PUBLIC RECORD

Dr Thillainayagam has lodged an appeal against decisions of this Tribunal. He remains free to practise unrestricted while the appeal is considered.

Dates: 02/10/2023 - 13/10/2023; 08/11/2024 - 12/11/2024; 12/12/2024; 17/03/2025 - 21/03/2025

Doctor:	Dr Andrew THILLAINAYAGAM
GMC reference number:	2922672
Primary medical qualification:	MB ChB 1984 University of Manchester

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 1 month

Tribunal:

Legally Qualified Chair:	Mr Neil Dalton
Lay Tribunal Member:	Mrs Ronno Griffiths (02/10/2023 – 13/10/2023) Ms Sarah McAnulty (08/11/2024 – 21/03/2025)
Registrant Tribunal Member:	Dr John Moriarty

Tribunal Clerk:	Miss Racheal Gill (02/10/2023 – 03/10/2023) Ms Ciara Fogarty (04/10/2023 – 13/10/2023; 12/12/2024) Mr Josh Dayco (08/11/2024 – 12/11/2024) Mrs Jennifer Ireland (17/03/2025 – 21/03/2025)

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Mark Harries KC, instructed by Keystone Law (02/10/2023 – 12/11/2024) Mr Mark Sutton KC, instructed by DWF Law (12/12/2024 – 21/03/2025)
GMC Representative:	Mr Thomas Coke-Smyth, Counsel

Attendance of Press / Public

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

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 - 13/10/2023

Background

1. Dr Thillainayagam is a Consultant Gastroenterologist and holds the qualifications MBChB, MRCP, MD and FRCP. He graduated from medical school in 1984 and became a Consultant in 1996.

2. His primary employment is as a Consultant Gastroenterologist and Hepatologist at Imperial College Healthcare NHS Trust, London ("Imperial"). He was appointed to this post as an expert in interventional endoscopy and then created a tertiary referral service for endoscopic retrograde cholangiopancreatography, pancreaticobiliary manometry, enteroscopy, endoscopic palliation of GI malignancy, colonic stenting, enteral stenting, oesophageal stenting, biliary stenting and thermal and alcohol ablation of exophytic oesophageal or colonic tumours. Shortly following his appointment, he was also asked to take over the gastrointestinal motility laboratory at Hammersmith Hospital and supervise the physiologist there. In addition to his NHS role at Imperial, he has a private practice which is conducted at both The London Clinic and at the private wing of Imperial.

3. The GMC allegations arise from his treatment of one patient, 'Patient A', in 2020 at the London Clinic ('the Clinic').

4. Patient A, an 85-year-old man, was referred to Dr Thillainayagam by his GP. He was referred due to complaints of reflux and difficulty eating, constantly feeling as if he would choke.

5. On 16 July 2020, following a gastroscopy under sedation and a 'Bravo' procedure performed by Dr Thillainayagam, Patient A was discharged from the Clinic. However, he became unwell overnight and was re-admitted to the Clinic the following day. After a few days, he was moved into intensive care.

6. Patient A spent a total of 8 days admitted to the Clinic and was at all times under the care and responsibility of Dr Thillainayagam.

7. It is now alleged that despite this, Dr Thillainayagam failed to visit Patent A to carry out his own assessment during his first three days of admission. It is also alleged that he placed reliance upon the assessments of Resident Medical Officers ('RMOs') instead of undertaking his own assessment of this patient and that doing so was inappropriate for the reasons set out in paragraph 4 of the Allegation. Finally, it is alleged that between 30 June 2020 and 28 July 2020, Dr Thillainayagam failed to maintain an adequate standard of record keeping in respect of his care of Patient A for the reasons particularised in paragraph 5 of the Allegation.

8. Patient A was subsequently transferred to Tonbridge NHS Trust. There, he was diagnosed with aspiration pneumonia. His condition deteriorated, and he died on 28 July 2020.

The Outcome of Applications Made during the Facts Stage

9. The Tribunal granted an application by Mr Coke-Smyth, counsel on behalf of the General Medical Counsel ('GMC'), made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to withdraw paragraphs 1, 2(b), 5(a) and 5(d) of the Allegation. The application was not opposed by Mr Harries KC, counsel on behalf of Dr Thillainayagam. The Tribunal's full decision on the application is included at Annex A.

10. The Tribunal granted Mr Coke-Smyth's application, made pursuant to Rule 17(6) of the Rules, to amend sub-paragraph 5(b)(ii)(2) of the Allegation. The application was opposed by Mr Harries. The Tribunal's full decision on the application is included at Annex A.

11. Subsequent to the above, the Tribunal granted Mr Coke-Smyth's further application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to withdraw paragraph 2(a) of the Allegation. Having heard from both parties, the Tribunal determined that this application could be made without injustice, and so acceded to the application. Given that the application was not opposed by Mr Harries, it is not the subject of a further Annex.

The Allegation and the Doctor's Response

12. The Allegation made against Dr Thillainayagam is as follows:

~~30 June 2020~~

~~1. On 30 June 2020 you had a telephone consultation ('the Consultation') with Patient A where you discussed performing a high-resolution manometry, diagnostic oesophagogastroduodenoscopy and a Bravo pH telemetry study ('the Procedure'), and you failed to obtain informed consent from Patient A, in that you did not adequately:~~

Withdrawn under Rule 17(6)

~~a. discuss alternative treatment options, including less invasive treatment options of:~~

Withdrawn under Rule 17(6)

~~i. doing nothing;~~

Withdrawn under Rule 17(6)

~~ii. increasing the dose of Patient A's proton pump inhibitor;~~

Withdrawn under Rule 17(6)

~~iii. performing a barium swallow to assess oesophageal motility and acid reflux;~~

Withdrawn under Rule 17(6)

~~iv. a simple diagnostic gastroscopy without Bravo pH to exclude a gastroesophageal tumour;~~

Withdrawn under Rule 17(6)

~~v. a simple diagnostic gastroscopy which would require less or no sedation;~~

Withdrawn under Rule 17(6)

~~vi. simple pH monitoring which would not require the withdrawal of rivaroxaban;~~

Withdrawn under Rule 17(6)

~~vii. an oesophageal manometry;~~

Withdrawn under Rule 17(6)

~~b. discuss the benefits of the Procedure;~~

Withdrawn under Rule 17(6)

~~c. discuss the risks of:~~

~~i. the Procedure;~~

Withdrawn under Rule 17(6)

~~ii. sedation;~~

Withdrawn under Rule 17(6)

~~iii. aspiration pneumonia;~~

Amended and withdrawn under Rule 17(6)

~~d. explain to Patient A that stopping his rivaroxaban as part of the Bravo procedure would put him at increased risk of a stroke and/or heart attack.~~

Withdrawn under Rule 17(6)

~~16 July 2020~~

~~2. On 16 July 2020 you undertook the Procedure on Patient A and you:~~

~~a. knew or should have known that the Procedure was not necessary to address Patient A's concerns;~~

Withdrawn under Rule 17(6)

~~b. prescribed a combination of medications, as set out in schedule 1 which were inappropriate because:~~

~~i. Patient A was 85 years old;~~

Withdrawn under Rule 17(6)

~~ii. the British Society of Gastroenterology guidelines on combined use of sedation and oral anaesthesia advise caution in the elderly;~~

Withdrawn under Rule 17(6)

~~iii. the European Commission on Medicines advises caution on the combined use of opiates and benzodiazepines and that doses should be minimised;~~

Withdrawn under Rule 17(6)

~~iv. such a combination would increase Patient A's risk of aspiration;~~

Withdrawn under Rule 17(6)

~~v. Patient A's history already indicated that aspiration was a potential problem.~~

Withdrawn under Rule 17(6)

Post Procedure

3. Between 17 July 2020 and 19 July 2020, during Patient A's admission, you failed to visit and assess Patient A.

Admitted and found proved

4. On one or more occasions between 17 July 2020 and 24 July 2020, you relied upon the assessments of Resident Medical Officers ('RMOs') via telephone instead of undertaking your own assessment of Patient A, which was inappropriate because:

a. it limited your ability to accurately assess the cause of Patient A's symptoms;
To be determined

b. you failed to adequately consider aspiration as the potential cause of Patient A's presentation;
To be determined

c. the RMOs had not completed specialist training in any discipline and were not on the General Medical Council Specialist Register;
To be determined

d. it was your responsibility to:

i. document clinical decisions;
Admitted and found proved

ii. document management plans;
Admitted and found proved

iii. manage Patient A;
To be determined

iv. examine and assess Patient A on a daily basis.
Admitted and found proved

Record keeping

5. Between 30 June 2020 and 28 July 2020, you failed to maintain an adequate standard of record keeping, in respect of your care of Patient A, in that:

~~a. following the telephone consultation on 30 June 2020 you did not record in your notes and/or clinic letter:~~

~~i. Patient A's World Health Organisation performance status classification;~~

Withdrawn under Rule 17(6)

~~ii. Patient A's Eastern Cooperative Oncology Group performance status classification;~~

Withdrawn under Rule 17(6)

~~iii. Patient A's Karnofsky score;~~

Withdrawn under Rule 17(6)

~~iv. having undertaken the actions as outlined at paragraphs 1.a. – 1.d.;~~

Withdrawn under Rule 17(6)

b. on 16 July 2020, you completed a consent form for the Procedure and you:

i. inappropriately recorded 'Bravo pH96 h' in the 'any extra procedures that sometimes become necessary during the procedure' section, when you knew that it was your intention to carry out a Bravo pH procedure;

To be determined

ii. failed to record:

1. details regarding sedation;

To be determined

2. ~~whether~~ <u>details of</u> any biopsies ~~were~~ <u>to be</u> taken;

Amended under Rule 17(6)

To be determined

3. the positioning of the Bravo capsule;

To be determined

c. on 16 July 2020 you undertook the Procedure on Patient A and you incorrectly recorded the dose of Fentanyl administered to Patient A;

Admitted and found proved

~~d. between 17 July 2020 and 19 July 2020, during Patient A's admission, you failed to record having undertaken the action as outlined at paragraph 3;~~

Withdrawn under Rule 17(6)

e. on 20 July 2020, you visited Patient A on the intensive care unit ('ICU') along with Mr B and Dr C and you failed to personally make a record of your review of Patient A including the outcome of any discussions;

To be determined

f. on 23 July 2020, you reviewed Patient A and you failed to personally record:

i. any detail or explanation of the events that led to Patient A's admission to the ICU;

To be determined

ii. possible causes for Patient A's admission to the ICU;

To be determined

iii. any guidance for the accepting NHS Trust concerning Patient A's future care and management;

To be determined

iv. any discussions with Patient A's family about Patient

To be determined

The Admitted Facts

13. At the outset of these proceedings, through his counsel, Mr Harries, Dr Thillainayagam 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

14. In light of Dr Thillainayagam's response to the Allegation, the Tribunal is required to determine whether the remaining facts are found proved.

Witness Evidence

15. The Tribunal received evidence on behalf of the GMC from the following witnesses:

- Ms D, Medical Director of the London Clinic, gave oral evidence in person and provided a witness statement dated 3 January 2023.

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

- Patient A's son dated 1 August 2021.
- Patient A's daughter dated 4 August 2021.

17. Dr Thillainayagam provided his own witness statement dated 29 August 2023 and also gave oral evidence at the hearing.

Expert Witness Evidence

18. The Tribunal received evidence from two expert witnesses in relation to Dr Thillainayagam. Their evidence addressed Dr Thillainayagam's conduct and his compliance with professional standards.

19. On behalf of the GMC, Professor E, Consultant Physician and gastroenterologist, gave oral evidence in person. He provided an expert report, dated 28 October 2021 and a supplemental expert report, dated 15 August 2022.

20. On behalf of Dr Thillainayagam, Dr F, Consultant Physician and Gastroenterologist/Hepatologist, gave oral evidence in person. He provided an expert report, dated 15 January 2023.

21. In addition to the above, Professor E and Dr F authored a joint expert report, dated 28 September 2023, addressing the outstanding paragraphs and subparagraphs of the Allegation as well as offering further expert opinion in relation to paragraph 3 of the Allegation.

Documentary Evidence

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

- The London Clinic's Policies on Admitting/Practising Privileges
- 'Overview of care document' prepared by Dr Thillainayagam
- Evidence of Dr Thillainayagam having spoken with Dr G, Tonbridge Wells Hospital
- Schedule of RMOs mentioned in Patient A's London Clinic records
- Core medical records of Patient A

The Tribunal's Approach

23. In reaching its decision regarding facts, the Tribunal has borne in mind that the burden of proof rests solely on the GMC. Dr Thillainayagam does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities.

24. In reaching its determination, the Tribunal took into account all the written and oral submissions from the parties.

25. The Tribunal also took into account the advice provided by the Legally Qualified Chair – which was provided in public session and upon which the parties were invited to comment. The Tribunal accepted fully that advice.

The Tribunal's Analysis of the Evidence and Findings

26. 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 4

27. The context in which paragraph 4 has been considered by the Tribunal is against the fact admitted by Dr Thillainayagam in paragraph 3 of the Allegation. Namely, that for the first three days of Patient A's re-admission to the London Clinic, Dr Thillainayagam failed to visit and assess his own patient.

28. Given that Allegation 3 is admitted, the Tribunal does not set out here in detail Dr Thillainayagam's reasons for not doing so; nor does it (beyond what is necessary to contextualise its view of paragraph 4), comment on the failing in Allegation 3 itself. These matters will be considered at Stage two as part of the wider consideration of whether Dr Thillainayagam's fitness to practise is impaired by reason of misconduct.

Paragraphs 4a, 4c and 4d(iii)

29. Although the Tribunal considered each of these sub-paragraphs separately, it is convenient to address them together.

30. In their joint report, the experts Professor E and Dr F state that if the Tribunal finds Dr Thillainayagam relied upon the assessments of Resident Medical Officers ('RMOs') via telephone instead of undertaking his own assessment of Patient A, then in those circumstances:

> *'[..]it was inappropriate by reason for the matters that are set out at 4a–d.*'

31. Dr F adds the caveat that '*he feels that daily examination is not mandatory, and examination can be tailored to clinical circumstances and progression'*.

32. He also suggests that '*it might have been reasonable to reduce consultant visiting by agreement with the hospital and the patient, but this does not include the essential visit that was needed on the morning after admission (which should have been of a nature similar to a NHS post-take ward round).*'

33. Mr Harries, in closing submissions, explained that his client conceded that he had relied, on one or more occasions, upon the assessments of RMOs via telephone instead of undertaking his own assessment; and accepted too that, in so doing, it had limited his ability to assess accurately the cause of Patient A's symptoms. He also accepted that the RMOs had not completed specialist training in any discipline and were not on the General Medical Council Specialist Register.

34. Mr Harries submitted that the issue was whether, in the circumstances, it had been 'inappropriate' for Dr Thillainayagam to have done so, notwithstanding the shared view of the experts.

35. Those circumstances included Dr Thillainayagam's detailed background knowledge of Patient A's clinical history, and his knowledge of the skills and competence of the RMOs upon whom he relied, as well as his knowledge of the results of the patient's investigations including blood tests and imaging. Mr Harries submitted that the RMOs were not being relied upon to provide the differential diagnosis, nor to deal with decisions that might be required in relation to Patient A. Moreover, the core reason Dr Thillainayagam had taken the decision to use RMOs, as described, was said to have been motivated by his desire to protect Patient A from an increased risk of Covid19 infection that might otherwise have been created by undertaking his own face-to-face assessment of Patient A on 17-19 July 2020. This was because Dr Thillainayagam himself was treating Covid19 patients within the NHS at the time.

36. Reflecting upon these issues, the Tribunal shared the experts' opinion that reliance upon RMO assessments was inappropriate by reason of those matters particularised in paragraphs **4a, 4c and 4d(iii)**. In the Tribunal's view, those matters go beyond the fact of failing to visit and assess Patient A.

37. Specifically in relation to paragraph 4a of the Allegation, it is accepted by Dr Thillainayagam that neither he nor the admitting doctor wrote a differential diagnosis, namely a list of possible causes of Patient A's symptoms. It would have been his usual practice to write a 'problem list' and, had he visited, he would probably have written such a list.

38. Under cross-examination, Dr Thillainayagam had accepted (1) aspiration was not a straight-forward diagnosis; (2) aspiration pneumonia was a significant chest infection; and (3) as a consultant he was better placed (having significantly more expertise) to assess these matters than the RMOs.

39. Dr Thillainayagam likewise accepted that, notwithstanding the particular RMOs were competent medics whose quality of work was known to him, as a matter of fact, none of them were consultants in his nor in any other field. They had neither completed specialist training, nor were they on the General Medical Council Specialist Register.

40. He also acknowledged that reliance upon RMO assessments limited his ability to discharge his responsibility to manage Patient A because (1) he could not see the patient, (2) it was more difficult to talk to the patient and discuss planned treatment options, (3) it was

harder to pass on information to Patient A's family, and (4) he would not have the hand-written clinical notes available to him.

41. Dr Thillainayagam ultimately was candid enough to accept, under cross-examination, that in retrospect it was bad management. It was, in his words, '*the wrong thing to do'.* Indeed, he adopted the word 'inappropriate' himself in relation to paragraphs 4a and 4c. The Tribunal also finds that it was inappropriate in relation to 4d(iii) for the reasons set out in paragraph 38/40 above.

42. As regards the contextual circumstances of Covid19, the Tribunal shared the view of Professor E:

> *'There can be no justification for stepping aside from his required duties in the private sector because of his Covid commitment. If he felt there was a conflict between both roles then he should have stopped seeing private patients.'*

43. If Dr Thillainayagam had indeed reached a considered decision not to visit on 17-19 July 2020 for Covid-related reasons, notably there was no evidence before the Tribunal to establish he had documented those thought-processes at the time. Neither was there evidence that he had discussed and agreed this approach with either the hospital, the patient or the patient's family.

44. In all the circumstances, and for the reasons set out above, the Tribunal finds **Paragraphs 4a, 4c and 4d(iii) proved.**

Paragraph 4b

45. In the Tribunal's assessment, the issue here is a narrow one. As drafted, Paragraph 4b requires the GMC to establish that if Dr Thillainayagam '*failed to adequately consider aspiration as the potential cause of Patient A's presentation'* he did so because he had inappropriately '*relied upon the assessments of Resident Medical Officers ('RMOs') via telephone instead of undertaking your own assessment of Patient A*'.

46. The Tribunal first considered whether there was a basis to find that Dr Thillainayagam failed adequately to consider aspiration as the potential cause of Patient A's presentation.

47. The shared view of the experts was that, certainly by 18 July, Patient A's worsening condition necessitated a differential diagnosis to include aspiration, and a treatment plan to include the prescribing of antibiotics (which would have addressed aspiration, as well as other things). As Dr F observed in cross examination, an accurate history is needed to reach an accurate diagnosis, and Dr Thillainayagam would have been better placed than an RMO to do this.

48. Dr Thillainayagam, did not either, directly or through the RMOs, document a differential diagnosis to include aspiration at that time. Indeed, there was no written differential diagnosis at all. Neither did he initiate the prescribing of antibiotics. Both experts are critical of his failure in these regards.

49. Therefore, although Dr Thillainayagam asserts that aspiration was always in his thoughts, in the Tribunal's judgment he had failed to consider it adequately by 18 July.

50. The Tribunal then considered whether that failure arose from the reliance upon assessments Dr Thillainayagam (had or had not) received from the RMOs. The Tribunal did not find sufficient evidence that it did. There is nothing documented by the RMOs reliance upon which could explain Dr Thillainayagam's failure. Rather, both experts were of the view that the decision to start antibiotics should have been made based upon the known history, the abnormal CT scan and the blood results.

51. In consequence, as a result of how this part of the Allegation is framed, the Tribunal finds **Paragraph 4b not proved.**

Paragraph 5b(i)

52. The entry of 'Bravo pH96H" was placed within the consent form under the '*Any extra procedures* […]' section rather than further up the form under '*Name of proposed procedure or course of treatment* [etc]'

In their joint report, the experts agree that:

> *'[…] it was inappropriate to place the Bravo pH96 in a section which is for:*
>
> > *"any extra procedures that **sometimes become necessary during the procedure**" (**emphasis added)***

This section is not simply about "any extra procedures". It is specifically about something that may become necessary during the main procedure. It is clear that Dr Thillainayagam always intended to do a Bravo pH96 procedure and this should have been recorded in the appropriate section of the consent form, namely in the section entitled:

> *"Name of proposed procedure or course of treatment (include brief explanation medical term not clear)"*

53. In oral evidence to the Tribunal, Dr Thillainayagam accepted that while a gastroscopy was the primary procedure he intended to perform, the 'Bravo' procedure was nevertheless something he had also always intended to undertake, barring any contra-indications arising during the gastroscopy.

54. He accepted, therefore, that the entry should have been in the section of the consent form identified by the two experts. He also accepted that his failure to place the entry in the correct part of the form represented an 'inadequate' standard of record-keeping in that regard, given the potential significance of the consent form as a 'legal document'.

55. The importance of clear, accurate record keeping is identified in Good Medical Practice ('GMP') (2013):

> ***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.*

56. In this instance, the placing of the Bravo entry in an incorrect part of the consent form created an absence of clarity on the issue of whether the Bravo procedure was intended. As Dr F noted during his cross-examination, the inappropriate recording of the Bravo procedure amounted to a 'technicality' in this instance; however, the consent form was an important document and when it is not completed clearly and accurately it can lead to questions arising around the validity of any consent. While the Tribunal accepted that the placing of the Bravo entry in the incorrect part of the form had not made any difference to the clinical care of Patient A, this did not mean that the error did not matter, although it might make it less serious.

57. Taking the above evidence together, the Tribunal accordingly found paragraph **5b(i)** proved. It did not amount to an adequate standard of record-keeping.

Paragraph 5b(ii) (1-3)

58. Although the Tribunal considered each of these sub-paragraphs separately, it is again convenient to address them together.

59. As framed, the Allegation in respect of all three sub-paragraphs is not that Dr Thillainayagam placed his entries regarding *sedation, biopsies* and *Bravo* in the wrong part of the consent form (i.e., as alleged regarding 'Bravo' in paragraph 5b(i) above), but simply that he *failed to record* those matters on the consent form at all.

60. In fact, the consent form contains entries by Dr Thillainayagam in relation to all three issues.

61. Although the allegation specifically refers to a failure to record '*details regarding*' sedation, '*details of*' any biopsies and the '*positioning of*' the Bravo caption, no evidence was placed before the Tribunal to establish that there was a requirement that the entries needed to contain any further detail. Indeed, when the Tribunal queried this issue with Professor E, he confirmed that no details were required.

62. Accordingly the Tribunal found the entirety of **Paragraph 5b(ii)(1-3) not proved.**

Paragraph 5e

63. Under cross-examination, Dr Thillainayagam accepted that, having visited Patient A on the intensive care unit ('ICU') along with Mr B and Dr C on 20 July 2020, he did not personally make a record of his review of Patient A including the outcome of any discussions.

64. He also accepted that he had understood at the time, having signed the Clinic's *Practicing Privileges* documents, that it was his responsibility to maintain the medical records, including recording visits to his patients; and that therefore, he should either (in his view) have made a record of the review himself or else ensured someone else had done so in his stead. He confirmed that his responsibilities in this regard did not cease if his patient was in ICU.

65. In oral evidence-in-chief, Dr Thillainayagam had also seemed to say he had assumed Dr C would make the record; the basis for his assumption being (in terms) that '*I had said to*[Dr C]*, "I assume you will make a note of our discussions"'.* However, under cross-examination, Dr Thillainayagam was less clear whether he had actually said this to his colleague, or whether he had simply assumed his colleague would make the note.

66. Reviewing the position, Professor E stated:

> *'[..]it was Dr Thillainayagam's responsibility to ensure that his clinical assessment and treatment plan for Patient A were recorded in the clinical records. When he signed the Practicing Privileges document he agreed that:*
>
> > *"you undertake to maintain a complete set of* ***medical records****, including progress notes, within the Clinic for each of your patients."*
> >
> > *and:*
> >
> > *"You agree:*
> >
> > *to record each visit clearly and contemporaneously in the patient's notes including the time of the visit to provide a clear and current medical treatment plan in the patient's notes"*

He added,

> *'[…] the Practicing Privileges document, which Dr Thillainayagam signed, makes it his personal responsibility to document patients' daily progress. For it to be acceptable for someone else to* [have] *made the entry on his behalf, Dr Thillainayagam would need to have read and confirmed that the entry was accurate and provide contemporaneous evidence of having done so*.'

Dr F wrote that,

> *'[…] across all Intensive Care Units, it is common practice for the clinical record of a consultant visit to be written by one of the Intensive Care Team, and in some Units there is a Standard Operating Procedure that prohibits visiting teams and clinicians*

from writing in the notes (so as to make sure that the Intensive Care Team is aware of all clinical actions and opinions at all times in a setting where there may be very many clinical interactions with each patient every day). However, it was necessary for Dr Thillainayagam to ensure that the record had been completed.'

67. The Tribunal determined the position to be as follows. There was no record of Dr Thillainayagam's review on that day, whether by him or by anyone else on his behalf. Under the terms of the Practicing Privileges policy in force at the time, Dr Thillainayagam had agreed he would '[…] *keep clear, accurate and contemporaneous patient records that report the relevant clinical findings, the decisions made, the information given to patients and any drugs or treatment prescribed […]'*

68. While the Tribunal noted Dr F's more general observation about ICU practices elsewhere, Dr Thillainayagam accepted that he knew the position at the London Clinic to be otherwise, as set out in the documentation he had signed. It was incumbent upon him to have made a record of his review and he did not do so – and neither did he check whether anyone else had done so.

69. In those circumstances, it is the Tribunal's determination that his failure to personally make a record of his review of Patient A, including the outcome of any discussions, amounted to an inadequate standard of record-keeping. Accordingly, the Tribunal finds **Paragraph 5e proved.**

Paragraph 5f(i-iv)

70. Upon his review of Patient A on 23 July 2020, Dr Thillainayagam made a written note. The GMC alleges that the note does not amount to adequate record-keeping because Dr Thillainayagam failed personally to record the information set out at 5f(i-iv).

71. For his part, Dr Thillainayagam agrees that the note contains none of the information set out in paragraph 5f, and that it was his only written note in relation to the entire period of his management of Patient A from the point of admission on 17 July 2020. He also agreed, in cross-examination, that he should have written a discharge summary.

72. However, Dr Thillainayagam does not accept that the note was, in itself, inadequate because (1) it adequately captured the review on that day, and (2) it was not intended to serve any more general purpose. In particular, he said it was not intended to provide a more

general handover note to Tonbridge Hospital; that handover process instead being facilitated by a telephone call by Dr Thillainayagam to a doctor at the receiving hospital. (In this regard, Dr Thillainayagam relies upon an iMessage from '24 July' as evidence that a handover telephone discussion took place with Dr G. The iMessage reads *'Hi* [Dr G] *really helpful to talk and many thanks for the handover – I'm sure I wouldn't have gathered all that from the notes'*).

73. In assessing the adequacy of the note of 23 July 2020, both experts in their joint report observe that '*the purpose of* [the note] *is unclear'.*

74. However, Professor E continues:

> *'If it was to provide guidance to the clinicians at Tonbridge Hospital, it should have given a detailed description of what it happened to Patient A over the preceding days and some comments on possible future management. If it was a summary of his management of Patient A, was at The London Clinic it fails to discuss this in any detail. Overall, as it is the only entry that he made it should, in my opinion, have covered all of these items.'*

75. Dr F's assessment is that '*in isolation, it is an adequate note entry, but as the only personal note entry from Dr Thillainayagam, it should have recorded a wider clinician impression of the illness to that date, and should have included a summary of information given to the patient (and family)*. Dr F adds, '*It would seem to be unlikely to have been intended to provide direct guidance to the clinicians in Tonbridge Wells.'*

76. The Tribunal shares the view of both experts that, in the absence of any other written note from Dr Thillainayagam in relation to a patient who had been under his care for eight days, the note ought to have recorded:

- any detail or explanation of the events that led to Patient A's admission to the ICU;
- possible causes for Patient A's admission to the ICU; and
- any discussions with Patient A's family about Patient A's current status and/or future care.

77. GMP is clear on the importance of continuity and coordination of care (§44):

'You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

> ***a*** *share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers'*

78. Given that Dr Thillainayagam knew he had made no previous written record of the care of a patient for whom he had accepted responsibility; he had not checked whether any note was made of the 20 July visit; and there was no evidence to suggest a separate written note was intended to be sent, whether by Dr Thillainayagam or anyone else; then - as the experts note, in terms - he should have personally recorded in writing those matters alleged in sub-paragraphs 5f.i, 5f.ii and 5f.iv.

79. While Dr Thillainayagam might (or might not) have communicated such information in his telephone call to Dr G, there is no written note of that conversation available to the Tribunal, and the absence of a written note creates the obvious risk that important information is not shared such as to facilitate appropriate continuity of care. In this regard, the Tribunal notes that the post-mortem report by the pathologist for the coroner indicates that *'no clinical summary was provided by the London Clinic regarding his admission there*.

80. To be clear, if the information relating to 5fi, ii and iv had been captured in writing elsewhere by Dr Thillainayagam, then the note of 23 July would not have been inadequate. Here, though, for the reasons given, his failure to do so amounted to a failure to maintain an adequate standard of record keeping in those respects. Accordingly, the Tribunal finds proved paragraphs f.i, f.ii and f.iv.

Paragraph 5f(iii)

81. In the joint expert report, Professor E says the entry should contain '*some comments on possible future management'.* Dr F does not suggest the entry should have included guidance on management. Dr Thillainayagam himself said *'I do not believe it would be appropriate for me to seek to provide guidance to an NHS Trust as to how it should treat a patient. Patient A was being transferred to the care of* [Dr G]*, who is an expert respiratory physician...'.*

82. Accordingly In relation to **paragraph 5 f(iii)**, the Tribunal considered that, while the presence of such guidance might have been helpful for the accepting NHS Trust, the balance of the evidence established no duty on Dr Thillainayagam to provide such guidance for the reasons he has given and therefore its absence did not itself render the record-keeping on 23 July 2020 less than adequate. Therefore, the Tribunal found **paragraph 5 f(iii) not proved.**

The Tribunal's Overall Determination on the Facts

83. The Tribunal has determined the facts as follows:

~~30 June 2020~~

~~1. On 30 June 2020 you had a telephone consultation ('the Consultation') with Patient A where you discussed performing a high-resolution manometry, diagnostic oesophagogastroduodenoscopy and a Bravo pH telemetry study ('the Procedure'), and you failed to obtain informed consent from Patient A, in that you did not adequately:~~

Withdrawn under Rule 17(6)

~~a. discuss alternative treatment options, including less invasive treatment options of:~~

Withdrawn under Rule 17(6)

~~i. doing nothing;~~

Withdrawn under Rule 17(6)

~~ii. increasing the dose of Patient A's proton pump inhibitor;~~

Withdrawn under Rule 17(6)

~~iii. performing a barium swallow to assess oesophageal motility and acid reflux;~~

Withdrawn under Rule 17(6)

~~iv. a simple diagnostic gastroscopy without Bravo pH to exclude a gastroesophageal tumour;~~

Withdrawn under Rule 17(6)

~~v. a simple diagnostic gastroscopy which would require less or no sedation;~~

Withdrawn under Rule 17(6)

~~vi. simple pH monitoring which would not require the withdrawal of rivaroxaban;~~

Withdrawn under Rule 17(6)

~~vii. an oesophageal manometry;~~

Withdrawn under Rule 17(6)

~~b. discuss the benefits of the Procedure;~~

Withdrawn under Rule 17(6)

~~c. discuss the risks of:~~

~~i. the Procedure;~~

Withdrawn under Rule 17(6)

~~ii. sedation;~~

Withdrawn under Rule 17(6)

~~iii. aspiration pneumonia;~~

Amended and withdrawn under Rule 17(6)

~~d. explain to Patient A that stopping his rivaroxaban as part of the Bravo procedure would put him at increased risk of a stroke and/or heart attack.~~

Withdrawn under Rule 17(6)

~~16 July 2020~~

~~2. On 16 July 2020 you undertook the Procedure on Patient A and you:~~

~~a. knew or should have known that the Procedure was not necessary to address Patient A's concerns;~~

Withdrawn under Rule 17(6)

~~b. prescribed a combination of medications, as set out in schedule 1 which were inappropriate because:~~

~~i. Patient A was 85 years old;~~
Withdrawn under Rule 17(6)

~~ii. the British Society of Gastroenterology guidelines on combined use of sedation and oral anaesthesia advise caution in the elderly;~~
Withdrawn under Rule 17(6)

~~iii. the European Commission on Medicines advises caution on the combined use of opiates and benzodiazepines and that doses should be minimised;~~
Withdrawn under Rule 17(6)

~~iv. such a combination would increase Patient A's risk of aspiration;~~
Withdrawn under Rule 17(6)

~~v. Patient A's history already indicated that aspiration was a potential problem.~~
Withdrawn under Rule 17(6)

Post Procedure

3. Between 17 July 2020 and 19 July 2020, during Patient A's admission, you failed to visit and assess Patient A.
Admitted and found proved

4. On one or more occasions between 17 July 2020 and 24 July 2020, you relied upon the assessments of Resident Medical Officers ('RMOs') via telephone instead of undertaking your own assessment of Patient A, which was inappropriate because:

a. it limited your ability to accurately assess the cause of Patient A's symptoms; Determined and found proved

b. you failed to adequately consider aspiration as the potential cause of Patient A's presentation; Not proved

c. the RMOs had not completed specialist training in any discipline and were not on the General Medical Council Specialist Register; Determined and found proved

d. it was your responsibility to:

i. document clinical decisions;
Admitted and found proved

ii. document management plans;
Admitted and found proved

iii. manage Patient A;
Determined and found proved

iv. examine and assess Patient A on a daily basis.
Admitted and found proved

Record keeping

5. Between 30 June 2020 and 28 July 2020, you failed to maintain an adequate standard of record keeping, in respect of your care of Patient A, in that:

~~a. following the telephone consultation on 30 June 2020 you did not record in your notes and/or clinic letter:~~

~~i. Patient A's World Health Organisation performance status classification;~~
Withdrawn under Rule 17(6)

~~ii. Patient A's Eastern Cooperative Oncology Group performance status classification;~~
Withdrawn under Rule 17(6)

~~iii. Patient A's Karnofsky score;~~

Withdrawn under Rule 17(6)

~~iv. having undertaken the actions as outlined at paragraphs 1.a. – 1.d.;~~

Withdrawn under Rule 17(6)

b. on 16 July 2020, you completed a consent form for the Procedure and you:

i. inappropriately recorded 'Bravo pH96 h' in the 'any extra procedures that sometimes become necessary during the procedure' section, when you knew that it was your intention to carry out a Bravo pH procedure;

Determined and found proved

ii. failed to record:

1. details regarding sedation;

Not proved

2. ~~whether~~ details of any biopsies ~~were~~ to be taken;

Amended under Rule 17(6)

Not proved

3. the positioning of the Bravo capsule;

Not proved

c. on 16 July 2020 you undertook the Procedure on Patient A and you incorrectly recorded the dose of Fentanyl administered to Patient A;

Admitted and found proved

~~d. between 17 July 2020 and 19 July 2020, during Patient A's admission, you failed to record having undertaken the action as outlined at paragraph 3;~~

Withdrawn under Rule 17(6)

e. on 20 July 2020, you visited Patient A on the intensive care unit ('ICU') along with Mr B and Dr C and you failed to personally make a record of your review of Patient A including the outcome of any discussions;
Determined and found proved

f. on 23 July 2020, you reviewed Patient A and you failed to personally record:

i. any detail or explanation of the events that led to Patient A's admission to the ICU;
Determined and found proved

ii. possible causes for Patient A's admission to the ICU;
Determined and found proved

iii. any guidance for the accepting NHS Trust concerning Patient A's future care and management;
Not proved

iv. any discussions with Patient A's family about Patient
Determined and found 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 - 20/03/2025

84. 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 Thillainayagam's fitness to practise is impaired by reason of misconduct.

The Evidence

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

86. In addition, Dr Thillainayagam provided a reflective statement, dated 4 March 2025, as well as giving further oral evidence at this stage of the hearing.

87. In addition, the Tribunal received evidence from the following testimonial witnesses on Dr Thillainayagam's behalf:

- Professor H, Consultant Surgeon, Imperial College London, by video link;
- Professor I, Advance Histopathology Laboratory Ltd, by video link;
- Ms J, a patient, by video link;
- Ms K, a patient, by video link

88. Furthermore, the Tribunal received:

- A large bundle of testimonials from Dr Thillainayagam's patients and colleagues; and
- A copy of his Continual Professional Development diary ('CPD'), showing relevant courses and training undertaken by him between 3 April 2024 and 26 February 2025. (This was in addition to an earlier iteration of the diary, together with supporting evidence, the Tribunal had previously received.)

89. No further evidence, written or oral, was provided on behalf of the GMC at this stage.

Submissions

90. On behalf of the GMC, Mr Coke-Smyth submitted Dr Thillainayagam's fitness to practise should be found impaired by reason of his misconduct. He referred the Tribunal to relevant paragraphs of GMP and to caselaw on impairment throughout his submissions.

91. Mr Coke-Smyth submitted that all paragraphs of the Allegation found proved were sufficiently serious to meet the threshold for misconduct. He submitted that there was agreement between the experts that the findings at paragraphs 3 and 4 of the Allegation fell seriously below the relevant standards. Further, in respect of paragraph 5, he submitted that the Tribunal should consider the seriousness of the proven record-keeping failings together in the context of the overall course of Patient A's treatment.

92. Mr Coke-Smyth submitted that there were two bases for current impairment. Firstly, the failings which led to the misconduct have not been sufficiently remediated, and secondly, the failings were sufficiently serious to bring the profession into disrepute.

93. Mr Coke-Smyth directed the Tribunal to the joint expert report of Professor E and Dr F to assist in its assessment of misconduct. He submitted that, in relation to Dr Thillainayagam's failure to visit Patient A, this was particularly serious in the context of Patient A, his vulnerability, his deterioration, and the absence of timely provision of antibiotics from 18 July 2020, when a chest infection was obvious. Further, he submitted that Dr Thillainayagam's reliance on the RMOs had a significant impact on Patient A's care in a number of respects, including diagnosis, and limited Dr Thillainayagam's ability to discharge his responsibilities to Patient A. In respect to the failures in record-keeping, Mr Coke-Smyth submitted that there was an absence of adequate written records from Dr Thillainayagam throughout Patient A's admission, as well as the proven inaccuracies.

94. Mr Coke-Smyth submitted that all of these failures, taken together, in respect of one patient, over a relatively short period, can be found to amount to a serious departure from the relevant standards, and amount to misconduct.

95. Turning to the matter of impairment, Mr Coke-Smyth submitted that there is a risk of repetition in this case, which arises due to Dr Thillainayagam's insufficient explanation, insight and reflection on the causes of the misconduct alleged. He submitted that it was not accepted that COVID-19 was the sole or even the predominant reason for Dr Thillainayagam's failure to visit, but was indicative of an attitudinal failing. He submitted that this attitudinal failing meant that the Tribunal could not be satisfied that the underlying cause of the misconduct has been fully remediated.

96. Mr Coke-Smyth submitted that a simpler explanation of the events, which was consistent with the notes and contemporaneous records was that Dr Thillainayagam just did not take this particular case as seriously as he should have done and failed to give this case his full attention by visiting. He submitted that Patient A was particularly vulnerable due to his age, the earlier Bravo procedure, and the prevalence of COVID-19, and having experienced the complications which he did, he was entitled to have been provided with in-person care by Dr Thillainayagam as his consultant. He submitted that Dr Thillainayagam's physical absence deprived Patient A of the best available care and hindered his ability to assess and manage Patient A.

97. Mr Coke-Smyth submitted that it was impossible to determine whether earlier provision of antibiotics or other in-person care would have prevented Patient A's decline and ultimate death. However, this delay to treatment provided the context to Dr Thillainayagam's

absence and his lack of direct management of Patient A's care. He submitted that this was not a case where it can be argued that, in Dr Thillainayagam's absence, there was no significant risk of harm or no harm.

98. Mr Coke-Smyth rejected Dr Thillainayagam's explanation that COVID-19 was the sole reason for his decision not to visit. He stated that this went against the conditions of practising privilege set out by the London Clinic, and there was no justification for Dr Thillainayagam to depart from his usual duties. Further, he submitted that it was concerning that having come to such a significant decision about Patient A's care, Dr Thillainayagam did not feel it necessary to communicate this to the London Clinic, or most importantly, Patient A's daughter. He stated that the Tribunal may feel that this suggests a degree of arrogance on Dr Thillainayagam's part.

99. Mr Coke-Smyth submitted that Dr Thillainayagam has not provided a full, insightful and candid reflective account of what lay behind his failure to visit Patient A. He submitted that if the Tribunal accepts that the issue in this case is attitudinal, then such a failing is more difficult to remediate than shortcomings in clinical skills or knowledge. He reminded the Tribunal of the account of Dr Thillainayagam's Responsible Officer, which details some issues regarding attitude, communication and time management that both pre and post date this incident. He submitted that in the absence of full insight and set against other attitudinal concerns, there is insufficient assurance to conclude that there has been full remediation and that the risk of repetition has been adequately reduced.

100. Mr Coke-Smyth submitted that a finding of impairment was necessary and in the public interest. He submitted that Dr Thillainayagam's actions had damaged the reputation of the profession. He stated that a finding of impairment would make plain the unacceptability of the underlying misconduct and publicly communicate this to both the public and the profession. He submitted that without a finding of impairment public confidence in the profession would be undermined, as it would see a serious and avoidable failure in care by an experienced, highly capable and senior doctor being met with no consequence.

101. On behalf of Dr Thillainayagam, Mr Sutton submitted that the issues of misconduct and impairment are a matter for the Tribunal and its assessment. Throughout his submissions, he directed the Tribunal to relevant caselaw.

102. Mr Sutton reminded the Tribunal that the allegations found proven in this case involve a single patient and a single phase of treatment, albeit extending over several days. He submitted that the Tribunal should weigh the context in which the criticised conduct took place, and specifically the doctor's concern about the risk of cross infection, given his engagement at that time in front line treatment of COVID-19 patients.

103. Mr Sutton acknowledged that the GMC does not accept that COVID-19 was the real rationale for Dr Thillainayagam's decision not to attend the patient in-person between 17 and 19 July. However, he submitted that the GMC has offered no credible alternative explanation. He submitted that the implication that Dr Thillainayagam was acting '*arrogantly*' or that he was indifferent to Patient A's case is completely at odds with the substantial body of testimonial materials presented to the Tribunal.

104. Mr Sutton submitted that the GMC acknowledged that the decision not to attend and assess Patient A represents the most serious complaint about Dr Thillainayagam's conduct. He submitted that Dr Thillainayagam acknowledged that it was a seriously erroneous decision and that it resulted in the provision of suboptimal care for Patient A. Further, Dr Thillainayagam fully accepted that the decision had consequences in relation to record-keeping and excessive reliance of the RMOs in Patient A's care.

105. Mr Sutton submitted that the Tribunal's findings demonstrate significantly deficient care, but it should take into account Dr Thillainayagam's rationale as a centrally relevant consideration in calibrating the gravity of his conduct and whether the same can be viewed as amounting to misconduct.

106. Mr Sutton submitted that there was no evidence before the Tribunal to suggest that had Dr Thillainayagam acted differently there would have been a different outcome. However, he submitted that Dr Thillainayagam fully recognised the importance of personally visiting and assessing the patient and acknowledged that patient care was compromised by his not doing so.

107. Mr Sutton stated that Dr Thillainayagam accepted that he could and should have resolved this perceived problem in way that achieved proper standards of care for his patient. Mr Sutton submitted that Dr Thillainayagam's rationale was to avoid the patient's inadvertent exposure to COVID-19, which he recognises was made in error, and was compounded by a failure to record the decision not to visit in Patient A's notes. He reminded

the Tribunal that Dr Thillainayagam recognised in retrospect that the higher-level PPE 3 protection could have been acquired if he had approached the Medical Director or the Matron at the London Clinic. Further, he stated that this higher-level protection was available when he attended the ICU on 20 and 23 July when he saw the patient on the cancer unit ward.

108. Mr Sutton stated that Dr Thillainayagam acknowledged the impact of his decision on Patient A and his family and accepted that he had a duty of care to attend the patient at his bedside. Further, Dr Thillainayagam would have been better placed to make a more experienced assessment than the RMOs, and without his visit, he did not write a differential diagnosis to account for the symptoms or a problem list, looking at the patient as a whole. He submitted that the decision not to visit Patient A was based on a faulty risk/benefit analysis and led to suboptimal management of his case and negatively impacted the experience of his family.

109. In respect to the findings which concern deficiencies of record-keeping, Mr Sutton stated that Dr Thillainayagam accepts that the Bravo procedure was a planned procedure, and he should therefore have written it in the planned procedure section of the patient's record. He submitted that Dr Thillainayagam recognised and accepted that what he did represented poor record-keeping because the consent form is an important legal document and must be completely accurate. He submitted that Dr Thillainayagam had put it in the wrong place, as he was unsure if he would be able to complete the procedure until viewing the pathology, which had created an absence of clarity and could lead to concerns and questions about the validity of the consent given.

110. Concerning the Fentanyl prescription, Mr Sutton submitted Dr Thillainayagam accepted that incorrect record-keeping in procedures, such as the incorrect recording of a drug dose, may have unintended effects on later management. He submitted that Dr Thillainayagam understood that his error might have later led to Patient A being denied adequate pain relief with opiate medication for fear of doing harm.

111. Mr Sutton stated that Dr Thillainayagam recognised that it was his duty to ensure that discussions about Patient A's care were adequately recorded, including an outline of the causes of the clinical problems and what precipitated his admission to ICU from his perspective, as well as a problem list and management plans. Further, Dr Thillainayagam accepted that it was his responsibility to check what had been written in his name, and to

document his conversation with the patient's family. He submitted that it was an obligation on a consultant in the practising privileges of The London Clinic to keep clear records. Mr Sutton submitted that Dr Thillainayagam did give an extensive handover to the receiving consultant respiratory physician via telephone. However, Dr Thillainayagam accepted that he neglected to write a discharge summary to go with the patient. He stated that Dr Thillainayagam acknowledged that his conduct represented a significant departure from proper practice and was not up to the standard that is expected of a consultant physician.

112. Mr Sutton submitted that Dr Thillainayagam has now extended the post procedure team check. He stated that Dr Thillainayagam has extended the double check that was already in place to ensure that correct doses of drugs are recorded in endoscopy nursing records and the controlled drug logbook, into a *'triple check'* that incorporates checking the endoscopy report as well. He submitted that Dr Thillainayagam assures the Tribunal that, in the light of its findings of fact, he will strive to be continually mindful about the need to maintain high standards of clinical practice.

113. Mr Sutton directed the Tribunal to take account of the targeted CPD that Dr Thillainayagam has undertaken, which included courses on communication with family and colleagues and record-keeping. He also directed the Tribunal to Dr Thillainayagam's reflections on these courses which had been provided to the Tribunal. He submitted that Dr Thillainayagam has also reviewed relevant literature, particularly around the COVID-19 pandemic as this formed part of his decision making at the time, and on maintaining comprehensive medical records.

114. Mr Sutton reminded the Tribunal of the testimonials submitted on behalf of Dr Thillainayagam, which all spoke highly of him. He submitted that the Tribunal has heard from some of those testimonial witnesses, who provide a consistent account of Dr Thillainayagam being a conscientious and compassionate doctor who always goes the '*extra mile'* to achieve the best treatment and outcome for his patients.

115. In conclusion, Mr Sutton invited the Tribunal to find, by reference to paragraph 37 of *R (on the application of Remedy UK Ltd) v GMC* [2010] EWHC 1245 (Admin), that Dr Thillainayagam's actions did not amount to misconduct. In the event the Tribunal was not with him on that issue, he submitted that it should find that there was no current impairment to Dr Thillainayagam's fitness to practise in all the circumstances.

The Tribunal's Determination on Impairment

116. Whilst the Tribunal has borne in mind the submissions made, the decision as to whether Dr Thillainayagam's fitness to practise is impaired is a matter for this Tribunal exercising its own judgment.

117. It is clear from the design of section 35c of the Medical Act 1983 that the Tribunal must adopt a two-stage approach:

a. First, it must decide whether one of the circumstances set out in the section is present (and the relevant one here is misconduct);

b. Second, if misconduct is present, it must then go on to determine whether, as a result, fitness to practise is impaired. Thus, it may be that, despite Dr Thillainayagam having been guilty of misconduct (if that is what the Tribunal finds), it may decide that his fitness to practise is not impaired. (*GMC v Cheatle* [2009] EWHC 645 [Admin] at paragraph 19)

Misconduct

118. The Tribunal reminded itself that misconduct has been defined by the Privy Council as '*a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* In that case, the Privy Council went on to say that '*The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances'* (*Roylance v GMC (No.2*) [2000] 1 AC 311*).*

119. Further, mere negligence does not amount to misconduct unless particularly serious. A single act/omission may amount to misconduct if particularly grave but is less likely to amount to misconduct than multiple acts/omissions (*GMC v Calhaem* [2007] EWHC 2606 (Admin) at paragraph 39).

120. For Dr Thillainayagam's conduct to amount to misconduct, '*it must be linked to the practice of medicine or [else it must be] conduct that otherwise brings the profession into disrepute, and it must be serious'* (*GMC v Calhaem* [2007] EWHC 2606 (Admin) at paragraph 36).

121. The behaviour must involve '*sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise' (Remedy).*

122. As to seriousness, this must be given its proper weight: it is conduct which would be regarded as deplorable by fellow practitioners (*Nandi v GMC* [2004] EWHC 2317 (Admin) at paragraph 31, approved by *Meadow v GMC* [2007] QB 462 at paragraph 200).

123. Reflecting on these matters, the Tribunal determined that the proved and/or admitted facts at paragraphs 3, 4 and 5 of the Allegation were each serious and amounted to misconduct. Its reasons are these.

Paragraph 3 of the Allegation

124. To recap, the circumstances here were that Dr Thillainayagam was responsible for the care of an 85-year-old man, Patient A.

125. The evidence of Patient A's daughter was that when her father became '*seriously ill*' on the night of 16 July, she made contact with Dr Thillainayagam. She says:

> '*[Dr Thillainayagam] confirmed there was a bed available at the London Clinic and asked me to bring my father in. Dr Thillainayagam told me that my father's illness would not be related to the procedure, and that he would have him home by lunch time the next day.*
>
> *I drove my father back to the London Clinic, as this seemed the most sensible thing to do at the time as he had undergone the procedure with Dr Thillainayagam the day before.*
>
> *My father was admitted to the London Clinic on the agreement with Dr Thillainayagam that this was for one night, and I paid for one night alone. My father had undergone the procedure privately with the London Clinic only due to the fact his local clinic was closed, and we could not afford to book him in for any significant period of time* […]'

126. In other words, the reason Patient A found himself specifically booked into the London Clinic was upon the request of Dr Thillainayagam (he '*asked me', 'he requested',* she said).

127. At the impairment stage, Dr Thillainayagam repeated his earlier recollection that it been her suggestion, not his, that her father be admitted to the London Clinic. He asserted that she had '*persuaded*' him to admit her father to the clinic as she did not want her father to go into A&E. However, the evidence of Patient A's daughter (in her statement, dated 4 August 2021, and exhibits, including her email of 9 August 2020) had been unchallenged at the Facts stage and she had not been called to give oral evidence. In those circumstances, the Tribunal determined that, on balance, it could properly rely upon her account as both truthful and accurate.

128. It was against that background that Patient A's daughter entrusted her father into the care of Dr Thillainayagam. Having done so, Dr Thillainayagam did not then visit her father to assess him for the first three days of admission – and he did so without consulting and seeking agreement for this approach with colleagues at the clinic, and in circumstances where there is no evidence of agreement with the patient or his family.

129. Two experts in this case, Professor E and Dr F, jointly state that in the private sector the admitting consultant is directly responsible for day-to-day management and assessment of the patient and that can only be done through a daily visit.

130. This general point is underscored by the specific directive set out in London Clinic's own Practicing Privileges ('PP') document (one which Dr Thillainayagam signed, thereby agreeing to adhere to its terms). At paragraph 1, PP stipulates:

> *'[…] a requirement that you always personally visit inpatient and outpatient undergoing treatment e.g. Oncology or Dialysis daily or more frequently at the request of the nurse in charge or RMO and whilst in critical care, twice daily.'*

131. The experts' shared view is that not visiting during the period set out in paragraph 3 of the Allegation constituted a failure of care- and one with associated risks:

> *'A failure to visit the patient is a failure in care. The risks associated with this failure are a lack of clinical examination by an appropriate specialist, leading to an inadequate differential diagnosis and not developing a specific treatment plan and reviewing those results so as to be able to appropriately modify that treatment plan over coming days.'*

132. Professor E asserts that Dr Thillainayagam should have visited Patient A '*at least once a day',* while Dr F's view was that *'it might have been reasonable to reduce consultant visiting by agreement with the hospital and the patient, but this does not include the essential visit that was needed on the morning after admission (which should have been of a nature similar to a NHS post-take ward round).'*

133. Accordingly (and notwithstanding Dr Thillainayagam's 'COVID-19' justification for his non-attendance, per paragraphs 35 and 42 to 43 of the Facts determination); the experts' shared opinion is that Dr Thillainayagam's conduct in relation to paragraph 3 of the Allegation was seriously below the standard to be expected of a reasonably competent registrant.

134. The Tribunal unequivocally shares that view. In terms of associated risks, one consequence of Dr Thillainayagam not having visited and assessed Patient A on 17, 18 and 19 July was that he had been unable adequately to consider aspiration as a cause of Patient A's presentation.

135. As Dr Thillainayagam put it himself in his reflective statement:

> *'I did not visit and therefore did not write a differential diagnosis to account for the symptoms or a problem list, looking at the patient as a whole. The RMO did not list the possible causes of the symptoms or write a problem list either. Not visiting led to suboptimal management. It meant that I did not have the handwritten notes in front of me to check, and that did limit my ability fully to inform the family of the clinical situation'.*

136. While the Tribunal had not found this failure to have arisen out of his reliance upon RMOs, nevertheless, it remained an aggravating consequence of his failure to visit and assess Patient A, and it was relevant to the Tribunal's assessment of seriousness of the misconduct.

137. The Tribunal noted that by his actions Dr Thillainayagam had failed to comply with paragraph 15 of GMP which states:

> *'15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*

a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

b promptly provide or arrange suitable advice, investigations or treatment where necessary

c refer a patient to another practitioner when this serves the patient's needs.'

138. To reiterate, this was misconduct which was serious. As Dr Thillainayagam himself noted in his reflective statement:

'I am bitterly disappointed at myself for departing from my usual practice, which would be to always assess the patient myself, to take my own history and to examine the patient using my own direct observation. In that way nuances in the history that would otherwise be unavailable to me, or subtle physical signs that may have eluded a less experienced clinician might be detected, which would enhance the quality of the clinical conclusions made about the patient.'

Paragraph 4 of the Allegation

139. As regards, Paragraph 4 of the Allegation, the Tribunal refers to its discussion in its determination on the Facts, at paragraphs 29 to 44.

140. Reflecting on Dr Thillainayagam's conduct here, the Tribunal noted the PP document had been clear:

'in the event of a RMO been called upon to assess a patient during the night, other than for routine reasons, it is incumbent upon you, if you are the lead Consultant, to visit that patient early the following day or make arrangements for an appropriately qualified colleague, with privileges, to visit the patient in the unlikely event that you are unable to attend'

141. Professor E assessed Dr Thillainayagam's conduct in paragraph 4 of the Allegation to have been seriously below the standard of a reasonably competent Consultant Gastroenterologist. He said that this was because, by Dr Thillainayagam's actions, Patient A's

'*care and daily assessment'* had been placed *'in the hands of junior doctors'.* Professor E continues:

> *'He relied on these assessments by a range of junior doctors, with no continuity of care, and gave advice based on their separate assessments'.*

142. For his part, Dr F also found aspects of Dr Thillainayagam's conduct here seriously below the required standard.

143. The Tribunal has determined that this aspect of Dr Thillainayagam's work also amounted to misconduct that was serious. He had not merely failed to visit and assess his own patient, but had repeatedly placed reliance, across a number of days, upon a throughput of junior colleagues who lacked his experience and expertise, who had no previous knowledge of the patient, and who were not in a position to provide continuity of care.

144. In these regards, the Tribunal found that (in addition to paragraph 15) paragraph 45 of GMP was engaged:

> *'45 When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.'*

145. As Dr Thillainayagam now acknowledges in his reflective statement:

> '[…] *In accordance with […] GMP […] delegation to colleagues must only be done if the individual has the necessary knowledge, skills and training to conduct the task.*
>
> *In delegating the clinical review to a junior clinician without specialist expertise, I recognise and accept that I fell short of the standards expected and was less able to appropriately clinically assess and manage the patient or maintain the required standards of recordkeeping. Not visiting the patient at admission, did limit my ability to some extent to accurately diagnose the cause of his symptoms.*
>
> *The RMOs, while clinically experienced, were not consultants. They had not completed specialist training in any specialty and therefore were not on the specialist register. As*

a consultant, I would have been better placed to make a more experienced assessment than the RMOs. It was my responsibility to manage the patient, visit and examine him daily, plan his management directly and explain my plans to him, include him in the decision-making, and document the clinical decisions and management plans.

I did not visit and therefore did not write a differential diagnosis to account for the symptoms or a problem list, looking at the patient as a whole. The RMO did not list the possible causes of the symptoms or write a problem list either. Not visiting led to suboptimal management. It meant that I did not have the handwritten notes in front of me to check, and that did limit my ability fully to inform the family of the clinical situation.'

Paragraph 5 of the Allegation

146. Commentary by the experts in relation to this aspect of Dr Thillainayagam's conduct was set out in the Facts determination, at paragraphs 52, 56, 66, 68 and 73 to 75.

147. Overall, the experts were agreed that:

'[…] 1. That it was inappropriate to place the Bravo pH96 in a section which is for: "any extra procedures that ***sometimes*** *become necessary during the procedure"* ***(emphasis added)***

2. That incorrect recording of the dose of medication administered does reflect inadequacy in record-keeping

3. That it was necessary for Dr Thillainayagam to ensure that the record had been completed on 20 July 2020.

4. That the purpose of the entry on 23 July 2020 is unclear and that it should have recorded a wider clinician impression of the illness to that date, and should have included a summary of information given to the patient (and family).

148. In Dr F's opinion, Dr Thillainayagam's record-keeping was '*below'* the standard to be expected of a reasonably competent registrant; while Professor E considered it to have been '*seriously below'* that standard.

149. Reflecting upon these matters, the Tribunal determined that Dr Thillainayagam's conduct in these respects engaged the following paragraphs of GMP:

> *'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:*
>
> *a relevant clinical findings*
>
> *b the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
>
> *c the information given to patients*
>
> *d any drugs prescribed or other investigation or treatment*
>
> *e who is making the record and when.*
>
> …
>
> *44 You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:*
>
> *a share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers*
>
> *b check, where practical, that a named clinician or team has taken over responsibility when your role in providing a patient's care has ended. This may be particularly important for patients with impaired capacity or who are vulnerable for other reasons.'*

150. Assessing seriousness with regard to paragraph 5 of the Allegation, the Tribunal recognised fully that record-keeping errors will sometimes occur, and that not every such error would necessarily amount to misconduct that was serious.

151. However, the Tribunal considered there was a pattern here; a sequence of failures of record-keeping, some of which were of particular importance given the circumstances of the case, for the reasons discussed at paragraphs 66 to 69 and 73 to 79 of its Facts determination.

152. The Tribunal considers these failures should properly be viewed together and when considered in the context of the overall care of Patient A, they become highly suggestive of a general carelessness and a lack of rigour by Dr Thillainayagam in the discharge of his professional responsibilities towards Patient A.

153. Thus, the Tribunal shares Professor E's assessment: this was record-keeping which was *'seriously below'* the standard to be expected of a reasonably competent registrant. It considers Dr Thillainayagam's misconduct here also to be serious.

154. As Dr Thillainayagam stated, in his reflective statement, in relation to record-keeping:

> *'[…] When I visited the patient on the ICU on 20 July 2020, I was accompanied by the Medical Fellow, who I had worked with for almost a decade. We discussed the patient and his clinical problems in detail and at length with the ICU staff, especially the ICU fellow. It was my duty to ensure that these discussions, including an outline of the causes of the clinical problems and what precipitated his admission to ICU from my perspective, as well as a problem list and management plans were written down by me or on my behalf by the Medical Fellow or ICU Fellow.*
>
> *In the latter instance it would be my responsibility to check what had been written in my name. I also failed to document my conversation with the family. It was an obligation on a consultant in the practising privileges of The London Clinic to keep clear records. As I did not check to see whether a note had been completed which properly recorded the patient's the journey to ICU, clinical decisions, problem list and management plans, my notes that day represented a progress note only.*

Once the patient was planned to be transferred, I did give an extensive handover to the receiving consultant respiratory physician. However, I neglected to write a discharge summary to go with the patient.

I acknowledge that my conduct represented a significant departure from proper practice and was not up to the standard that is expected of a consultant physician, especially one of my experience [….] It also fails to fulfil the obligations I had signed up to in the practicing privileges of The London Clinic […]'

155. The Tribunal has concluded that Dr Thillainayagam's conduct, as found proved at paragraphs 3, 4 and 5 of the Allegation, fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct that is serious.

156. For the avoidance of doubt, in forming this view the Tribunal kept in mind throughout its deliberations Dr Thillainayagam's assertion (per paragraph 35 of the Facts determination) that these matters all arose out of a considered but flawed decision by him, one made in good faith, not to visit Patient A personally, due to the risk of exposing him to the COVID-19 infection.

157. The Tribunal recognised that at the time Dr Thillainayagam was working in the difficult circumstances of a national health emergency, treating patients with COVID-19. This was at considerable personal risk. However, even taking this assertion at its highest, the Tribunal was not persuaded this could fully account for the facts under consideration.

158. Rather, the totality of Dr Thillainayagam's conduct indicated that there was a carelessness and a level of complacency in his care for Patient A. In other words, having decided not to visit his patient, he did so without making an enquiry whether any PPE-3 was available, without discussing his decision with the medical director or the patient's family (who were paying for his services and relying upon his particular expertise), and seemingly without discussing this with any of the RMOs upon whom he relied. Neither, as the Tribunal noted (at paragraph 43 of the Facts determination), did he record his thought-processes anywhere. (The absence of adequate record-keeping finds its echo in paragraph 5 of the Allegation.)

159. These shortcomings were not momentary. They persisted over a number of days. In the Tribunal's view, they were indicative of Dr Thillainayagam having initially formed an

inaccurate view of the ongoing risk in Patient A's health and then, having done so, taking a seriously inadequate approach to his professional responsibilities in relation to that patient.

160. For these reasons, the Tribunal did not accept Mr Sutton's submissions (per paragraph 37(10) of *Remedy*) that Dr Thillainayagam's actions were not capable of constituting misconduct.

Impairment by reason of misconduct

161. Having determined that the facts found proved amounted to serious misconduct, the Tribunal went on to consider whether, as a result of that misconduct, Dr Thillainayagam's fitness to practise is currently impaired.

162. The Tribunal reminded itself that:

a. The question of whether Dr Thillainayagam's fitness to practise is impaired is posed, and is to be answered, in the present tense; the Tribunal looks forward not back. However, in order to form a view as to the fitness of a person to practise today, the Tribunal will have to take into account the way in which Dr Thillainayagam has acted, or failed to act, in the past (*Meadow v GMC* [2006] EWCA Civ 1390);

b. Case law has established that it must be '*highly relevant'* in determining if a doctor's fitness to practise is impaired '*that, first, his or her conduct which led to the charge is easily remediable; that, second, it has been remedied; and, third, that it is highly unlikely to be repeated'* (*R (on the application of Cohen) v GMC* [2008] EWHC 581 [Admin]);

c. The attitude of Dr Thillainayagam to the matters which give rise to the specific allegation against him is (in principle) something which can be taken into account either in his favour, or against him, by the Tribunal. (*Nicholas- Pillai v GMC* [2009] EWHC 1048 [Admin]).

163. In relation to the above considerations, the Tribunal determined that the conduct forming the subject of the Allegation could indeed be remedied.

164. Dr Thillainayagam's detailed reflective statement and his oral evidence at the impairment stage indicate that, over time, he has gained a great deal of insight into what had

occurred, what he might do differently in future, and the skills and knowledge that might equip him to do so. He has also apologised.

165. The Tribunal considered that his insight, coupled with his extensive CPD diary entries, and changes made to his practice, suggests he would be unlikely to find himself in this position again.

166. Moreover, the numerous highly favourable testimonials, from patients and colleagues alike, all attest to his clinical skills, as well as to their experience of his record-keeping aptitude, and to his patient care. Taken together, their accounts suggest that Dr Thillainayagam's behaviour in relation to the care of Patient A was out of character.

167. Nevertheless, the Tribunal remains concerned (for the reasons set out in the Misconduct discussion above) that COVID-19 cannot explain fully Dr Thillainayagam's misconduct. It is not persuaded he truly understands yet how all aspects of it came to pass. This prevents the Tribunal concluding insight and remediation is complete. Accordingly (and with the statutory overarching objective in mind), the Tribunal cannot assert with sufficient confidence that such conduct is '*highly*' unlikely to be repeated.

168. In addition, the Tribunal was mindful of the guidance of the High Court in *CHRE v NMC and Grant* [2011] EWHC 927 [Admin] at paragraph 74 ('*Grant'*):

> *'In determining whether a practitioner's fitness to practice is impaired by reason of misconduct, the Tribunal should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role**; but also whether the need to uphold proper professional standards, and public confidence in the profession, would be undermined if a finding of impairment were not made in the particular circumstances.'*** (The Tribunal's emphasis)

169. Here, the seriousness of the misconduct and the multiplicity of GMP breaches tends toward the need for the making of such a finding.

170. Finally, therefore, bearing in mind all these considerations, the Tribunal reminded itself of the question it should ask, per *Grant* at paragraph 76, namely:

'do the findings of fact in respect of this doctor's [deficient professional performance] show that his fitness to practise is impaired in the sense that he;

a. has in the past acted 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 liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached or liable in the future to breach one of the fundamental tenets of the medical profession […]'

(quoting Dame Janet Smith in paragraph 25.67 in her Fifth Report from Shipman).

171. For the reasons set out above, The Tribunal determined that limbs (a), (b) and (c) from the above were all engaged and present in this case.

172. The Tribunal has therefore determined that Dr Thillainayagam's fitness to practise is currently impaired by reason of his misconduct.

Determination on Sanction - 21/03/2025

173. Having determined that Dr Thillainayagam's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

Submissions

174. On behalf of the GMC, Mr Coke-Smyth submitted that the appropriate sanction was one of suspension. He referred the Tribunal to the Sanctions Guidance (2024) ('the SG') and the Tribunal's own findings at the previous stages of the hearing.

175. Mr Coke-Smyth submitted that this case engaged the second and third limbs of the statutory overarching objective. He reminded the Tribunal that any sanction must be proportionate, but the reputation of the profession as a whole is more important than any individual doctor.

176. In regard to mitigating features, Mr Coke-Smyth submitted that Dr Thillainayagam is of previous good character and has no findings made against him. He stated that the Tribunal has found that the misconduct in this case can be remediated, and that Dr Thillainayagam has a high level of insight, but that is not yet complete. He reminded the Tribunal of its finding that the conduct is unlikely to be repeated. He submitted that Dr Thillainayagam has provided positive testimonials, which show him to be an extremely capable and otherwise well-respected doctor. He submitted that Dr Thillainayagam has expressed remorse and apologised.

177. Considering aggravating features, Mr Coke-Smyth reminded the Tribunal of its finding that full insight is lacking in respect of the most serious allegation, namely failing to visit Patient A and Dr Thillainayagam's reliance on RMOs. He stated that the Tribunal has not accepted that Dr Thillainayagam's conduct was explained solely by COVID-19 as has been stated. Mr Coke-Smyth submitted that Dr Thillainayagam's conduct was not born of incompetence, but rather carelessness and a lack of rigour. He submitted that the misconduct was not momentary but continued over a number of days. Further, Patient A was vulnerable due to his age and clinical history, and Dr Thillainayagam was absent at a critical period, and Patient A ultimately died.

178. Mr Coke-Smyth submitted that suspension is the appropriate sanction. He stated that it would act as a deterrent and send a message that Dr Thillainayagam's behaviour was unbefitting a registered doctor. He submitted that the misconduct in this case was serious but falls short of being fundamentally incompatible with registration.

179. Mr Coke-Smyth submitted that suspension would be sufficient to address the misconduct, declare standards for members of the profession and uphold public confidence in the profession. Further, a suspension would send a very clear message in respect of this type of misconduct.

180. Mr Coke-Smyth, turning to other possible sanctions, submitted that conditions would not be appropriate given the seriousness of the misconduct found. He stated that the issue in this case was not Dr Thillainayagam's ability to practise safely, but his attitude and judgement.

181. Mr Coke-Smyth made no submission as to the length of suspension and stated that the requirement for a review was a matter for the Tribunal's judgement.

182. On behalf of Dr Thillainayagam, Mr Sutton submitted that the circumstances of the case were such that the Tribunal might consider taking no action. Throughout his submissions he referred the Tribunal to the SG, relevant caselaw and the Tribunal's own findings at the previous stages of the hearing.

183. Mr Sutton reminded the Tribunal that sanctions should not be punitive and must be proportionate. Further, the Tribunal should start with the least restrictive and balance the public interest with the interests of Dr Thillainayagam.

184. Mr Sutton submitted that there was an established public interest in allowing skilled and useful clinicians to remain in practice. He stated that a finding of impairment is an important marker in its own terms, sending a message about the Tribunal's assessment of the implications of the conduct, the ramifications on the standing of the profession and the maintenance of public confidence in the profession.

185. Mr Sutton submitted to the Tribunal that it must balance the aggravating and mitigating factors of the case. He directed the Tribunal to the relevant paragraphs of the SG, and stated that the issues in this case relate to a single phase of treatment of a single patient. He submitted that the incident took place over three to four days, approximately five years ago. He reminded the Tribunal that, significantly, this occurred during the COVID-19 pandemic, a time in which Dr Thillainayagam was working as a frontline worker within the NHS. Mr Sutton submitted that Dr Thillainayagam had maintained that he was trying to limit the risk of COVID-19 infection to Patient A, but he fully accepted that he should have found a way to negate that risk that allowed him to deliver an appropriate standard of care to Patient A. He submitted that this was not to excuse his action, but to offer an explanation for why he took the decisions he did.

186. Mr Sutton directed the Tribunal to its determination on impairment and stated that Dr Thillainayagam embraced the observations made by the Tribunal regarding his insight, remediation and the characterisation of his behaviour being '*out of character*'. He submitted that COVID-19 formed the '*central plank*' of Dr Thillainayagam's case, and at the time, he perceived that by virtue of his working on COVID-19 wards in the NHS, he represented an infection risk to his patient. He submitted that it would be wrong to expect Dr Thillainayagam to recant this at this stage, but he fully conceded that it was in hindsight an erroneous judgement which led to a diminution in the standard of care Patient A was entitled to expect.

He submitted that COVID-19 being the reason for his decision making was not rejected by the Tribunal, but neither was it clearly accepted. He submitted that Dr Thillainayagam accepted that there were a number of features which should have been avoided had he spoken to the medical director.

187. Mr Sutton reminded the Tribunal that Dr Thillainayagam has demonstrated persuasively and impressively that he has undertaken the requisite reflection and remediation of his practice. He directed the Tribunal to Dr Thillainayagam's reflective statement and submitted that all of the essential criticisms of his practice have been engaged with in that document.

188. Mr Sutton submitted that a finding of misconduct was a salutary lesson. He stated that there were no issues in relation to Dr Thillainayagam's clinical practice that would warrant an order of conditions or a suspension. He submitted that the real purpose of sanction in this particular case, would be the more symbolic purpose of upholding the second and third limbs of the overarching objective.

189. Mr Sutton invited the Tribunal to consider what is truly required in this rather unusual case. He stated that the case was unusual as there was a very narrow compass in terms of the period of time when the relevant events unfolded. Further it took place in the critical context of the COVID-19 pandemic, which fundamentally influenced Dr Thillainayagam's decision making.

190. Mr Sutton submitted that a suspension would be disproportionate and would have very significant personal and professional ramifications on Dr Thillainayagam, who is the sole financial provider XXX. He submitted that a suspension could lead to Dr Thillainayagam losing his job, which would have a detrimental impact.

191. Mr Sutton stated that if the Tribunal was against his primary submission that no action was required, then he would submit that the Tribunal consider imposing conditions on Dr Thillainayagam's registration. He suggested that the Tribunal could impose a condition requiring Dr Thillainayagam to further reflect on how matters came to pass. He stated that he disagreed that conditions were unsuitable in this case and contended that in the particular circumstances of the case a lesser sanction than suspension should be considered.

The Tribunal's approach to Sanction

192. The decision as to the appropriate sanction to impose, if any, is a matter for this Tribunal exercising its own judgement.

193. In reaching its decision, the Tribunal has taken account of the SG and GMP. It has borne in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it may have a punitive effect.

194. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Thillainayagam's interest with the public interest. It has also taken into account the statutory overarching objective.

195. The Tribunal has already given detailed determinations on facts and impairment and has taken those matters into account during its deliberations on sanction.

196. The Tribunal was unable to identify any aggravating factors in this case.

197. Although Dr Thillainayagam's insight is not yet quite complete, it is at a very advanced stage. The Tribunal has determined that there are clear, evidence-based reasons to think its completion will have occurred shortly, once Dr Thillainayagam has reflected upon the impairment determination with the same care that he demonstrably applied to the Tribunal's facts determination. The Tribunal develops this theme below in its discussion in the context of mitigation.

198. The Tribunal reminded itself of the contents of the Responsible Officer's statement (24 January 2023). It noted that, in 2017, a MHPS disciplinary process was undertaken into behaviour by Dr Thillainayagam. Given that it was concluded by means of 'informal action' and 'supporting measures', the Tribunal did not consider it represented an aggravating factor for present purposes.

199. That matter aside, the Tribunal is unaware of any other disciplinary matters having been established against him. While it notes there were (and, possibly, there remain) other matters pending in relation to two MHPS investigations; these remain unresolved and so the Tribunal does not attach to them any weight at this stage. Moreover, the Tribunal notes Mr Coke-Smyth's confirmation that Dr Thillainayagam was of previous good character and that there were no findings against him by his regulator.

200. The Tribunal considered Mr Coke-Smyth's submission that Patient A was vulnerable by virtue of his age and clinical presentation and that, therefore, to have failed to visit him at a critical time in his care (during a period when antibiotics should have been administered, according to the experts), amounted to an aggravating factor. However, the Tribunal considered that while this behaviour went to the seriousness with which it viewed the facts as a whole, it did not amount of itself to an 'aggravating' factor.

201. The Tribunal then went on to identify the following mitigating factors.

202. Firstly, it noted that Dr Thillainayagam was a doctor with three decades of professional experience at the level of Consultant. During that time, he had been of good character and there were no findings against him by his regulator. Accordingly, the Tribunal determined that the misconduct currently under consideration was entirely out of character for Dr Thillainayagam.

203. Secondly, the Tribunal took into account the circumstances in which the misconduct occurred. As the Tribunal noted in paragraph 74 of its impairment determination, at the time of these events Dr Thillainayagam was working at the frontline, and at his own personal risk, in the difficult circumstances of a national health emergency, treating patients with COVID-19. Although, as the Tribunal has already indicated, this does not fully account for his actions, nevertheless those circumstances mitigate, to some extent, his conduct.

204. Thirdly, remediation. Dr Thillainayagam has been methodical in providing a considerable amount of evidence to demonstrate the steps he has taken to addresses concerns about his conduct and behaviour. This takes the form of an extensive 45-page CPD diary, certificates of confirmation in relation to courses he has undertaken, and a 10-page reflective statement.

205. Fourthly, insight. As the Tribunal indicated at the impairment stage, Dr Thillainayagam's insight is now at an advanced stage (paragraphs 81 to 82, impairment determination). It is not yet complete, in the Tribunal's assessment, because he has not clearly demonstrated an understanding why those matters at paragraphs 74 to 76 of the impairment determination cannot reasonably be assessed as having arisen as part of his response to COVID-19. However, although the Tribunal does not yet find his insight complete; it is fortified by his detailed response to the Tribunal's facts determination, and it

considers that, when he has an opportunity to reflect with equal care on the impairment determination, Dr Thillainayagam's journey to complete insight will be short.

206. Fifthly, the Tribunal noted Dr Thillainayagam's expressions of regret and apology. These were clear and fulsome, coupled with taking steps to improve by learning from mistakes and preventing similar events recurring.

207. Finally, the Tribunal bore in mind the testimonials provided on Dr Thillainayagam's behalf. It is commonplace for such testimonials usually to speak highly of the registrant before his or her regulator. In this instance, however, the Tribunal was particularly struck by their quality. Not only were they numerous, and covering the large expanse of his professional career, but each was vociferous – both from patients and colleagues – in attesting to his virtues as a doctor. Their comments addressed in detail the care he had provided, the high level of clinical skills he brought to bear, and (particularly notable, in light of the Allegation he faced) the detailed and fully-rounded approach he took to every aspect of each patient's needs. For example:

Ms K, Patient:

> *'At every stage of my recovery he has explained in great detail the likely causes of my symptoms and the treatment he prescribed and any potential side effects. His investigations have always been thorough and he made sure I understood the results. My recovery has been a difficult process physically and mentally and he has supported not only me but also my husband at every step. I have copies of all of his detailed correspondence with my GP and my oncologist which have been a constant source of reference.....*
>
> *He has always been available for advice when I have needed it and he has equipped me with the understanding and treatment plan for when problems occur.....*
>
> *I personally cannot fault my treatment under Dr Thillainayagam and along with his medical expertise and care will be forever grateful for his kindness during a very difficult time for myself and for my family.'*

Ms J, Patient:

> *'From the moment I met Dr Thillainayagam I felt in extremely safe hands. Wonderfully knowledgeable, experienced, proactive, caring, kind, fair, trustworthy, to the point, efficient, highly professional yet personable.'*

Professor I, Professional Colleague:

> *'From my direct observations of his interactions and communications received from Dr Thillainayagam, I regarded him as meticulous in his care. If evidence is required, I would refer you to examine the details and depth in his clinic letters, which were always intended to achieve the best care for his patients..... He always made himself available to patients and colleagues but invariably prioritised patients themselves and I observed his empathetic interactions with them.'*

Professor L, Professional Colleague 'XXX':

> *'My experience is that he has provided outstanding care to my patients, with expert and experienced clinical diagnoses and therapeutic opinions. He is always available even out of hours. He spends a lot of time with my patients, writing very detailed and comprehensive clinical notes and medical reports. Over these years, I have not known one instance of failure to examine one of my patients or to provide comprehensive medical reports.'*

The Tribunal's Determination on Sanction

No action

208. In reaching its decision as to the appropriate sanction, if any, to impose in Dr Thillainayagam's case, the Tribunal first considered whether to conclude the case by taking no action. Taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

209. The Tribunal considered the submissions of Mr Sutton but determined that the seriousness of its findings required the imposition of a sanction. It determined that there were no '*exceptional circumstances*'. Particularly as the Tribunal has not accepted that

COVID-19 had wholly explained his misconduct, for the reasons set out at the impairment stage.

210. Consequently, the Tribunal determined that it would not therefore be sufficient, proportionate or in the public interest to conclude this case by taking no action.

Conditions

211. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Thillainayagam's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable.

212. The Tribunal had regard to paragraph 81 of the SG which states:

> *'81 Conditions might be most appropriate in cases:*
>
> *a involving the doctor's health*
>
> *b involving issues around the doctor's performance*
>
> *c where there is evidence of shortcomings in a specific area or areas of the doctor's practice*
>
> *d where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision.'*

213. While the Tribunal recognised that paragraph 81 did not limit the circumstances in which conditions might be appropriate; nevertheless, on the facts of this case, conditions would not be appropriate on the facts proved.

214. Moreover, the Tribunal was clear that the imposition of conditions would not be proportionate in this case. To recap, a vulnerable 85-year-old patient had been admitted to the London Clinic at Dr Thillainayagam's request, and then had not been visited by him for three days - during a critical phase when, if he had been treated by someone with the appropriate experience and expertise, his chances of survival could have increased.

215. The Tribunal noted that the expert Professor E puts it more strongly than that:

'On the balance of probabilities, an experienced consultant physician would have diagnosed a serious respiratory infection, considered the possibility of Covid and arranged [the patient's] immediate transfer to an NHS facility, where all appropriate investigations would have happened rapidly and a clear diagnosis with appropriate treatment have been initiated, leading to [the patient's] survival in my opinion.'

216. The Tribunal has, therefore, determined that it would not be sufficient to impose conditions on Dr Thillainayagam's registration. They would be insufficient to meet the public interest and to maintain proper professional standards of conduct for the members of the profession.

Suspension

217. The Tribunal then went on to consider whether a period of suspension would adequately protect the public, maintain public confidence in the profession and uphold proper standards for its members. In considering whether to impose a period of suspension on Dr Thillainayagam's registration, the Tribunal had regard to paragraphs 91, 92 and 93 of the SG which provide:

'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

> *93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49)'*

218. The Tribunal also considered the guidance at paragraphs 97(a), (e), (f) and (g), which it considered to be of particular relevance in this case.

> *'97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> *a A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.*
>
> *…*
>
> *e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> *f No evidence of repetition of similar behaviour since incident.*
>
> *g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

219. The Tribunal had regard to its findings at impairment stage, namely that Dr Thillainayagam's conduct was a serious departure from GMP and that his actions had therefore breached a fundamental tenet of the profession.

220. The Tribunal considered that while his misconduct was serious, it was remediable. Dr Thillainayagam had already taken some steps to remediate. Whilst the Tribunal was of the view that Dr Thillainayagam had not yet gained full insight into his misconduct, the outstanding areas of reflection were discrete and the steps he has taken to date demonstrate

that he is willing to engage and reflect upon his actions. Given the developing nature of his insight, the Tribunal considered that Dr Thillainayagam was unlikely to repeat his misconduct. However, the Tribunal did consider that there was more work required, particularly into the underlying causes of his decision making and why he deviated so significantly from his usual practise.

221. The Tribunal had regard to the factors it has identified as aggravating and mitigating and its assessment of the scale of the misconduct. Overall, the Tribunal decided that this case was not one where Dr Thillainayagam's misconduct was fundamentally incompatible with continued registration. Therefore, it considered that erasure would not be appropriate or proportionate, nor would it be in the public interest.

222. In light of the above, the Tribunal determined that a period of suspension would be an appropriate and proportionate sanction when considering Dr Thillainayagam's interests alongside the public interest. The Tribunal took into account the impact that this sanction may have upon Dr Thillainayagam. However, in all the circumstances the Tribunal concluded that his interests are outweighed by the need to maintain public confidence in the profession and to declare and uphold proper standards of conduct and behaviour.

Length of Suspension

223. In determining the length of the suspension, the Tribunal had regard to paragraphs 99 to 102 of SG and the table following paragraph 102.

224. The Tribunal considered the aggravating factors in this case and acknowledged that this was a serious departure from the principles set out in GMP.

225. The Tribunal also had regard to the mitigating factors of the case in considering the length of the suspension, including Dr Thillainayagam's long career and the overwhelmingly positive testimonial evidence, which demonstrate that he is otherwise a good doctor. The Tribunal acknowledged that there was a public interest in allowing an otherwise competent doctor to return to practise as soon as possible, whilst still upholding the statutory overarching objective.

226. Taking all these elements into account, the Tribunal was satisfied that imposing a period of one month's suspension was appropriate and proportionate. This reflected the fact

that the Dr Thillainayagam has developed insight with a discrete area remaining to reflect upon.

227. In the Tribunal's view, a one-month suspension was sufficient to satisfy the need to promote and maintain public confidence and to send out a clear message to the profession that this type of conduct is unacceptable, in order to maintain proper professional standards. This period of suspension will also give Dr Thillainayagam sufficient time to further reflect and develop his insight in relation to his care of Patient A.

Review

228. In determining whether to impose a review, the Tribunal had regard to Paragraphs 163 and 164 of the SG dealing with review hearings state:

> *'163 It is important that no doctor is allowed to resume unrestricted practice following a period of conditional registration or suspension unless the tribunal considers that they are safe to do so.*
>
> *164 In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. […]'*

229. For the reasons set out above, the Tribunal is satisfied that a review following a short suspension of one month, where there are no patient safety concerns, and where Dr Thillainayagam has remediated and shown a significant degree of insight would serve no useful purpose. In the circumstances, the Tribunal determined that it is not necessary to direct a review hearing.

Determination on Immediate Order - 21/03/2025

230. Having determined that Dr Thillainayagam's registration should be subject to an order of suspension for a period of one month, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

231. On behalf of the GMC, Mr Coke-Smyth did not make an application for an immediate order.

232. On behalf of Dr Thillainayagam, Mr Sutton made no submissions.

The Tribunal's Determination

233. In reaching its decision, the Tribunal considered the relevant paragraphs of the SG and exercised its own independent judgement. In particular, it took account of paragraphs 172, 173 and 178:

> '*172* *The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. …*
>
> *173* *An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> *…*
>
> *178* *Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'*

234. The Tribunal determined that there were no clinical concerns in this case, nor was an immediate order necessary to protect members of the public. There was no significant risk of repetition in this case. Therefore, the Tribunal was not satisfied that an order was necessary to protect public confidence in the profession, or that it was otherwise in the public interest or Dr Thillainayagam's best interests.

235. This means that Dr Thillainayagam's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal. If Dr Thillainayagam does lodge an appeal, he will remain free to practise unrestricted until the outcome of any appeal is known.

236. There was no interim order in place to revoke.

237. That concludes this case.

ANNEX A – 13/10/2023
Application to amend the allegation under Rule 17(6)

238. At the outset of proceedings, Mr Coke-Smyth, Counsel on behalf of the GMC, made an application pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to amend the Allegation and withdraw paragraphs 1, 2(b), 5(a) and 5(d). He submitted that the GMC was no longer seeking to pursue these paragraphs in light of the evidence in the joint expert report by Professor E and Dr F.

239. In those regards, the application was not opposed by Mr Harries, Counsel on behalf of Dr Thillainayagam.

240. Mr Coke-Smyth then made an application under Rule 17(6) to amend paragraph 5(b)(ii)(2) of the allegation. The proposed amendment is as follows.

From:

> *5. Between 30 June 2020 and 28 July 2020, you failed to maintain an adequate standard of record keeping, in respect of your care of Patient A, in that:*
>
> *b. on 16 July 2020, you completed a consent form for the Procedure and you:*
>
> *ii. failed to record:*
>
> *2. whether any biopsies were taken;*

To:

> *2. <u>details of any biopsies to be taken;</u>*

241. Mr Coke-Smyth submitted that the proposed amendment clarified that the biopsy procedure was prospective and, as such, the re-wording ensured accuracy. He submitted that both expert witnesses had formulated their opinion on the basis of the biopsy being a prospective procedure. He submitted that the proposed amendment could be made without injustice to Dr Thillainayagam's case as the GMC's underlying criticism would remain unchanged. Accordingly, the proposed amendment neither required a change of approach by

Dr Thillainayagam, nor did it require further evidence from the defence in response to that amendment. Mr Coke-Smyth added that he had spoken to Mr Harries about the intended amendment approximately three weeks ago.

242. Mr Harries opposed the GMC's application to amend paragraph 5(b)(ii)(2) of the allegation. He submitted that the amendment was one that could have been affected much sooner, and that indeed his legal team had raised the issue with GMC as long ago as January 2022. He submitted that the original allegation had been drafted in the past tense, whereas the proposed amendments now accuse Dr Thillainayagam of failing to input details before the event took place. He submitted that this fundamentally shifted the nature of allegation against Dr Thillainayagam and that to do so at this stage would amount to injustice.

The Tribunal's Approach

243. In considering the application the Tribunal had regard to Rule 17(6) of the Rules which states:

> *Where, at any time, it appears to the Medical Practitioners Tribunal that—*
>
> *(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and*
>
> *(b) the amendment can be made without injustice,*
>
> *it may, after hearing the parties, amend the allegation in appropriate terms.*

244. In relation to the GMC application to withdraw paragraphs 1, 2(b), 5(a) and 5(d) of the Allegation, the Tribunal noted that there was no objection from Mr Harries. Having heard from both parties, the Tribunal was satisfied that no injustice would be caused to Dr Thillainayagam. Accordingly, the Tribunal granted the GMC application.

245. The Tribunal then went on to consider the proposed amendments to sub-paragraph 5(b)(ii)(2) of the allegation. It bore in mind submissions from parties and considered whether the amendments can be made without injustice to Dr Thillainayagam.

246. The Tribunal determined that, although the proposed amendment could have been made sooner, there was no objective basis to find that amendment would now cause

injustice to Dr Thillainayagam. It was satisfied that the amendment could be made without injustice. It was also satisfied that the amended application better reflected the evidence upon which the Allegation was based. On that basis, the Tribunal therefore decided to grant the application and amend paragraph 5(b)(ii)(2) of the allegation, in accordance with the proposed amendments set out above.

ANNEX B – 12/11/2024

Adjournment Application

247. Mr Harries made an application pursuant to Rule 29(2) of the Rules, that the hearing should be adjourned.

248. The background was that this case had been stood down on Friday 8 November 2024, following an unopposed application by Mr Harries. The basis of that application had been that an issue had arisen which, until resolved, placed Mr Harries in professional difficulties regarding his continued involvement in the case. He had indicated that, such was its nature, he was unable to refer to the difficulty other than in the most oblique terms. However, he was optimistic that by 11 November, the issue would be resolved and, if not, Mr Harries would have to consider whether to withdraw from the proceedings.

249. It was against that background Mr Harries updated the Tribunal that, despite considerable efforts (including both him and his instructing solicitor obtaining their own written independent legal advice), the 'issue' had not been resolved. He explained that, therefore, neither he nor his instructing solicitor could continue to act for Dr Thillainayagam.

250. Mr Harries emphasised (as he had done on 8 November 2024) that this decision implied no criticism of Dr Thillainayagam.

251. Consequent upon it, though, Mr Harries said that Dr Thillainayagam now sought an adjournment in order to engage new legal representation.

252. When considering that application, Mr Harries submitted that the Tribunal should bear in mind XXX Dr Thillainayagam currently faced (this was developed in private session). He submitted that the pressure of these proceedings had XXX. Mr Harries added that, while it was a matter for the Tribunal, the prospect of Dr Thillainayagam representing himself was something he would have concerns about, from a professional position.

253. In response, Mr Coke-Smyth submitted that the GMC's position on the application was neutral. He said that it was difficult to take a positive position on the application without knowing more details of the 'issue'; however, he understood the reason why further information had not been disclosed.

254. Mr Coke-Smyth informed the Tribunal that this was not an Allegation where an interim order was currently in place, neither was it one where the GMC could identify an immediate risk of patient harm. However, when considering the adjournment application, he reminded the Tribunal that the case was 'getting older' and there is strong public interest in its conclusion.

Tribunal's Determination

255. The Tribunal reminded itself that, per Rule 29(2) of the Rules, it was empowered to grant an adjournment. It bore in mind that, in coming to its decision, it was required to strike a balance between fairness to Dr Thillainayagam and fairness to the GMC. The Tribunal recognised fully the need to deal with the hearing fairly and justly, taking into consideration the over-arching objective and the public interest.

256. Having reflected upon these considerations, the Tribunal determined that, notwithstanding the age of the case, fairness and the interests of justice meant that Dr Thillainayagam should be given the opportunity to instruct new legal representation. This was a case of some complexity, and the next stage of the hearing (namely, to determine whether this doctor's fitness to practise is impaired by reason of misconduct) might be anticipated to include consideration of, and submissions upon, the experts' analyses, insofar as they bore upon that question. In such circumstances, Dr Thillainayagam was likely to benefit from legal representation.

257. Therefore, the Tribunal has determined to grant the adjournment in order to afford Dr Thillainayagam the opportunity to secure new legal representation.

258. The Tribunal is adjourning the hearing until 12 December 2024.

259. By that date, the Tribunal expects Dr Thillainayagam to have acted expeditiously to instruct new legal representation, such that his new representative will be in a position on 12 December 2024 to fix an early substantive hearing date to deal with the outstanding Stage (or Stages) of the case.

260. The Tribunal would also wish to use 12 December 2024 to address any further preliminary issues that might have arisen between the GMC and Dr Thillainayagam over the intervening period. Accordingly, it expects a process of liaison to have occurred between the parties in the meantime to enable any such issues be able to be dealt with by the Tribunal on that date.

261. By agreement of both parties, the hearing on 12 December 2024 will take place virtually.

262. The Tribunal notes that Dr Thillainayagam has requested a full transcript of the hearing. The preparation of that transcript is underway.

263. The hearing is now adjourned.

ANNEX C – 12/12/2024
Application to fix and directions

264. The case was listed today to fix a substantive hearing date and to address such miscellaneous matters, if any, that might have arisen as a result of the instruction by Dr Thillainayagam of his new legal team.

Submissions

265. Mr Mark Sutton, KC, counsel for the doctor, indicated that the only issue was that there was now a possibility that live evidence might be called at Stage 2. On that basis, he submitted it would be prudent to list the case for five days to ensure Stage 2 and (if necessary) Stage 3 could be heard on the next occasion. The submission was not opposed by Mr Coke-Smyth, counsel for the GMC.

266. Mr Coke-Smyth submitted that any further evidence by either party should be provided no later than two weeks prior to the resumed hearing commencement date. Mr Sutton KC, having liaised with those instructing him, confirmed he would ensure compliance with this.

The Tribunal's Determination

267. The Tribunal has determined that the hearing would resume in person for five days, 17-21 March 2025, at St James' Building, Manchester.

268. The Tribunal directs that any further evidence by either party should be provided no later than 5.00pm on 3 March 2025.

Non-confidential schedule

Schedule 1

Date	Details of Drug
16 July 2020	Xylocaine – throat spray
16 July 2020	Midazolam intravenous 1 milligram
16 July 2020	Buscopan intravenous 20 milligram
16 July 2020	Fentanyl iv intravenous 100 microgram.