**Neutral Citation Number: [2024] EWHC 567 (Admin)**

**Claim No: AC-2022-BHM-000222**

**IN THE HIGH COURT OF JUSTICE**
**KINGS BENCH DIVISION**
**ADMINISTRATIVE COURT**

Priory Courts
33 Bull Street
Birmingham, B4 6DS

Date: 12 March 2024

**HIS HONOUR JUDGE RICHARD WILLIAMS**
**(Sitting as a High Court Judge)**

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**THE KING on the application of**
**PATRICIA ROGERS**

**Claimant**

**- and –**

**THE GENERAL MEDICAL COUNCIL**

**Defendant**

**- and –**

**DR FAISAL PATEL**

**Interested Party**

- - - - - - - - - - - - - - - - - - - - -

**Anne Whyte K.C.** (instructed by Knights) for the **Claimant**
**Peter Mant** (instructed by GMC Legal) for the **Defendant**

Hearing dates: 19th December 2023 and 12 March 2024

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**JUDGMENT**

## Introduction

1. This is my judgment following the trial of a claim seeking to challenge by way of judicial review the decision of The General Medical Council ("***the GMC"***) not to refer to the Medical Practitioners Tribunal ("***the Tribunal***") allegations that Dr Faisal Patel made retrospective amendments to the medical notes of Mr Victor Loder without any indication that the notes had been altered, when or why.

2. Mr Loder sadly passed away on 13 January 2016, aged 74, from mesothelioma caused by asbestos exposure at work.

3. The Claimant, Ms Patricia Rogers, is the former partner of Mr Loder. In her written evidence, the Claimant acknowledges that Mr Loder's cancer may not have been preventable, but she describes the pain and suffering that her late partner went through for over 7 months as "unimaginable" and "heart-breaking to see". Whilst I have very considerable sympathy for the suffering the Claimant and Mr Loder must have endured, ultimately I am exercising a supervisory jurisdiction over the decision making process of the GMC. As such, I am not entitled to substitute my own views and must be careful not to allow emotions to influence my decision.

4. Dr Patel admits that on 19 August 2015, and after he learnt on or around 13 August 2015 that Mr Loder had been diagnosed with cancer following a CT scan on 11 August 2015, he retrospectively altered the clinical records of Mr Loder for 26 May 2015 and 10 June 2015 without dating or explaining those alterations. As a result, those alterations appeared as if part of the original record. For ease of reference, I have highlighted those retrospective amendments in bold where the relevant clinical records are set out below by way of the chronology.

5. The Medical Act 1983 provides that:

   "(1A) The over-arching objective of the [GMC] in exercising their functions is the protection of the public.

   (1B) The pursuit by the [GMC] of their over-arching objective involves the pursuit of the following objectives—

   (a) to protect, promote and maintain the health, safety and well-being of the public,

   (b) to promote and maintain public confidence in the medical profession, and

   (c) to promote and maintain proper professional standards and conduct for members of that profession."

6. The Tribunal makes decisions about doctors' fitness to practise when cases are referred to it by the GMC. The case examiners of the GMC ("***Case Examiners***") are specialist decision makers, who following investigation determine whether allegations against doctors are referred to the Tribunal.

7. Whilst the Tribunal is a statutory committee of the GMC, it is independent of the GMC in its decision making.

8. If the Tribunal finds allegations proven and that the doctor's fitness to practise is impaired, the Tribunal may impose the following sanctions:

a. Conditions on registration (Up To 3 Years);

b. Suspension from the medical register (Up To 12 Months); or

c. Erasure from the medical register.

**Chronology**

9. Mr Loder was registered as a patient at Fairview Medical Practice ("***Fairview MP***") where Dr Patel worked as a partner.

10. In 2006, Dr Patel referred Mr Loder to a chest clinic. The discharge letter, dated 18 October 2006, stated:

> "The original symptoms have gone and he's extremely well, so all that's left are his chest x-ray changes.
>
> These are typical for somebody who worked with asbestos a long time ago, and it sounds as if he probably did when he was working as a plumber after leaving school for 10 years. They are of no significance and would not be expected to affect his lung function which in fact is excellent. After all he hasn't smoked for many years.
>
> This explains the nature of these minor chest x-ray changes which can be ignored, and I've discharged him."

11. In 2012, Mr Loder was diagnosed with myelodysplastic syndrome, which was an unrelated blood condition. The Haematology Speciality Doctor in his letter to Fairview MP, dated 7 November 2012, stated that:

> "His previous investigations include a chest CT scan, which showed no clinically significant lymphadenopathy but multiple calcified pleural plaques and some incidental calcified granulomata, in keeping with asbestos exposure. It also revealed some renal simple cysts."

12. During an appointment, Dr Patel referred Mr Loder to cardiology. The referral letter dated 16 February 2015 stated:

> "I would be grateful if you could see this gentleman who came to see me after seeing his haematologist for his myelodysplasia check up. He complained of a vague central chest pain that has been there the last 4-5 weeks. It is there most of the time but at times gets worse. He denies it being worse on exertion. He denies radiation, vomiting or sweating. He denies any cough or respiratory symptoms either. He was sent by the haematologist to A+E whereby he had an ECG which showed a sinus arrythmia as his pulse was irregular. His troponin was mildly raised at 17. They suggested his symptoms may be other angina related or gastritis related. I have started him on omeprazole but in view of his raised troponin and his ongoing chest pain I would be grateful for your urgent help. He is hypertensive which is well controlled. He is also an ex-smoker. I hope that you can help with his further management."

13. On 6 March 2015, Mr Loder attended the Rapid Access Chest Pain Clinic where no heart problems were identified, although an urgent CT scan was to be arranged.

14. There were delays in arranging the CT scan and, in the meantime, Mr Loder saw Dr Patel on 10 April 2015 complaining of chest pain. Dr Patel referred him to A&E to be seen acutely the same day. The referral letter stated that:

> "I would be very grateful if you could see this gentleman acutely today. Mr Loder presented to us in February after having presented to his haematologist with chest pains (he is under their care for myelodysplasia). His haematologist sent him to A+E and he had serial ECG and troponin which was normal. They advised that he may have stable angina or gastritis and was advised GP follow up. He came to see me and he described his pain as not that bad and not that frequent. But he had a lot of belching at the time, I suggested that we start a PPI and refer him to rapid access CP clinic. He was seen in the clinic and was advised to have a cardiac CT done. Unfortunately due to a mix up, he has then been asked to have stress echo in May. Unfortunately he and his wife have come to see me today and his pains are getting more frequent. It is central to the right side and is occurring multiple times. He is getting extremely worried about this pain. He is not taking aspirin due to his stomach side effects, PPI made no difference to his pain. BP is 129/72, pulse 80. I would be grateful if you could rule out unstable angina and perform serial ECG/troponin again, I also suspect there may be some anxiety related effects as he and his wife are extremely concerned about this pain."

15. On 5 May 2015, Mr Loder attended a haematology appointment. The clinic letter, dated 12 May 2015, stated:

> "With regards to his painful chest symptoms, if a cardiological underlying cause has been excluded, then I would suggest consideration of a respiratory opinion, due to the background history of pleural calcification on a background of asbestos exposure. I would be grateful if you considered this."

16. On 26 May 2015, Mr Loder saw Dr Patel, who agreed to make a respiratory referral. The note of the appointment records (with my emphasis added in bold):

> Problem Chest Pain (Review)
>
> History came with wife. no stress echo result back yet. reviewed letter from haematology - suggested resp referral. wife and pt very upset – still in a lot of pain with chest, still no answers as to why in pain. **Patient has had previous history of asbestos exposure. 2 chest XR's done in Feb and April does not show any acute pulmonary lesions. Pleural plaque on left side which is stable from previous films also. patient denies any respiratory symptoms now as cold previously settled. denies any cough/haemoptysis/weight loss/ shortness of breath. also patient felt doesn't feel like it is his lungs causing symptoms**
>
> Examination O/E - blood pressure reading 110/50 mmHg
>
> Medication Gabapentin 100mg capsulesOne To Be Taken Three Times A Day 84 capsule
>
> Comment Plan 1. agreed to start gabapentin for neuralgia pain 2. refer SGH as per haematology advice 3. discussed beta blocker- pt has stopped amlodipine - to repeat in 2152 and if rising, consider bisoprolol as per cardiology advice 4. **agreed to refer to respiratory clinic for patient for rv**"

17. The referral letter stated:

> "I would be very grateful if you could see this gentleman in your clinic. Mr Loder suffers hypertension, myelodysplasia and chronic rhinitis. He presented to his routine haematology follow up in February whereby he was complaining of mild right sided chest pain and he was found to have an irregular heart rhythm. He was sent to A+E whereby they stated he either had gastritis or stable angina. He was asked to see us for follow up. The pain is in the right side of the chest, it is now radiating to the right arm. It is there all the time now and is causing him a lot of distress. He denies any respiratory symptoms but he has a background history of asbestos exposure. We arranged a CXR and referred him to the rapid access cardiology clinic. They organised a stress echocardiogram which he has been told was normal. His 24th ECG showed several runs of supraventricular ectopics and the cardiologist has suggested a small dose of beta blocker. However he is still in a lot of pain. He and his wife are extremely concerned about the pain as they have no answer to it and it is getting worse. He saw his haematologist who suggested a referral to you to at least rule out a respiratory cause for his pain. I believe that his pain may be neuralgic with a high degree of anxiety (which is very odd because when the pain started in February, he was not bothered by it at all and it is ever since we started investigating it, his anxiety levels seem to be rising). He has rejected analgesia all this time because he did not want to take any but has finally agreed to trialling some gabapentin."

18. On 10 June 2015, Mr Loder again saw Dr Patel. The note of the appointment records (with my emphasis added in bold):

> "Problem Chest pain (Review)
>
> History ongoing CP. pt feels is getting worse. **discussed whether anxiety may be partly causing his pain and also whether there may be a neuralgic element to his pain. long discussion with patient and wife. suggested may trial short course diazepam to see if it helps him relax.**
>
> Examination O/E – blood pressure reading 138/72 mmHg
>
> Medication Diazepam 5mg tablets One To Be Taken Twice A Day 6 tablet
>
> Comment Plan 1. agreed to trial diazepam short course 2. discussed massage/acupuncture 3. Refer CIMS also as physio may help **if there is a neuralgic cause for his pain**"

19. On 6 August 2015, Mr Loder was seen by the respiratory clinic, which recommended an urgent CT chest scan to rule out mesothelioma.

20. The CT scan was undertaken on 11 August 2015.

21. On 13 August 2015, Fairview MP was made aware of the CT results and recorded "cancer confirmed."

22. On 19 August 2015, and as set out in bold above, Dr Patel made retrospective, undated and unexplained amendments to Mr Loder's notes for 26 May and 10 June 2015.

23. On 8 September 2015, Mr Loder made a Subject Access Request for disclosure of his medical records.

24. In 2015 to 2016, the Claimant made an initial complaint to the GMC about the quality of Dr Patel's care, but it decided not to take any action.

25. Mr Loder died as a result of his cancer on 13 January 2016.

26. In November 2020, the Claimant raised additional concerns with the GMC that Dr Patel had retrospectively amended Mr Loder's medical records.

27. In her witness statement dated 9th February 2022, the Claimant states that:

> "[19.] Victor and I discussed Dr Patel's substandard care and dismissive attitude and he said he wanted to register with a different GP. We also wanted to know what Dr Patel had recorded on Victor's medical records as neither of us were confident that medical papers and records would be lost, or altered. Because we knew Dr Patel had been informed of the cancer diagnosis and he had not contacted Victor. We decided to ask for the medical records as a Subject Access Request (SAR).
>
> ……
>
> [21.] The SAR was submitted on 8 September 2015 and …….. passed to Dr Patel to action….
>
> [22.] ….. I was notified on 23 September 2015 that the full records were available to collect, which I did on the same day…….
>
> [23.] We went through the documents and identified many things which gave rise to concerns or were untrue. In particular Dr Patel recorded some conversations which did not take place. He stated, "also patient felt doesn't feel like it is his lungs causing symptoms" and "patient denies any respiratory symptoms." Both are untrue. Victor did not say this. Not once, in all GP appointments, were lungs, pleural plaques or asbestos exposure ever mentioned by Dr Patel, and pleural plaques were never mentioned on referral letters or forms.
>
> …….
>
> [28.] In 2019….. Irwin Mitchell… advised that I could obtain a copy of the audit trail as I believed some referral letters and details recorded on Victor's medical records, were untrue and had been altered. This would enable me to compare the audit trail entries with the entries on the medical records and referral letters, I received, following the SAR.
>
> [29.] I received the audit trail in January 2020 and realised immediately the many discrepancies from the SAR medical records. I believe the retrospective alterations and additions were made by Dr Patel on Victor's notes medical records and these were very concerning……..
>
> ……
>
> [31.] This aggressive cancer did not reach stage 4 overnight and the PET scan report and image show the cancer was advanced and had metastasised. It was

irrefutable evidence that Victor had this terrible pain which impacted on every aspect of his life…… I believe withholding the Pet scan report is relevant because it clearly states the progression of the cancer to a probable staging of T4N2M1a, which disproves many of Dr Patel's untrue statements in the medical records and referrals. I believe this was Dr Patel's attempt to avoid criticism and accountability of his shocking treatment to, and of, Victor."

28. The GMC commissioned its own independent GP expert review. The expert report of Dr Davies ("***the Independent Expert***") is dated 16 May 2022 and states as follows:

**"[4.] Whether there is a manner in which retrospective amendments ought to be done**

Sometimes changes are needed to a patient's medical record - for example if wrong information has been recorded. Such alterations should be shown as additions to the notes recording when the new note is being added, and why the change is necessary. The key is that the original record and the new information are shown as separate entries in the medical record.

…….. To quote from [***MPS An essential guide to medical records 6.7.2020 (accessed 29.3.22)***],

"Original – notes should not be retrospectively amended without making clear when the amendments have been made and why. In the event that you have made a factual error, do not obliterate the entry that you wish to correct. Instead, run a single line through it so it can still be read and add the correction including the date and your signature. Failure to do so could lead to allegations of dishonesty, attempting to pass amendments off as part of the original record. Amendments to electronic records can be tracked by audit trail and should be clearly marked on the file."

This teaching about how, when and why medical records need altering has been present throughout my medical career (I graduated in 1989).

**[5.] Whether it was adequate and appropriate for Dr Patel to amend Patient A's records on 19th August 2015, adding detail to the consultations of 26th May and 10th June 2015**

Dr Patel may have been right to add additional information or reflections about the consultations on 26th May 2015 and 10th June 2015. However, any such additions should have been shown as new entries and been dated and timed with explanation of why the additional information has been added, and why now. It is not acceptable to alter a contemporary record several weeks after the consultation has occurred. To do so casts doubt on both the original record and the new information."

……

**[6.] Whether the amendments made are relevant to an assessment of Dr Patel's care of Patient A, taking into consideration Mrs Rogers' statement**

The amendments made add to the clinical picture of the consultations of 26th May 2015 and 10th June 2015. In themselves they are probably helpful clinical

additions providing additional detail and context. They could help in the assessment of Patient A's care.

However, they are misleading because the additional entries made on 19th August 2015 are added to the existing record and so appear to be part of the contemporary record when in fact they are later amendments and additions. This modifies the original contemporary record rendering it unreliable as evidence. It means that we cannot now rely on either the original or the amended record since the accuracy of both is called into question. If we cannot rely on the basic honesty of the clinical record and of doctors who build this record then we are seeing very poor medical practice, seriously below the standards of accuracy and honesty expected of any doctor.

Evidence added after the event is intrinsically less credible than evidence recorded at the time of an event. Recall bias, memory issues, modification in light of subsequent events can all colour and change how the original event is perceived and recorded. For medico-legal issues it is always better to evaluate a contemporary document (however flawed it may be) than to try and separate out contemporary evidence from later additions.

Ms Rogers has questioned the primary accuracy of the amendments themselves. The fact that they are later additions is clear from the audit file and from Irwin Mitchell solicitor letter.

Ms Rogers alleges that the additional entries are factually inaccurate. If this allegation is accepted by the GMC and an MPTS panel then Dr Patel's conduct here would be dishonest. Making a late amendment to notes is deplorable. Making a dishonest late amendment to the notes is worse."

29. On 30 June 2022, the GMC notified Dr Patel of the following 5 allegations:

    a. On 19 August 2015 Dr Patel amended [Mr Loder's] records of his consultations with him on 26 May 2015 and 10 June 2015 - ("***Allegation 1***").

    b. These actions were inappropriate in that Dr Patel failed to add the text as a new entry and which indicated (i) the date and time when the amendment was made; (ii) that the amendment was retrospective; and (iii) why the amendment was required - ("***Allegation 2***").

    c. The amendments included untrue information in that –

        i. Dr Patel did not discuss Mr Loder's previous history of asbestos exposure with him in any consultation;

        ii. Mr Loder did not say that he did not feel it was his lungs causing symptoms;

        iii. Mr Loder did not deny any respiratory symptoms; and

        iv. Mr Loder had complained of pain, reduced mobility, fatigue, shortness of breath, cough with specs of blood - ("***Allegation 3***").

d. In making amendments that included such untrue information, Dr Patel's actions were dishonest - ("***Allegation 4***").

e. Dr Patel's actions were intended to avoid potential allegations of failings in his care of Mr Loder following Dr Patel becoming aware of the radiology report of the CT scan on 11 August 2015 - ("***Allegation 5***").

30. By letter dated 28 July 2022, Dr Patel's solicitors admitted on behalf of Dr Patel the first two allegations, but denied the remaining allegations. It was explained that:

> "Dr Patel was frankly not thinking forensically at all when making the amendments to the records he did. He is a diligent General Practitioner who was in receipt of a surprising and rare diagnosis. He wished to review the records to see if there were any lessons which could be learned and in doing so was concerned that the notes that he had made of the two consultations in question did not come to the high standards he sets himself in relation to record keeping. It is submitted that medical records are there to record the consultation and the salient features of what occurred during the consultation. They are also there as a space within which a practitioner may record their thought processes. Dr Patel did not feel that the notes that he made contemporaneously adequately reflected either the extent of the discussions that he had with VL and his partner (which were extensive) but also importantly his thought processes in particular in relation to the referral for a respiratory opinion. The additions that he made were made in order to better reflect what had happened. They were not made for any other forensic reason. The additions were made some 5 or 6 days following the receipt of the diagnosis and there was of course at that time no intimation of any allegations of failing of care.
>
> …….. It is accepted that Dr Patel made the amendments alleged. It is also accepted that the manner in which he did so was inappropriate and with the benefit of hindsight Dr Patel recognises that the proper way to make any such amendment is by way of separate dated entry. We submit that this is an uncharacteristic lapse of concentration on Dr Patel's behalf. Indeed he will say that he was not fully cognisant of the fact that such amendments were not fully transparent in an electronic system. We are instructed that when viewing the entries on the live computer system the entries show an icon which indicate that the entry has been amended however the reality is that that was far from Dr Patel's mind at the time he made the amendment. He simply did not consider the possibility as he was not thinking in a forensic manner at all. He has reflected and learned about this matter. We submit that this is an isolated lapse in an otherwise unblemished career and it is certainly a lesson that Dr Patel will have taken to heart and it will not be a mistake that is repeated in the future. It is therefore an error which is capable of remediation, and has been remediated and therefore the chances of repetition are remote."

31. On 6 September 2022, the Case Examiners decided that the allegations against Dr Patel should not be referred to the Tribunal.

32. On 25 November 2022, the Claimant's solicitors sent a letter before claim in proposed judicial review proceedings.

33. The GMC's letter of response dated 2 December 2022 confirmed that (i) a review of the Case Examiners' decision was being undertaken and (ii) the GMC was

reserving its position in respect of the substantive claim pending the outcome of the review.

34. On 5 December 2022, the present proceedings were commenced.

35. On 9 February 2023, the GMC upheld the decision of the Case Examiners on review by concluding that the original decision had been correctly made.

**Applicable legal framework**

36. In making their determinations, the Case Examiners must have due regard to the "Guidance for the Investigation Committee and case examiners" ("***the Guidance***") and not depart from it without cogent reasons.

37. The Annex B to the Guidance provides as follows:

> "**The Realistic Prospect Test**
>
> [1] The "realistic prospect" test will apply to both the factual allegations and the question whether, if established, the facts would demonstrate that the practitioner's fitness to practise is impaired to a degree justifying action on registration. It will reflect a genuine (not remote or fanciful) possibility. It is in no-one's interest for cases to be referred to a medical practitioners tribunal when they are bound to fail. On the other hand, cases which raise a genuine issue of impaired fitness to practise justifying action on registration are for the medical practitioners tribunal to decide.
>
> [2] In performing their task, the case examiners and members of the Investigation Committee:
>
> a should bear in mind that the medical practitioners tribunal is required to be persuaded that the facts are more likely than not to be true: the facts need to be proven 'on the balance of probabilities'. The standard of proof applicable in any proceedings is that applicable to civil proceedings;
>
> b are entitled to assess the weight of the evidence;
>
> c should not, however, normally seek to resolve substantial conflicts of evidence;
>
> d should proceed with caution (given that, among other considerations, the case examiners are working from documents alone and the evidence before them may be untested);
>
> e should proceed with particular caution in reaching a decision to halt a complaint where the decision may be perceived as inconsistent with a decision made by another public body with medical personnel or input (for instance, an NHS body, a Coroner or an Ombudsman) in relation to the same or substantially the same facts and, if the case examiners/ Investigation Committee does reach such a decision, should give reasons for any apparent inconsistency;
>
> f should be slower to halt a complaint against a practitioner who continues to practise than against one who does not;

g if in doubt, should consider whether any further investigation is appropriate and in any event should lean in favour of allowing the complaint to proceed to a medical practitioners tribunal;

h should bear in mind that whilst there is a public interest in medical practitioners not being harassed by unfounded complaints, there is also a public interest in the ventilation before a medical practitioners tribunal in public of complaints which do have a realistic prospect of establishing impaired fitness to practise;

i in considering whether to issue a warning should bear in mind that the standard of proof is that applicable to civil proceedings."

38. The Guidance provides that:

**"Presumption of impaired fitness to practise**

[24] There are certain categories of case where the allegations, if proven, would amount to such a serious failure to meet the standards required of doctors, that there will be a presumption of an issue of impaired fitness to practise. These tend to fall within seven main headings:

a sexual assault or indecency

b sexual or improper emotional relationships with a patient or someone close to them

c violence

d dishonesty

e unlawfully discriminating in relation to characteristics protected by law

f knowingly practising without a licence

g gross negligence or recklessness about a risk of serious harm to patients.

[25] Where allegations fall under one of the seven headings, there is a presumption of impaired fitness to practise. This means that, where there is evidence to support the allegations, in order to avoid a referral to a medical practitioners tribunal the presumption of impairment must be rebutted.

[26] The presumption of impairment may only be rebutted where:

- in violence and dishonesty cases, the nature of the conduct is such that the doctor would not pose a risk to patients, to public confidence or to proper professional standards and conduct ie it is at the lower end of the spectrum of seriousness.

- in all presumption of impairment cases there are exceptional reasons for concluding that a referral to tribunal is not necessary.

[27] In light of the particular issues that arise in cases involving a doctor who is unwell, issues relating to a doctor's health may in some circumstances amount to exceptional reasons for concluding that a referral to tribunal of an allegation that

carries a presumption of impairment is not necessary but would not always do so. This means the fact an allegation has a presumption of impairment does not preclude the agreement of undertakings where there is cogent evidence the conduct is closely linked to health concerns. A close link between the doctor's health and an allegation with a presumption of impairment, where any risk to patients and public confidence in the medical profession would be addressed by agreeing undertakings in relation to the doctor's health, can be a proportionate way to address a matter as long as the misconduct is at the lower end of the spectrum of seriousness (see guidance on Health and Misconduct).

[28] Where the case examiners do not refer the case to a medical practitioners tribunal, they will need to be particularly careful to record detailed reasons for having not done so.

[29] There may be instances where, following a full investigation, the case examiners decide that the case does not meet the realistic prospect test because there is no realistic prospect of establishing the case evidentially. If the case examiners decide to close a case on these grounds, detailed reasons should be provided. Case examiners should consider seeking legal advice, in these circumstances, if it has not already been provided."

39. Rule 12 of General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended) provides that a decision of the Case Examiners not to refer an allegation to the Tribunal may be reviewed on limited grounds being:

"[(2)] (a) the decision may be materially flawed (for any reason) wholly or partly; or

(b) there is new information which may have led, wholly or partly, to a different decision".

**Grounds of challenge**

Ground 1 (Allegation 3) and Ground 2 (Allegation 4)

40. I have taken Ground 1 and Ground 2 together because they are closely connected.

41. Allegation 3 is that Dr Patel included untrue information in his retrospective amendments. In particular, it was the Claimant's evidence that the following entries were untrue:

    a. "*patient denies any respiratory symptoms now as cold previously settled. patient denies any cough/haemoptysis/weight loss/ shortness of breath*"; and

    b. "*also patient felt doesn't feel like it is his lungs causing symptoms*".

42. Allegation 4 is that Dr Patel acted dishonestly by including the untrue information in his retrospective amendments.

43. It was Dr Patel's stated position that the additional information was true.

44. The Case Examiners concluded that there was no realistic prospect of a Tribunal finding on the balance of probabilities that the amendments were untrue and thereby dishonest:

"Allegation 3

It is alleged that additions made by Dr Patel to the notes of the consultation of 26 May 2015 were untrue.

We consider all the additions, and the evidence available as to whether they were true or not:

'*patient has had previous history of asbestos exposure. 2 chest XR's done in Feb and April does not show any acute pulmonary lesions. pleural plaque on left side which is stable from previous films.*'

From the evidence available to us, and while it is not our role to make findings of fact, it seems clear that this addition is factually correct. The information is not disputed that Mr Loder did have a previous history of asbestos exposure. The records also corroborate what Dr Patel added in respect of the chest x-ray reports from February and April 2015.

Ms Rogers states that Dr Patel did not discuss these points with Mr Loder during the 26 May 2015 consultation, while Dr Patel disagrees and says the previous history of exposure to asbestos was discussed, indeed it was the reason why he referred Mr Loder to the respiratory physician.

For the purposes of considering this allegation, it is not necessary to resolve this conflict of evidence. This is because the addition makes no mention of any discussion with Mr Loder about these matters, it simply states Mr Loder's medical history, and the history is in itself accurate.

'*also patient denies any respiratory symptoms now as cold previously settled. denies any cough/haemoptysis/weight loss/shortness of breath*.'

There is a conflict of evidence in respect of this addition.

Ms Rogers stated that Mr Loder did not deny respiratory symptoms, in fact he had repeatedly reported to Dr Patel that he had coughed up blood (haemoptysis) and was short of breath. He also reported pain, reduced mobility and fatigue.

Dr Patel, while accepting that Mr Loder had reported haemoptysis and shortness of breath previously, said Mr Loder did not report those symptoms on 26 May 2015. In fact he reported that he had recovered from a previous cold, which had been noted in an earlier consultation.

It is not our role to seek to resolve substantial conflicts of evidence. However, we are able to assess the weight, if any, we should give to a particular piece of evidence in deciding whether there is a realistic prospect of proving the relevant allegation.

We are mindful that the GMC must prove the allegation on the balance of probabilities; the doctor does not have to prove anything.

With regard to Ms Rogers' account that Mr Loder repeatedly reported haemoptysis and shortness of breath to Dr Patel, we note that in her statement for the GMC she did not detail on precisely which occasions Mr Loder reported these

symptoms. It is clear from the records that Mr Loder had reported such symptoms on other occasions. If this matter was before a tribunal, it is likely that Ms Rogers would be asked to provide further comment on how she knew these symptoms were discussed on this specific occasion.

As to Dr Patel's account, a tribunal might be expected to give weight to the doctor's contemporaneous records. The evidential value of the record of the GP consultation in this case is undermined because it was made several months after the event.

That said, there is a contemporaneous record in the form of Dr Patel's letter referring Mr Loder to the respiratory clinic. In this letter Dr Patel stated that Mr Loder '*denies any respiratory symptoms but he has a background history of asbestos exposure'*. This letter provides support for Dr Patel's evidence that, on the day of the consultation, it was Dr Patel's understanding that Mr Loder did not report any respiratory symptoms.

The tribunal would also be likely to take into account that, when Mr Loder was seen by Dr C less than a week later, on 1 July 2015, Dr C recorded a history that Mr Loder had '*no associated cough, wheeze or sputum'*.

Having carefully considered all the evidence, we conclude that there is no realistic prospect of a tribunal finding on the balance of probabilities, this addition to be untrue.

'*also patient felt doesn't feel like it is his lungs causing symptoms*'

Again, there is a conflict of evidence in respect of this addition.

Ms Rogers stated that Mr Loder did not say he didn't feel his lungs were causing his symptoms, in fact she and Mr Loder did not know what was causing the symptoms.

Dr Patel, however, said Mr Loder and Ms Rogers were up to that point concerned primarily about a cardiological cause for the symptoms. Previous records made reference to the personal and understandable reasons for their concerns.

There is no contemporaneous record to support Dr Patel's account over that of Ms Rogers. However even if it could be proved that Mr Loder did not hold the view reported by Dr Patel, we believe it would not be possible to prove that this was not Dr Patel's understanding of Mr Loder's views, in light of the previous history of cardiology referrals and tests.

'4. agreed to refer to respiratory clinic for patient for rv'

It is evident that Dr Patel did agree to refer Mr Loder, and he wrote the referral letter the same day. This statement therefore appears to be accurate."

45. Ground 1 and Ground 2 are that the Case Examiners erred in law by failing to consider properly or at all the presumption of impairment when considering whether:

    a. the retrospective amendments to the clinical record of 26th May 2015 were untrue – Allegation 3.

b. Dr Patel's actions in making the untrue retrospective amendments to the clinical record of 26 May 2015 were dishonest – Allegation 4.

46. The Claimant argues:

a. In accordance with the Guidance –

i. allegations of dishonesty are considered so serious that, "where there is evidence to support the allegations, in order to avoid a referral to a medical practitioners tribunal the presumption of impairment must be rebutted"; and

ii. the "presumption of impairment may only be rebutted where: ……..in dishonesty cases, the nature of the conduct is such that the doctor would not pose a risk to patients, to public confidence or to professional standards and conduct ie it is at the lower end of the spectrum of seriousness."

b. The allegation that some of Dr Patel's additions were untrue was one of dishonesty.

c. The opinion of the independent expert on this issue was damming -

> "[The Claimant] alleges that the additional entries are factually inaccurate. If this allegation is accepted by the GMC and an MPTS panel then Dr Patel's conduct here would be dishonest. Making a late amendment to notes is deplorable. Making a dishonest late amendment to the notes is worse."

d. The presumption of impairment was engaged yet not applied to Allegation 3 and Allegation 4. The Case Examiners did not even refer to the presumption in their decision.

e. The Case Examiners failed to consider or make reference to the impact of Dr Patel's actions on public confidence or professional standards or exceptional reasons justifying the rebuttal of the presumption.

47. It strikes me that Ground 1 and Ground 2 turn on whether or not the presumption of impaired fitness to practise was ever engaged in relation to Allegation 3 and Allegation 4. Largely for the reasons argued by the GMC, I do not find that the presumption was so engaged:

a. The realistic prospect test that Case Examiners apply in deciding whether or not to make a referral to the Tribunal is twofold -

i. is there a realistic prospect of the alleged facts being found proved by the Tribunal ("***Limb 1***"); and

ii. if so, is there a realistic prospect of the doctor's fitness to practise being found to be impaired to a degree justifying action on registration ("***Limb 2***").

b. The Guidance must be read as a whole and in context. In doing so, it is clear that the presumption relied upon by the Claimant applies only to Limb 2 of the realistic prospect test and only once Limb 1 has been satisfied –

i. the relevant section of the Guidance is headed "Presumption of impaired fitness to practise";

ii. paragraph 24 of the Guidance by way of explanation states (with my emphasis added)

> "There are certain categories of case where the allegations, <u>if proven</u>, would amount to such a serious failure to meet the standards required of doctors, that there will be a presumption of an issue of impaired fitness to practise"; and

iii. paragraph 29 of the Guidance concludes

> "There may be instances where, following a full investigation, the case examiners decide that the case does not meet the realistic prospect test because there is no realistic prospect of establishing the case evidentially. If the case examiners decide to close a case on these grounds, detailed reasons should be provided."

48. In the present case, the Case Examiners gave detailed reasons why evidentially they did not consider that the Limb 1 test was met in relation to Allegation 3 and Allegation 4. Having concluded that the Limb 1 test was not met, they effectively decided to close the case in relation to those allegations. In those circumstances, the Case Examiners were not required, and did not, consider whether or not the Limb 2 test was met. It was only in relation to the Limb 2 test that the presumption would have been engaged and fallen for consideration. Therefore, the Case Examiners did not err in their approach in this regard such that Ground 1 and Ground 2 of the claim must fail.

49. In her skeleton argument, the Claimant seeks to raise a number of additional points that essentially challenge the Case Examiners' assessment of the weight of the evidence when considering Limb 1 in relation to Allegation 3 and Allegation 4. However, I do not consider that it would be procedurally fair for me to determine each and every one of those additional points having regard to:

a. The overriding objective of dealing with cases justly and at proportionate cost includes "ensuring that the parties are on an equal footing", "saving expense", "ensuring that [the case] is dealt with expeditiously and fairly" and "enforcing compliance with rules, practice directions and orders" – Civil Procedure Rules ("***CPR***") r.1.1.

b. CPR 54A PD para. 4.2(1)(b) provides that the claim form must include or be accompanied by "a clear and concise statement of the grounds for bringing the claim…. to enable the parties and the court to identify the essential issues alleged to arise."

c. In the present case, HHJ Tindal in his order dated 27 June 2023 recorded that "the Claimant's pleading is unsatisfactory as the Arguable Grounds have to be patiently teased out of them as I have done. The Defendant

should properly understand the case it has to meet and so I will direct amendment and perfection of the Grounds".

d. By further order dated 13 September 2023, HHJ Tindal granted permission to the Claimant to apply for judicial review "on the basis set out in the Amended Statement of Facts and Grounds only."

e. Despite the opportunity given to the Claimant to replead her case, the Claimant's perfected grounds then failed to include the additional points now being raised.

f. To allow the Claimant to pursue the additional points at this trial would be wholly contrary to the overriding objective.

50. That said, I make the general observation that the Guidance on the realistic prospect test states that Case Examiners "are entitled to assess the weight of the evidence" when "performing their task". In reaching their conclusion, the Case Examiners attached significant weight to the other undisputed and near contemporaneous records, which were more consistent with Dr Patel's version of events. In my judgment, that approach was entirely reasonable when, if the case had proceeded to the Tribunal, the Claimant and Dr Patel would have been giving evidence as to their recollections of conversations that took place several years ago, which would necessarily have given rise to particular problems before the Tribunal. Quite understandably, it is often difficult for witnesses to remember accurately what was said so long ago. In seeking to resolve such conflicting evidence the Tribunal itself would no doubt have placed significant reliance upon the other undisputed and near contemporaneous records.

Ground 3 (Allegation 5)

51. Ground 3 is that the Case Examiners erred in law by adopting the wrong approach to the question of whether Dr Patel's amendments were intended to avoid potential allegations of failings in care and, as such, were dishonest.

52. The Claimant argues:

a. The Case Examiners failed to appreciate the nature of this allegation and elided it with the previous allegations that the additional entries were untrue and dishonest. They plainly approached this allegation on the basis that if Allegation 3 and Allegation 4 failed, Allegation 5 must fail for the same reasons.

b. This approach was irrational and unlawful. An accurate retrospective entry can still be dishonestly motivated. There is nothing to suggest that the Case Examiners examined Dr Patel's motivation with any care or caution.

c. This allegation asserted that Dr Patel was motivated to act as he did because he feared, following the diagnosis of cancer, that there might be a complaint or allegation of sub-standard care. It is immaterial whether such complaints or allegations followed or whether they had any merit.

53. The GMC argues:

a. On the facts of this case, the Case Examiners concluded that, if the amendments were factually accurate (or Dr Patel believed them to be accurate), there was no realistic prospect of proving that they were intended to avoid potential allegations of failings in care. Such a conclusion was not irrational or otherwise unlawful.

b. At the time the amendments were made there was no intimation of any complaint or claim. Indeed, nor could such a complaint or claim be reasonably anticipated since, the referral made at the appointment on 26 May 2015 was the appropriate referral for that diagnosis.

c. The Claimant's assertion that the amendments may have been made to "bolster notes" and reflect thought processes that might not have taken place is far-fetched. The undisputed evidence is consistent with Dr Patel having had in mind Mr Loder's history of asbestos exposure and/or reported absence of respiratory symptoms –

    i. The haematologist's letter recommended a respiratory opinion because Mr Loder had a history of lesions and exposure to asbestos;

    ii. Dr Patel discussed the haematologist's recommendation with Mr Loder at the appointment on 25 May 2015; and

    iii. Dr Patel made express reference to the history of asbestos exposure in a referral letter drafted the same day.

d. Whilst the Claimant may disagree with the Case Examiners' conclusion on Allegation 5, their approach was not wrong and their conclusion was rational.

54. The Case Examiners' decision regarding Allegation 5 was:

> "As discussed above, we do not believe a tribunal would find, more likely than not, that the additions made by Dr Patel to the record of the consultation on 26 May 2015 were untrue. It therefore follows that the allegations of dishonesty, and intention to avoid criticisms of care, would fall away; allegations 4 and 5 would not be capable of proof."

*Limb 1*

55. In my judgment, the Case Examiners were wrong to have concluded that Allegation 5 was not capable of proof just because more likely than not a Tribunal would have concluded that the retrospective entries were true. An accurate retrospective entry can still be dishonestly motivated.

56. The Independent Expert was of the strongly expressed opinion that, even if the information contained in the amendments was true and clinically helpful, the amendments were still (with my emphasis added):

> "misleading because the additional entries made on 19th August 2015 are added to the existing record and so appear to be part of the contemporary record when in fact they are later amendments and additions. This modifies the original contemporary record rendering it unreliable as evidence. It means that we cannot

now rely on either the original or the amended record since the accuracy of both is called into question."

57. The Guidance states:

"**Dishonesty**

[46] Evidence a doctor has been dishonest can represent a very serious breach of our professional standards and pose a risk of confidence in the medical profession.

[47] *Good medical practice* provides that doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession.

[48] Examples of dishonesty in professional practice can include:

……..

- Improperly amending patient records"

58. The GMC argues that at the time the amendments were made there was no intimation of any complaints of failings in care such that there was never any realistic prospect of proving that the amendments were intended to avoid any potential complaints. However, the Case Examiners failed to give any or any proper consideration to the following factors and any reasonable inferences that the Tribunal might subsequently draw from those factors:

    a. The nature and timing of the amendments -

        i. They were made several weeks after the consultation had occurred and, notwithstanding the passage of time, they were substantial;

        ii. They were made within 5 or 6 days after Dr Patel became aware of the cancer diagnosis; and

        iii. Dr Patel's solicitors in their letter dated 28 July 2022 stated that Dr Patel on learning of the cancer diagnosis "wished to review the records to see if there were any lessons which could be learned." However, if there was a learning exercise, no separate note of the case review has been disclosed or indeed any explanation as to what, if any, lessons were learnt upon learning of the "surprising and rare diagnosis".

    b. The adequacy of the explanation given for why Dr Patel failed to date his amendments and explain why they were required. In his solicitors' letter dated 28 July 2022, it was variously stated that –

        i. "Dr Patel was frankly not thinking forensically at all"; and

        ii. "He simply did not consider the possibility as he was not thinking in a forensic manner at all."

    c. The stated reason for making the retrospective amendments –

i. In his solicitors' letter it was stated that having embarked upon the learning exercise, Dr Patel

> "was concerned that the notes that he had made of the two consultations in question did not come to the high standards he sets himself in relation to record keeping……. Dr Patel did not feel that the notes that he made contemporaneously adequately reflected either the extent of the discussions that he had with VL and his partner (which were extensive) but also importantly his thought processes in particular in relation to the referral for a respiratory opinion."

ii. That explanation was consistent with the explanation given in Dr Patel's earlier letter dated 28 October 2020 where he stated

> "With regard to the issue of the record amendments, I can confirm that I made those amendments with the purpose of more fully articulating my thought process during the consultations."

iii. Whilst the Independent Expert did not have sight of the solicitors' letter dated 28 July 2022, he did have sight of Dr Patel's earlier letter dated 28 October 2020. The Independent Expert was of the opinion that "Dr Patel's response to the evidence presented of his having altered the clinical records is inadequate."

d. The manner in which the amendments were discovered –

i. It would not have been obvious to Mr Loder that the clinical record had been amended. They added to the existing record and gave the appearance of being part of the contemporary record;

ii. When responding to Mr Loder's SAR and thereafter to the initial complaint regarding the standard of care, Dr Patel failed to disclose that the clinical record had been amended; and

iii. It was only through the subsequent audit trail that the Claimant was able to identify the amendments.

e. Ultimately, Dr Patel's credibility as to why he made the amendments was in issue. The Annex to the Guidance states that Case Examiners are entitled to assess the weight of the evidence, but they (i) "should not, however, normally seek to resolve substantial conflicts of evidence" and (ii) "should proceed with caution (given that, among other considerations, the case examiners are working from documents alone and the evidence before them may be untested)".

59. The Case Examiners did not properly consider whether there was a realistic prospect of the Tribunal finding that more likely than not Dr Patel had been attempting to pass the amendments off as part of the original record, by not dating and explaining them, in order to avoid potential allegations of failings in care. The Case Examiners appear to have simply accepted without question or critical analysis what was stated in correspondence sent by or on behalf of Dr Patel.

*Limb 2*

60. The Guidance states that:

> "[14] The case examiners will apply the following test at the conclusion of the investigation stage:
>
> The investigation committee or case examiner must have in mind the GMC's duty to protect the public which includes promoting and maintaining the health, and safety and well-being of the public; public confidence in the profession; and, proper standards and conduct for doctors, in considering whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration."

61. In applying that test, the Case Examiners failed to consider that:

    a. A finding by the Tribunal that Dr Patel had amended the notes to avoid potential allegations of failings in care would amount to a finding of dishonesty engaging the presumption of impairment.

    b. the Guidance states (at para [33]) that "Evidence of….. remediation will … carry less weight in" cases where there is a presumption of impaired fitness to practise. Such cases "are unlikely to fall into the category of cases that are easily remediable."

    c. The Guidance states that where the presumption of impaired fitness to practise arises in a case of dishonesty, Case Examiners should be alert to factors which would increase the overall risk including where –

        i. (at para [57 d]) "The dishonesty involved an attempt to conceal….clinical errors or deficiencies…"

        ii. (at para [57 h]) the "doctor has demonstrated a lack of insight in relation to their dishonest behaviour."

<u>Ground 4 – Allegation 1 and Allegation 2</u>

62. Ground 4 is that the Case Examiners failed to provide adequate reasons for their decision in circumstances which include Dr Patel having admitted that the retrospective amendments were inappropriate and the evidence from the Independent Expert, who concluded that Dr Patel's conduct "fell seriously below the standard expected of a reasonable competent GP".

63. The Case Examiners decided that:

> "We find that there is a realistic prospect of allegations 1 and 2 being found capable of proof. These relate to Dr Patel inappropriately making retrospective amendments to medical records. The amendments were inappropriate because he did not make clear when the addition was made, by whom, and why it was made.
>
> We accept the expert's opinion that this fell seriously below the standard expected of a reasonably competent GP because it undermines the credibility of the record.

We also note the expert's view that the additions, in themselves, appear to be helpful clinical additions. Furthermore we note that there is no dispute about the accuracy of some of the comments added by Dr Patel, which reflected Mr Loder's clinical history and Dr Patel's management plan. Where there was a dispute, we have explained that we do not believe the addition can be proved to be inaccurate and the disputed addition did not materially affect Mr Loder's ongoing care.

When considering whether Dr Patel's admitted departure from the standards expected in respect of his record keeping, on a single occasion on 19 August 2015, is sufficiently serious to require action on his registration, we must keep in mind that the primary purpose of the GMC's fitness to practise proceedings is to protect the public against future harm from those who are not fit to practise, rather than to punish a doctor for past misdoings.

We must decide whether there is a realistic prospect of establishing that the doctor's fitness to practise is currently impaired: this decision looks forward to what a doctor may do now or in the future, rather than to actions committed in the past. This means we should take into account whether the doctor's failings are easily remediable, whether they have been remedied (and to what extent), and whether they are likely to be repeated.

This incident took place seven years ago, and Dr Patel's Responsible Officer and employers report no concerns since about Dr Patel's conduct. Dr Patel has been fully registered with the GMC since 2006 and he has no fitness to practise history.

With regard to his record keeping failing, Dr Patel has acknowledged the failing and expressed his regret for it. He has provided evidence that he has refreshed his knowledge of the standards required in respect of record keeping by completing relevant professional development courses. We have been informed of no other concerns, before or since, about his records.

In these circumstances, we are of the view that there is no realistic prospect of demonstrating that the doctor poses an on-going risk to patient safety and is not currently fit to practise. Further, in the absence of evidence that the doctor displayed a reckless disregard of his clinical obligations, we do not consider that there is a realistic prospect of a finding of impairment solely in order to maintain public confidence in the profession."

64. It is argued on behalf of the Claimant that:

a. The Case Examiners were required to proceed with particular caution given the conclusions of the Independent Expert and be slower to halt a complaint against a practitioner who continued, as Dr Patel did, to practise. None of these factors feature as considerations in the reasons given.

b. Given the allegations of dishonesty and the fact that there was evidence to support such allegations, the reasons fail to mention the presumption of impairment to practise.

c. The Case Examiners' focus on remediation failed to refer to the diminished weight such issues have where the presumption of impaired fitness arises.

d. The Case Examiners did not comment upon the relevance of the timing of Dr Patel's amendments or his failure to explain why he had failed to date and explain his additional entries at the time he made them.

e. The Case Examiners did not explain adequately why the serious criticisms in the report of the Independent Expert did not of themselves merit referral to the Tribunal.

f. The Case Examiners failed to explain why Dr Patel's admitted inappropriate conduct did not offend public confidence in the profession, focusing rather on protecting patient safety. This was not the correct test, merely part of the correct test.

g. In applying the passage of time in Dr Patel's favour, the Case Examiners failed to have regard to the amendments only having emerged due to the Claimant's persistence in requesting some years later an audit trail.

65. It is argued on behalf of the GMC that:

a. The court should only interfere with a decision on the ground of inadequate reasons if the aggrieved party can satisfy it that they have been substantially prejudiced by the failure to give reasons.

b. The arguments now advanced are not relevant to Allegations 1 and 2. The presumption of impairment did not apply.

c. The Case Examiners clearly identified the factors which led them to the conclusion that Allegations 1 and 2 ought not to be referred to the Tribunal -

i. The passage of time;

ii. The absence of concerns reported by the responsible officer;

iii. The absence of any other fitness to practise history; and

iv. Dr Patel's acknowledgment of fault, expressions of regret and evidence of remediation.

d. The Claimant may disagree with the Case Examiners decision on this point, but their reasons were clear and more than sufficient to enable the Claimant to understand why the allegations against Dr Patel were not referred to the Tribunal.

66. I am satisfied that Ground 4 proceeds on the alternative assumed hypothetical basis that the admitted retrospective amendments were both accurate and not intended to avoid potential allegations of failings in care. In other words, Dr Patel's amendments, although "inappropriate", were not dishonestly motivated such that the presumption of impairment was not engaged in relation to Allegation 1 and Allegation 2.

67. In mitigation, the Case Examiners placed reliance on the facts that:

a. "Dr Patel has acknowledged the failing and expressed his regret for it." However, the Case Examiners failed to consider and weigh in the balance

the evidence of the Independent Expert that Dr Patel's earlier letter "shows a worrying lack of concern and insight into why the changes he has made to the notes on 19th August 2015 are important. This lack of insight and understanding is concerning."

b. Dr Patel "has provided evidence that he has refreshed his knowledge of the standards required in respect of record keeping by completing relevant professional development courses." However, Dr Patel's solicitors' letter stated that "with the benefit of hindsight Dr Patel recognises that the proper way to make any such amendment is by way of separate dated entry." The Case Examiners failed to consider that the duty imposed upon Dr Patel in respect of retrospective amendments was twofold. It was not simply to date the entry, but also to record an explanation as to why the entry was required.

68. The Case Examiners also placed reliance on the fact that it was an isolated incident that took place seven years ago. The Guidance states that:

> "[79] An isolated lapse from high standards of conduct – such as an atypical rude outburst – would not normally, in itself, suggest that the doctor's fitness to practise should be in question. The sort of misconduct….. which may however, indicate a lack of integrity, an unwillingness to practise ethically or responsibly or a serious lack of insight into obvious problems of poor practise will bring a doctor's registration into question."

The Case Examiners failed to consider and weigh in the balance that Dr Patel had not disclosed or volunteered the fact that he had made the amendments either when he supplied the medical records to Mr Loder in 2015 or at any time during the period of the initial complaint in 2015 – 2016.

69. The Case Examiners accepted the opinion of the Independent Expert that Dr Patel's action "fell seriously below the standard expected of a reasonably competent GP because it undermines the credibility of the record". However, they concluded that "in the absence of evidence that the doctor displayed a reckless disregard of his clinical obligations, we do not consider that there is a realistic prospect of a finding of impairment solely in order to maintain public confidence."

70. The Independent Expert variously stated:

a. "The amendments…. In themselves .. are probably helpful…. [but] they are misleading because [they] … are added to the existing record and so appear to be part of the contemporary record… rendering it unreliable as evidence….either for clinical practice or in a legal or regulatory context."

b. "If we cannot rely on the basic honesty of the clinical record and of doctors who build this record then we are seeing very poor medical practise, seriously below the standards of accuracy and honesty expected of any doctor."

c. "Making late amendment to notes is deplorable."

d. "if a doctor's notes cannot be trusted then the doctor's own integrity and honesty come into serious doubt."

e. "It is behaviour [that]…. Specifically.. breaches Good Medical practice [which provides that] You must make sure that your conduct justifies your patients trust in you and the public's trust in the profession".

f. "Retrospective alteration of the medical record is an action that would be considered deplorable by medical colleagues. I cannot see any justification ….. for this action."

g. "The overall standard of care here is seriously below standard. Retrospective alteration of medical records is deplorable conduct as it ruins the accuracy of the medical record……It makes the clinical record unreliable, and if we cannot trust in the basic accuracy of the medical record then clinical care is severely compromised."

h. "The behaviour by Dr Patel raises questions about his clinical standards and his honesty and integrity."

i. "The only conclusion I can reach is that the behaviour here is seriously below the standards expected of a reasonably competent general medical practitioner."

The Case Examiners stated that Dr Patel's actions were "inappropriate" but not "reckless". However, the evidence of the Independent Expert was much more damning. The Case Examiners failed properly to consider the strongly expressed opinions of the Independent Expert that Dr Patel's actions were altogether misleading, deplorable, seriously sub-standard, lacking in integrity and unjustified. Further, and as a consequence, the Independent Expert believed that clinical care and patient/public trust were severely compromised.

71. In my judgment, the explanation given by the Case Examiners as to why they thought that there was no realistic prospect of the Tribunal making a finding of current impairment was insufficient and inadequately reasoned particularly having regard to the strongly expressed opinions of the Independent Expert. If the Case Examiners did not fully accept the opinions of the Independent Expert, they ought to have given reasons for not doing so.

**The proper target for judicial review**

72. The GMC argues that the decision of the Case Examiners has now been superseded by the GMC review decision, which is the proper target for any claim against the GMC for failure to refer the allegations against Dr Patel to the Tribunal. Therefore, the claim against the Case Examiners' decision should be dismissed.

73. The GMC concedes that judicial review is a flexible process and the court is generally concerned with substance over form. At the time of the Claimant's letter of claim, which triggered the GMC review, the Claimant had not seen either the report of the Independent Expert or the letter from Dr Patel's solicitors dated 28 July 2022. The GMC's letter, dated 9 February 2023, enclosing a copy of the review decision stated that if the Claimant "is still dissatisfied with the outcome, the only option available is to ask the courts for a Judicial Review of the original decision."

74. The question here for the court involves an element of double rationality. Was the GMC review decision, that the decision of the Case Examiners was not "materially

flawed", itself reasonably open to the review decision maker, even if the court might have reached a different conclusion.

75. In my judgment, the GMC review decision unreasonably failed to identify material flaws in the Case Examiners' decision:

    a. The review decision concluded that "In relation to the allegations considered, I note that the Case Examiners have carried out a detailed analysis of the allegations put to Dr Patel…… In my view, there has been a significantly detailed analysis of the issues and evidence in this matter." However, the Case Examiners were plainly wrong to have concluded that Allegation 5 was not capable of proof just because more likely than not the Tribunal would have concluded that the retrospective entries were true. An accurate retrospective entry can still be dishonestly motivated.

    b. The Case Examiners' decision as to why there was no realistic prospect of the Tribunal making a finding of current impairment on the basis that Allegation 1 and Allegation 2 were admitted was insufficient and inadequately reasoned. In particular, and having regard to the exceptional and sustained criticism by the Independent Expert of Dr Patel's admitted and inappropriate actions, it was not reasonably open to the review decision maker to conclude that "I am satisfied that Case Examiners have placed appropriate weight to the expert opinion." For the reasons I have already given, the Case Examiners plainly failed properly to consider and weigh in the balance the strength of the evidence of the Independent Expert.

**Conclusion**

76. The claim succeeds on Ground 3 and Ground 4.

77. The decisions of 6 September 2022 and 9 February 2023 are quashed so far as they relate to Allegation 1, Allegation 2 and Allegation 5 such that those allegations fall to be reconsidered by the Case Examiners.