Neutral Citation Number: [2022] EWHC 137 (Admin)

Case No: CO/1902/2021

IN THE HIGH COURT OF JUSTICE
AT MANCHESTER
ADMINISTRATIVE COURT

Manchester Civil Justice Centre
1 Bridge Street West
Manchester M60 9DJ

Date: 25/01/2022

Before :

MR JUSTICE FREEDMAN

- -

Between :

DR ADILYA RAHIM

Appellant

- and –

GENERAL MEDICAL COUNCIL

Respondent

- -
- -

Mr Kevin McCartney (instructed by **Hempsons**) for the **Appellant**
Ms Alexis Hearnden (instructed by **General Medical Council Legal Department**) for the **Respondent**

Hearing dates: 13 October 2021

- -

Approved Judgment

Covid-19 Protocol: This judgment was handed down by the Judge remotely by circulation to the parties' representatives by email and release to Bailii. The date and time for hand-down is deemed to be Tuesday 25 January 2022 at 11.15am

.....

MR JUSTICE FREEDMAN:

I Introduction

1. This is a case relating to allegations which were found to be proven of dishonest alterations by a general practitioner, Dr Rahim, of her medical notes without any indication that the notes had been altered. Following a hearing lasting ten days, the Medical Practitioner's Tribunal ("the Tribunal") found the majority of the charges alleged against Dr Rahim proved. As the conduct included findings of dishonesty, a subsequent determination of present impairment was inevitable. Finally, the Tribunal determined that despite her glowing testimonials and good character, the public interest required that Dr Rahim should be erased from the medical register with immediate effect.

2. In short, the GMC alleged that on 2 January 2018 and 16 January 2018, Dr Rahim had consultations with Patient A. There was a conflict of evidence as to whether Patient A had presented with shortness of breath. The notes of Dr Rahim at the time were to the effect that Patient A had shortness of breath and there was no reference to a chest X-ray. Subsequently, under a different doctor, there was a chest X-ray and a diagnosis of lung cancer. After Dr Rahim heard of the diagnosis, she revisited her notes and on 7 August 2018 she amended the notes to show that there was no shortness of breath in the entry for 2 January 2018 and that if not better, there would be a chest X-ray in the entry for 16 January 2018. There was nothing in the amended notes to indicate that the notes had been amended. Following a complaint made in December 2018, Dr Rahim responded with a copy of the amended notes giving an account as per the amended notes without referring to the fact that the notes had been amended.

3. The first ground of appeal was that the charges were mutually inconsistent and unclear and giving rise to injustice. That arose in the following circumstances. The GMC's case was that there was a clinical failure based (in summary only) on a failure to send Patient A for a chest X-ray when she complained of shortness of breath. The GMC further alleged that the amendments to the notes were a dishonest cover up of this clinical failure. Dr Rahim admitted on her case that the original notes were wrong, and her case was that she was not dishonest. She said that she was correcting the notes to reflect what had happened. At that point, the GMC added charges of inadequate notetaking.

4. This was on the basis of taking Dr Rahim' case at face value. If the original notes were wrong such that they required correction, then the original notes were inadequate. This contradicted the other charges (as originally and maintained) which were based not on inadequate notetaking, but on the original notes being accurate and the subsequent amendments being false and dishonest. In circumstances set out in more detail below, the Tribunal treated the admissions of Dr Rahim as withdrawn and found that the original notes were accurate and that the subsequent amendments were false and dishonest.

5. The other grounds of appeal can be summarised as follows:

    (1) Ground 2: Wrong refusal of GMC to disclose material capable of undermining reliability or credibility of Patient A;

(2) Ground 3: Wrong failure of the Tribunal to order disclosure of the same;

(3) Ground 4: Wrong prohibition of the Tribunal of cross examination of the expert Dr Williams in respect of Patient A's medical notes for 2 March 2018;

(4) Ground 5: Wrong approach of Tribunal to factual determination by determining allegations 5 – 7 before the clinical allegations;

(5) Ground 6: Wrong assessment of the facts by the Tribunal.

6. In this judgment, the Court will first consider the legal framework. It will then set out the facts of the case. Then it will consider the first ground of appeal and the allegations about mutually contradictory grounds of appeal giving rise to alleged injustice. Before considering the remaining grounds, the reasoning of the Tribunal which led to the findings of dishonesty will be considered. This judgment will then consider each of Grounds 2-6.

II Legal framework

7. The legal framework is as follows.

8. Section 40 of the MA 1983 provides a right of appeal to the High Court against a sanction imposed by the Tribunal The relevant part of s 40 provides:

> *"(1) The following decisions are appealable decisions for the purposes of this section, that is to say -*
>
> *(a) a decision of a Medical Practitioners Tribunal under section 35D above giving a direction for erasure, for suspension or for conditional registration or varying the conditions imposed by a direction for conditional registration;*
>
> ...
>
> *(7) On an appeal under this section from a Medical Practitioners Tribunal, the court may –*
>
> *(a) dismiss the appeal;*
>
> *(b) allow the appeal and quash the direction or variation appealed against;*
>
> *(c) substitute for the direction or variation appealed against any other direction or variation which could have been given or made by a Medical Practitioners Tribunal; or*

(d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court,

and may make such order as to costs (or, in Scotland, expenses) as it thinks fit."

9. CPR r 52.21 provides:

"(1) Every appeal will be limited to a review of the decision of the lower court unless -

(a) a practice direction makes different provision for a particular category of appeal; or

(b) the court considers that in the circumstances of an individual appeal it would be in the interests of justice to hold a re-hearing.

...

(3) The appeal court will allow an appeal where the decision of the lower court was -

(a) wrong; or

(b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court."

10. Paragraph 19 of PD52D provides:

"(1) This paragraph applies to an appeal to the High Court under –

...

(e) section 40 of the Medical Act 1983;

...

(2) Every appeal to which this paragraph applies must be supported by written evidence and, if the court so orders, oral evidence and will be by way of re-hearing."

11. The Appellant refers to the judgment of Julian Knowles J in *Khan v General Medical Council* [2021] EWHC 374 (Admin) at paras. 54-65. In his judgment, Julian Knowles J referred to the judgment of Cranston J in *Yassin v the General Medical Council* [2015] EWHC 2955 (Admin) [32], who explained the scope of an appeal under s 40 in the following terms:

> *"32. Appeals under section 40 of the Medical Act 1983 are by way of re-hearing (CPR PD52D) so that the court can only allow an appeal where the Panel's decision was wrong or unjust because of a serious procedural or other irregularity in its proceedings: CPR 52.11. The authorities establish the following propositions:*
>
> *(i) The Panel's decision is correct unless and until the contrary is shown: Siddiqui v. General Medical Council [2015] EWHC 1996 (Admin), per Hickinbottom J, citing Laws LJ in Subesh v. Secretary of State for the Home Department [2004] EWCA Civ 56 at [44];*
>
> *(ii) The court must have in mind and must give such weight as appropriate in that the Panel is a specialist tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserves respect: Gosalakkal v. General Medical Council [2015] EWHC 2445 (Admin);*
>
> *(iii) The Panel has the benefit of hearing and seeing the witnesses on both sides, which the Court of Appeal does not;*
>
> *(iv) The questions of primary and secondary facts and the over-all value judgment made by the Panel, especially the last, are akin to jury questions to which there may reasonably be different answers: Meadows v. General Medical Council, [197], per Auld LJ;*
>
> *(v) The test for deciding whether a finding of fact is against the evidence is whether that finding exceeds the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible: Assucurazioni Generali SpA v. Arab Insurance Group [2003] 1 WLR 577 , [197], per Ward LJ;*
>
> *(vi) Findings of primary fact, particularly founded upon an assessment of the credibility of witnesses, will be virtually unassailable: Southall v. General Medical Council [2010] EWCA Civ 407 , [47] per Leveson LJ with whom Waller and Dyson LJJ agreed;*
>
> *(vii) If the court is asked to draw an inference, or question any secondary finding of fact, it will give significant deference to the decision of the Panel, and will only find it to be wrong if there are*

> *objective grounds for that conclusion: Siddiqui, paragraph [30](iii);*
>
> *(viii) Reasons in straightforward cases will generally be sufficient in setting out the facts to be proved and finding them proved or not; with exceptional cases, while a lengthy judgment is not required, the reasons will need to contain a few sentences dealing with the salient issues: Southall v. General Medical Council [2010] EWCA Civ 407, [55]-[56];*
>
> *(ix) A principal purpose of the Panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the medical profession so particular force is given to the need to accord special respect to its judgment: Fatnani and Raschid v General Medical Council [2007] EWCA Civ 46 , [19], per Laws LJ."*

12. The Appellant also referred to the decision of the Warby J (as he then was) in *R(Dutta) v GMC* [2020] EWHC 1974 (Admin), [21] who referred to circumstances where despite the foregoing, the appellate tribunal may reach a different conclusion at para. 21:

> *"…*
>
> *(5) In this context, the test for deciding whether a finding of fact is against the evidence is whether that finding exceeds the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible: Yassin, [32(v)].*
>
> *(6) The appeal Court should only draw an inference which differs from that of the Tribunal, or interfere with a finding of secondary fact, if there are objective grounds to justify this: Yassin, [32(vii)].*
>
> *(7) But the appeal Court will not defer to the judgment of the tribunal of fact more than is warranted by the circumstances; it may be satisfied that the tribunal has not taken proper advantage of the benefits it has, either because reasons given are not satisfactory, or because it unmistakably so appears from the evidence: Casey [6(a)] and cases there cited, which include Raschid and Gupta (above) and Meadow [125-126], [197] (Auld LJ). Another way of putting the matter is that the appeal Court may interfere if the finding of fact is 'so out of tune with the evidence properly read as to be unreasonable': Casey, [6(c)], citing Southall [47] (Leveson LJ)."*

III The contested history of what occurred

13. This is taken largely from the what the Claimant in the skeleton on her behalf referred to as the summary of the primary case for the GMC. Dr Rahim was a general practitioner (GP) partner at a surgery in Kent. Patient A attended the surgery on 2 January 2018, presenting with a chesty cough which had been present for some months. She had previously been examined by Dr X on 14 November 2017 when she had given a history of the cough and he had examined her and listened to her chest.

14. When she saw Dr Rahim, Patient A asserted that she told her that she had seen Dr X and repeated the history which she previously had provided to him. Dr Rahim said that Patient A did not mention her previous consultation with Dr X. She gave a history of nasal/sinusitis clinical complaints which was documented in her previous medical notes. Dr Rahim examined her and gave a diagnosis of post-nasal drip and prescribed amoxicillin. Dr Rahim measured her oxygen saturation levels which were normal and recorded that she was not breathless at rest.

15. The consultation notes recorded, '*SOB (shortness of breath) and chest feels tight'.* The evidence of Patient A and the case against Dr Rahim was that the note reflected the history that Patient A did present as having shortness of breath.

16. Patient A returned to see Dr Rahim on 16 January 2018. Her symptoms had changed to the extent that she now had a productive cough with green sputum and felt achy and feverish. Patient A also said in terms that she repeated the history provided to Dr Rahim on 2 January 2018. Dr Rahim prescribed a further course of a different antibiotic, clarithromycin, for a period of 7 days.

17. Thereafter Patient A transferred to a different surgery. She requested a copy of her medical notes and saw Dr B on 2 March 2018. He recorded a history of 'pan' sinusitis and prescribed further antibiotics. On 13 April 2018, he referred Patient A for a chest X-ray and after a second X-ray Patient A was diagnosed with lung cancer.

18. In the summer of 2018, Dr Rahim learned that Patient A had been diagnosed with lung cancer. On 7 August 2018, she reviewed her notes, which were inactive notes (in that the patient had by this stage moved to another surgery). She saw that the notes referred to "SOB" and believed that they had been written in an incorrect manner. She said that her normal practice was to write "SOB" for shortness of breath and where there was no shortness of breath a minus sign before the "SOB". She believed that she had simply omitted the minus sign.

19. She amended Patient A's now *inactive* medical records retained and archived at Dr Rahim's surgery in the following ways:

> ***"2nd January 2018***
> *"SOB and chest tight", was amended to "no SOB but chest tight". Dr Rahim also added the entries "no chest pain" and "no weight loss"*
> ***16th January 2018***

Dr Rahim added "last cxr 2016 clear review if not better with view of cxr."

20. Dr Rahim gave evidence to the effect that the amended record referred to what occurred, namely that there was no shortness of breath. She gave evidence that the amendments and additions were corrections to provide a true record of what she had observed at the time.

21. On 31 December 2018 Patient A complained about Dr Rahim's clinical care and the failure to refer her for a chest X-ray. In her written response, Dr Rahim gave an account of the consultation at variance from that which was originally recorded in the unamended consultation notes. She also sent a copy of the now amended notes along with her letter of response. However, the records which Patient A obtained were the unamended notes, which were different from amended notes.

22. The GMC alleged that the notes as unamended were an accurate and contemporaneous record of the consultation. It alleged that the amendment to the notes and the fact that they were sent with the response to the complaint together comprised a dishonest attempt to cover up an error, namely that Dr Rahim should have referred Patient A for a chest X- ray.

23. The charges also alleged a number of clinical failings. The central clinical criticism was that if Dr Rahim was told of both a cough and shortness of breath on 2 January 2018 and/or 16 January 2018, the NICE guidance mandated a referral for a chest X-ray. Dr Williams (the GMC expert) and Dr Middleton (the defence expert) were agreed that if Dr Rahim's account was correct then her clinical diagnosis and management were reasonable. It therefore followed that central to the case was whether the Tribunal were satisfied that Patient A had said she had shortness of breath and/or whether Dr Rahim had failed to tell her to return if the symptoms did not improve.

24. The account of Dr Rahim was that she amended the inactive notes on 7 August 2018. She did so not to mislead, but to correct her own record. Since the notes were inactive, there was no question of her utilising the notes. Subsequently, when she received the complaint, she gave an account of what she believed had occurred with the assistance of the amended record. She mistakenly left the amended notes with other documentation which were unintentionally sent to Patient A when she answered the complaint.

25. Dr Rahim said in evidence that had she been told of shortness of breath, she would have referred Patient A for an X-ray in accordance with NICE guidance. Her diagnosis and patient management were because there was no history of shortness of breath. She denied that she had acted dishonestly. She observed that she was aware that her actions were audited, and it would be immediately apparent from such audit records that she had amended the notes. Further, Patient A had access to the unamended notes.

IV Ground 1: the inconsistent cases

26. The primary case was the wrong diagnosis and the dishonesty to cover up the wrong diagnosis. Following service of Dr Rahim's witness statement, the GMC amended the

charges and further alleged that if Dr Rahim's case was or might be true, then she failed to make adequate record of the consultations including her working diagnosis and clinical management. Dr Rahim accepted some of these charges and the GMC was informed that she would accept allegations 1(d)(i) -(iii) and 2(d)(iii). They were that Dr Rahim failed to make an adequate record of the consultation in that she recorded "SOB" rather than "no SOB", she did not record the absence of chest pain and she did not record the absence of weight loss (allegations 1(d)(i-iii)), and the discussion regarding Patient A's X-ray (allegation 2(d)(iii)). She admitted those charges at the start of the hearing, and the Chair announced the allegations proved in accordance with Rule 17(2)E of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 which reads as follows:

> *"(2) The order of proceedings at the hearing shall be as follows—*
>
> *...*
>
> *(e) where facts have been admitted, the Chairman of the FTP Panel shall announce that such facts have been found proved"*

27. After the Tribunal announced that the matters admitted were proved Mr Grey, Counsel then appearing for the GMC, asked the Tribunal not to follow the Rules and to find the matters not proved at this stage, as the admissions were contrary to the primary GMC case. It was submitted on behalf of Dr Rahim that it was possible to have a primary and a secondary case provided that they were not mutually exclusive, but in this case, they were mutually exclusive. Following the opening submissions, the Chair stated that she was going to advise the Tribunal that the facts remained in dispute. Mr McCartney for Dr Rahim refused to withdraw the admissions. The Tribunal found inter alia that the *"admissions were withdrawn and found not proved."* It was Dr Rahim's case before the Tribunal and this Court on appeal that this was not correct. The admissions were not withdrawn.

V The submission of Dr Rahim

28. Mr McCartney for Dr Rahim submitted that the added charges were a serious procedural irregularity. They were mutually exclusive of the primary charges. The notes were only inadequate if Dr Rahim's account of the consultations of 2 January 2018 and 16 January 2018 was correct. There were the following problems caused by these additions, namely:

(1) It made it unclear what was the GMC's case in that it was not clear whether the case was on the basis that Dr Rahim acted as per her account of the consultations or that her account of the consultations was false in which case there was no scope for the additional charges.

(2) It was possible to have alternative counts where the lesser count was subsumed within the greater count, but not where the lesser count was in contradiction of the

greater count, and where the evidence led by the regulator was contrary to the evidence on which the lesser count depended.

(3) Once admissions were made in respect of the lesser counts, then under the Rules, it was incumbent on the Tribunal to accept the admissions in which case the contradictory greater counts could not be proceeded with.

(4) In this case, the admissions were accepted. The Tribunal did not have power to treat them as being withdrawn. In any event, they were not withdrawn.

(5) There was a real prejudice in having contradictory counts in that it ignored the fact that the burden of proof was on the regulator at all times, and a party could not condemn herself by admissions which were in any event contradictory to the case led by the regulator.

29. Dr Rahim drew attention to the case of *Sloan v General Medical Council* [1970] 1 WLR 1130 before the Privy Council. In that case, there were charges alleging that the doctor represented that the purpose of pills and injections was to procure a miscarriage and that an operation for the termination of pregnancy had been performed. The effect of this charge was either that the representation was false in which case money had been obtained for the service by deceit or the representation was true in which case illegal abortions had been performed. Either way, the doctor would have been guilty of infamous conduct, as professional misconduct was then called. Lord Guest, giving the opinion of the Privy Council, said:

> *"Their Lordships cannot too strongly deprecate the preferment of charges in this form. If it is desired to prefer alternative charges then they should be preferred in the alternative in the recognised form leaving the committee to decide on the evidence which alternative has been established. In their Lordships' view it is embarrassing to the doctor to prefer a charge which on the face of it is ambiguous and presents two alternatives for the committee's consideration. This in fact was a "trap charge" so that whichever explanation was given by the doctor he could not fail on the view of the respondent to be convicted. Upon the facts as known to the respondent before the charge was preferred it was reasonably plain upon the evidence of the girls and upon the statements made by the doctor to the police that the representations made by him were false, made by him for the designed purpose of preventing the girls going at an earlier stage to a professional abortionist and were made in conformity with his religious beliefs. In these circumstances their Lordships fail to understand why the charge initially was not one of making false representations that the pills and injections were given with the intention of procuring a miscarriage and that an operation to that end had been performed. There was evidence that the pills*

> *and injections were not intended to procure a miscarriage. There was no evidence that an illegal operation had been performed. Their Lordships hope that the practice of preferring charges in this way will not be continued."*

30. The mischief of the rolled-up charge was that it would not be possible for the practitioner to know for which of the two offences he or she had been convicted. However, on the facts of *Sloan v GMC*, the only matter really before the Tribunal had been the false representation and not conducting an illegal abortion. Accordingly, there was no prejudice caused to the doctor, and the finding of infamous conduct stood. Dr Rahim says that in the instant case, the charges represented trap charges whereby Dr Rahim stood to be convicted on whatever was found. It was procedurally unfair for her to find that whichever she would defend herself, she might find herself guilt of professional misconduct.

31. In an additional written argument dated 20 October 2021 with the permission of the Court, Mr McCartney on behalf of Dr Rahim made submissions of an analogy between criminal law and regulatory law, submitting that there could be alternative, but not mutually exclusive, charges. Reference was made to *R v Nelson* [2016] EWCA Crim 1517 about the undesirability of leaving very similar charges to a jury. However, that has no direct application to the instant case. Reference was also made to *Hussain v Ahmed* [2021] EWHC 2213 about a refusal to permit an amendment, but that was because the amendment would have been inconsistent with the evidence and the documents and thus did not satisfy the threshold of arguability. In a responsive argument of 25 October 2021, Ms Hearnden for the GMC referred to a decision of the Divisional Court of *R (Kuzmin) v GMC* [2019] EWHC 2120 (Admin) in which Hickinbottom LJ (with whom Butcher J agreed) adverted to significant differences between criminal and civil proceedings and how disciplinary proceedings were civil proceedings despite the very serious potential consequences. The use of analogies between the two different types of proceedings was therefore of limited utility.

VI The submission of the GMC

32. The GMC submitted that it was in order to have a primary charge and a secondary charge. Looking at the public interest, if a defence advanced by a doctor itself amounted to professional misconduct, then the doctor should be charged with that charge too. It was obvious that the charges about a failure to made adequate records was an alternative charge to cater for the contingency that Dr Rahim may not be found guilty of the primary charges. When the admissions were made, the Tribunal was entitled following submissions to refuse the admissions (even if they had been accepted in the first place) because they contradicted the primary basis of the charges against Dr Rahim.

33. There is no law which prevents the laying of alternative charges even where the evidence for the lesser charge was in contradiction to the primary and graver charge. The position was never unclear to Dr Rahim. In any event, once the admissions had been removed, and the trial proceeded, it was clear that the case was all about the primary charges. Ultimately, the primary charges were found proved and there was uncertainty of what was the professional misconduct found against her.

VII Discussion

34. It would have been better if the charges had been expressed to be alternatives which only arose in the event that there had not been guilt found in respect of the graver charges of dishonesty and the clinical failures identified. In that event, it might have been that the admissions would not have been accepted at all. Nevertheless, the nature of the alternative pleas was stated in clear terms when the final amendments were sent to the Tribunal in March 2021 in the following terms, namely:

> *"'Please note that the final Rule 15 allegations differ from the draft allegations previously disclosed to you as amendments were made following consideration of the joint expert report.*
>
> *Paragraph 1a concerns the alleged failure to refer for a chest x-ray on 2 January 2018.* ***Paragraph 1. d. i, ii, iii and 2. d. iii are all 'alternatives' relating to inadequate record keeping in the event that the Tribunal accept Dr Rahim's version of events.***
>
> *Paragraphs 5 and 6 relate to inadequate record keeping in the event that the Tribunal find that the original records were an accurate record of the consultation and that the amendments made in August resulted in inaccuracies.' (emphasis added).*

35. There is no authority which prevents preferring lesser charges based on the admissions of a doctor even if they contradicted the primary case of the GMC. This was not a case like the case of *Sloan* where there was a rolled-up charge so that whichever way it fell, the doctor would be liable, and it was possible in theory that it would not be apparent on which basis he had been found guilty. In fact in *Sloan*, this did not arise because it was obvious that the only operative charge was the false representation that abortifacients had been administered. In the instant case against Dr Rahim, in the findings which took place, it was apparent that the operative charges were (1) the failure to act on shortness of breath and to take precautionary steps which would have led to the diagnosis of lung cancer, (2) the dishonest alteration of the notes so as to conceal that shortness of breath had been discovered, and (3) the dishonest account to Patient A in the face of the complaint including provision of the amended notes without confessing to the amendments.

36. There was no breach of natural justice because it was obvious from the start that the extra charges were lesser charges if the primary case failed. There was no prejudice to Dr Rahim just as there was no prejudice to the doctor in *Sloan.* It is possible in theory that there could have been a problem in finding Dr Rahim guilty simply of the lesser charges based on the admission of Dr Rahim. If the primary charges had not been found because they had not been proved on the balance of probabilities, then it did not necessarily follow that the lesser charges had been proved. Assume that the primary charges had not been proved because it was evenly balanced, namely the evidence pointed neither to the fact that they had been committed nor to the fact that they had not been committed. In those circumstances, it would in theory be possible to say that the lesser charges would not be proved because the veracity of admissions was not proved on the balance of probabilities.

37. That theoretical possibility did not arise in the circumstances of this case because the primary case against Dr Rahim was proved on the balance of probabilities. The charges where the admissions had been treated as withdrawn did not therefore arise for consideration. It did not matter that admissions had been made or that the admissions had been accepted, because in my judgment, the Tribunal was entitled before proceeding with their adjudication to treat the admissions as if they had been withdrawn. The fact that it was not technically correct to say that the charges had been withdrawn did not matter: that was only infelicitous language. It would have come to the same thing if the Tribunal had said that they were not prepared to treat the admissions as valid until and unless the inconsistent and more serious charges had been the subject of adjudication.

38. The Rules do not require that the Tribunal act upon the admissions by accepting them and thereby removing from their adjudication the primary charges. In my judgment, it did not follow from the fact that the lesser charges had been proved on the basis of admissions that the Tribunal was not entitled to go on to consider the more serious charges. The Tribunal was entitled to consider that it was premature to treat the admissions as proved when they contradicted the facts underlying the primary case. Instead, it treated the admissions as withdrawn on the basis that they contradicted the primary case.

39. There was not a stage when there was an election to accept the lesser charges in lieu of the primary charges. The reasons for this are as follows. First, the primary charges were never withdrawn and there was always an intention to adjudicate upon the same. There was therefore no election by approbating the lesser charges whilst reprobating the primary charges. On the contrary, there was nothing done by the GMC to abandon the primary charges whether expressly or by conduct. Second, insofar as it was a decision of the Tribunal, its acceptance of the admissions did not mean that the lesser charges were to be treated as dealt with instead of the primary charges. This was simply a building block on the way towards reaching a final decision. The Tribunal was not functus officio until the conclusion of the hearing. As part of the process towards their final decision, the Tribunal was entitled to go on to deal with the primary charges and in the interim treating the admissions as in effect withdrawn did not amount to a procedural irregularity.

40. The first ground of appeal is therefore rejected on the basis that there was no procedural irregularity. It follows that the Tribunal was entitled, as it did, to consider the primary case and to prefer Patient A's account as being consistent with the contemporaneous note. It was entitled then to consider that there had been a clinical misjudgement. There was also dishonesty in the amendment of the notes without pointing out in the notes that they were amended and further dishonesty in the way in which Dr Rahim dealt with the complaint including by sending the amended notes without highlighting that they had been amended.

VIII The reasoning of the Tribunal

41. Before considering the other grounds of appeal, consideration is given to the basis on which the Tribunal found that the case was proved against Dr Rahim. It is important to have this in mind in consideration of the matters which follow in order to understand the criticisms of the Tribunal in the context of their reasoning process in the decision. The numbers in brackets are to paragraph numbers of the decision of the Tribunal.

42. The Tribunal stated that it *"bore in mind the defence submissions that she may not be a reliable historian as she appeared to be complaining of other doctors not properly following up her cough. These complaints, it was submitted, were not supported by the relevant consultation notes [24]."* It also *"bore in mind that the GMC submissions that [Dr Rahim] was making those amendments 7 months after the consultation when her memory regarding the consultations are likely to have deteriorated [25]."* It concluded that *"the primary source of evidence was the consultation notes themselves, both the original and the amended versions [26]."*

43. As regards Patient A's evidence, the Tribunal *"bore in mind that Patient A was remembering a consultation that happened some time ago, she was looking at it as a patient who had been diagnosed with lung cancer and as a patient who had seen the original consultation notes. The Tribunal also bore in mind that Patient A had sought to criticise at least one other doctor (referred to in this determination as 'Dr B') for failing to record her complaints properly. Although there was no evidence from Dr B about the consultation before it the Tribunal noted that the GMC had received a complaint about Dr B*[1] *from Patient A and closed it within 7 days. In all the circumstances, the Tribunal was cautious with regard to the weight it placed on Patient A's account and determined to not rely solely on it [76]."*

44. This showed that the Tribunal was wary about Patient A and in particular because she had sought to criticise at least one doctor. The reference to at least one doctor is because there may have also been a complaint about the doctor with whom the consultations took place in March/April 2018, albeit that the decision made no express reference to that doctor.

[1] It is apparent that Dr B here is a reference to Dr X.

45. The Tribunal accepted there may have been reasons for Patient A to have stood out to Dr Rahim as someone who did not normally consult with her and who did not like her [48] and [78]. However, it concluded at [79] that:

> *"The Tribunal was of the view, however, that Dr Rahim's evidence lacked credibility that she would remember both consultations to the extent of the detail that was claimed 7 months' later. She would have seen many hundreds of patients and had many more consultations in that time. There was no real reason given for the details of the consultations as opposed to the patient herself to stand out, given the passage of time."*

46. The Tribunal found that the changes in the notes were "significant" [[80]. It was not a minor typographical error. It was not only that she "missed a minus" before shortness of breath, but also that she changed the word "and" to "but" and recorded a conversation for the first time about "no weight loss" (as opposed to no reference to weight loss) and about "no chest pain" (as opposed to no reference to chest pain). Likewise, as for the change from "no reference to chest x-ray" in the note of 16 January 2018 to "last cxr 2016 clear review if not better with view of cxr", there was no reason not to refer back to the 2016 notes if she had looked back to them at the time, and it was much more likely that her awareness of this detail came from her review of the Patient A's notes on 7 August 2018 [93].

47. The response to the complaint read as if it was based on an original and contemporaneous note of the consultations [102]. There was no explanation to say that the consultation notes had been amended [100]. There was a duty on a doctor to note that there had been an amendment in relying on the note when corresponding with a patient or anyone else [105]. It would not have been obvious to Patient A from the letter of response by itself that the records had been amended [107].

48. In the summary of the decision, the following should be interpolated. The above paragraph of this judgment is consistent with the terms of the response which read in part as follows:

> "The written response was in the following terms:
>
> *"Looking back at your computer notes, I can summarise that I saw you in January 2018 for your presentation of persistent cough... **shortness of breath**ing, but said your chest feels tight. There is **no reported weight loss or chest pain** or coughing up blood.... on examination you did not look breathless at rest.... you returned 14 days later, and this time you reported the continuing cough. And this time with productive green sputum in the back of your throat, along with feverish feeling, again on chest examination. Your lung field sounded clear without wheezing or crepitation.. And to review you with a view of chest x-ray if things **I did mention that your last chest***

> ***x-ray in 2016 was normal*** *has (sic) not improve after the second course of antibiotic...[emphasis added]"*

49. Although Dr Rahim said that she did not intend to send the notes with the written response, it will be noted that in the body of the response, it was said to be written "looking back at your computer notes". It was not said, "looking back at your computer notes as amended several months after the notes were first written." Without more, this was an implied representation that the letter was being written by reference to the contemporaneous notes of the examination of Patient A at the appointments of 2 and 16 January 2018.

50. The Tribunal found that Dr Rahim knew that her amendments were untrue for the following reasons:

(1) It was not appropriate to amend the records in the way in which Dr Rahim did even as a learning exercise; if there was a learning exercise, a separate note of the case review would have been appropriate [118-121] and [129];

(2) When the amendments were made, Dr Rahim had no knowledge that Patient A had the original, unamended notes [123];

(3) It was reasonable to infer that Dr Rahim anticipated a complaint about her failure to refer for further investigations including a chest X-ray, and that she amended the notes for use to defend any anticipated criticism by Patient A of any clinical failure [125] and [128].

51. The Tribunal set out and applied the test for dishonesty set out in the Supreme Court case of *Ivey v Genting Casinos* [2017] UKSC 67 at para. 74. It concluded as follows:

> *"131. Having therefore determined that Dr Rahim had deliberately set out to amend the notes in anticipation of a potential complaint with regard to her clinical care the Tribunal determined she was subjectively dishonest.*
>
> *132. Ordinary decent people would find that the amendment of the consultation notes in anticipation of a complaint was wholly inappropriate and very serious. The Tribunal therefore determined that her actions were objectively dishonest.*
>
> *133. Based on all the evidence, the Tribunal was of the view that it was likely Dr Rahim was both subjectively, and objectively dishonest when she amended the notes."*

52. It is now necessary to consider each of Grounds 2-6, albeit that Grounds 2 and 3 can be considered together since Ground 2 is about the failure of the GMC to disclose material and Ground 3 is about the Tribunal failing to order disclosure of the same.

IX Ground 2 and 3:

Ground 2: Wrong refusal of GMC to disclose material capable of undermining reliability or credibility of Patient A, and Ground 3: Wrong failure of the Tribunal to order disclosure of the same.

(a) Submission of Dr Rahim

53. After consulting with Dr X, Patient A made a complaint against Dr X. That complaint was dismissed by the GMC within 7 days. Patient A said that she had discussed the matter with the GMC solicitor, Mr. James McDermott, and asked him to investigate it. In her statement, Patient A asserted that when she saw Dr X on 14 November 2017, she had provided a history of her cough to him. She asserted that he had listened to her chest and found it to be clear. They had a discussion about whether it was viral or bacterial and source. However, the notes of the consultation made no reference to any complaint of a cough and dealt with her depression. She also said that she trusted Dr X completely. She asked if the notes of Dr X had been changed, but Mr McDermott said that that did not appear to be the case. This undermined the evidence of Patient A, that she made a complaint of a cough to Dr X at the consultation of 14 November 2017. There was also a contradiction between Patient A's evidence that she trusted Dr X completely with the statement that she had made a complaint to the GMC about his professional conduct.

54. Further, Patient A asserted that she had given a history of a cough and shortness of breath, stroke and asthma-like symptoms to Dr B whom she saw on 2nd March 2018. Here, too, there was no record of her account in Dr B's medical notes. Further, when Patient A was referred for an x-ray on 13 April 2018, the reason given for the referral was a cough alone, and there was no mention of shortness of breath. Either Patient A had not given the history to Dr X and Dr B as she asserted, or they had both failed to write it in the notes. If she had not given that history as the notes indicated, it was submitted on behalf of Dr Rahim that this was supportive of the fact that Patient A had not complained of shortness of breath to Dr Rahim, either on 2nd January. 2018 or 16 January 2018 as Doctor Rahim asserted.

55. In the light of Patient A's evidence, the defence applied for disclosure of any complaint which Patient A made about Dr X. The GMC stated that a complaint had been made on 29th January 2020 but was dismissed on 5th February 2020. The GMC did not disclose the details of the complaint, why it was dismissed, or even who considered it. The GMC asserted that the requested material was a "red herring" since the instant complaint was not about Dr X.

56. On Day 2, Mr McCartney on behalf of Dr Rahim sought further disclosure in respect of the details of discussions between Patient A and the GMC solicitor concerning Dr X, which prompted the Chair to observe: "*I'm bound to say, Mr McCartney, as to who the conversation was with, whether it was in email or whether it was by telephone, may not take your case any further and may be of very marginal relevance. What you wanted to know is was there a complaint against Dr X and what happened to it, and you know the answer to those questions. We're told by Mr Grey that there's nothing further in the content of those documents that are relevant to those issues to disclose, posing the questions both you and I have put on the record now as to credibility and reliability".*

(b) The submission of the GMC

57. The GMC submitted that it had made all further disclosures from which it could be inferred that nothing said in Patient A's evidence that was known to be materially inaccurate had not been disclosed. In the appeal, the GMC said that in the event that the Court required further assistance at the hearing, copies of the relevant attendance notes/complaint form about Dr X would be available for review de bene esse. There were said to be 16 pages. These documents were not supplied to Dr Rahim who did not seek them, nor was there an application on behalf of the GMC to adduce them. Faced with this, the Court did not look at the documents on the basis that there was no application to adduce them and that there was no reason to depart from a starting point that the appeal should be decided in the first instance on the materials before the original court or tribunal. If an application were made to adduce new material, it would usually be subject to the test in *Ladd v Marshall* [1954] 1 WLR 1489.

(c) Discussion

58. In my judgment, there is no reason to believe that there were additional documents capable of supporting or adversely affecting the other party's case. This was the approach of the GMC at the hearing, and when the matter was reviewed with new Counsel Ms Hearnden on the appeal, it was confirmed that *"Obviously the primary submission is that the GMC says it has turned its mind to the proper test and disclosed what needs to be disclosed."* (p.65 of the transcript).

59. It follows that the offering of documents de bene esse was in case the Court should not be satisfied by that submission. In any event, the Court was not required to examine the documents without an application by either party for the Court to review the documents. The Court will not infer that this shows that there were no further documents to disclose, but the Court does arrive at this conclusion from a different route, namely that it has not been shown that the disclosure was inadequate.

60. In my judgment, the nature of disclosure is that the parties act as gatekeepers, having professional duties to make the relevant disclosure. In this case, the matter of disclosure was considered by the Tribunal and the GMC. It has not been shown that the matter was neglected by either or that there was a wrong test applied or that the matter was not evaluated. It has not been shown that there is an inference that there are or are likely to be documents which have not been disclosed which ought to have been disclosed.

61. The Tribunal was also entitled to come to the view that the area of the request was of very marginal relevance. The Tribunal in its judgment did take the view that Patient A may *"not be a reliable historian"*. Her complaints were not supported by the consultation notes (para. 24 of the decision). Further, the Tribunal was cautious about the weight to be attached to the evidence of Patient A (para. 76 of the decision).

62. In all the circumstances, there was no procedural error either in the non-production of further documents, nor in the case management decision of the Tribunal not to order such production. If, contrary to the foregoing, there was a procedural error, it was submitted by the GMC that it was not a serious procedural error because it was one which made no difference to the outcome. It is recognised that this is a high threshold: see *R (Smith) v North Eastern Derbyshire Primary Care Trust* [2006] 1 WLR 3315, 3321. In this case, the information that the Tribunal had about Patient A who trusted Dr X yet complained about him, and further who claimed that three doctors had failed to record symptoms, was enough to suggest that Patient A was indeed an unreliable historian. In the instant case, it was primarily the contemporaneous document, that is the unamended record, and the view of Dr Rahim's evidence regarding the amendments, that led to the decision in this case. This therefore is a case where if, which has not been established, there was a failure of disclosure, it has not affected the outcome and no prejudice has occurred. There has been no serious procedural error.

X Ground 4: Wrong prohibition of the Tribunal of cross examination of the expert Dr Williams in respect of Patient A's medical notes for 2 March 2018

(a) Submission of Dr Rahim

63. There was evidence from Patient A that she had told Dr B in March 2018 about her asthma-like symptoms and/or cough. In cross-examination Dr Williams was asked what he would have expected to occur if a doctor had read the previous notes of Patient A. The purpose of the question was to try and establish that if Dr B had been told the history which Patient A asserted, coupled with Dr Rahim's notes, his clinical management would be expected to be quite different, notably he would have been subject to the mandatory NICE guidance to refer for an X-ray, which he did not do.

64. Mr Grey, Counsel on behalf of the GMC before the Tribunal, objected to this line of cross-examination. The defence submitted that the absence of any note of Patient A's asserted history, coupled with the fact that Dr B did not refer her for an X-ray on the basis of

shortness of breath, was relevant to Patient A's reliability/credibility. It put in issue whether she had given that history to Dr B at all. The Chair said in oral argument:

> *"You can see that there is nothing to be gained by asking Dr Williams about this apart from potentially to criticise [Dr B], who is not giving evidence at the tribunal – which you have already"*

65. It was submitted that the purpose of the question was not to criticise Dr B, but to establish that it was unlikely that Patient A had given the history of shortness to breath/asthma/cough to him or else he would have acted upon it.

66. The medical notes had been adduced by the GMC and undermined Patient A's account. Neither Dr X nor Dr B gave evidence. The Tribunal observed that the history Patient A said that she provided to Dr X was not recorded, and her purported complaint was rapidly dismissed. A similar observation could be made in respect of the consultation with Dr B, however the Tribunal prohibited exploration of the point with the GMC expert and made limited reference to it in its determination.

67. If the defence had been allowed to explore this issue, then consistent with the criticism of Dr Rahim (based on Patient A's account) Dr Williams was likely to have opined that he would have expected a doctor in Dr B position to accurately record the history and adopt a different clinical course distinct from prescribing a further course of antibiotics. It would have been highly supportive of Dr Rahim's case, as it would have further undermined the reliability of the evidence of Patient A regarding the accuracy of her recollections and the history she provided to three different doctors on three different occasions.

(b) Submission of the GMC

68. The record in respect Dr B's consultation with Patient A on 2 March 2018 was the subject of questions. Patient A was cross-examined about the consultation with Dr B [T1/49-T1/50]. (She was also cross-examined about Dr X at [T1/38-1/43] and [T1/46-T1/47]). Dr B did not give evidence and did not provide a witness statement. It was put to Dr Williams that "*We obviously don't have Dr B here, but interpreting it [the record] as best we can, Dr B has taken a history of sinusitis and has tried to address that problem by dealing with infection and dealing with nasal drops"* [T3/28C]. Dr Williams offered some comment/speculation and counsel for the GMC interjected on the basis that the exchange was "*getting into the realms of assumption and speculation. There is no direct evidence save for the record and I'm just concerned that this is a witness who can't answer to what was told to a doctor in a moment he wasn't present in*" [T3/28F]. The Chair agreed: "*the record is what the record is…The only person who can speak to these records as part of these proceedings is Patient A and you explored it with Patient A"* Later, the Chair

directed that matters should focus upon the Appellant's conduct, rather than Dr B [T3/33-34].

69. The GMC submitted that the Chair's interventions were properly made to ensure that speculation was avoided and that expert evidence was limited to points upon which the expert could offer an opinion. The defence was not hampered from making the point about Patient A's credibility, and her repeated complaint that doctors did not accurately record what she said, which was fully understood by the Tribunal (as evidenced by the exchanges with the Chair).

(c) Discussion

70. In my judgment, the observations of the Chair were properly made. There was no procedural irregularity. The matter was fully tested with Patient A. Her credibility was seriously undermined where it was inconsistent with contemporaneous notes. As a matter of case management, the Tribunal was entitled to avoid speculation on the part of Dr Williams and to confine the examination to the evidence of Patient A and the contemporaneous notes.

71. If and insofar as what is being said is that the absence of a note of shortness of breath by Dr B was evidence that Dr Rahim may have been correct in her recollection that there was no shortness of breath in January 2018, the response is as follows. First, the Tribunal was able to take that into account without evidence from Dr Williams about this. Second, the Tribunal was entitled to come to the conclusion that Dr Rahim's contemporaneous record was likely to be correct in that she was unlikely to have recalled what occurred in the consultations 7 months after the event. This was decisive together with Dr Rahim's cover up, namely her conduct in amending the notes without any indication that they were amended, and then passing off the same as original notes in the context of a complaint.

72. In view of the foregoing, there was no procedural irregularity. There was a case management decision which was available to the Tribunal. If, which is not accepted, there was an irregularity, it was not a serious one. It caused no injustice in that the decisive points were the ones set out in the preceding paragraph as a result of which the Tribunal came to an unimpeachable decision.

XI Ground 5: Wrong approach of Tribunal to factual determination by determining allegations 5 – 7 before the clinical allegations

(a) The submission of Dr Rahim

73. It was submitted on behalf of Dr Rahim that there was a serious procedural irregularity in that by focussing first on whether the amendments to the records were not accurate and not on the clinical shortcomings in allegations 1(i-iii) and 2(a.-c.), the Tribunal failed to concentrate on the medical approach of Dr Rahim. Had it concentrated on the medical

approach, it would or could have accepted the submission that the approach of Dr Rahim evidenced that Patient A's condition was as recorded in the amended notes. Her medical examination and approach evidenced that there was no shortness of breath: had there been, a different approach would have been adopted. It was the wrong approach to start with the amendments to the notes, and that was because the Tribunal had neglected to consider the probative effect of the way in which Dr Rahim did treat Patient A. If the Tribunal had adopted this approach, then it would or could have considered the amendments of the notes in a different manner.

(b) The submission of the GMC

74. The GMC submitted that there was no significance in deciding allegations 5 – 7 first. The question at the heart of the case was what Patient A had reported to Dr Rahim shortness of breath and the other matters contained in the unamended note in the consultations of January 2018. In reaching the conclusion which the Tribunal, it took into account the evidence and the various arguments. It did not look at the matter without considering the management of Patient A. It did not simply look at the original notes and the amendment of the notes.

(c) Discussion

75. In my judgment, the argument that the consideration should not have started with deciding allegations 5 – 7 ignores the fact that at the heart of the case was whether the amended records of the consultations of 2 and 16 January 2018 were accurate records of what occurred. There was nothing unfair or illogical about approaching matters in that way: the Tribunal placed significant weight on the contemporaneous (unamended) records and considered the evidence of Patient A and the Appellant. In relation to the amendment relating to the consultation of 2 August 2018, the Tribunal concluded "*In all the circumstances, the Tribunal found that it was more likely than not that, when making the amendments set out at Schedule 1 on 7 August 2018, Dr Rahim failed to make an accurate record of the consultation on 2 January 2018 in that she recorded 'no SOB', when Patient A had reported shortness of breath"* (para.84).

76. In relation to the consultation of 16 January 2018, the Tribunal found that the amended note "*review if not better with cxr*" was not discussed at the consultation, and it was not therefore an accurate record (facts determination, para.95).

77. The Tribunal was well within its powers in approaching the evidence in the way in which it chose to do so. I accept the submission made on behalf of the GMC, namely that in reaching the conclusion which the Tribunal did, it took into account the evidence and the various arguments before it. It was argued before the Tribunal that the clinical management of Patient A indicated that there could not have been an indication of shortness of breath, since if there had been, the treatment would have been different. The fact that the Tribunal did not specifically refer to this argument does not mean that it did not consider it. The

Tribunal was entitled to conclude that far more probative, and in the end the decisive, were the points referred to at paragraphs 41-51 above of this judgment, which include all the references to the decision of the Tribunal. They show the careful attention which the Tribunal gave to the case. They include points made about the notes as originally taken, the nature and the extent of the amendments and the difficulties of recollection 7 months after the event. These points were considered alongside the amendment of the notes by Dr Rahim without indicating that they had been amended and the terms of the letter responding to the complaint in January 2018 referring specifically to the notes as if they were contemporary notes. The Tribunal heard the evidence over days and evaluated the totality of the evidence and came to the conclusions which it was entitled to reach.

78. Having set out its position on the true content of the discussions at each attendance, the Tribunal went on to consider the clinical allegations against those findings of fact. The Appellant's criticism of the Tribunal's approach to the evidence of the Appellant and Dr Middleton (Appellant's skeleton paras.38-42) fails to acknowledge that the Tribunal had determined that Patient A had reported shortness of breath on 2 January 2018 and as such, the Appellant's management plan/advice/recording fell to be assessed on the basis of that finding.

79. This criticism is an impermissible attempt to impugn the fact finding of the Tribunal which the Tribunal at first instance was bound to consider, and it infringes the principles set out by Cranston J in *Yassin v the General Medical Council* set out above. This ground, in addition to the above grounds referred to, must be rejected.

XIII Ground 6: Wrong assessment of the facts by the Tribunal.

80. Ground 6 reads as follows:

> *"The Tribunal failed to consider either adequately or at all:*
>
> *a) The evidence which impacted upon the reliability/credibility of patient A, in particular, the contrast between her evidence and medical notes.*
>
> *b) The clinical pathway adopted by Dr Rahim, which was consistent with the defence case that patient A had stated that she had no shortness of breath.*
>
> *c) Those parts of the medical notes which were supportive of Dr Rahim's assertion that she had not complained of shortness of breath.*
>
> *d) The evidence of Dr Rahim and Dr Middleton that postnasal drip was a frequent cause of a chronic cough.*

e) The significance of patient A's clinical presentation on 16th January 2018, which was indicative of a respiratory infection.

f) The evidence given by Doctor Rahim and Dr Middleton with regard to the follow up advice provided to patient A."

81. Point (a) about Patient A is subsumed largely in the discussion of Ground 2. It was because Patient A's account was not consistent with the notes of the other doctors that the Tribunal was cautious of the weight to be attached to Patient A's account and decided not to rely solely upon it. The criticisms about the evaluation of Patient A contained at para. 67 of the skeleton argument on behalf of Dr Rahim is, in my judgment, an attempt to re-argue the weight to be placed on each item in the case and does not identify points of law or errors of approach on the part of the Tribunal. The shortcomings of Patient A's evidence were manifest.

82. The Tribunal's approach to the evidence was to determine whether the facts alleged had been proved; to give separate consideration to evidence in relation to each individual allegation; and noting that the burden of proof rests on the GMC not the doctor (facts determination, paras.16- 20). The Tribunal's analysis as to the notes, the amendments and the evidence of the witnesses in relation to each consultation is set out under the headings of allegation 5 (para.74- 85), allegation 6 (paras.86-96) and allegation 7 (paragraphs 97-109). That was an entirely proper approach.

83. The Tribunal found far more probative the nature of the original notes and the way in which they were amended than addressing what had been said by the diagnosis and the treatment. As noted by Ms Hearnden in her written submission on behalf of the GMC at para. 90 "*The suggestion that the MPT "failed to address the full clinical picture" (skeleton, para.39) is in reality a challenge to the MPT's findings of fact on the primary case. Those findings were properly and fairly made and there is no basis on appeal for interference with the same."*

84. Contrary to the approach urged in Ground 6, the Tribunal was entitled to attach considerable, and, in the end, decisive weight to the original notes before their amendment, namely that shortness of breath was a feature of Patient A's presentation. The Tribunal took into account that it was unlikely that Dr Rahim would have a better recollection 7 months after the event of what Patient A had said than at the time that she wrote the note. It also took into account the nature of the amendments and the failure to identify that they were amendments in the face of concern about a possible complaint, and about the passing off of the notes as the unamended notes in the face of a complaint.

85. The suggestion that the Tribunal was bound to accede to the argument that "the full clinical picture" provided a more reliable pathway to the determination of how Patient A must have presented herself is an attempt to challenge findings of fact which were properly and fairly made by the Tribunal. Applying the tests of Cranston J in *Yassin v the General Medical*

Council set out above, there is no basis for this Court to interfere with the findings of fact of a specialist tribunal, having seen the witnesses, and having appraised the evidence as a whole and bringing to bear their specialist knowledge to its adjudication.

86. There was also an allegation of an inconsistency of approach by the fact that allegation 2(d)(iv)(5) was found proved (*"failed to make an adequate record of the consultation in that you did not record information relevant to the follow up of unexplained chronic cough including shortness of breath"*: see facts determination para.72-73). The Tribunal followed the joint expert view expressed on the basis of the amended records (which the Appellant averred were correct). In the factual scenario where the Appellant recorded "no SOB" (i.e. the amended records) but Patient A reported shortness of breath, the experts agreed that "this was a serious failing because SOB is a key symptom in relation to chronic cough and presence or absence of SOB should be recorded accurately": see para.4.1.1.1 of the joint report. On the basis of that evidence, the Tribunal was entitled to find allegation 2(d)(iv)(5) proved.

87. In my judgment, the Tribunal was entitled to reach the conclusions which it did, and so this ground too must fail.

XIV Conclusion

88. Despite the thorough and detailed arguments ably presented by Mr McCartney on behalf of Dr Rahim, each of the appeal grounds is dismissed. The decision of the Tribunal was not wrong nor was there a serious procedural or other irregularity or any injustice thereby. It follows that the appeal is dismissed.