PUBLIC RECORD

Dates: 03/03/2025 - 11/03/2025

Doctor:	Dr Faisal PATEL
GMC reference number:	6122732
Primary medical qualification:	MB BS 2005 University of London

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Not Impaired

Summary of outcome

No warning

Tribunal:

Legally Qualified Chair	Mrs Emma Gilberthorpe
Lay Tribunal Member:	Mr Paul Curtis
Registrant Tribunal Member:	Dr John Moriarty

Tribunal Clerk:	Ms Hinna Safdar

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Martin Forde, KC, instructed by DAC Beachcroft
GMC Representative:	Ms Laura Barbour, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 07/03/2025

Background

1. Dr Patel qualified in 2005 from St George's Hospital Medical School, University of London. He has been working as a GP Partner at the Leander Family Practice Thornton Heath since November 2020. At the time of the Allegation, Dr Patel was working as a salaried GP at Fairview Medical Centre ('the Practice') in London. He worked there from 2011 to 2020.

2. The allegation that has led to Dr Patel's hearing can be summarised as follows: on 19 August 2015, Dr Patel received a letter informing him of Patient A's cancer diagnosis. Dr Patel accessed Patient A's medical records and made amendments to the medical records in respect of consultations held on 26 May 2015 and 10 June 2015. It is alleged that Dr Patel failed to add the text as a new entry, and failed to indicate that the amendments were made retrospectively. It is accepted that the contents of the amendments were true. It is further alleged that Dr Patel made the amendments to avoid criticism of his care of Patient A and that his actions were dishonest.

3. The amendments came to light in 2020 following Patient A's partner, Ms B, requesting an audit trail of the medical records. The audit showed that the amendments had been made by Dr Patel on 19 August 2015 in respect of consultations that occurred 10 to 12 weeks prior. The changes were not marked as retrospective and as such appeared to be part of the original contemporaneous records.

4. The General Medical Council (GMC)'s case is that Dr Patel amended the records to avoid criticism of his care towards Patient A, specifically his record-keeping which is an aspect of patient care. Ms Laura Barbour, Counsel on behalf of the GMC, contended that the appropriate action would have been to add a separate note, clearly marked as retrospective. The GMC asserted that Dr Patel's actions were dishonest due to improper motive, even if the content of the amendments were true.

The Allegation and the Doctor's Response

5. The Allegation made against Dr Patel is as follows:

That being registered under the Medical Act 1983 (as amended):

1. On 19 August 2015 you made amendments to Patient A's medical records in respect of consultations you had with Patient A on:

    a. 26 May 2015 by adding the text as set out in Schedule 1; Admitted and found proved

    b. 10 June 2015 by adding the text as set out in Schedule 2. Admitted and found proved

2. When you acted in the manner described at paragraph 1 you failed to:

    a. add the text as a new entry; Admitted and found proved

    b. indicate:

        i. the date and time when the amendment was made; Admitted and found proved

        ii. that the amendment was retrospective; Admitted and found proved

        iii. why the amendment was required. Admitted and found proved

3. Your actions as described at paragraphs 1 and 2 were so as to avoid criticism of your care towards Patient A. To be determined

4. When you acted in the manner described at paragraph 1 you knew the amendments you had made to Patient A's records as described at paragraph 2 would appear as part of the contemporaneous medical record. Admitted and found proved

5. Your conduct at paragraphs 2 was dishonest by reason of paragraphs 3 and 4. To be determined

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

The Admitted Facts

6. At the outset of these proceedings, through his counsel Mr Martin Forde, KC, Dr Patel made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

7. In light of Dr Patel's response to the Allegation made against him, the Tribunal is required to determine whether his actions were so as to avoid criticism of his care towards Patient A and whether his conduct was dishonest.

Evidence

Witness evidence

8. The Tribunal received evidence on behalf of the GMC from the following witness:

- Ms B, Patient A's partner, in person

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

- Mr D, the Practice Manager at the Practice since October 2013.

10. Dr Patel provided his own witness statement, dated 3 February 2025, and also gave oral evidence at the hearing. In addition, the Tribunal received evidence from the following witnesses on Dr Patel's behalf:

- Dr C, a GP partner at Leander Family Practice, via video link
- Dr E, a GP partner at Leander Family Practice, via video link
- Dr F, a salaried GP at Fairview Medical Centre, via video link

11. The Tribunal also received evidence on behalf of Dr Patel in the form of testimonials from the following witnesses who were not called to give oral evidence:

- Dr H, a GP at Fairview Medical Centre, dated 28 January 2025

- Dr G, an Associate Director for GP Training, dated 30 January 2025
- Dr I, a GP at Fairview Medical Centre, dated 29 January 2025
- Ms J, the Practice Manager for New Addington Group Practices, dated 5 February 2025
- Ms K, a qualified Assistant Practitioner, dated 30 January 2025

Expert Witness Evidence

12. The Tribunal also received evidence from Dr L, an expert witnesses on behalf of the GMC. Dr L is a Clinical Advisor and Educator for Local Care Direct (LCD) and commenced this role in April 2018. Dr L reviews clinical incidents and concerns about quality of medical care in the GP out of hours setting.

Documentary Evidence

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

- Subject Access Request, Email to Fairview Medical Practice from Patient A, dated 9 September 2015
- Email exchange with Fairview Medical practice and Ms B, dated 23 September 2015
- Patient A's PET SCAN, dated 24 August 2015
- Letter from Irwin Mitchell to Dr Patel, dated 22 October 2020
- Dr Patel's response to Irwin Mitchell Solicitors, dated 28 October 2020
- Patient A's Medical Records
- Audit of Patient A's Medical Records
- Access Audit of Patient A's Medical Records
- Dr Patel CV
- Record Keeping Course Certificates, dated 1 November 2020 and 15 June 2021
- Expert Report of Dr L, dated 16 May 2022
- Supplemental Report of Dr L, dated 11 November 2024

The Tribunal's Approach

14. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Patel does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

15. The Tribunal referred to the test for dishonesty as set out by Lord Hughes at paragraph 74 of the case of *Ivey v Genting Casinos 2017 UKSC 67.* This requires the Tribunal prior to the making of a finding of dishonesty to look at the circumstances. Lord Hughes said,

> *"When dishonesty is in question, the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence. Often in practice (determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge of belief of the facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying (the objective) standards of ordinary decent people. There is no requirement the Defendant must appreciate that what he has done is by those standards, dishonest."*

16. The Tribunal recognised that the GMC's case is brought on the basis of *"dishonesty because of improper motive"* rather than *"dishonesty because of falsity*" *Moneim v General Medical Council 2011 [EWA C327]* (Admin) which clarified that writing something that is true into patient records can amount to a dishonest act.

17. In considering the credibility of any witness the Tribunal took into account the unreliability of memory and that witness evidence should therefore be considered and tested by reference to objective facts, and in particular as shown in contemporaneous documents. Where possible, its factual findings should therefore be based on objective facts as shown by contemporaneous documents. When considering documents, the Tribunal took into account when they were made, by whom and for what purpose. The Tribunal considered all of the evidence before coming to a conclusion about a witness's credibility.

18. The Tribunal accepted that when being asked to draw any inferences, it must be able to discount any other explanation before making a finding of dishonesty.

19. In the case of *Jenyo v GMC [2016] EWHC 1708(Admin),* where it was accepted that deliberate alterations had been made by the doctor, Andrew J said the doctor's *'credibility was at the heart of the issue that the panel had to decide*.'

20. Previous good character of a doctor is not determinative as to whether or not they did or did not do what is alleged. It is not a defence. However, good character will be relevant in two ways: (1) propensity of the doctor to act in the way alleged and (2) their credibility.

21. Judging the weight to be given to the doctor's good character and its relevance at the Facts stage is a matter for the Tribunal, taking account of all the evidence, admissions made, law and submissions by counsel.

The Tribunal's Analysis of the Evidence and Findings

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

Paragraph 3

23. The Tribunal had to determine whether it was more likely than not that Dr Patel made amendments to Patient A's medical records, without indicating they were retrospective entries, so as to avoid criticism of his care towards Patient A.

24. The Tribunal referred to Dr Patel's witness statement in which he said,

> *"The diagnosis came as a shock to me. Patient A had not presented with any obviously respiratory symptoms and the overwhelming presentation in my mind at the time when combined with the significant concerns expressed by Patient A and Ms [B] that the symptoms were cardiological in origin had led to the multiple cardiological referrals and investigations I have referred to above. Accordingly I took the opportunity to review patient A's case notes to see if there were any signs which I had missed. Principally this was for my own learning as this was the first time I had experienced a patient who had a mesothelioma related malignancy.*
>
> *When reviewing the notes it became clear to me that while I had done my best to make a relatively full note of the consultations we had, unfortunately I had not been as clear or as full as I might have been. In large part this was due to the length of the consultations which invariably were lengthy and exceeded the allotted appointment time. Whilst I was happy to attend to patient A and Ms [B] for as long as they needed this inevitably truncated the time available to prepare the note of the consultation.*
>
> *Accordingly when I reviewed the notes and in particular those of 26 May 2015 and 10 June 2015 I saw that I had not recorded features of the discussion we had and which*

had influenced my management at that time. I therefore thought it appropriate and indeed helpful to add those points of clarification to the original note I had made thereby improving the accuracy of the note of the consultations we had on those occasions."

25. In oral evidence, Dr Patel acknowledged that he was shocked by Patient A's diagnosis of mesothelioma. He stated that he reviewed Patient A's medical records to check if there were any signs he had missed, describing this process as an act of "*self-reflection"* and amended the records in an effort to "*improve the accuracy of the note of the consultations we had on those occasions."*

26. Dr Patel explained that he reviewed the notes to identify any potential oversights, primarily for his own learning, as this was his first encounter with a patient diagnosed with mesothelioma. He admitted that his original notes were not as clear or comprehensive as they could have been. He accepted making the amendments and failing to mark them as retrospective and acknowledged his failing.

27. The Tribunal was of the view that Dr Patel's oral evidence was consistent and unwavering with his witness statement, in which he elaborated on his motivations. In addition, it was consistent with his initial reply to Irwin Mitchell's request in 2020, in which he said, *"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 those consultations. I accept that these should have been clearly annotated as retrospective entries."*

28. The GMC's case was that Dr Patel made the amendments to Patient A's medical records as he feared a complaint from Patient A and Ms B due to their strained relationship.

29. Ms B, in her oral evidence, told the Tribunal that she had been frustrated as she believed Dr Patel was "*going through the motions*".

30. The Tribunal noted that referral letters written by Dr Patel were comprehensive and measured and did not necessarily support the claim of a strained relationship. Dr Patel's oral evidence was that he did not consider the relationship between him and Patient A and Ms B was strained. He told the Tribunal *"I thought we had established a good relationship"* adding that "*although they were difficult at times, they were professional and respectful… I did not anticipate a complaint."*

31. In respect of the amendments Dr Patel made to Patient A's medical records, it is accepted that all of the information was factually correct. Dr L provides that the amendments were "*probably helpful clinical additions providing detail and context. They could help in the assessment of Patient A's care."* The Tribunal found this supported Dr Patel's assertion that his primary intention was to improve the accuracy of the records rather than to avoid criticism.

32. The Tribunal also considered whether the amendments were made to avert criticism of Dr Patel's clinical care. It could not determine how adding more detail, which was factually correct and already contained within Patient A's medical records, would have averted criticism of his clinical care.

33. The Tribunal accepted that care encompasses both direct clinical care and record-keeping. The Tribunal therefore went on to consider whether the amendments were made to avoid criticism of his record- keeping. Dr Patel himself conceded that he should have made the amendments differently, recording that they were retrospective. While it found no fault with Dr Patel's clinical care, it acknowledged that the way he amended the records was incorrect, meaning his record-keeping had been inadequate.

34. The Tribunal noted that if Dr Patel's primary concern had been to avoid criticism of his note-taking, it was unlikely that he would have amended the records in a manner that was easily identifiable and in a manner which was against recognised practice.

35. Ultimately, the Tribunal found that Dr Patel's amendments were not made to avoid criticism of his care of Patient A. Rather, they were driven by his intention to ensure that Patient A's medical notes were more accurate and comprehensive. The Tribunal accepted Dr Patel's explanation as plausible and supported by the evidence. Consequently, it found Paragraph 3 of the Allegation not proved.

Paragraph 5

36. The Tribunal had to determine whether it was more likely than not that Dr Patel's conduct was dishonest.

37. The Tribunal has found, in relation to Paragraph 3 of the Allegation, that Dr Patel's actions were motivated by a desire to create a more accurate and comprehensive record,

rather than to avoid criticism. This conclusion played a significant role in assessing whether his conduct was dishonest.

38. In considering the issue of dishonesty, the Tribunal applied the test established in *Ivey v Genting Casinos (2017 UKSC 67)*, which requires an examination of both the subjective state of mind of the individual and whether their actions would be considered dishonest by the standards of an objective, reasonable person. The Tribunal has found that Dr Patel's subjective state of mind was focused on improving the accuracy and completeness of Patient A's medical notes. He accepted that the amendments would appear as part of the contemporaneous medical records, however, his primary concern was ensuring the notes were accurate and thorough.

39. Having found Dr Patel lacked any dishonest motive, the Tribunal further reasoned that no objective person would consider his conduct to be dishonest. The Tribunal determined that Dr Patel's amendments were motivated by a genuine desire to improve the record-keeping rather than to avoid criticism, it concluded that there was no dishonest motive underlying his actions. As a result, the Tribunal found that Dr Patel's conduct was not dishonest.

40. The Tribunal therefore found Paragraph 5 of the Allegation not proved.

The Tribunal's Overall Determination on the Facts

41. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

1. On 19 August 2015 you made amendments to Patient A's medical records in respect of consultations you had with Patient A on:

    a. 26 May 2015 by adding the text as set out in Schedule 1; Admitted and found proved

    b. 10 June 2015 by adding the text as set out in Schedule 2. Admitted and found proved

2. When you acted in the manner described at paragraph 1 you failed to:

a. add the text as a new entry; Admitted and found proved

b. indicate:

i. the date and time when the amendment was made; Admitted and found proved

ii. that the amendment was retrospective; Admitted and found proved

iii. why the amendment was required. Admitted and found proved

3. Your actions as described at paragraphs 1 and 2 were so as to avoid criticism of your care towards Patient A. Determined and found not proved

4. When you acted in the manner described at paragraph 1 you knew the amendments you had made to Patient A's records as described at paragraph 2 would appear as part of the contemporaneous medical record. Admitted and found proved

5. Your conduct at paragraphs 2 was dishonest by reason of paragraphs 3 and 4. Determined and found not proved

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

Determination on Impairment - 10/03/2025

42. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Patel's fitness to practise is impaired by reason of misconduct.

The Evidence

43. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

Submissions

On behalf of the GMC

44. Ms Laura Barbour, Counsel, stated that she was not instructed to make any submissions at this stage and set out that impairment was a matter for the Tribunal's independent judgement.

On behalf of Dr Patel

45. Mr Martin Forde, KC, addressed the specific allegations against Dr Patel, particularly the amendments he made to Patient A's records. Mr Forde acknowledged that Dr Patel accepted he should have made it clear that the additions to the notes were not contemporaneous, but it was accepted that the amendments were not incorrect or dishonest. Mr Forde pointed out that the Tribunal considered in its determination on fact that the referral letters prepared by Dr Patel were of a high standard, comprehensive, and measured. The Tribunal had also not found that the amendments were made to avoid criticism. Mr Forde submitted that the additions, while not contemporaneous, were factually correct and provided useful clinical context. He submitted that the incident was a "*momentary lapse*" in an otherwise unblemished career, lasting less than three minutes, and emphasised that Dr Patel has acknowledged the error in his record-keeping.

46. Mr Forde critiqued the GMC's expert, Dr L's, evidence which he described as *"internally contradictory".* He noted that while Dr L initially described the amendments as "*misleading,*" he also acknowledged that the added information was clinically useful and factually accurate. Mr Forde submitted that "*misleading*" does not imply a guilty state of mind, and since the Tribunal has not found Dr Patel to be dishonest, the amendments should not meet the threshold for misconduct. He further highlighted that Dr L described it as "*an isolated incident seriously below*" the standard but also noted that there was context and explanation for the amendments. Mr Forde submitted that Dr L's uncertainty undermines the consistency of the evidence against Dr Patel.

47. Mr Forde submitted that even if the Tribunal finds Dr Patel's actions amounted to misconduct, it is easily remediable and has been remediated. Mr Forde submitted that Dr Patel has undertaken significant professional development, including courses on good record-keeping, and has demonstrated a commitment to improving his practice. Mr Forde submitted that, as according to case law, if the conduct is easily remediable and there is no risk of repetition, impairment should not be found. Mr Forde highlighted that there has been no repetition of similar incidents in the nine and a half years since the event, and he

submitted that the events were a "*momentary misjudgement*" in an otherwise exemplary career.

48. Mr Forde drew the Tribunal's attention to the numerous testimonials provided on Dr Patel's behalf, which attested to his conscientiousness and high standard of practice. He also referenced Dr Patel's witness statement, in which Dr Patel expresses regret for the distress caused to Patient A and Ms B and acknowledged that the amendments may have been inadvertently misleading. However, Dr Patel maintained that his actions were not intentional or deliberate, and he was focused on ensuring the accuracy of the records. Mr Forde emphasised that Dr Patel has shown insight into his actions and has taken steps to address any deficiencies in his practice.

49. Mr Forde submitted that the Tribunal should therefore not find Dr Patel's fitness to practise currently impaired. He submitted that the incident was an isolated lapse, that Dr Patel has demonstrated insight and remediation, and that there is no risk of repetition. He emphasised the significant impact that a finding of impairment would have on Dr Patel's career, describing it as a "*lifelong mark*" that would affect his professional standing and relationship with his regulator. Mr Forde urged the Tribunal to consider the totality of the evidence and the context of Dr Patel's otherwise exemplary career in reaching their decision.

The Relevant Legal Principles

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

51. The Legally Qualified Chair (LQC) reminded the Tribunal of the overarching objective, which is to protect, promote, and maintain the health, safety, and well-being of the public, to uphold public confidence in the medical profession, and to maintain proper professional standards and conduct. The LQC emphasised that these objectives must be considered as a whole, and no single limb should be given excessive weight. The purpose of fitness to practise proceedings is not to punish the practitioner but to protect the public and maintain confidence in the profession. The tribunal must look forward, not backward, in assessing whether a doctor's fitness to practise is currently impaired.

52. The LQC outlined a two-stage approach for the Tribunal to follow: (1) to determine whether the proven facts amount to misconduct, and (2), if misconduct is found, determine whether the doctor's fitness to practise is currently impaired as a result of that misconduct.

The LQC stressed that these are separate questions, and a finding of misconduct does not automatically result in a finding of impairment. The Tribunal must exercise its own judgment in assessing the seriousness of the misconduct and its implications for the doctor's current fitness to practise.

53. The LQC provided guidance on the definition of misconduct, referencing the case of *Roylance v GMC*. Misconduct involves an act or omission that falls short of the standards expected of a medical practitioner. The Tribunal should consider the standards set out in the GMC's *Good Medical Practice ('GMP') 2013* and assess whether the doctor's actions were sufficiently serious to amount to misconduct. The LQC noted that:

- A single negligent act is less likely to cross the threshold of misconduct unless it is particularly grave.
- Misconduct must be serious and that would be regarded as deplorable by fellow practitioners.
- Behaviour that is trivial, inconsequential, or a temporary lapse is not to be regarded as professional misconduct.

54. The LQC reminded the Tribunal that the assessment of seriousness is a matter of judgment based on the facts and circumstances of the case, viewed in light of all the evidence and submissions.

55. If the Tribunal finds misconduct, it must then consider whether the doctor's fitness to practise is currently impaired. The LQC highlighted that impairment is not automatic and depends on whether the doctor's actions or omissions pose a risk to the public, the profession, or the fundamental tenets of medical practice. The Tribunal was assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as adopted in the High Court in CHRE v NMC and Paula Grant [2011] EWHC 297 Admin with regard to commonly occurring features that are likely to be present when impairment is found:

> *''a. Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. Has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.''

56. The LQC reminded the Tribunal that public confidence in the medical profession is a critical consideration. Even if a doctor does not currently pose a risk to patients, a finding of impairment may still be necessary to uphold professional standards and maintain public trust. The tribunal must weigh the need to protect the public and uphold confidence in the profession against the doctor's insight, remediation, and risk of repetition.

57. The LQC noted that if the tribunal finds no current impairment, it may still consider issuing a warning to the doctor, subject to representations from the parties. However, this option is not available if the tribunal finds impairment. The LQC emphasised that the tribunal must provide clear reasons for its decision, whether it finds impairment or not.

The Tribunal's Determination on Impairment

Misconduct

58. In determining whether Dr Patel's fitness to practise is impaired by reason of misconduct the Tribunal first considered whether the facts admitted by Dr Patel amount to misconduct.

59. Dr Patel has admitted that he knew the amendments he had made to Patient A's records as described would appear as part of the contemporaneous medical record. The Tribunal bore in mind that it did not find that this had constituted dishonesty as it had accepted Dr Patel's evidence that his motivations were to ensure Patient A's medical records were accurate and comprehensive, and the amendments made were factually correct and from information contained in other areas of Patient A's medical notes.

60. The Tribunal referred to *Good Medical Practice 2013* ('GMP'), and had regard to the paragraphs 19, 21(e), 65 and 71:

"19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

21 Clinical records should include:

…

e who is making the record and when.

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession."

61. In Dr L's expert report, dated 16 May 2022, he was asked to comment on '*Whether the amendments made are relevant to an assessment of Dr Patel's care of Patient A, taking into consideration [Ms B]'s statement*' and he set out the following:

"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…"

62. Dr L was then asked to explain why aspects of care was seriously below. He said,

"This creates a misleading impression that the notes were contemporary when in part they are now amended and retrospective. This means that the notes cannot be relied on as a contemporary written record of events. This renders the notes inaccurate and unreliable either for clinical practice or in a legal or regulatory context."

63. In his Supplemental Report, dated 11 November 2024, Dr L stated, *"I think the fact of the original alterations being made was seriously below the standard expected of a reasonably competent general medical practitioner."* He maintained this view in in his oral evidence.

64. The Tribunal considered that whilst it had not found any intention from Dr Patel to be dishonest, it acknowledged the lack of any indication that the amendments were added in retrospect meant the medical records, in appearing as contemporaneous, had the capability of being misleading.

65. The Tribunal accepted Dr L's evidence and determined that the failings admitted by Dr Patel in respect of the retrospectively amended medical notes, engaged paragraphs 19, 21(e) and 65 of GMP. Dr Patel had failed to take reasonable steps to ensure the amendments would appear as retrospective and so had failed in his duty to keep clear and accurate records.

66. Therefore, although Dr Patel's actions were confined to a single event and the Tribunal had not found him to have been dishonest in relation to the retrospective amendments, the public should be able to trust that medical records are accurate. The Tribunal determined that the failings admitted were significant departures from GMP. It considered these amounted to misconduct, which was serious, and had the potential to affect the public's confidence in the medical profession.

Impairment

67. Having found that some of the facts admitted amounted to misconduct which was serious, the Tribunal went on to consider whether, as a result of this, Dr Patel's fitness to practise is currently impaired by reason of his misconduct.

68. In determining whether a finding of current impairment of fitness to practise is necessary, the Tribunal looked for evidence of insight, remediation and the likelihood of repetition, bearing in mind the three elements of the overarching statutory objective. It considered that insight and remediation are important in order for a doctor to recognise areas of their practice and behaviour that require improvement, and to take appropriate and relevant steps to address them, thus reducing the likelihood of repetition.

69. The Tribunal first considered evidence of Dr Patel's insight. It noted that in relation to the amendment of Patient A's medical records, Dr Patel made admissions in his witness statement and at the hearing itself through formal admissions and in his oral evidence. The Tribunal considered that Dr Patel has shown good and effective insight into his failures.

70. The Tribunal considered that Dr Patel's actions were clearly capable of remediation and noted that he has completed targeted CPD, including courses in record keeping, dated 1 November 2020 and 15 June 2021, in respect of the matters which arose as part of this case. This '*momentary lapse*' was an event that spanned over the course of a few minutes, and Dr Patel undertook timely remediation by attending the courses, including one on 1 November 2020, shortly after he became aware of the concerns regarding the amendments to Patient A's medical records.

71. The Tribunal again reminded itself of written and oral evidence provided at during the hearing about Dr Patel's good character and the high esteem in which he is held. It noted the testimonial evidence which demonstrated his excellence as a clinician who is complimented on his honesty and integrity. It observed that the matters before this Tribunal stemmed from a one-off incident in an otherwise long and unblemished career. It noted the passage of time since these events, and that there has been no repetition of the misconduct.

72. The Tribunal was therefore satisfied that through his early admissions, his reflections, his apology, his CPD, and the evidence he has provided to this Tribunal, Dr Patel has shown full insight into his actions to address his misconduct.

73. The Tribunal was also satisfied that Dr Patel has remediated his misconduct in the work he has undertaken to address his misconduct. This, together with the evidence of his previous long unblemished career and powerful testimonials satisfied the Tribunal that the risk of repetition was negligible.

74. The Tribunal carefully considered and balanced the three elements of the statutory overarching objective. It accepted that there were no patient safety concerns in this case.

75. The Tribunal had regard to whether a finding of impairment was necessary on public interest grounds in order to uphold proper professional standards. It reminded itself of the finding it had made in relation to misconduct and the fact that these issues had been the subject of regulatory proceedings. The Tribunal considered the finding of misconduct was sufficient to highlight to the wider profession that Dr Patel's conduct was unacceptable.

76. The Tribunal recognised its finding that Dr Patel's misconduct was serious and had the potential to affect the public's confidence in the profession. However, the Tribunal concluded that a fully informed member of the public, made aware of the circumstances of this case, including the lapse of time since the events set out in the Allegation, and his long

unblemished career, would be satisfied that a finding of impairment was not necessary in this case to uphold public confidence in the profession.

77. Therefore, the Tribunal determined that public confidence in the medical profession would not be undermined if a finding of impairment was not made in the particular circumstances of this case.

78. The Tribunal therefore determined that Dr Patel's fitness to practise is not currently impaired by reason of misconduct.

Determination on Warning - 11/03/2025

79. As the Tribunal determined that Dr Patel's fitness to practise was not impaired, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules, whether a warning should be imposed.

Submissions

On behalf of the GMC

80. Ms Barbour made no submissions on the matter of issuing a warning to Dr Patel.

On behalf of Dr Patel

81. Mr Forde, KC, submitted that a warning would be disproportionate in the circumstances. He emphasised that Dr Patel has a promising medical future, which includes ongoing interactions with funders, medical commissioners, and potential career advancements, such as becoming a principal in his practice. A warning, while publicly visible for only two years, would have long-term implications, as Dr Patel would be required to disclose it throughout his medical career.

82. Mr Forde submitted that imposing a warning would be unduly punitive given the context of the case. He submitted that Dr Patel has demonstrated insight, expressions of regret, and apology for the incident. Mr Forde highlighted that the incident was isolated, and pointed to Dr Patel's previously unblemished professional history. Additionally, Mr Forde emphasised the rehabilitative and corrective steps Dr Patel has taken, as well as the strong and glowing testimonials, attesting to his professional competence and character. Mr Forde submitted that these factors mitigate the need for a warning.

83. Mr Forde further submitted that a warning would serve no practical purpose. Dr Patel understood that he breached GMP. In light of this, Mr Forde submitted that the Tribunal should not feel compelled to impose a warning, as Dr Patel has already internalised the lessons from the proceedings and taken steps to ensure such an incident does not recur.

The Relevant Legal Principles

84. The Tribunal received and accepted legal advice from the LQC.

85. The need for a warning must be based on the factual findings in respect of the allegation made in the particular case.

86. The purpose of a warning is to allow a Tribunal to indicate to a doctor that any given conduct, practice or behaviour represents a departure from the standards expected of a member of the profession and should not be repeated.

87. A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected, to a degree which warrants a formal response by the Tribunal. It will be appropriate where there has been a significant departure from GMP. There is no definition of the word *"significant"* in the Medical Act or the *Guidance on warnings* and it should be given its ordinary meaning.

88. The Tribunal should have regard to the current *Guidance on warnings* issued by the GMC in April 2024. The factors to be taken into account include:

1. A clear and specific breach of guidance.
2. The practitioner's conduct approaches, but falls short of, the threshold for a finding of impairment.
3. The concerns being sufficiently serious that if there were a repetition they would likely result in a finding of impaired fitness to practise.
4. A need to formally record the particular concerns.

The Tribunal's Determination on Warning

89. The Tribunal had regard to paragraphs 14, 16, 20, 26 and 32 of the *Guidance on warnings* (2024):

14 Warnings should be viewed as a deterrent. They are intended to remind the doctor that their conduct or behaviour fell significantly below the standard expected and that a repetition is likely to result in a finding of impaired fitness to practise. Warnings may also have the effect of highlighting to the wider profession that certain conduct or behaviour is unacceptable.

16 A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:

- *there has been a significant departure from Good medical practice, or*
- *there is a significant cause for concern following an assessment of the doctor's performance.*

20 The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.

a There has been a clear and specific breach of Good medical practice or our supplementary guidance.
b The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor's fitness to practise has not been found to be impaired.
c A warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely relating to a doctor's health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.
d There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).

26 In deciding whether to issue a warning the decision maker should apply the principle of proportionality, weighing the interests of the public with those of the practitioner. It is important to bear in mind, of course, that warnings do not restrict the practitioner's practice and should only be considered once the decision maker is satisfied that the doctor's fitness to practise is not impaired.

32 If the decision makers are satisfied that the doctor's fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of factors to determine whether a warning is appropriate. These might include:

a the level of insight into the failings
b a genuine expression of regret/apology
c previous good history
d whether the incident was isolated or whether there has been any repetition
e any indicators as to the likelihood of the concerns being repeated
f any rehabilitative/corrective steps taken
g relevant and appropriate references and testimonials.

90. In considering the factors set out in the Guidance, the Tribunal reminded itself of its findings at the impairment stage. It determined that Dr Patel has a high level of insight into his failures, has reflected on his misconduct and taken effective steps to remediate this and prevent repetition. He has accepted fault, apologised, and shown genuine expressions of regret and remorse. The Tribunal noted that all of the evidence before it demonstrates that Dr Patel is practising safely and has not repeated the misconduct.

91. The Tribunal considered that Dr Patel has a long unblemished career, and a warning would be both punitive and disproportionate. Taking all the applicable factors and guidance into account, whilst recognising the serious misconduct it had found, the Tribunal determined that it was satisfied that the finding of misconduct was sufficient to mark the degree of seriousness in this case and to address the public interest and it was not necessary, appropriate or proportionate to further mark the misconduct by a warning.

92. The Tribunal concluded that the circumstances of this case do not warrant a formal response, and it would therefore not be appropriate to issue a warning.

93. There is no interim order to be revoked.

94. That concludes this case.

SCHEDULE 1

- ‘now as cold previously settled’;
- ‘also patient doesn’t feel like it is his lungs causing symptoms’;
- ‘4.agreed to refer to resptiraotyr clinic for patient for rv’ (sic);
- ‘patient has had previous history of asbestos exposure. 2 chest XR’s done iin Feb and April does not show any acute pulmorany lesions. Pleural plaque on left side which is stable from previous films. Also patient denies any respiratory symptoms, denies any cough/haemoptysis/weight loss/shortness of breath’ (sic).

SCHEDULE 2

- ‘if there is a neuralgic cause for his pain’;
- ‘discussed whether anxiety may be partly causing his pain and also whether there may be a neuralgic element to his pain. Long discussions with patient and wife. Suggested may trial short course diazepam to see if helps him relax’.