted
that Patient A’s oxygen saturation was around 97% and his respiratory rate was
around 16. This was a change from the previous day, when Mr Shah had spoken to
Patient A’s wife and reassured her that he was stable but that he may require a
tracheostomy if he developed severe breathlessness.

31. The Tribunal had regard to the GMC’s guidance, Good Medical Practice
(2006), and in particular paragraph 3 which, under the heading Good Clinical Care,
states:

‘3. In providing care you must…

f. keep clear, accurate and legible records, reporting the relevant
clinical findings, the decisions made, the information given to patients,
and any drugs prescribed or other investigation or treatment…’
Record of Determinations –
Medical Practitioners Tribunal

32. The Tribunal considered that checking a patient’s vital signs, especially respiratory rate and oxygen saturation in a patient with stridor, albeit this was done by reviewing an Early Warning Chart, and the declaration by the patient of an episode of breathlessness which had subsequently resolved, amounted to a consultation with relevant clinical findings which should have been recorded.

33. Having considered all the evidence, the Tribunal was satisfied that Mr Shah had consulted with Patient A on 28 October 2012 and failed to keep adequate records. Accordingly, it found this paragraph of the Allegation proved.

Paragraph 3

34. The Tribunal had regard to Mr J’s expert report in which he stated:

‘In my opinion if a middle grade doctor is concerned regarding the condition of a patient in stridor, then it is the consultant’s duty to attend, especially if a clear request is made.’

35. It is clear from the hospital telephone logs that Dr C called Mr Shah’s mobile. The Tribunal was not assisted by the fact of Dr C having called Mr Shah as it heard that it was normal practice for her to call him to update him following a ward round.

36. The Tribunal had regard to Dr C’s letter, dated 15 November 2012, to Mr K, the Consultant ENT Surgeon with responsibility for Patient A’s cancer treatment, in which she sets out her account of her involvement in Patient A’s care.

37. Dr C stated that on reviewing Patient A during the ward round on 28 October 2012 she noted that although his pulse oximetry readings were ‘ok’ at 97% and his general condition satisfactory, Patient A looked ‘a little agitated’. Dr C stated that she was unable to understand why and she was told that he had had ‘some sort of panic attack’. She stated that his appearance disturbed her and she rang Mr Shah to request that he come in and see Patient A himself. Dr C stated that Mr Shah ‘did not show any inclination to come in’ and that he asked her what more she thought he could offer as she had done all that was needed. She stated that Mr Shah told her that she was experienced and that she needed to be more confident about her clinical findings. Dr C stated that although she told Mr Shah that she would very much appreciate a senior colleague reviewing Patient A, it was to no avail. She stated that she was ‘mortified by this and felt too embarrassed to tell anyone as [she] thought it would be the equivalent of undermining or grassing on a senior colleague’. Dr C informed Mr K that she checked on Patient A two to three times later in the day/evening and his pulse oximetry continued to remain in the high 90s range.
38. In his Trust witness statement, Mr Shah stated that Dr C had called him on 28 October 2012 to provide him with an update on patients that she had seen during the ward round, including Patient A, and that this was standard practice. Mr Shah stated that he did not recall any ongoing concerns being raised with him about Patient A’s condition during the call. He also stated that he did not recollect Dr C asking him to come to hospital to see Patient A but that if she had his normal practice would have been to return to the hospital as requested.

39. There is no evidence before the Tribunal that Mr Shah had ever previously failed to attend to review a patient when asked and it was satisfied that it would be out of character for him not to attend when asked. The Tribunal noted that on Dr C’s account, Mr Shah reassured her about her abilities and the Tribunal considered that this could possibly indicate that he believed that he had dealt with Dr C’s request. However, Dr C’s letter to Mr K clearly sets out her concerns and her feelings of embarrassment when Mr Shah showed no inclination to attend. The Tribunal noted that Dr C continued to check on Patient A after her call to Mr Shah and it was satisfied that she had been concerned enough about Patient A to ask Mr Shah to attend to provide a second opinion.

40. Having considered all the evidence, the Tribunal was satisfied that on 28 October 2012 Mr Shah was requested to attend on Patient A and he failed to do so. Accordingly it found this paragraph of the Allegation proved.

The Tribunal’s Overall Determination on the Facts

41. The Tribunal has determined the facts as follows:

1. On 27 October 2012 you failed to perform or direct a flexible nasal endoscopy on Patient A. Deleted following Rule 17(2)(g) submissions

2. On one or more occasions between 28 to 29 on 28 October 2012 you consulted with Patient A and you failed to keep adequate and appropriate records. Determined and found proved as amended

3. On 28 October 2012 you were requested to attend on Patient A and you failed to do so. Determined and found proved

Determination on Impairment - 26/06/2019

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

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence as follows:

- Evidence of Continuing Professional Development (CPD) spanning the period 2013 to 2019
- Mr Shah’s Curriculum Vitae
- Copies of Mr Shah’s 2017 and 2018 appraisals
- Patient feedback questionnaire reports (2014 and 2018)
- Colleague feedback reports (2014 and 2018).

3. The Tribunal also heard oral evidence from Mr J, the GMC expert, who was recalled to answer additional questions regarding the significance of Mr Shah’s failure to attend on 28 October 2012 when asked to do so by Dr C.

Submissions

4. On behalf of the GMC, Mr Kitching accepted that for any conduct to amount to misconduct it has to be serious. Mr Kitching submitted that if the Tribunal conclude that Dr C’s concerns arose after Mr Shah’s review of Patient A, but before her phone call to him, then Mr Shah’s failure to attend was seriously below the standard to be expected. Mr Kitching referred the Tribunal to the GMC’s guidance, Good Medical Practice (2006) (GMP).

5. In relation to impairment, Mr Kitching acknowledged that the matters before the Tribunal took place in 2012 and involved a single action in relation to a single patient. However, he submitted that there has been no real acknowledgement of fault by Mr Shah and that the Tribunal should consider the question of his insight and remediation.

6. On behalf of Mr Shah, Mr McDonagh submitted that the proven facts in this case do not amount to misconduct but that, in any event, Mr Shah’s fitness to practise is not impaired.

7. Mr McDonagh referred to Mr J’s expert evidence that Mr Shah’s failure to keep adequate records was below but not seriously below the standard to be expected. In respect of Mr Shah’s failure to attend on Patient A when requested to do so by Dr C, Mr McDonagh submitted that the Tribunal could properly conclude that this was below, but not seriously below, the standard to be expected in the absence of a clear deterioration in Patient A’s condition being conveyed to Mr Shah by Dr C.

8. Mr McDonagh submitted that the facts of this case amount to a single isolated incident in an otherwise unblemished career. He referred the Tribunal to the positive
Record of Determinations –
Medical Practitioners Tribunal

patient and colleague feedback submitted on Mr Shah’s behalf at this stage of proceedings and stated that Mr Shah has continued to act as a successful consultant.

The Relevant Legal Principles

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

10. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct which was serious and then whether the finding of serious misconduct could lead to a finding of impairment.

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

The Tribunal’s Determination on Impairment

12. The Tribunal first considered whether the facts as found proved amounted to misconduct.

13. The matters that could potentially constitute misconduct in this case are limited to Mr Shah’s failure to record details of his consultation with Patient A on 28 October 2012 and his failure to attend on Patient A on 28 October 2012 when requested to do so by Dr C.

14. The Tribunal had regard to sub-paragraphs 2(a) and (b), 3(f) and paragraph 41(b) and (c) of GMP, which state:

   ‘2. Good clinical care must include:

   a. adequately assessing the patient’s conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient’s views, and where necessary examining the patient

   b. providing or arranging advice, investigations or treatment where necessary...

   3. In providing care you must...
Record of Determinations –
Medical Practitioners Tribunal

f. keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment…’

41. Most doctors work in teams with colleagues from other professions. Working in teams does not change your personal accountability for your professional conduct and the care you provide. When working in a team, you should act as a positive role model and try to motivate and inspire your colleagues. You must:

a. ...

b. communicate effectively with colleagues within and outside the team

c. make sure that your patients and colleagues understand your role and responsibilities in the team, and who is responsible for each aspect of patient care…’

15. In respect of Mr Shah’s proven failure to record details of his consultation with Patient A on 28 October 2012, the Tribunal accepted that Mr Shah’s failure breached the principles set out in the guidance. However, it noted that Mr Shah’s record keeping failing was limited to a single consultation with one patient on one day in the context of an informal review carried out by Mr Shah. The Tribunal noted that Mr Shah’s review did not alter the care or treatment plan for Patient A and his failure to record it did not contribute to any adverse outcome for Patient A.

16. The Tribunal accepted Mr J’s evidence that Mr Shah’s failing in record-keeping fell below, but not seriously below the standards to be expected, and that other consultants may not have made a record of the consultation in the same circumstances. Accordingly, the Tribunal did not consider that Mr Shah’s failing in respect of record keeping fell significantly below the standards expected as to amount to misconduct.

17. In respect of Mr Shah’s failure to attend on Patient A on 28 October 2012 when requested to do so by Dr C, the Tribunal accepted that that Mr Shah’s failure breached the principles set out in the guidance. However, the Tribunal has previously stated that there was no evidence before it that Mr Shah had ever previously failed to attend to review a patient when asked and it was satisfied that his non-attendance was out of character. The Tribunal also stated that it believed that it was possible that Mr Shah thought that he had dealt with Dr C’s concerns by reassuring her about her abilities.

18. The Tribunal had regard to the expert evidence of Mr J who was of the opinion that if Dr C had conveyed to Mr Shah that there had been a deterioration in
Record of Determinations – Medical Practitioners Tribunal

Patient A’s condition, further to Mr Shah’s informal review, then his failure to come in was seriously below the standards to be expected. However, Mr J also stated that if nothing had changed over the period then it would be open to Mr Shah to decide to see how things went. Mr J agreed that it was part of the training and management role of a consultant to reassure a junior doctor regarding their abilities.

19. The Tribunal noted that there is no objective evidence of Patient A’s deterioration following Mr Shah’s ‘informal review’. The evidence indicates that Dr C developed a subjective feeling of unease following the ward round. However, this was not supported by any clinical findings. Although Dr C made a note in Patient A’s records at 12.30 to record a panic attack the Tribunal was satisfied that this referred to an incident that had taken place during the night and was not something that had developed after the ward round or after Mr Shah’s review.

20. The Tribunal was satisfied that Mr Shah’s failure to attend amounted to a miscommunication between Dr C and Mr Shah in which they both failed to understand or confirm the other’s position. There is no evidence before the Tribunal that Patient A’s subsequent deterioration in the early hours of 29 October 2012 was in any way related to Mr Shah’s non-attendance and it is accepted that Mr Shah attended following the deterioration.

21. The Tribunal accepted Mr J’s evidence that Mr Shah’s failing to attend in the absence of any deterioration in Patient A’s condition fell below, but not seriously below, the standards to be expected. Accordingly, the Tribunal did not consider that Mr Shah’s failure to attend on Patient A when requested fell significantly below the standards expected as to amount to misconduct.

22. Having determined that the facts in this case do not amount to misconduct, the Tribunal has accordingly determined that Mr Shah’s fitness to practise is not impaired.

Confirmed
Date 24 June 2019

Mrs Julia Oakford, Chair

MPT: Dr SHAH
ANNEX A – 18/06/2019
Submissions under Rule 17(2)(g)

1. At the close of the case on behalf of the General Medical Council (GMC), Mr McDonagh, Counsel on behalf of Mr Shah, made submissions under Rule 17(2)(g) of the GMC (Fitness to Practise) Rules 2004 (the Rules) in respect of paragraphs 1 and 2 of the Allegation. Rule 17(2)(g) states:

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

2. Mr McDonagh referred the Tribunal to the case of R v Galbraith [1981] 1 WLR 1039, an authority in the criminal jurisdiction suggesting the appropriate approach of this Tribunal to the sufficiency of evidence, and quoted the test set out by Lord Lane CJ as follows:

‘(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty – the judge will stop the case. (2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.

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

Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness’s reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.’

3. In respect of paragraph 1, Mr McDonagh submitted that there is no evidence before the Tribunal that could enable it to find that Dr Shah had failed to perform or direct a flexible nasal endoscopy on Patient A.

4. Mr McDonagh submitted that there was no duty on Mr Shah to ‘perform’ the endoscopy and that it was open to him to delegate the procedure, which he did. He referred to Dr C’s evidence to Dr I, during her Trust interview on 25 February 2013, in which she accepted that she was the one who was going to assess Patient A and that this would have included an endoscopy. Mr McDonagh stated that Dr B was also
Record of Determinations –
Medical Practitioners Tribunal

told by Dr C that she would do the endoscopy. Mr McDonagh referred to Mr J’s expert evidence that, in these circumstances, Mr Shah was not required to ‘run down the ward’ and ‘direct’ her to do an endoscopy.

5. Mr McDonagh further submitted that although a decision was made on 27 October 2012 to delay the endoscopy until 28 October 2012, Mr J, the GMC expert witness, confirmed that this decision was acceptable and breached no duty.

6. In respect of paragraph 2, Mr McDonagh stated that the GMC case is that there was no ‘attendance’ by Mr Shah on the ward after the ward round in the morning of 28 October 2012. Mr McDonagh stated that the only evidence of an ‘attendance’ comes from Mr Shah’s documentation which includes his discussions with Dr I and his statement.

7. In his witness statement to the Trust, dated 14 November 2015, Mr Shah estimated that he was on the ward for about 20 minutes on Sunday 28 October 2012. He stated that his standard practice would have been to briefly review each of the ENT patients. His recollection was that Patient A was stable and seemed normal when he saw him with an oxygen saturation of 97% and respiratory rate of about 16. Mr Shah stated that he did not make any notes during the round.

8. Mr McDonagh submitted that it is a matter of clinical judgement whether any material information is gleaned from the ‘walk around’ which would amount to a ‘consultation’ that would require a record to be made. He referred to Mr J’s evidence that, although there was to be no change to the treatment plan which was to be continued, it was ‘ideal’ that a record be made in these circumstances as the ‘significance here was of reassuring staff that management was appropriate and it was more than just greeting the patient, it was checking the respiratory rate’.

9. Mr McDonagh submitted that ‘ideal’ cannot connote a breach of duty as it relates to a higher or ‘gold’ standard. He submitted that Mr Shah’s attendance on the ward did not amount to a consultation which would require Mr Shah to make a record.

GMC response

10. Mr Kitching, Counsel on behalf of the GMC, opposed Mr McDonagh’s submissions under Rule 17(2)(g).

11. In respect of paragraph 1, Mr Kitching accepted that Mr J confirmed that the endoscopy procedure could be delegated by Mr Shah and he stated that this was reflected in the wording ‘or direct’ contained within paragraph 1 of the Allegation.

12. Mr Kitching submitted that the best evidence as to the plan for Patient A is set out in the clerking note of Dr B timed at 15.05. Mr Kitching accepted that the
note was not written contemporaneously with the discussion between Mr Shah and Dr C but he submitted that it must have been written within minutes of the plan being formulated. The plan included a note that an endoscopy was to be done on Sunday 28 October 2012.

13. Mr Kitching submitted that Mr J considered that it was not appropriate to leave the endoscopy until the following day in the absence of a clinical reason not to do one on 27 October 2012. Mr Kitching submitted that there is evidence from which the Tribunal could conclude that no endoscopy was performed at all on Saturday 27 October 2012. He submitted that if Mr Shah had agreed with Dr C that the endoscopy could wait until the following day, and he did not come back on the ward to do it himself as he claims, then there was a failure on his part as alleged.

14. In respect of paragraph 2, Mr Kitching submitted that the GMC’s primary case is that Mr Shah probably did not return to the ward at all on Sunday 28 October 2012. He acknowledged that the only evidence that Mr Shah did return to the ward comes from his own statements. Mr Kitching submitted that there is therefore evidence on which this Tribunal could conclude that he did consult with Patient A and failed to keep an adequate record.

The Tribunal’s decision

15. The Tribunal has borne in mind that its role at this stage of proceedings is not to make findings of fact but to determine whether the evidence heard is such that, taking the GMC’s case at its highest, the Tribunal could find an alleged fact proved on the balance of probabilities. It applied the Galbraith test, reminding itself that taking the evidence at its highest does not mean that the Tribunal should pick out the best bits of the GMC evidence and ignore the rest. It is the evidence taken as a whole that the Tribunal must look at.

Paragraph 1

16. The Tribunal first considered Mr McDonagh’s submission in relation to paragraph 1 of the Allegation.

17. The Tribunal accepted that an alleged failure to do something arises out of a duty, in this case the duty to either perform or direct a flexible nasal endoscopy on Patient A.

18. The Tribunal had regard to the evidence of Mr J, expert witness on behalf of the GMC. In his report, dated 22 December 2017, Mr J stated that in his opinion it was essential for a flexible nasal endoscopy to be performed on Patient A to determine the degree of obstruction and to assist in the decision making regarding Patient A’s care. Mr J stated that he would have expected the ENT consultant either to perform the procedure or to have advised a suitable member of the team, for
Record of Determinations –
Medical Practitioners Tribunal

example Dr C, to perform the procedure. In his oral evidence Mr J altered his position to confirm that, although it would be unusual, there may be circumstances in which the endoscopy could be delayed until the following day.

19. The Tribunal noted that Mr J was clear in his evidence that there was no requirement for Mr Shah to personally perform the endoscopy and that it was open to him to delegate it. The evidence reflects that the procedure was delegated to Dr C who was an appropriately trained person.

20. Having considered all the evidence, the Tribunal was satisfied that, taking the GMC case at its highest, insufficient evidence has been adduced to enable it to find that, on 27 October 2012, Mr Shah had failed to perform or direct a flexible nasal endoscopy on Patient A. Accordingly, the Tribunal determined to uphold Mr McDonagh’s submission under Rule 17(2)(g) in respect of paragraph 1 of the Allegation.

Paragraph 2

21. The Tribunal went on to consider Mr McDonagh’s submission in relation to paragraph 2 of the Allegation.

22. The Tribunal had regard to the confirmed Minutes of the Preliminary/informal meeting held between Mr Shah and Dr I on 19 November 2012. These record the following:

‘Mr Shah stated that Patient A was admitted to ward 5 on the Saturday (27th) afternoon. He was comfortable and stable with his Oxygen saturation were acceptable (about 98%) and RR was around 20. He stated that he saw Patient A on Saturday and again on Sunday morning. His Oxygen saturation was around 97% and RR was around 16. He spoke to his wife and reassured her that he was stable and may require making an opening in trachea unless he develops severe breathlessness...’.

23. It would appear from the evidence that Mr Shah had made some sort of clinical assessment of Patient A in which he had noted the patient’s oxygen levels and respiratory rate which had changed since the previous assessment on Saturday 27 October 2012. He also appears to have discussed future management.

24. Having considered all the evidence, the Tribunal was satisfied that sufficient evidence had been adduced that could enable it to make a finding in respect of paragraph 2 of the Allegation. Accordingly, it determined to reject Mr McDonagh’s submission under Rule 17(2)(g) in respect of paragraph 2 of the Allegation.