PUBLIC RECORD

Dr Lee appealed decisions of this Tribunal. On 19/12/25, the High Court dismissed Dr Lee's appeal. Therefore, Dr Lee's registration was suspended from 19 December 2025 for a period of 12 months.

The judgment can be found here.

Dates: 04/11/2024 - 15/11/2024; 16/01/2025; 29/04/2025 – 02/05/2025

Medical Practitioner's name:	Dr Siong LEE
GMC reference number:	3266423
Primary medical qualification:	MB ChB 1987 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, 12 months
Review hearing directed

Tribunal:

Legally Qualified Chair	Mr David Raff
Lay Tribunal Member:	Ms Jo Palmiero
Medical Tribunal Member:	Dr Carl Egdell

Tribunal Clerk:	Mrs Anne Bhatti (04/11/2024 – 15/11/2024) Mr Laurence Millea (16/01/2025) Mrs Jennifer Ireland (29/04/2025 – 02/05/2025)

Attendance and Representation:

Medical Practitioner:	Present, represented

Medical Practitioner's Representative:	Ms Vivienne Tanchel, Counsel, instructed by the MDDUS (04/11/2024 – 16/01/2025); instructed by Weightmans (29/04/2025– 02/05/2025)
GMC Representative:	Ms Sarah Barlow, 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 - 16/01/2025

1. This determination will be handed down in private as it refers to XXX. However, as this case concerns allegations of misconduct against Dr Lee a redacted version will be published at the close of the hearing.

Background

2. Dr Lee qualified in 1987 from Manchester University. He trained as a Surgical Trainee until 1995 before retraining in General Practice. Dr Lee obtained his JCPTGP certificate in 1996. Between 1997 and 2021, Dr Lee was a GP Partner at King Street Medical Centre, Dukinfield, Cheshire ('the Practice'). Throughout this period, he also worked for several out of hours organisations including Healthcall, MEDS, Aspire Locum and Gotodoc.

3. At the time of the events relevant to these proceedings, Dr Lee was working as a GP at the Practice. The Practice was taken over by Dr B, GP in July 2017, and Dr Lee retired from full time GP work in July 2021. He currently spends most of the year in Africa and Asia undertaking Christian Mission work. When he is in the UK, he undertakes adhoc locum GP work.

4. The allegation that has led to Dr Lee's hearing can be summarised as, that in February 2018 and May 2020, Dr Lee made false entries in Patient A's medical records. It is also alleged that in a letter to Patient A, dated 9 June 2020 ('the Letter'), Dr Lee made a number of false statements about the care and treatment provided to Patient A when he knew that Patient A had already raised concerns about the clinical care and treatment received. It is alleged that Dr Lee's actions were dishonest.

5. The initial concerns were raised with the GMC by Dr B, GP, the Practice.

The Outcome of Applications Made during the Facts Stage

6. At the close of the GMC's case on day two of the hearing, Ms Vivienne Tanchel on behalf of Dr Lee, made an application pursuant to Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), as to whether sufficient evidence, taken at its highest, had been provided for a Tribunal, properly directed, to find some or all of the facts proved.

7. The Tribunal granted the application under Rule 17(2)(g) in respect of paragraphs: 2(b); 4(e); 5(d); 5(e) in respect of the cross reference to Paragraph 4(c) only; and 5(f) in respect of the cross reference to Paragraph 2 only.

8. The Tribunal refused the application under Rule 17(2)(g) in respect of paragraphs: 4(a)(i); 4(a)(ii); 4(a)(iii); 4(a)(iv); 4(b); 4(c); 4(d); 5(a); 5(b); 5(c); 5(e) except in respect of the cross reference to Paragraph 4(c); and 5(f) except in respect of the cross reference to Paragraph 2.

9. The Tribunal's full decision on the application is included at Annex A.

The Allegation and the Doctor's Response

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

1. On 27 November 2017, you made an entry within Patient A's medical records that you had reviewed his blood test results ('the Results'). You subsequently edited this entry, in that you added a note on:

a. 13 February 2018, which stated 'u/s scan prostate', indicating that an ultrasound scan was to be undertaken; **Admitted and found proved**

b. 12 May 2020, which stated you had had a telephone consultation with Patient A on 27 November 2017; Admitted and found proved

c. 13 May 2020, which stated that Patient A 'does not want a DRE'. Admitted and found proved

2. In or around February 2018, you completed a referral to Mediscan ('the Referral'):

a. requesting an ultrasound scan of Patient A's abdomen, pelvis, ~~RUB~~ KUB and prostate, and Amended under Rule 17(6). Admitted and found proved

b. ~~you wrote 'Urgent not heard anything' on the Referral~~. Deleted after a successful Rule 17(2)(g) application

3. Within a letter dated 9 June 2020 ('the Letter'), you wrote or caused to be written: 'I requested for you to attend surgery for a digital rectal examination (DRE) to examine your prostate but you phoned me to discuss the results. I recall that you did not want a prostate examination. At the time you did not report any symptoms of prostate enlargement or prostate cancer'.

Admitted and found proved

4. You knew that:

a. on 27 November 2017 you had not:

i. requested an ultrasound of Patient A's prostate; To be determined

ii. had a telephone consultation with Patient A; To be determined

iii. discussed the Results with Patient A; To be determined

iv. discussed with and/or recommended a Digital Rectal Examination ('DRE') to Patient A; To be determined

b. on 27 November 2017, Patient A had not declined to undergo a DRE; To be determined

c. concerns had been raised by Patient A regarding the care and treatment you provided and/or did not provide to him at the time you wrote the Letter or caused the Letter to be written; To be determined

d. the Referral was the first time that you had referred Patient A for an ultrasound scan of his prostate; To be determined

e. ~~including the words 'Urgent not heard anything' on the Referral would give the false impression that you had previously referred Patient A for an ultrasound scan on his prostate~~. Deleted after a successful Rule 17(2)(g) application

5. Your actions at paragraph:

a. 1.a. were dishonest by reason of paragraph 4.a.i.; To be determined

b. 1.b. were dishonest by reason of paragraph 4.a.ii.; To be determined

c. 1.c. were dishonest by reason paragraphs 4.a.iv. and 4.b.; To be determined

d. ~~2. were dishonest by reason of paragraphs 4.d. and 4.e.~~; Deleted after a successful Rule 17(2)(g) application

e. 3. were dishonest by reason of paragraphs 4.a.ii., 4.a.iii., 4.a.iv., 4.b. and ~~4.c.~~; Rule 17(2)(g) application granted in respect of cross reference to Paragraph 4(c). Remainder of Paragraph 5(e) to be determined

f. 1., 2. and 3. were carried out to avoid potential criticism of the care and treatment you provided and/or did not provide to Patient A. Rule 17(2)(g) application granted in respect of the cross reference to Paragraph 2. Remainder of Paragraph 5(f) to be determined

The Admitted Facts

11. At the outset of these proceedings, through his counsel, Ms Tanchel, Dr Lee made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of 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.

Witness Evidence

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

- Dr C, GP, the Practice, witness statement dated 29 May 2024, by video link;
- Ms D, Clinical Business Manager, the Practice, witness statement dated 23 May 2023, by video link;
- Dr B, GP Partner, the Practice, witness statement dated 8 May 2025, in person;
- Mr E, Operations Manager of Mediscan Diagnostic Services Limited ('Mediscan'), witness statement dated 23 May 2024, by video link.

13. The Tribunal also received evidence on behalf of the GMC in the form of a witness statement from the following witness who was not called to give oral evidence because he was deceased:

- Patient A, witness statement dated 16 November 2023.

14. Dr Lee provided his own witness statement dated 23 May 2023 and also gave oral evidence at the hearing.

Summary of witness evidence

Patient A

15. Patient A was Dr Lee's patient at the Practice. Patient A made a complaint to the Practice regarding Dr Lee's failure to action a high prostate specific antigen ('PSA') which was found as result of his blood test in November 2017.

16. From approximately July 2019 he had been passing blood in his urine. He was sent for urology examination on 24 September 2019 and on 7 November 2019, he was diagnosed with locally advanced prostate cancer. He stated that he was told by both the oncologist and the urology nurse that his medical records showed that November 2017 blood test results had disclosed an elevated PSA level but, he stated, that he had not been told the result of this blood test. He said that the nurse had said to him, *'did you know that you had a raised PSA level back in 2017?'*. He said that this was the first time he had heard of the raised PSA level and that it was a shock to find that out and that he felt he had not been looked after properly. Patient A commenced a clincial negligence claim against Dr Lee regarding Dr Lee's failure to action the PSA result.

17. In late April or early May 2020 Patient A sent a complaint letter to the Practice outlining Dr Lee's alleged failure. The Letter was registered in the medical records as having been received by the Practice on 11 May 2020. A response was not initially received and a follow-up letter was sent by Patient A.

18. The Practice responded to Patient A's complaint on 9 June 2020 by letter. Patient A stated that, notwithstanding the terms of this response, Dr Lee did not request him to attend the surgery for a DRE, nor did Dr Lee explain what a DRE was. Patient A stated that he did not telephone Dr Lee on 27 November 2017 to discuss the results of his blood test and indeed that he had never even telephoned Dr Lee before. He further stated that Dr Lee never discussed the results of the blood test with him and that he did not inform him of the raised PSA result.

Ms D

19. Ms D was the Clinical Business Manager ('Practice Manager') of the Practice.

20. A complaint letter was received in April 2020 from Patient A in relation to a delayed diagnosis, Ms D was not initially involved in dealing with the complaint. On 30 January 2023 at the request of Dr B she ran an audit report of Patient A's medical records from February 2017. The audit was run using EMIS, the Practice's clinical record system. Within EMIS there were a number of different kinds of audits that could be run, but for Patient A, she specifically ran a Patient Record audit which she filtered to show certain dates.

21. The audit showed that Dr Lee had edited Patient A's medical records. The medical records for Patient A's 27 November 2017 consultation were edited by Dr Lee on 18 February 2018, 12 and 13 May 2020.

22. Under oral cross examination, it was clear that there was more than one way to undertake an audit of the records and in particular to highlight retrospective amendments. However, Ms D did not use the ICON and was not aware of what it signified.

Dr B

23. Dr B was a GP Partner at the Practice. In February 2023 he referred a concern that he had regarding Dr Lee retrospectively amending Patient A's medical records to the GMC. He had asked Ms D to run an EMIS audit on Patient A's medical records and he reviewed the audit. He could see from the audit that Dr Lee had amended the medical records.

Mr E

24. Mr E was the Operations Manager of Mediscan Diagnostic Services Ltd ('Mediscan'), Mediscan was a provider of ultrasound. Mediscan work with various GP Practices, and they use the EMIS system to record referrals received and the results.

25. Mr E stated that he believed that Mediscan stopped using fax to receive referrals in 2016 and that all referrals from that point were made by email, or the EMIS system. They checked their EMIS record for Patient A and confirmed that according to EMIS, Mediscan had only ever received one request to scan Patient A (in March 2018). They checked their email system to see if there were any other referrals from the Practice between 27 November 2017 and 5 March 2018 for Patient A. There was no record of emails before 2020 as they had been deleted. Notwithstanding Mr E's belief that no referrals were received by fax after 2016, it was clear that the February/March 2018 ultrasound referral was made by fax thus raising the possibility that a referral could have been made by fax in November 2017.

Dr C

26. At the time of working with Dr Lee, Dr C was working at the Practice as a GP. Dr C had seen Patient A on 29 July 2019 and 5 August 2019 regarding an issue with small amounts of blood mixed in urine in the context that he was known to have had renal stones for many years. Dr C was also involved in the care of Patient A after Dr Lee had seen Patient A on 13 February 2018 about left groin pain and arranged for an ultrasound scan to rule out a hernia. Dr C saw Patient A on 26 March 2018 for a follow-up regarding the groin pain following the ultrasound scan.

Dr Lee

27. Dr Lee knew Patient A well. Despite the passage of time since the index events, he stated that he had been able to maintain a good recollection of his involvement in Patient A's care.

28. Dr Lee stated in his oral evidence that he had returned from holiday mid-November 2017 and came back to 800 plus tasks.

29. It was uncontested that a blood test carrried out on Patient A was undertaken on 27 November 2017 and that the results of that blood test were made available that same day. He stated that in line with his usual practice, he would have reviewed the blood test result

and seen that it required actioning as the PSA score was high (9.4). He recalled that he telephoned Patient A, from the telephone in his consultation room. His recollection was that Patient A was unavailable to take his call but Patient A telephoned the Practice shortly after and the call was put through to Dr Lee.

30. Dr Lee stated that he would have explained to Patient A that the PSA score was borderline/high and in line with his usual practice also explained that this could be related to kidney stones, or a urinary tract infection, or possible constipation, or recent intercourse. In his written statement he said that he could not recall the precise wording that he used in this discussion with Patient A. However, in his oral evidence he was adamant that he said to Patient A that he needed to, *'stick his finger up his backside*'.

31. It was Dr Lee's usual practice to ask patients with elevated PSA whether they had symptoms of prostate problems. He would have asked Patient A to attend the Practice for a DRE. He would have explained what this entailed and that he would insert his finger into Patient A's rectum to feel his prostate. He stated that Patient A declined this. He would have asked Patient A to repeat a PSA in three to six months time to monitor the levels.

32. Dr Lee stated that, in light of Patient A's refusal of a DRE, he planned to refer him for an ultrasound scan of the prostate. He said in his written statement that he was confident that he would have actioned the referral albeit that it may have not been properly sent by the Practice, or received by Mediscan. However, under oral cross examination he accepted that it was, 'quite likely' that he had not actioned the referral in November 2017.

33. Dr Lee opened a consultation entry within the records on 27 November 2017 but he accepted that he failed to record any discussion about the potential implications of the blood test result and any necessary investigations in the midst of what was a busy day. He stated that this was a failure of record keeping rather than any indication of dishonesty.

34. Dr Lee's next involvement in Patient A's care was on 2 January 2018 when he had a telephone consultation with him to discuss symptoms of a chesty cough, aches and pains all over the body, in addition to nausea and shivering.

35. The next consultation with Patient A was at the Practice on 13 February 2018, as Patient A reported a lump and painful groin for two years. Dr Lee examined the area and noted an intact hernia orifice in the left groin and no inguinal hernia. Dr Lee arranged a

referral to Mediscan for an ultrasound of the abdomen and pelvis to investigate left groin pain and also the kidney ureter and bladder and prostate. The referral was faxed on 27 February 2018. Dr Lee stated that the referral may not have gone from the Practice or Mediscan may not have recorded it on their system. The referral had to be sent three times.

36. Dr Lee stated that in February 2018 when he amended the November 2017 record to refer to, '*u/s prostate*' he did not know about the concerns about his care that were subsequently raised by Patient A.

37. The referral reached Mediscan, and Patient A underwent the ultrasound scan. In the report dated 12 March 2018, the prostate was noted to be normal but bilateral renal stones, focal hydronephrosis in the left kidney and a left inguinal hernia were identified.

38. Dr Lee saw Patient A again at the Practice on 6 September 2019. Dr Lee actioned a fast-track referral for suspected urological cancer. Patient A received a diagnosis of prostate cancer in November 2019. Patient A then made a complaint to the Practice which was recorded in the medical records as having been received on 11 May 2020 and the Practice responded to the complaint on 9 June 2020. A clinical negligence claim then followed.

39. Dr Lee accepted that he had retrospectively edited Patient A's medical records for 27 November 2017 on three occasions in order to clarify the note, '*make routine appointment*' that he had made on that day.

40. Dr Lee accepted that he updated the medical records to reflect a telephone consultation. Dr Lee firmly maintained that he had a telephone consultation with Patient A. He said that during that telephone consultation with Patient A he discussed the PSA results with him and the need for a DRE. He stated that Patient A declined to undergo a DRE, and it was for this reason that Dr Lee opted to go down the route of a referral for a prostate ultrasound, to further investigate the raised PSA. Patient A had not raised concerns regarding Dr Lee's care in February 2018.

41. Dr Lee stated that he had retrospectively updated the medical records to provided a clear and accurate record of events. Dr Lee stated in his oral evidence that the fact that amendments had been made retrospectively would be self-evident to any clinician reading Patient A's medical records. This was because there was an icon ('ICON') that would only appear in the case of a retrospective amendment. If one clicked on the ICON it would show

the retrospective amendments. The existence of the ICON and the effect of clicking on it were accepted as agreed facts by the GMC. Dr Lee stated in his witness statement that he regretted that he had not made it clear on the face of the medical records that he had made the amendments retrospectively. In Dr Lee's oral evidence, he stated that it was a failure of recording keeping rather than an attempt to mislead. Dr Lee stated that the purpose of making the 12 and 13 May 2020 amendments was to clarify the position in light of the complaint that had been received from Patient A.

42. Dr Lee denied that his actions were dishonest.

Agreed facts between the parties

43. The agreed facts between the parties are set out as follows.

44. There was an ICON which would display on the Practice's EMIS system against the date of the relevant entry, if the record had been amended subsequently to that relevant date. By clicking on that ICON one would be taken through to the relevant amended records.

45. A referral form for an ultrasound scan was sent by fax from the Practice to Mediscan on the following dates: 13 and 27 February 2018. Another copy of the referral was sent to Mediscan by fax on 5 March 2018.

46. In relation to the entry on Patient A's medical records dated 27 November 2017 at 17:20, Dr Lee received the blood test results and had chosen the option *'Make routine appointment'* from the pre-determined drop-down list.

Documentary Evidence

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

- Patient A's medical records and consultation notes, various dates;
- Patient A's complaint letters and the Practice's response dated 9 June 2020;
- Audit report of 27 November 2017 consultation between Patient A and Dr Lee, various dates.

The Tribunal's Approach

48. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. As Ms Tanchel rightly

stated in her submissions. Dr Lee does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

49. The Tribunal had regard to the cases of *Dutta v GMC [2020] EWHC 1974 (Admin)* ('Dutta') and *Khan v GMC [2021] EWHC 374 (Admin)* ('Khan'). In Dutta, the judge stated that the Tribunal had made a fundamental error in assessing a witness's credibility based largely, if not exclusively, on their demeanour when giving evidence. The best approach from a judge was to base factual findings on inferences drawn from documentary evidence and known or probable facts.

50. As per the case of Khan, the Tribunal would not assess a witness's credibility exclusively on their demeanour when giving evidence. The Tribunal would consider all the evidence before it, before coming to a conclusion about a witness's credibility. It was open to the Tribunal not to rule out the whole of a witness's evidence based on credibility; credibility can be divisible.

51. Dr Lee was of good character. He had no previous disciplinary matters proved against him. Good character was not a defence to the Allegation Dr Lee faces, but it was relevant to the Tribunal's consideration of the case. Firstly, Dr Lee had given evidence. His good character supports his credibility and was a positive feature of Dr Lee which the Tribunal would take into account when considering whether it accepted his evidence. Secondly, the fact that Dr Lee was of good character and had no previous disciplinary findings against him may make it less likely that he acted as was alleged against him. What weight should be given to Dr Lee's good character on the facts of this particular case was a decision for the Tribunal to make. In making that assessment, it was entitled to take into account everything it had been told about Dr Lee.

52. The Tribunal bore in mind the case the legal test for dishonesty as set out by the *Supreme Court in Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67* ('Ivey v Genting'). The Tribunal must first ascertain (subjectively) the state of Dr Lee's own knowledge or belief as to the facts. The question was not whether the belief he held was reasonable, the question was whether it was genuinely held. The reasonableness of the belief was a matter of evidence going to whether he genuinely held the belief, but it was not a requirement that the belief itself must be reasonable. The Tribunal would then consider whether that conduct was

dishonest by the standards of ordinary decent people. There was no requirement that Dr Lee must appreciate that what he had done was, by those standards, dishonest.

53. The Tribunal had been referred to a number of testimonials in the context of the likelihood or otherwise of the doctor having undertaken the behaviours alleged in certain of the allegations. The Tribunal would consider these testimonials and attach what weight it considered appropriate. The Tribunal was mindful that, whilst evidence of good character might be relevant to credibility and propensity in relation to these allegations, the significance of such evidence should not be overstated, and should not detract from the primary focus on the evidence directly relevant to the alleged wrongdoing.

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

55. The Tribunal could draw reasonable inferences from the facts. However, it would not speculate and, in particular, would not speculate about what other evidence there might have been.

56. Patient A's witness statement had been admitted into evidence as hearsay. The Tribunal bore in mind that hearsay evidence must be treated with caution. The Tribunal would consider carefully what weight, if any, could be attached to it insofar as it was relevant to the Allegation and the findings the Tribunal had to make. A hearsay account could not be given the same weight as if the witness had appeared before the Tribunal and had given oral evidence on oath and been subject to questioning by the Tribunal and in cross examination. Factors that would influence the weight to be attached to this hearsay evidence included the extent to which it was supported by other evidence and whether it was consistent with that evidence. The Tribunal could also have regard to when the statement was made in relation to the events in question, whether it involved multiple hearsay and whether Patient A had any motive to conceal or misrepresent matters. The Tribunal was entitled to consider the nature of hearsay evidence relied upon: for example a signed witness statement accompanied by a statement of truth would likely be considered preferable to notes by one person of what they were told by another. Factors that would undermine the reliability of hearsay evidence, included either internal inconsistencies in the hearsay evidence and/or inconsistencies with the testimony of other witnesses.

The Tribunal's Analysis of the Evidence and Findings

Analysis

57. The various paragraphs of the Allegation flow from the factual allegations that:

- The ultrasound scan referral referred to in Patient A's medical records of 27 November 2017 (entered retrospectively by Dr Lee on 13 February 2018) was not requested by Dr Lee on 27 November 2017.
- A conversation referred to in the retrospective notes relating to 27 November 2017 entered by Dr Lee on 12 and 13 May 2020 did not happen, and that Dr Lee knew that it did not happen and therefore he acted dishonestly.

58. In the statement of Patient A (now deceased) which was admitted as hearsay evidence, Patient A asserted that no such referral or conversation took place. Dr Lee asserted that they did take place and that his failures were of poor record keeping and not dishonesty.

59. Ms Tanchel on behalf of Dr Lee and Ms Barlow on behalf of the GMC, made a number of submissions in relation to the above issues and the Tribunal's analysis of their submissions is set out below.

Preliminary Observations

60. The Tribunal first addressed certain general submissions made by Ms Tanchel and made the following preliminary observations:

- In the Tribunal's Rule 17(2)(g) determination, it had in a number of cases, determined that a properly directed Tribunal could find certain issues proven. However, that did not in any way reverse the burden of proof, which falls squarely on the GMC to prove its case on the balance of probabilities.
- The Tribunal agreed with Ms Tanchel's submission that it should not proceed from an assumption that the evidence of a particular witness was credible but should look at all the evidence in the round. The Tribunal agreed that Patient A could have been erroneous in his recollection of the events without having lied. The Tribunal evaluated the content of Patient A's witness statement in light of the fact that Ms Tanchel had not had the opportunity to cross examine Patient A and further the factors to be taken into account in the consideration of the hearsay evidence as set out above.
- Patient A's evidence may have been affected by what he was told by the oncologist and the nurse in 2019 although the Tribunal noted that in fact Patient A did have cancer and that there had been a raised PSA level of 9.4 in his blood test on 27 November 2017.

Analysis of key issues

No cancer diagnosis in March 2018.

61. Ms Tanchel submitted that Dr Lee would have had no incentive to invent the conversation about Patient A given that the March 2018 ultrasound had indicated that his prostate was normal. However, the Tribunal thought it significant that at the point when Dr Lee made the amendments on 12 and 13 May 2020 (Patient A's complaint letter having been recorded as received by the Practice on 11 May 2020) he would have been aware that Patient A had been diagnosed with terminal prostate cancer. It was reasonable to infer that Dr Lee may well have been concerned that a failure on the face of the records to take any action on 27 November 2017 in respect of a raised PSA level of 9.4 would reflect badly on him.

Failure of record keeping as opposed to dishonesty

62. Ms Tanchel submitted that Dr Lee was clarifying the medical records so that they reflected what had actually happened. She also submitted (and the Tribunal agreed with this submission) that merely because something was not set out in the notes it did not automatically follow that it did not happen. She further submitted that Dr Lee had not long since returned from holiday and had given evidence that he had had to work through more than 800 tasks and emails. She reminded the Tribunal that Dr Lee had given evidence that XXX. However, notwithstanding these submissions the Tribunal found that the retrospective amendments were not an accurate reflection of what took place and that Dr Lee knew that to be the case for the following reasons:

- Dr Lee himself had acknowledged that the potential health issue for Patient A was 'serious', which was why he stated that he remembered the alleged conversation. However, as there was such a serious issue that made it all the more likely in the Tribunal's view that if the conversation had indeed taken place, he would have included it in the contemporaneous notes.
- The contemporaneous note simply refers to a routine appointment and nothing more. In the Tribunal's view this sits oddly with and was inconsistent with the tenor and content of the detailed telephone conversation Dr Lee alleges he had with Patient A.
- On other occasions (for example when Dr Lee recorded a consultation about a chesty cough in January 2018) the contemporaneous notes are appropriately detailed.
- When he amended the notes in February 2018 to refer to the ultrasound scan Dr Lee made no reference to the alleged telephone conversation which was only

included in the notes one and two days after the Practice recorded the receipt of the complaint letter in May 2020. If, as he asserted, Dr Lee's purpose in amending the records in February 2018 was to create an accurate record it would have been logical for him at the same time to have included the contents of the 27 November 2017 telephone conversation if it had indeed taken place.

- Dr Lee conceded in oral evidence that it was '*quite likely*' that he did not make the ultrasound scan referral until February 2018. This was inconsistent with Dr Lee's assertion that the referral was prompted by Patient A's refusal to undertake a DRE in November 2017.
- It seemed to the Tribunal that if a patient had refused an examination (in this case DRE) which the doctor believed to be necessary in the context of a potential diagnosis of prostate cancer, that would be all the more reason to make a reference to it in the contemporaneous notes.
- There was no record in the medical notes to any discussions following up the alleged November 2017 conversation.
- Patient A was unequivocal in his witness statement in stating that: *"I did not call Dr Lee on 27 November 2017 to discuss the results of my blood test, I have never even phoned him before. Dr Lee never discussed the results of the blood test with me and he did not inform me of the raised PSA result."*

Significance of contemporaneous note of need for routine appointment

63. Ms Tanchel stated that Dr Lee's contemporaneous note of 27 November 2017 of the need for a routine appointment demonstrated that he was being honest. The Tribunal was of the view that this does not answer the question why Dr Lee did not refer to the potentially serious issue of the heightened PSA test result, the requirement for a DRE and the refusal of it. Indeed, the fact that he made such a note without reference to the prostate issue and the suggestion of a DRE was, in the Tribunal's view, more likely to be indicative of the fact that those matters were not raised.

Mediscan – was the 27 November 2017 referral made?

64. Notwithstanding the evidence of Mr E that fax referrals ceased as of 2016, it was clear that the February/March 2018 referral was made by fax. Further, the fact that the 2018 referral had to be made three times before it was actioned illustrated that Mediscan's adminstrative procedures for dealing with fax referrals were less than foolproof. Accordingly, the Tribunal was satisfied that there was a possibility that due to administrative errors a fax referral that a doctor had made might possibly have never been actioned.

However, the Tribunal was satisfied that it was likely that Dr Lee had not requested an ultrasound of Patient A's prostate in November 2017 for the following reasons:

- Unlike the February/March 2018 referrals where there were Docman records on EMIS for each attempted referral there was no such Docman entry for November 2017.
- There was no record of any follow-up as to why the ultrasound had not taken place.
- Patient A's statement was clear that Dr Lee had not discussed the results of the blood test with him and had not arranged for an ultrasound scan of his prostate at that time.
- Dr Lee admitted in cross examination that it was '*quite likely*' that he had not requested an ultrasound of Patient A's prostate of November 2017.

Complaint not legal claim

65. Ms Tanchel stated that it was accepted by the GMC that in its application to admit Patient A's witness statement as hearsay, the GMC had said that the response of Dr Lee had been to matters raised in context of a legal claim. However, this was not correct; his response was to the May 2020 letter of complaint from Patient A. The Tribunal was satisfied that Ms Tanchel's submission to this effect was correct. However, neither paragraph 4(c) nor any other part of the Allegation depended upon legal proceedings having been issued or threatened. Paragraph 4(c) referred only to concerns having been raised by Patient A regarding the care and treatment that Dr Lee provided.

66. The Tribunal noted that what it was being asked to consider related to concerns having been raised by Patient A and not to legal proceedings issued by Patient A.

Why would Dr Lee have asked for a scan if Patient A had not refused a DRE?

67. Ms Tanchel submitted that the reason Dr Lee would have referred Patient A for a scan would have been because he had refused a DRE. However, the Tribunal was not satisfied that a DRE would have been sufficiently definitive that no further investigation would have been necessary. Indeed Dr B stated in his evidence that a DRE would not be sufficient on its own to diagnose a cancer. Moreover, the Tribunal has concluded that Dr Lee did not refer Patient A for an ultrasound scan on 27 November 2017. Accordingly, the first time Dr Lee had made such a referral was on 13 February 2018. The Tribunal inferred from this that Dr Lee took the opportunity of the ultrasound that was being undertaken to tag on the request for an examination of the prostate. The likelihood of this inference being correct was supported by the following:

- It was only on 13 February 2018 that the record of a referral for an ultrasound scan was made.
- It was a reasonable inference that when Dr Lee saw Patient A on 13 February 2018 he reviewed his records and at that point picked up on the raised PSA level.
- There was no indication in the medical records of that time of any discussion around Patient A's prostate.
- When Patient A discussed the results of the ultrasound scan with Dr C on 26 March 2018, they spoke about his groin pain and his kidneys. However, there was, per the records, no mention of his prostate. If Patient A had been previously made aware of his raised PSA level and potential prostate cancer issue, Patient A would have been likely to have discussed that with Dr C.

The purpose of the 2018 scan

68. Ms Tanchel submitted that it cast doubt on the credibility of Patient A's evidence that he had recollected that the purpose of 2018 scan was for examination of his kidneys rather than his groin. In fact, the referral form included amongst other things a request for a kidney scan and the medical records of the consultation with Dr C reporting on the scan make mention of a discussion about kidney stones. The Tribunal was of the view that Patient A's evidence was not inconsistent on this point.

What Dr Lee knew when he made May 2020 amendments

69. Ms Tanchel submitted that by the time he made the May 2020 amendments to the records, Dr Lee would have known that the March 2018 ultrasound indicated no problem with the prostate. However, in the Tribunal's view this ignores the crucial point that Practice had received a serious complaint alleging a missed diagnosis of a terminal cancer based on an elevated PSA test which the patient said had not been actioned. The May 2020 additions were then used to form the essence of the response which Dr Lee has admitted he wrote or caused to be written to the letter of complaint. Even if, as seemed unlikely to the Tribunal, the oncologist and nurse were incorrect in their assumption in connecting the raised PSA level to the ultimate diagnosis of Patient A's prostate cancer this would still have been a matter of considerable concern to Dr Lee. The report of their comments by Patient A did, as Ms Tanchel suggested, amount to multiple hearsay but it was not disputed that Patient A did indeed have prostate cancer. Nor was there any dispute that the November 2017 blood test disclosed an elevated PSA level.

Timing of Patient A's witness statement

70. Ms Tanchel submitted that Patient A's witness statement was made in November 2023 some six years after the event occurred. She submitted that the argument put forward by the GMC that it was buttressed by the fact that it was consistent with Patient A's complaint letter of May 2020 was circular. However, the Tribunal took the view that its consistency with the letter of complaint was relevant in that the letter of complaint was written much nearer in time to the original events of November 2017.

The fullness of doctors' notes

71. Ms Tanchel stated that Dr C had, on at least one ocassion, made a less than full note of a consultation, illustrating the fact that doctors could make incomplete notes without being dishonest. The Tribunal determined that the issue was not whether Dr C had made full notes. The question the Tribunal had to consider was the accuracy or otherwise of the retrospectively amended entries and whether Dr Lee had been dishonest in making them. The Tribunal was of the view that given the elevated PSA level test result and the fact that Patient A had allegedly declined the necessary investigation, it would, for the reasons previously stated, be a reasonable inference to assume that if that had indeed occurred, Dr Lee would have made a point of reflecting it in the contemporaneous notes.

A serious complaint?

72. Ms Tanchel submitted that it was relevant that letter of May 2020 came from Patient A himself and was in the nature a complaint rather than a formal legal notice and that the GMC had adduced no evidence of the level of seriousness of the complaint. However, the Tribunal noted that it was not being asked to determine whether the complaint was 'serious'. A doctor receiving a complaint of an undiagnosed life-limiting cancer (which it was alleged could and should have been diagnosed at an earlier opportunity due to the elevated PSA level) would have given rise to warning signs and would have been likely to have been taken very seriously.

The 9 June 2020 response to the letter of complaint

73. Ms Tanchel submitted that Dr Lee did not write the letter of response ('Letter') and that it does not state that the records were contemporaneous. However, there was a clear inference from the Letter that the wording in relation to 27 November 2017 under the heading *'Dr Lee'* was drafted by Dr Lee. It was written in the first person and it was described as a '*statement from the Clinicians'*, Dr Lee and Dr C. Moreover, Dr Lee had admitted in respect of Paragraph 3 of the Allegation that he wrote or caused the relevant words to be written.

74. The Tribunal concluded that Dr Lee had written or caused to be written his response to the complaint, which was included in the Letter, which was prepared by Ms I, Operations Business Manager, the Practice.

The transparency of the retrospective amendments?

75. Ms Tanchel submitted that the retrospectivity of the amendments made by Dr Lee in February 2018 and May 2020 was transparent for the following reasons:

- Dr Lee in his oral evidence indicated that he had told his colleagues that he had retrospectively amended the records at a meeting after receipt of the letter of complaint. (Dr C had no recollection of the meeting. Dr B recalled the meeting. However, the issue as to whether Dr Lee disclosed at that meeting that the records had been amended retrospectively was not put to Dr B).
- The ICON would have made it obvious to any clinician that the retrospective amendments had been made.

However:

- The Tribunal noted that Dr Lee had made no mention in his written statement of having raised this issue in the meeting.
- Nor had Dr Lee raised the issue of the ICON in his witness statement (his explanation was that he had only recently been reminded of it when he used the EMIS system in a locum post).
- It was not clear on the face of the ICON what it signified and indeed Ms D the Practice Manager clearly did not appreciate its significance.
- The medical notes that Dr Lee added in February 2018 and May 2020 did not on their face make clear that they had been retrospectively incorporated.

On balance the Tribunal concluded that Dr Lee had not been as transparent as he should have been as to the retrospectivity of the amendments. However, it was not necessary for the Tribunal to come to that conclusion in order to establish that Dr Lee knew that he had not had a telephone conversation with Patient A, nor discussed the Results with him, nor discussed and/or recommended a DRE and that Patient A had not declined a DRE. As per paragraph 62, the Tribunal was satisfied that Dr Lee knew all these things to be incorrect, notwithstanding what he had said in the medical notes and the Letter. That was sufficient to

establish proof of the relevant paragraphs of the Allegation whether or not the retrospectivity of the amendments was transparent.

Dr Lee's approach to these proceedings

76. Ms Tanchel submitted that Dr Lee's approach to these proceedings demonstrated his fairness and honesty. For example:

- A number of facts had been agreed which in each case accorded with what he had suggested.
- He had acknowledged that Patient A was a pleasant man with whom he had a good relationship.
- He had admitted in cross examination that it was '*quite likely*' that he had not made the November 2017 referral.

77. Against these factors the Tribunal weighed the following:

- There had been a number of issues (the ICON, his assertion that he had told his colleagues at their meeting about the retrospectivity of the amendments, his holiday in Malaysia and the effect of XXX) which Dr Lee had first raised in the course of his oral evidence which the Tribunal might have expected to form part of his previous witness statement.
- He had said in his witness statement that '*I cannot recall the precise wording I used in this discussion with Patient A'* whereas in his oral testimony Dr Lee was adamant that he had specifically said to Patient A that he needed to, '*stick his finger up his backside'*.
- He had stated in his written statement that '*I am confident that I would have actioned the referral'* on 27 November 2017 whereas in his oral evidence he stated that it was '*quite likely*' that he did not.

Character of Dr Lee

78. Ms Tanchel had submitted, and it was accepted by the Tribunal that it was in Dr Lee's favour that there had been no prior regulatory proceedings against Dr Lee despite him being a doctor for some 30 years. Ms Barlow on behalf of the GMC, accepted Dr Lee was a man of previous good character.

79. Ms Tanchel also stated that it would make no sense for a doctor at the end of his career to lie in respect of treatment of a single patient. However, the Tribunal was of the view that it was plausible that Dr Lee would not want to end his career with a successful clinical negligence claim being made against him.

Testimonials

80. The Tribunal believed that Dr Lee's long career, and his unblemished record should count in his favour. Further, the Tribunal had received a number of testimonials testifying to Dr Lee's honesty, bluntness and good character. In Dr J's testimonial dated 21 August 2024 he stated that, '*dishonesty would be wholly inconsistent with his character*'. In Dr G's testimonial dated 26 October 2024, he stated '*I completely and strongly support him in his honesty, personal integrity and professionalism as a doctor and as a person. I would be delighted to be his patient if I live in Manchester knowing that I will be cared for with compassion, kind consideration and as 'his family'*.

81. The Tribunal was mindful that whilst it may be out character for a doctor to commit an act of dishonesty, it was nonetheless possible that he might have done so. Whilst giving due weight to the testimonials and Dr Lee's previous good character this would not retract from the primary focus on the evidence directly relevant to the alleged wrongdoing.

Patient A's relationship with Dr Lee

82. Ms Barlow submitted that Dr Lee had stated that Patient A was a '*nice man*' with whom he had a good relationship. She therefore suggested that this rendered it unlikely that he was a patient likely to raise problems unless they were genuine. The Tribunal was not persuaded that there was significant force in this argument.

No repetition of blood test

83. Ms Barlow submitted that Dr Lee had conceded in his evidence that following the raised PSA test result Patient A should have had repeat blood tests, every three to six months, but this was not done. In the Tribunal's view this supports the finding that no action was taken in November 2017 as result of the raised PSA test result.

The 2 January 2018 consultation

84. Ms Barlow submitted that in Patient A's medical records dated 2 January 2018 a note of a telephone consultation with Dr Lee made no mention of any subsequent conversations

regarding the ultrasound scan. The Tribunal was of the view that if such an investigation had been referred then it would have been likely to have been discussed on that occasion.

Discussion of 2018 ultrasound scan

85. Ms Barlow submitted that the entry in the medical records relating to the scan, whilst referring to the need for an investigation into a potential hernia, made no reference to the raised PSA level and potential examination of Patient A's prostate. The Tribunal was of the view that this supported the inference that Dr Lee had tagged the investigation of the prostate onto the February 2018 ultrasound referral (which was being undertaken for a different purpose) without addressing this with Patient A.

Dishonesty

86. The Tribunal considered whether, if it found that Dr Lee knew that matters he set out in the medical records and the letter of 9 June 2020 were incorrect, would ordinary, decent people view him as having acted dishonestly? It determined that ordinary, decent people would view the deliberate falsification of medical records and a deliberate attempt to mislead Patient A in response to his complaint as dishonest.

Summary

87. In summary the Tribunal determined that the retrospective additions to the records referred to in paragraphs 1(a), 1(b) and 1(c) of the Allegation were unlikely to have arisen merely from poor contemporaneous record keeping. Rather, the Tribunal was satisfied for the following principal reasons that Dr Lee knew that they were incorrect and nonetheless made the amendments:

- If on 27 November 2017 Dr Lee had had the telephone conversation with Patient A in which Patient had refused a DRE he would have been likely to have made a contemporaneous note, due to the significance of that refusal in the context of a potentially serious condition.
- Dr Lee had not requested an ultrasound of Patient A's prostate on 27 November 2017 – the Tribunal's reasoning on this point being set out in Paragraph 64.
- When Dr Lee made the amendment on 13 February 2018 to refer to the alleged ultrasound scan referral on 27 November 2017 (which Dr Lee now admitted in oral evidence he '*quite likely*' did not make on that date) he had made no reference at that stage to the telephone consultation nor to the refusal of a DRE.
- When Dr Lee made the amendment on 12 May 2020, he failed to include reference to the refusal of the DRE which was only added in the subsequent note of 13 May 2020.

- Dr Lee had himself acknowledged the importance of making contemporaneous records and asserted that was his usual practice and yet on three occasions he had made non-contemporaneous amendments and had not in the wording of those amendments made it clear that they were being made retrospectively.
- There was nothing in the medical notes to indicate any follow-up of the conversation that Dr Lee alleged had occurred on 27 November 2017.
- The contemporaneous notes (as opposed to the retrospective amendments) accord with the statement of Patient A.

88. In the light of the above analysis the Tribunal concluded that Dr Lee had not requested an ultrasound scan of Patient A's prostate on 27 November 2017 and that the telephone conversation alleged in the medical notes to have occurred on 27 November 2017 added on 12 and 13 May 2020 did not occur. Accordingly, the Tribunal determined the outstanding paragraphs of the Allegation as follows:

Paragraph 4(a)(i)

89. The Tribunal was satisfied that Dr Lee knew that on 27 November 2017 he had not requested an ultrasound of Patient A's prostate.

Accordingly, the Tribunal found Paragraph 4(a)(i) of the Allegation proved.

Paragraph 4(a)(ii)

90. The Tribunal was satisfied that Dr Lee knew that on 27 November 2017 he had not had a telephone consultation with Patient A.

Accordingly, the Tribunal found Paragraph 4(a)(ii) of the Allegation proved.

Paragraph 4(a)(iii)

91. The Tribunal was satisfied that Dr Lee knew that on 27 November 2017 he had not discussed the Results with Patient A.

Accordingly, the Tribunal found Paragraph 4(a)(iii) of the Allegation proved.

Paragraph 4(a)(iv)

92. The Tribunal was satisfied that Dr Lee knew that on 27 November 2017 he had not discussed with and/or recommended a DRE to Patient A.

Accordingly, the Tribunal found Paragraph 4(a)(iv) of the Allegation proved.

Paragraph 4(b)

93. The Tribunal was satisfied that Dr Lee knew that on 27 November 2017 Patient A had not declined to undergo a DRE.

Accordingly, the Tribunal found Paragraph 4(b) of the Allegation proved.

Paragraph 4(c)

94. The Tribunal was satisfied that Dr Lee knew concerns had been raised by Patient A regarding the care and treatment he provided and/or did not provide to him at the time he wrote the Letter or caused the Letter to be written.

Accordingly, the Tribunal found Paragraph 4(c) of the Allegation proved.

Paragraph 4(d)

95. The Tribunal was satisfied that Dr Lee knew that the Referral was the first time that he had referred Patient A for an ultrasound scan of his prostate.

Accordingly, the Tribunal found Paragraph 4(d) of the Allegation proved.

Paragraph 5(a)

96. The Tribunal had found that Dr Lee knew that he had not requested an ultrasound scan of Patient A's prostate on 27 November 2017. On that basis the first element of the test of dishonesty in *Ivey v Genting* (subjective knowledge on the part of Dr Lee) is satisfied. On the basis that despite the note he made Dr Lee knew that he had not requested an ultrasound of Patient A's prostate on that date, the Tribunal also concluded that he had acted dishonestly by the standards of ordinary decent people.

Accordingly, the Tribunal found Paragraph 5(a) of the Allegation proved.

Paragraph 5(b)

97. The Tribunal had found that Dr Lee knew that he had not had a telephone consultation with Patient A on 27 November 2017. On that basis the first element of the test of dishonesty in *Ivey v Genting* (subjective knowledge on the part of Dr Lee) is satisfied. On

the basis that despite the note he made Dr Lee knew that he had not had the telephone conversation, the Tribunal also concluded that he had acted dishonestly by the standards of ordinary decent people.

Accordingly, the Tribunal found Paragraph 5(b) of the Allegation proved.

Paragraph 5(c)

98. The Tribunal had found that Dr Lee knew that on 27 November 2017 he had not discussed with and/or recommended a DRE to Patient A and that on 27 November 2017, Patient A had not declined to undergo a DRE. On that basis the first element of the test of dishonesty in *Ivey v Genting* (subjective knowledge on the part of Dr Lee) is satisfied. On the basis that despite the notes he made Dr Lee knew that he had not discussed with and/or recommended a DRE to Patient A and that Patient A had not declined to undergo a DRE, the Tribunal also concluded that he had acted dishonestly by the standards of ordinary decent people.

Accordingly, the Tribunal found Paragraph 5(c) of the Allegation proved.

Paragraph 5(e)

99. The Tribunal has found that Dr Lee knew that he had not had the telephone conversation with Patient A, not discussed the Results with Patient A, not discussed with and/or recommended a DRE to Patient A, and that Patient A had not declined a DRE as per Paragraphs 4 (a)(ii), 4a(iii), 4 (a)(iv) and 4 b of the Allegation. On that basis the first element of the test of dishonesty in *Ivey v Genting* (subjective knowledge on the part of Dr Lee) is satisfied. On the basis that he had written or caused the wording of the Letter at Paragraph 3 of the Allegation, notwithstanding that on the Tribunal's findings he knew that wording to be untrue, the Tribunal also concluded that he had acted dishonestly by the standards of ordinary decent people.

Accordingly, the Tribunal found Paragraph 5(e) of the Allegation proved.

Paragraph 5(f)

100. The actions admitted in Paragraph 1 of the Allegation were the addition of the notes on 13 February 2018 (u/s prostate), 12 May 2020 (telephone consultation) and 13 May 2020 (Patient A declining a DRE).

The 13 February 2018 note preceded any complaint by Patient A. However, the Tribunal was of the view that the most likely explanation for the retrospective addition of the note as to the ultrasound scan on 27 November 2017, was that Dr Lee had only then appreciated the significance of his lack of action in respect of 27 November 2017 PSA result. The Tribunal concluded that its purpose was to forestall potential criticism of Dr Lee not having made a referral immediately following the November 2017 PSA results. The May 2020 notes followed very shortly after the receipt by the Practice of Patient A's letter of complaint which was reported as received on 11 May 2020. The Tribunal was satisfied that such a complaint (particularly one relating to an alleged non diagnosis of a potentially terminal illness) would be taken very seriously, notwithstanding that it did not constitute or threaten a legal claim. Accordingly, the Tribunal was satisfied that the addition of medical notes on 12 May and 13 May 2020 was designed to avoid potential criticism of the care and treatment Dr Lee provided and/or did not provide to Patient A.

101. With regard to Paragraph 3 of the Allegation, the Letter was in response to the letter of complaint to the effect amongst other things that Patient A's blood test of 27 November 2017 showed an elevated PSA level indicative of potential prostate cancer which should have been acted upon at that time. Dr Lee's assertion that he requested Patient A to attend surgery for a DRE and that Patient A did not want a prostate examination (which conversation the Tribunal had found had not occurred) was in the Tribunal's view designed to deflect blame and hence avoid criticism of the care and treatment provided.

Accordingly, the Tribunal found Paragraph 5(f) of the Allegation proved.

The Tribunal's Overall Determination on the Facts

102. The Tribunal has determined the facts as follows:

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

1. On 27 November 2017, you made an entry within Patient A's medical records that you had reviewed his blood test results ('the Results'). You subsequently edited this entry, in that you added a note on:

    a. 13 February 2018, which stated 'u/s scan prostate', indicating that an ultrasound scan was to be undertaken; **Admitted and found proved**

b. 12 May 2020, which stated you had had a telephone consultation with Patient A on 27 November 2017; Admitted and found proved

c. 13 May 2020, which stated that Patient A 'does not want a DRE'. Admitted and found proved

2. In or around February 2018, you completed a referral to Mediscan ('the Referral'):

a. requesting an ultrasound scan of Patient A's abdomen, pelvis, ~~RUB~~ KUB and prostate, and Amended under Rule 17(6). Admitted and found proved

b. ~~you wrote 'Urgent not heard anything' on the Referral~~. Deleted after a successful Rule 17(2)(g) application

3. Within a letter dated 9 June 2020 ('the Letter'), you wrote or caused to be written: 'I requested for you to attend surgery for a digital rectal examination (DRE) to examine your prostate but you phoned me to discuss the results. I recall that you did not want a prostate examination. At the time you did not report any symptoms of prostate enlargement or prostate cancer'.

Admitted and found proved

4. You knew that:

a. on 27 November 2017 you had not:

i. requested an ultrasound of Patient A's prostate; Determined and found proved

ii. had a telephone consultation with Patient A; Determined and found proved

iii. discussed the Results with Patient A; Determined and found proved

iv. discussed with and/or recommended a Digital Rectal Examination ('DRE') to Patient A; Determined and found proved

b. on 27 November 2017, Patient A had not declined to undergo a DRE; Determined and found proved

c. concerns had been raised by Patient A regarding the care and treatment you provided and/or did not provide to him at the time you wrote the Letter or caused the Letter to be written; Determined and found proved

d. the Referral was the first time that you had referred Patient A for an ultrasound scan of his prostate; Determined and found proved

e. ~~including the words 'Urgent not heard anything' on the Referral would give the false impression that you had previously referred Patient A for an ultrasound scan on his prostate~~. Deleted after a successful Rule 17(2)(g) application

5. Your actions at paragraph:

a. 1.a. were dishonest by reason of paragraph 4.a.i.; Determined and found proved

b. 1.b. were dishonest by reason of paragraph 4.a.ii.; Determined and found proved

c. 1.c. were dishonest by reason paragraphs 4.a.iv. and 4.b.; Determined and found proved

d. ~~2. were dishonest by reason of paragraphs 4.d. and 4.e.~~; Deleted after a successful Rule 17(2)(g) application

e. 3. were dishonest by reason of paragraphs 4.a.ii., 4.a.iii., 4.a.iv., 4.b. and ~~4.e.~~; Rule 17(2)(g) application granted in respect of cross reference to Paragraph 4(c). Remainder of Paragraph 5(e) determined and found proved

f. 1., 2. and 3. were carried out to avoid potential criticism of the care and treatment you provided and/or did not provide to Patient A. Rule 17(2)(g) application granted in respect of the cross reference to Paragraph 2. Remainder of Paragraph 5(f) 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 - 30/04/2025

103. 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 Lee's fitness to practise is impaired by reason of misconduct.

The Evidence

104. 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.

105. Dr Lee provided a reflective statement to the Tribunal, dated 25 April 2025. In addition, he provided certificates of Continual Professional Development ('CPD') courses completed in March 2025.

106. The Tribunal also received in support of Dr Lee six testimonials from colleagues and friends, all of which it has read.

Submissions

107. On behalf of the GMC, Ms Barlow submitted that Dr Lee's actions amount to serious misconduct and that his fitness to practise is currently impaired. Throughout her submissions, Ms Barlow referred the Tribunal to relevant authorities and paragraphs of Good Medical Practice (2013) ('GMP').

108. Ms Barlow submitted that by acting dishonestly on three separate occasions, Dr Lee has breached a fundamental tenet of the profession. She stated that in a case of dishonesty in the circumstances found by the Tribunal, namely dealing with medical records directly and on three separate occasions, it is almost inevitable that a finding of misconduct must follow.

109. Ms Barlow submitted that the issue of impairment is a matter for the Tribunal's own judgement, and should be considered in relation to the statutory overarching objective. She submitted that this was not a clinical case, but rather overwhelmingly a case which deals with

public confidence in the medical profession and the maintenance of proper professional standards and conduct for the members of the profession as a whole.

110. Ms Barlow submitted that Dr Lee has brought the medical profession into disrepute and has breached one of the fundamental tenets of the medical profession. She submitted that confidence in the profession would certainly be undermined if a finding of impairment were not made in a case which involved dishonesty on three separate occasions in relation to entries in a patient's medical records.

111. Ms Barlow submitted that dishonesty constitutes a breach of a fundamental tenet of the profession and lies at the top end of the spectrum of gravity of misconduct. She stated that the overarching concern is the public interest, maintaining confidence in the profession and upholding standards and not the interest of the individual practitioner. She accepted that a finding of impairment does not automatically follow from a finding of dishonesty.

112. Ms Barlow submitted that the dishonesty in this case was not an isolated incident, and this should be considered alongside other factors such as Dr Lee's attitude, his testimonials, and the risk of repetition. She submitted that the balance of those matters falls overwhelmingly in favour of a finding of impairment.

113. Ms Barlow submitted that Dr Lee had behaved dishonestly by knowingly and deliberately putting false information in medical records on three separate occasions, which occurred some distance apart. Further, he repeatedly breached a fundamental tenet of the profession. She submitted that Dr Lee's fitness to practise is currently impaired by reason of that dishonesty. She stated that his actions are likely to bring the profession into disrepute and undermine public confidence in the profession.

114. On behalf of Dr Lee, Ms Tanchel submitted that Dr Lee does not challenge that the findings of this Tribunal amount to misconduct. She stated that this did not equate to an acceptance by Dr Lee of the findings of fact, but an acceptance of the reality that those facts that had been found proved amount to misconduct.

115. Throughout her submissions, Ms Tanchel referred the Tribunal to relevant authorities that the Tribunal should consider.

116. Turning to the matter of impairment, Ms Tanchel submitted that the Tribunal should take into consideration that this is a public interest case rather than a patient safety issue.

117. Ms Tanchel submitted that whatever this Tribunal concludes as to whether this in fact was an isolated incident or a series of incidents, what is plainly unarguable is that this related to circumstances involving a single patient in the context of a career which commenced in 1996 as a GP, and ended shortly after the occurrence of these events. Further, she highlighted that there has been a passage of more than seven years since the first alteration in 2018, and close to five years since the subsequent alterations in 2020.

118. Ms Tanchel submitted that there is absolutely no evidence upon which this Tribunal could conclude that there is a risk of repetition of this behaviour. She stated that the fact Dr Lee is no longer a practising clinician was a minor consideration for the Tribunal, but should be taken into account when balancing the risk to the public and public interest. She submitted that there has been no repetition since 2020, and invited the Tribunal to consider the salutary effect of these proceedings on any clinician.

119. Ms Tanchel invited the Tribunal to consider the Sanctions Guidance (2024) ('the SG') in particular paragraphs 30 to 41. She highlighted that these dealt with remediation and referred to the documents submitted on behalf of Dr Lee. She submitted that Dr Lee acknowledges the findings of the Tribunal, although he does not concede that he was dishonest. She directed the Tribunal to take into consideration the significant steps Dr Lee has taken to understand the importance of the public interest and to understand why the public may be concerned about dishonest conduct on part of a clinician. She submitted that the Tribunal has seen Dr Lee's reflective statement and should take note of his understanding of why dishonest conduct, even if it is not within the clinical context, is important, and why it is of concern to the profession

120. Ms Tanchel also directed the Tribunal to take into account the CPD that Dr Lee has undertaken and his reflections on it in the context of the findings made by this Tribunal.

121. Ms Tanchel then turned to the matter of the rejected defence. She submitted that Dr Lee continues to deny his dishonesty. She stated that Dr Lee has taken the time to review his own performance and conduct by attending courses, listening to the discussions and engaging in reflection, to the extent that he understands the significance of the failure to make full contemporaneous records. Ms Tanchel submitted that the fact of undertaking the

courses, and the reflective process, shows a level of insight into why it is inappropriate to make entries into records retrospectively, even without accepting the dishonesty.

122. Ms Tanchel submitted that whilst Dr Lee does not accept the facts as found proven by the Tribunal, he does accept that had he been dishonest, then this would amount to impropriety. She submitted that there is insight to the extent that Dr Lee obviously understands that dishonest behaviour is not acceptable. However, she stated that the difficulty in this case is whether it would be a fair trial if a clinician were not able to properly defend themselves for fear of later increased repercussions. Ms Tanchel invited the Tribunal to consider with great care whether, because Dr Lee continues to maintain his innocence of dishonesty, that must inevitably lead to a finding of impairment. She summarised the principles laid out in the case of *Sawati v GMC* [2022] EWHC 283 (Admin) as to the effect of a rejected defence and the caution that a Tribunal should exercise before determining that the maintenance of the defence should be construed as indicative of a lack of insight. Thus, Dr Lee's maintenance of his defence should not be construed as demonstrating a lack of insight. She submitted that Dr Lee had shown a clear understanding of the implications of the determination reached by the Tribunal on the facts notwithstanding that he did not agree with the conclusions the Tribunal had reached. She invited the Tribunal to consider the testimonials, and reflective statement submitted by Dr Lee.

The Relevant Legal Principles

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

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

125. The Tribunal must determine whether Dr Lee's fitness to practise is currently impaired, taking into account his conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

126. The Tribunal was reminded that whilst there is no statutory definition of impairment the guidance provided by Dame Janet Smith in the *Fifth Shipman report* as adopted by the *High Court in CHRE v NMC and Paula Grant* [2011] EWHC 927 (Admin) ('Grant') would be of assistance in its consideration of impairment. In particular the Tribunal should consider whether its finding of facts showed that Dr Lee's fitness to practise is impaired in the sense that he:

> *'a. Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. Has in the past and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

127. The Tribunal was advised that the purpose of fitness to practise hearings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. Consequently, the test of current impairment is a forward looking one.

128. This case involves a rejected defence in respect of an allegation of dishonesty. The Tribunal considered the factors for consideration in respect of the approach for the Tribunal to adopt to a rejected defence as set out by Mrs Justice Collins in the High Court in the case of *Sawati* and summarised as follows:

> '*109. In short, before a Tribunal can be sure of making fair use of a rejected defence to aggravate sanctions imposed on a doctor, it needs to remind itself of Lord Hoffmann's starting place that doctors are properly and fairly entitled to defend themselves, and may then find it helpful to think about four things: (i) how far state of mind or dishonesty was a primary rather than second-order allegation to begin with (noting the dangers of charging traps) – or not an allegation at all, (ii) what if anything the doctor was positively denying other than their own dishonesty or state of knowledge;*

(iii) how far 'lack of insight' is evidenced by anything other than the rejected defence and (iv) the nature and quality of the defence, identifying clearly any respect in which it was itself a deception, a lie or a counter-allegation of others' dishonesty.

110. These are all evaluative matters. Tribunals need to make up their own minds about them, and their relevance and weight, on the facts they have found. But they do need to direct their minds to the tension of principles which is engaged, and check they are being fair to both the doctor and the public. They need to think about what they are doing before they use a doctor's defence against them, to bring the analysis back down to its simplest essence.'

129. The Tribunal has borne in mind all three limbs of the statutory overarching objective:

- to protect and promote the health, safety and wellbeing 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 the medical profession.

The Tribunal's Determination on Impairment

Misconduct

130. In determining whether Dr Lee's fitness to practise is impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amount to misconduct.

131. The Tribunal had regard to paragraphs 19, 65, 68 and 71 of GMP, which provide:

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

68 *You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.*

…

71 *You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.*

a You must take reasonable steps to check the information is correct.

b You must not deliberately leave out relevant information.'

132. The Tribunal was satisfied that Dr Lee's actions in dishonestly amending medical records on three separate occasions was misconduct. Whilst dishonesty can occur in a variety of ways, in the Tribunal's view, Dr Lee's misconduct was serious. In reaching this conclusion, the Tribunal noted that on 13 February 2018, 12 May 2020 and 13 May 2020, he dishonestly altered records relating to an appointment on 27 November 2017. It also took into account that two of the revisions occurred after Patient A raised concerns about his care.

133. The Tribunal was satisfied that fellow practitioners would be shocked to learn what Dr Lee had done and would agree that his conduct was unacceptable. The Tribunal was satisfied that Dr Lee's conduct was in direct breach of the paragraphs of GMP set out above, because it involved serious dishonesty and so breached the trust the public places in its doctors.

134. The Tribunal also noted that Dr Lee accepted that his conduct as found proved by the Tribunal would amount to misconduct.

135. Therefore, the Tribunal has concluded that Dr Lee's conduct fell sufficiently short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct.

<u>Impairment by reason of misconduct</u>

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

137. The Tribunal first considered the categories of impairment set out by Dame Janet Smith in her fifth Shipman report and adopted in *Grant*. It concluded that three of the four limbs of the test were engaged. The Tribunal considered that Dr Lee's conduct brought the medical profession into disrepute and that he had breached a fundamental tenet of the profession. The Tribunal also noted that Dr Lee has been found to have acted dishonestly.

138. The Tribunal considered whether Dr Lee's misconduct was capable of being remediated, has been remediated, and whether it was likely to be repeated. In so doing, it considered whether there was evidence of Dr Lee's insight into his misconduct and any steps he has taken to remediate it.

139. The Tribunal was mindful that dishonesty is difficult to remediate but not impossible. It looked for evidence of insight, remediation and the likelihood of repetition and balanced those against the three limbs of the statutory overarching objective.

140. In considering the issue of insight, the Tribunal had regard to the reflective statement submitted by Dr Lee. It considered that Dr Lee has shown an understanding of the importance of honesty and probity in dealings with patients and colleagues. The Tribunal noted that Dr Lee has undertaken some targeted remedial activities, which were relevant to the matters before this Tribunal, particularly his recent attendance on a probity and ethics course.

141. The Tribunal also took into account the testimonials submitted on behalf of Dr Lee, which showed Dr Lee to be an experienced and well thought of doctor and friend. It also acknowledged Dr Lee's previously unblemished record.

142. The Tribunal took into consideration Dr Lee's denial of the Allegation, and his maintained position that he did not act dishonestly. The Tribunal considered that, per *Sawati,* this rejected defence had no impact on its assessment of his insight. Dr Lee is entitled to defend himself against an allegation, and it would be wrong to expect him to completely change his position following a finding of fact. Further, it would be wrong to hold this against

him as a lack of insight. Dr Lee does not need to accept the Tribunal's findings of fact in order to demonstrate insight.

143. However, the Tribunal was of the opinion that Dr Lee still lacks insight into the impact of his actions on others, particularly the impact on Patient A and the wider profession. The Tribunal was concerned that Dr Lee, in his oral evidence at the facts stage, sought to place blame on Patient A, and stated that Patient A had *'stabbed [him] in the back'*. It was clear to the Tribunal that Dr Lee has not reflected fully on the impact of his actions on Patient A. Whilst Dr Lee has considered honesty in a general sense and the need to be honest in his work, he has not fully explored honesty in relation to the impact that dishonest conduct has on the reputation of the profession and, most importantly, the impact it would have on his patients.

144. The Tribunal next considered the risk of repetition. The Tribunal was satisfied that there was not a high risk that Dr Lee would behave in this manner again in the future, as he understands the significance of good record keeping. However, it could not be satisfied that Dr Lee has sufficient insight into the impact of his actions. Therefore, the Tribunal was unable to conclude at this stage that the risk of repetition was low.

145. In considering whether Dr Lee's fitness to practise is currently impaired, the Tribunal balanced his limited insight and the assessed limited risk of repetition against the overarching objective.

146. The Tribunal considered that Dr Lee's acts of dishonesty would damage public confidence in the profession if a finding of impairment was not made. The Tribunal was satisfied that a member of the public in full knowledge of the facts of the case would be extremely concerned about a doctor acting in the way Dr Lee did and would find it difficult to understand why a Tribunal would not find that his fitness to practise was impaired. The Tribunal was also of the view that given its findings of fact and serious misconduct, a finding of impairment of fitness to practise was necessary to promote and maintain proper standards of conduct for the medical profession. The Tribunal was not satisfied that this was a sufficiently exceptional case that a finding of impairment should not be made in the light of its findings of serious dishonesty in respect of the accuracy of medical records.

147. The Tribunal has therefore determined that Dr Lee's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 02/05/2025

148. Having determined that Dr Lee'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

149. On behalf of the GMC, Ms Barlow submitted that the appropriate and proportionate sanction in this case was one of erasure. She directed the Tribunal to relevant sections of the Sanctions Guidance (2024) ('the SG') and the Tribunal's previous determinations.

150. Ms Barlow submitted that Dr Lee behaved dishonestly by knowingly and deliberately inputting false information onto Patient A's medical records on three separate occasions and then repeating that in his response letter to Patient A. She submitted that, in doing so, Dr Lee breached a fundamental tenet of the profession.

151. Ms Barlow submitted that taking no action would not be appropriate in this case and conditions would neither be appropriate nor workable. She submitted that erasure is the only proper sanction that would meet the overarching objective.

152. Ms Barlow submitted that the Tribunal should consider the identified breach of a fundamental tenet of the profession. She stated that doctors should accurately record their interactions with and treatment of a patient, and not retrospectively amend records to cast a favourable light on any error or omission. Further, doctors should not dishonestly respond to a patient complaint, nor should they falsify records in order to support that contention. She submitted that those actions would undoubtedly seriously damage the reputation of the profession and undermine it in the eyes of the public.

153. Ms Barlow submitted that, whilst there was no admission of dishonesty by Dr Lee, there was no suggestion that this was an aggravating factor of the case. However, she stated that this does deprive Dr Lee of the mitigation that early acceptance would provide.

154. Ms Barlow stated that there is evidence of some insight, and the Tribunal has assessed the risk of repetition as neither high nor low. She submitted that the Tribunal should

have this in mind, while considering the fundamental aspects of the role of a doctor, including being trustworthy, acting with integrity and the duty of candour. She submitted that the Tribunal should consider the reputation of the profession as a whole, over and above the interests of the individual practitioner when determining the appropriate sanction.

155. Ms Barlow submitted that lapse of time since the behaviour is specifically mentioned as a mitigating factor, and the Tribunal should have regard to the fact that it took some time for the conduct to be revealed and referred to the GMC. Further, she submitted that Dr Lee was not honest and open in his response to the complaint from Patient A, and he did not apologise, which now cannot happen.

156. Turning to aggravating factors, Ms Barlow submitted that there has been no acceptance of the Allegation, as opposed to maintaining a defence, which differs from the terms of *Sawati*. Further, the Tribunal has found that there is a lack of insight.

157. Ms Barlow submitted that Dr Lee's behaviour was fundamentally incompatible with continued registration. She stated that there had been an abuse of the position of trust held by a doctor. She submitted that Dr Lee sought to deflect blame in order to avoid criticism of the care and treatment that he provided to Patient A, putting his own needs ahead of those of his patient.

158. Ms Barlow referred the Tribunal to the sections of the SG which deal with dishonesty, and submitted that those applied in this case as the dishonesty was persistent and covered up.

159. Ms Barlow submitted that the public and patients would not expect a doctor who falsified records in the way that Dr Lee did, on three separate occasions and compounding those falsifications in response to a complaint, for his own benefit and in order to deflect blame and criticism, to continue to enjoy registration. For those reasons, she submitted that the only appropriate sanction was one of erasure.

160. On behalf of Dr Lee, Ms Tanchel submitted that this is not a case in which conditions could be formulated to adequately reflect the findings of this Tribunal, and agreed that the Tribunal should be considering whether a lengthy suspension or erasure was appropriate.

161. Ms Tanchel submitted that the appropriate sanction in this case was one of suspension. Throughout her submissions, she referred to the SG and the Tribunal's determinations.

162. Ms Tanchel submitted that the submission that a member of the public would be dismayed to learn of Dr Lee's continued registration exists within a vacuum. She reminded the Tribunal of the testimonials submitted on his behalf, including those confirmed after the Tribunal had made its factual findings. In her submission, they were direct evidence of the fact that it would not be correct to say that members of the public or the profession would inevitably require that Dr Lee should be erased from the register.

163. Further, Ms Tanchel submitted that the entries made by Dr Lee were made as early as 2018, long before any complaint was received. The last relevant entries were made in May 2020, almost five years ago. Ms Tanchel submitted that to say the dishonesty was covered up would be incorrect, as it would be absolutely plain to anyone who checked, by clicking on the relevant icon, that these entries were made retrospectively, so it cannot be right to say that this was in any way a sophisticated attempt to cover everything up.

164. Ms Tanchel submitted that Dr Lee has, in his reflections, demonstrated that he is making efforts to prevent the behaviour recurring. She reminded the Tribunal that Dr Lee has no fitness to practise history, and the testimonials provided evidence that he is an excellent clinician with more than three decades of providing very good care to his patients. She also reminded the Tribunal of the personal and professional matters which were relevant to Dr Lee at the time that these events took place, including the enormous number of tasks that he was presented with when he returned from leave, XXX.

165. Ms Tanchel submitted that this was not a case where Dr Lee had no insight and had not started the process of remediation. She stated that the opposite has been found by the Tribunal in its determination on impairment.

166. Ms Tanchel submitted that accepting Ms Barlow's submission that a failure to cooperate in an inquiry or a patient complaint when the very issue in the case was Dr Lee's failure in responding to the patient complaint would be double counting. She stated that it would be unfair to do this.

167. Ms Tanchel submitted that it was clear from the SG that suspension could be used to send out a clear signal that Dr Lee's behaviour was unacceptable in line with the Tribunal's reasoning at paragraph 44 of its determination on impairment.

168. Ms Tanchel submitted that there is no suggestion in the Tribunal's previous determinations that Dr Lee's behaviour is fundamentally incompatible with continued registration. Further, she submitted that the Tribunal has determined that there is not a significant (or '*high'* in the Tribunal's word) risk of repeating the behaviour. She submitted that, in light of the Tribunal's findings, a period of suspension with a review would give Dr Lee an opportunity to demonstrate to a Tribunal further insight and that the risk of repetition is low.

The Relevant Legal Principles

169. The Tribunal reminded itself that the decision as to the appropriate sanction to impose, if any, was a matter for it alone, exercising its own judgment. In reaching its decision on sanction, the Tribunal had regard to the SG.

170. The Tribunal bore in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it noted that any sanction imposed may have a punitive effect. It reminded itself that in deciding what sanction, if any, to impose, it should consider the sanctions available, starting with the least restrictive.

171. Throughout its deliberations, the Tribunal had regard to the overarching objective, which includes the protection of the public, the maintenance of public confidence in the profession, and the promotion and maintenance of proper professional standards and conduct for members of the profession. It applied the principle of proportionality, balancing Dr Lee's interests with the public interest, but on the basis that the reputation of the profession as a whole is more important than the interests of an individual doctor.

The Tribunal's Determination on Sanction

172. The Tribunal identified what it considered to be the aggravating and mitigating factors in this case.

Aggravating factors

173. The Tribunal first considered the aggravating factors.

174. The Tribunal first took into account Dr Lee's insight. It was of the view that he does have partial insight, but that he still lacks insight in specific areas, particularly the impact of his dishonesty on Patient A, the wider profession and his patients. This lack of full insight has led the Tribunal to conclude that there remains a limited risk of repetition.

175. Specifically, in relation to Patient A, the Tribunal also considered that Dr Lee had shown a lack of insight; he admitted that he had amended Patient A's medical records retrospectively and he had not made this clear in the response to Patient A's letter raising concerns about his treatment, and he had not apologised for this. It was of the view that Dr Lee has not demonstrated an understanding of how his actions impacted Patient A.

176. The Tribunal also considered that this case involved acts of dishonesty, including falsifying information in Patient A's medical records, so that Dr Lee could avoid criticism. In doing this, Dr Lee placed his own interests above those of Patient A.

Mitigating Factors

177. The Tribunal then went on to consider the mitigating factors.

178. The Tribunal acknowledged that Dr Lee has no previous fitness to practise history and is of previous good character, against the background of a long career of close to 30 years. Further Dr Lee had made admissions before this Tribunal to part of the Allegation, including making the amendments to the records.

179. The Tribunal considered the circumstances leading up to the incident to be a mitigating factor. It took into account that, at the relevant time in November 2017, Dr Lee had just returned from leave to a lengthy list of more than 800 tasks, for which he had little to no support to complete. It considered that this was the beginning of events, which ultimately led to his dishonest acts. Whilst this did not for one moment excuse Dr Lee's dishonesty, it did consider it to be relevant background.

180. The Tribunal took into account that five years has elapsed since the most recent act of dishonesty, and that there was no evidence of further episodes of dishonesty in that time, or indeed in the course of Dr Lee's long career prior to the events that are the subject of the Allegation.

181. The Tribunal had received positive testimonial evidence about Dr Lee. In particular, the Tribunal had regard to the testimonial evidence of:

- Dr F, a former colleague of Dr Lee's who had joined his list as a patient based on his experiences with him;
- Dr G, who described Dr Lee as follows:

  'He has my utmost regards as an excellent first-class GP, highly principled man with the highest personal integrity, passionate about caring for his patients and doing the best for them and their family as a doctor, often in challenging NHS circumstances. He goes well beyond his normal duties as a GP, getting to know them and treating them with respect, compassion and diligence in a highly professional capacity.'

- Ms H, his former practice manager, who stated that:

  'He was always very approachable and communicated well when I had any queries etc. I had a good working relationship with Dr Lee, he had strong moral principles and personal integrity. I found him to be trustworthy, reliable and honest.'

182. The Tribunal also had regard to its assessment of Dr Lee's insight. It took into account that Dr Lee had developed some insight, although he still lacks full insight in particular as to the effects of his actions on Patient A. The Tribunal noted that Dr Lee has taken some steps to remediate and has provided a reflective statement following targeted CPD.

183. The Tribunal balanced the aggravating and mitigating factors throughout its deliberations and went on to consider each sanction in order of ascending severity, starting with the least restrictive.

No action

184. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

185. The Tribunal was satisfied that there were no exceptional circumstances in Dr Lee's case which could justify it taking no action. Further the Tribunal considered that concluding the case by taking no action would be insufficient to protect the public interest and would not mark the seriousness of Dr Lee's dishonest conduct.

Conditions

186. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Lee's registration. The Tribunal had regard to paragraphs 81, and 85 of the SG, which state:

> *'81 Conditions might be most appropriate in cases:*
>
> *a involving the doctor's health*
>
> *b involving issues around the doctor's performance*
>
> *c willing to respond positively to retraining, with evidence that they are committed to keeping their knowledge and skills up to date throughout their working life, improving the quality of their work and promoting patient safety*
>
> ...
>
> *85 Conditions should be appropriate, proportionate, workable and measurable.'*

187. The Tribunal noted that the case did not fit within the examples in paragraph 81, as a type of case where conditions may be most appropriate.

188. The Tribunal considered that no conditions could be formulated which would be appropriate, workable or measurable. Further, the Tribunal determined that the imposition of conditions would not be sufficient to mark the seriousness of Dr Lee's actions or to address the Tribunal's findings of impairment.

189. The Tribunal concluded that an order of conditions would not be appropriate to maintain public confidence in the profession, and to promote and maintain proper professional standards and conduct for members of the profession.

Suspension

190. 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 Lee'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)'*

191. The Tribunal also considered the SG 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.'*

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

193. The Tribunal went on to consider whether it was accurate to describe Dr Lee's dishonesty as '*persistent*'. The Tribunal noted that whilst it had found that Dr Lee had inaccurately altered Patient A's notes on three occasions, the three amendments all emanated from the same alleged interaction, which occurred at a time of workload stress for Dr Lee.

194. The Tribunal considered that while his misconduct was serious, it was remediable. Dr Lee had already taken some steps to remediate. This has involved completing a number of targeted CPD courses, including several on probity and ethics. Whilst the Tribunal was of the view that Dr Lee had not yet gained full insight or yet fully remediated his dishonesty, the steps he has taken to date demonstrate that he is willing to engage with the process. Given the developing nature of his insight, the Tribunal considered that there remained a limited risk of Dr Lee repeating his dishonesty. The Tribunal did not believe that this risk was significant, due to his remediation and reflections to date. This included his reflective statement prepared in March 2025, which was prepared after attending relevant CPD courses. However, the Tribunal did consider that there was more work required to demonstrate that Dr Lee understands the impact of his dishonesty on Patient A, the wider profession and on his patients.

195. The Tribunal had regard to the factors it has identified as aggravating and mitigating and its assessment of the scale of the misconduct. It also noted that a number of factors listed in paragraph 109 of the SG as possibly indicating erasure as an appropriate sanction were present in this case:

> *'109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> *…*
>
> ***b** … deliberate … disregard for the principles set out in Good medical practice…*
>
> *…*
>
> ***d** Abuse of position/trust …*
>
> *…*
>
> ***h** dishonesty…*
>
> ***i** Putting their own interests before those of their patients…'*

196. However, the Tribunal decided that this case was not one where Dr Lee's misconduct was fundamentally incompatible with continued registration. The findings of dishonesty (whilst serious in the Tribunal's view) all linked back to one day in the course of Dr Lee's long career. Furthermore, the Tribunal had identified significant mitigating factors as set out in paragraphs 31 to 35 above, including his long, unblemished career, the difficult circumstances in which he was operating, his developing insight and the fulsome testimonials of his former colleagues. It was satisfied that the public and members of the profession, being aware of this context, would consider that a significant period of suspension would be a sufficient marker to maintain public confidence in the profession and uphold proper professional standards. Accordingly, it considered that erasure would not be appropriate or proportionate, nor would it be in the public interest.

197. The Tribunal thus determined that a period of suspension would be an appropriate and proportionate sanction. The Tribunal took into account the impact that this sanction may

have upon Dr Lee. 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

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

199. The Tribunal considered the aggravating factors in this case and acknowledged that this was a serious departure from the principles set out in GMP, and that Dr Lee had put his own interests above those of his patient.

200. The Tribunal also had regard to the mitigating factors of the case in considering the length of the suspension, including Dr Lee's previous good character.

201. Taking all these elements into account (and in particular to mark appropriately the serious instances of dishonesty), the Tribunal was satisfied that imposing a period of 12 months' suspension was appropriate and proportionate. This reflected serious nature of his dishonest conduct. In the Tribunal's view, a 12-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.

202. This period of suspension will also give Dr Lee sufficient time to further develop his insight in relation to the dishonesty findings and to continue to take action to remediate. The Tribunal was satisfied that a reasonable and well-informed member of the public or the profession would be satisfied that this was a proportionate response to Dr Lee's dishonest conduct.

203. Accordingly, the Tribunal determined to suspend Dr Lee's registration for a period of 12 months.

Review

204. The Tribunal determined to direct a review of Dr Lee's case. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Lee to demonstrate how he has developed

insight, taken further steps to remediate and reflected on his dishonest conduct. It therefore may assist the reviewing Tribunal if Dr Lee provides:

- Evidence of any courses and other activities he has undertaken in order to demonstrate remediation of his dishonesty;
- Evidence that he has gained insight;
- Evidence that he has kept his knowledge and skills up to date, including any CPD; and
- Any other information that he considers will assist.

Determination on Immediate Order - 02/05/2025

205. Having determined that Dr Lee's registration should be suspended for a period of 12 months, 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

206. On behalf of the GMC, Ms Barlow submitted, that having particular regard to the findings of the Tribunal, an immediate order is necessary to protect public confidence in the profession and uphold standards for members of the profession. Ms Barlow referred the Tribunal to the relevant paragraphs of the SG, and stated that an order was necessary in the public interest. She reminded the Tribunal of the seriousness of the matters that led to the substantive direction, and invited it to consider whether it was appropriate for Dr Lee to continue in unrestricted practice. She stated that there was no interim order in place.

207. On behalf of Dr Lee, Ms Tanchel submitted that an immediate order is not necessary. She submitted that the purpose of sanction is to mark the serious nature of breaches of GMP and the Tribunal's finding of dishonesty, but stated that is not enhanced by an immediate order. She submitted that immediate orders are necessary where there are clinical issues or concerns about public safety, although not exclusively per the SG. She submitted that any member of the public who is concerned about the reputation of the profession, and how the profession treats findings of dishonesty will have the information available to them via the MPTS website, but in this case an immediate order serves no purpose.

The Tribunal's Determination

208. In reaching its decision, the Tribunal considered the relevant paragraphs of the SG and exercised its own independent judgment. 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.'

209. 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 Lee's best interests.

210. This means that Dr Lee'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 Lee does lodge an appeal, he will remain free to practise unrestricted until the outcome of any appeal is known.

211. There was no interim order to revoke.

212. That concludes this case.

ANNEX A – 11/11/2024

Application under Rule 17(2)(g)

213. The GMC closed its case on 5 November 2024, and it was therefore open to Dr Lee, under Rule 17(2)(g) of the Rules, to make submissions as to whether sufficient evidence, taken at its highest, had been provided for a Tribunal, properly directed, to find some or all of the facts proved. Rule 17(2)(g) of the Rules states:

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

214. Ms Tanchel confirmed that the application related to the following paragraphs of the Allegation: 2(b), 4(a)(i) to (iv), 4(b) to 4(e) and 5(a) to 5(f) being those paragraphs which Dr Lee denied excluding those which the GMC had indicated it no longer intended to pursue.

Submissions on behalf of Dr Lee

215. Ms Tanchel submitted that the remaining paragraphs of the Allegation be found not proven because the evidence before the Tribunal was so tenuous, contradictory and/or inadmissible that taken at its highest, a properly directed Tribunal could not properly find the allegations proven.

216. Ms Tanchel referred to the case of *R v Galbraith [1981] 1 WLR 1039* ('Galbraith') which sets out that:

> *'(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.*

(2) The difficulty arises where there is some evidence but it is of a tenuous character; for example, because of inherent weakness or vagueness, or because it is inconsistent with other evidence.

(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.

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

217. Ms Tanchel also referred the Tribunal to the relevant authorities of: *R v Shippey [1988] Crim LR 767, R v F(S) [2012] 1 All ER 565*, *S v General Medical Council [2015] EWHC 364 (Admin), Re H (Minors) (Sexual abuse: standard of proof) [1996] AC 563, Sharma v GMC [2014] EWHC1471, Beard v the General Osteopathic Council [2019] EWHC 1561(Admin), Ivey v Genting Casinos: [2017] UKSC 67P, GMC v Razza [2004] EWHC 205 (Admin), Miller & Another v Health Service Commissioners for England [2018] EWCA Civ 144, Lawrance v General Medical Council* [2015] EWHC (Admin), *Fish v General Medical Council [2012] EWHC 1269 (Admin), Basson v GMC [2018] EWHC 505(Admin)* and *Khan v GMC [2021] EWHC 374 (Admin).*

Patient A's evidence

218. Ms Tanchel invited the Tribunal to consider the evidence of Patient A. She stated that it was logical that if the Tribunal was persuaded that there was insufficient evidence on which a properly directed tribunal could find that the phone conversation had taken place, then the other allegations cannot proceed.

219. Ms Tanchel invited the Tribunal to consider the following points in respect of Patient A's witness statement, all of which she submitted, undermined the weight that can be placed upon it and on which Patient A would have been cross examined:

- It was signed on the 16 November 2023 some 6 years after the appointment in 2017;
- Patient A had undergone a shocking diagnosis;
- Patient A had received significant and ongoing traumatic treatment;
- At the time of the witness statement the legal proceedings were well in train;

- When the letter of complaint was written it was not a complaint against Dr C and Dr Lee;
- Patient A erroneously recollects that the ultrasound in 2018 was for his kidney, in fact it was for his hernia and for the prostate due to the elevated PSA;
- The entry on the 27 November which demonstrates that some action was taken in respect of the results by Dr Lee;
- The evidence makes plain that legal action was not commenced in early 2020 as asserted.

220. Ms Tanchel submitted that limited weight should be attached to Patient A's evidence. She stated that when the decision to bring the allegations was made and at the time of the hearsay application, the evidential picture was very different to what the Tribunal has now heard.

221. Ms Tanchel stated that the foundation of the GMC's case was that in May 2020, and following being put on notice of legal action, Dr Lee, amended medical records to add false information: namely that there had been a telephone consultation with Patient A in which he had declined a DRE. However, it was now known that the first time Patient A's solicitors contacted the Practice was in early October 2020 which was some six months after the record was added. Ms Tanchel submitted that there was no evidence that there was any legal claim contemplated let alone in train at the time that the amendments were made.

222. Ms Tanchel submitted that by the time Patient A signed his witness statement for these proceedings, a legal claim was proceeding through the necessary steps, and Patient A refers to a *'legal claim'*, when in fact in May 2020 when the amendments were made and in June 2020 when the Practice replied to the letter of complaint, there was no such claim. Ms Tanchel stated that had Patient A's attendance at the hearing been possible he would have been cross examined on this issue. She submitted that any amendments to the clinical records made in 2018 could not possibly be linked to the complaint.

223. Ms Tanchel submitted that the GMC had failed to call any evidence of when the pre action letter or the claim itself was served on the Practice. She stated that the Tribunal is aware that on the 6 October 2020 solicitors instructed on behalf of Patient A requested medical evidence and that on the 22 October 2020 a letter was sent to them- the only proper inference being that that was the response to the request for medical records. Ms Tanchel submitted that on 27 October 2020 there is a reference to a further letter from the Patient

A's solicitors in the medical records, but the Tribunal has no evidence as to what it was. Furthermore, she submitted that there was no evidence when a pre-action letter or a claim was in fact received.

224. Ms Tanchel stated that in evidence Dr B was unclear about the date on which a claim was made. He initially stated that he thought that the claim may have come as late as 2022, by which time Dr Lee had retired. She submitted that even taking his evidence at its highest it was in 2020, it certainly was not prior to May 2020.

225. Ms Tanchel stated that Dr B agreed that a complaint was different from a legal claim, that complaints are often dealt with at local level and in this case a response to the complaint was provided to Patient A. Dr B further agreed that National Health Service Resolution ('NHSR') would only be contacted in respect of claims and not for complaints. Ms Tanchel submitted that the only proper inference that this Tribunal could draw is that the Practice would not have replied to Patient A on 9 June 2020, if a claim had been made. The reply was in respect of a complaint.

226. Ms Tanchel submitted that the Tribunal has no evidence that in 2017 Patient A was in fact suffering from cancer or whether Dr Lee was in any way liable for the claim or believed himself to be so liable at the time the note was amended. She submitted that the evidence before the Tribunal, and which Dr Lee would himself have been aware by the time the retrospective entries in the record were made, was that on the 5 March 2018, the prostate was not enlarged. Dr C did not diagnose cancer when Patient A saw him in 2019, despite an added symptom of blood in the urine. Ms Tanchel submitted that it was significant that the GMC has not pursued any clinical allegations and has not provided any clinical evidence to the Tribunal.

227. Ms Tanchel stated that following enquiries made on behalf of Dr Lee the Tribunal is now aware from the agreed facts, that on the 27 November 2017, when the pathology results were received it was Dr Lee who read them and it was, he who entered that a routine appointment was necessary. Thus, when the GMC's case was first opened, it was on the basis that Dr Lee had not done anything about these results and had simply missed them. Ms Tanchel submitted that this is now demonstrably incorrect. Furthermore, she submitted that it was entirely consistent with Dr Lee then calling Patient A to offer him an appointment for the DRE and Patient A returning the call during which the now disputed conversation took

place. Ms Tanchel reminded the Tribunal that it was undisputed evidence that Patient A had been a patient of Dr Lee for a considerable period of time.

Ms D's evidence and the Clinical Records

228. Ms Tanchel stated that Ms D was asked to check the clinical records in 2023. This was some two years after Dr Lee left the Practice and therefore, he was unable to access the records himself. Ms Tanchel submitted that Ms D's evidence did not assist the Tribunal in determining dishonesty in this case because:

- She was unaware that an icon made it obvious when a record had been edited. It is understood that this icon was present in 2018 and 2020, however the only proper inference which can be drawn is that because Dr Lee retired in 2021 he would not have known of its existence had it not been there at the time. Thus, it would be impossible to hide the retrospective edits;
- The audit trail which she undertook demonstrates the time at which the edits were made;
- The scan requests had been sent at least three times.

229. Ms Tanchel submitted that Ms D undertook a search of the records without a full understanding of the system and that any evidence from her in support of a finding of dishonesty was so tenuous as to be fundamentally unreliable.

230. Ms Tanchel submitted that as the presence of the icon was raised in cross examination, the only inference available to the Tribunal was that Dr Lee was aware of it at the time he made his entries. This undermines any proposition that he would knowingly make an untruthful entry and seek to hide the edit as he was aware that anybody could click on the icon. Furthermore, she submitted that this supports an inference that he may not have considered the need to mark the record as retrospective because the icon itself would put anybody on notice of the same. She stated that it was clear from the screenshot that only those records which had been edited have the icon.

231. Ms Tanchel submitted that the evidence of Ms D demonstrates:

- That she was not aware of the icon, but Dr Lee was;
- The icon was there, and the Tribunal can now see from the screen shot that it shows the audit;
- That the case was put on the wrong basis – there were a number of attempts to send the fax;

- Ms D did not find the other relevant information until asked to do so by those instructed by Dr Lee.

232. Ms Tanchel submitted that the contemporaneous records are not evidence in support of the fact that the disputed conversation did not take place. An assertion that they are was misguided and at odds with relevant jurisprudence. Ms Tanchel reminded the Tribunal that the proposition that if something does not appear in the records (as the disputed conversation did not when the records were initially completed) it did not happen was no longer good law.

Mediscan Evidence

233. Ms Tanchel submitted that the evidence from Mediscan was fundamentally undermined in two important respects. Firstly, Mr E stated that fax referrals were stopped in 2016, which the Tribunal is now aware was plainly incorrect. Secondly, the only referral in the Mediscan screenshot was that of the 5 March 2018. However, the Tribunal is aware that the referral was made on the 13 February and again on 27 February 2018. Ms Tanchel submitted that this makes clear that the Mediscan procedures are not infallible and that errors can and do occur. Furthermore, she submitted that processing a fax referral was not automated and therefore subject to the vagaries of human error. As such one inference which cannot be excluded by the Tribunal was that the referral which Dr Lee said that he sent in November 2017 was misplaced by Mediscan.

Dr B

234. Ms Tanchel stated that Dr B was asked by the Tribunal about how a Docman entry in the notes was entered. He explained that this was an entry which could be made by the administrative staff when they had completed a task. Ms Tanchel reminded the Tribunal that the GMC now concedes that some faxes were sent by somebody other than Dr Lee and that that person may have been the person who wrote the words on the fax dated 27 February 2018.

235. Ms Tanchel submitted that there was insufficient evidence to support an allegation that Dr Lee did not make a referral for an ultrasound scan in 2017. She stated that it was a logical inference from the information now available to the Tribunal that Dr Lee may have asked a receptionist to fax the referral and for whatever reason this was not done. Equally it was possible that it was faxed but not received by Mediscan.

Paragraphs 4 (a) (b) and (d)

236. Ms Tanchel submitted that the evidence of Patient A was inherently unreliable and tenuous when considered in light of the other evidence now available and taking into account the circumstances in which it was obtained. She stated that the Tribunal had no evidence on what has happened to the claim or the clinical basis on which it was made. Ms Tanchel submitted that in light of the evidence a properly directed Tribunal could not find on the balance of probabilities that a fax referral was not sent in November 2017.

Paragraph 5

237. Ms Tanchel submitted that when considering the following key issues, no properly directed Tribunal could find that Dr Lee was dishonest in any of the actions he took:

- Any retrospective/edited entry to the records was immediately obvious by clicking in the icon to any user of the system. Dr Lee was aware of that;
- There was no evidence that Dr Lee had in fact done anything wrong in the care that he provided the patient or that he believed he had;
- The claim was not submitted at the time the edits were made;
- The 2018 edits were undertaken before the complaint had been made.

Conclusion

238. Ms Tanchel submitted that in applying the relevant law to the facts of this case, there was no evidence to support the contested allegations and/or such evidence as there is, is so tenuous, vague or weak that no properly directed Tribunal could find the allegations proven.

Submissions on behalf of the GMC

239. Ms Barlow referred the Tribunal to the case of *Dutta v GMC [2020] EWHC 1974 (Admin)* which sets out the approach to assessing evidence, and the requirement to assess evidence against unchallenged, contemporary documentary evidence where that is available. She submitted that whilst it was accepted that it is wrong to assume poor practice simply because something is not noted in medical records, that does not dilute the evidential importance of a contemporaneous record when assessing the evidence as a whole.

240. Ms Barlow submitted that the foundation of the GMC's case was not, and has never been, that Dr Lee amended medical records following being put on notice of legal action.

241. Ms Barlow reminded the Tribunal of paragraph 4(c) of the Allegation, she submitted that this refers directly to the Letter of the 9 June 2020 sent to Patient A in response to his

complaint of the 11 May 2020. In regard to paragraph 5(f) of the Allegation, she submitted that it directly alleges that the admitted amendments, referral for a scan in February of 2019 and the letter of 9 June 2020 were carried out to avoid potential criticism of the care and treatment provided and/or did not provide to Patient A.

242. Ms Barlow reminded the Tribunal of the GMC's opening which accords with the allegations:

- Dr Lee did not action the PSA level in November of 2017 when he should have done.
- He probably realised his error on 13 February 2018, when reviewing the notes of Patient A prior to the consultation relating to kidney stone investigations: this is the date of the first material amendment to the medical record. The scan referral on 27 February 2018 adds on the elevated PSA level.
- In 2020 he made the amendments shown dishonestly in direct response to the complaint made by Patient A.

243. Ms Barlow submitted that the legal action that appears to have commenced after the response to the letter was received, forms no part of the allegations, nor had the GMC ever suggested that any action of Dr Lee was in response to a legal claim.

244. Ms Barlow stated that Patient A refers to having consulted solicitors prior to drafting the letter of complaint, his evidence being that they assisted with that draft. However, she submitted that the GMC had never suggested that either the Practice or Dr Lee would have been directly aware of this at the time (no matter what they may have feared may happen).

245. Ms Barlow stated that the criticism of the GMC for failing to provide evidence of pre-action letters or the time that legal action was commenced was therefore unfounded. She submitted that the GMC had never suggested that the amendments were a response to legal action, and this forms no part of any allegation. Furthermore, in any event, that action appears to be Dr Lee himself.

246. Ms Barlow reminded the Tribunal that the evidence of Patient A had been, by reason of his death, admitted as hearsay. She stated that by definition, he cannot be cross-examined and ultimately the weight that was to be given to his evidence will be a matter that requires assessment. Ms Barlow submitted that the fact that it was hearsay and cannot be cross-examined does not render it so fundamentally undermined as to be incapable of acceptance because:

- Whilst the statement is dated the 16 November 2023, it refers directly to events set out in the letter of complaint that was received by the Practice on the 11 May 2020.
- Patient A had received a shocking diagnosis, the shock being compounded by the fact that it was the first time that he had learned of the raised PSA level in 2017; it will be a matter for the Tribunal to assess whether the shock Dr Lee expressed is supportive of his complaint, in that he might be expected to readily recall that it was a diagnosis with no warning.
- The recollection of Patient A accords precisely with the original and unamended records of the 27 November 2017 that only referred to *"make routine appointment"*. There was no contemporaneous record of a telephone appointment, or of any discussion at all with Patient A, or of any elevated PSA level, symptoms, DRE or ultrasound.
- The memory of Patient A as to the reason for the referral being kidney stones accords with the result of the referral of the 13 February 2018. The history that he gave on that date is recorded as *"lump and painful left groin 2 years"*. It is not suggested by Dr Lee, nor is it recorded, that there was any discussion of prostate/elevated PSA with Patient A on 13 February 2018.
- There was no referral document created (in contrast to the referrals of the 13 February, 27 February and 5 March 2018) on 27 November 2017.

247. Ms Barlow stated that the evidential picture had changed in two respects only:

- A scan document was created by Dr Lee on three occasions. All were sent to Mediscan, who appear to have lost the first two.
- There is an icon on the EMIS system that, when clicked on, shows the history of amendments made.

248. In relation to the scan document, Ms Barlow submitted that the evidence now demonstrates that once a scan referral document is created, a doctor will leave it to administrative staff to send to Mediscan. She stated that whilst it was not known who added the words *"urgent not heard anything"* to the referral document, it seems overwhelmingly probable that this will have been a member of the admin staff. Ms Barlow stated that even if it was Dr Lee, that could not be criticised in circumstances where two previous scan referrals had gone missing. She submitted that for that reason it would be wrong of the GMC to allow Paragraphs 2(b) and 4(e) of the Allegation to continue and therefore the GMC do not oppose the application in respect of those allegations, nor the effect that that will have on Paragraphs 5(d) and 5(f) of the Allegation in relation to paragraph 2(b) of the Allegation.

249. Ms Barlow submitted that the evidence in relation to the referral that was created by Dr Lee in February and March of 2018 does not fundamentally undermine the evidence in relation to the 27 November 2017. She stated that whilst the creation of scan documents was plain on the face of the medical records in relation to the creation of the three scan referrals of February and March 2018, there was no similar document created on the 27 November 2017. Ms Barlow submitted that the GMC's case was that there was no referral made on that date. She submitted that the medical records, together with the evidence of Dr B, Ms D and Mediscan demonstrate that when a referral is made, the creation of the scan document is recorded on EMIS. The referrals of February and March 2018 which the Tribunal now knows were made, support this proposition. Ms Barlow stated that no referral was recorded on the face of EMIS on the 27 November 2017 and the reference to a scan referral being made was a retrospective amendment. She submitted that both of these facts entirely support the proposition that no referral document was ever created or sent on that date. Furthermore, Dr Lee was clear in his witness statement that he would have actioned the referral. However, this was not shown on the face of the records.

250. Ms Barlow submitted that the evidential picture in relation to the icon was that it did exist and that clicking on it would reveal the history of amendment. She stated that this evidence comes from Ms D and can only demonstrate the following:

- The icon exists and clicking it will show an amendment history.
- She was unaware of this function of EMIS until she gave her evidence and thereafter investigated.

251. Ms Barlow submitted that the evidence of Ms D did not and cannot prove that Dr Lee would have been aware of the icon at the time that he made the amendments, nor that he would therefore not have felt the need to mark the record as retrospective given the presence of the icon. She submitted that this was particularly the case as the evidence of Dr Lee himself, in his witness statement dated as recently as the 9 September 2024:

- Makes no mention at all of the icon, which one might reasonably expect if that was his case.
- Accepts *"I regret that this was amended retrospectively and not labelled as such. I do recognise the importance of good, clear and accurate record keeping and ensuring that the reason for the later additions is clearly recorded"*.
- If the case of Dr Lee is that he was aware of the icon and assumed that all would therefore be able to clearly see his amendments, it would be entirely reasonable,

indeed expected, that this would be included within the witness statement served in these proceedings in respect of serious allegations.

- The amendments themselves were not drawn to the attention of anybody, whether at the time of the letter of complaint as legal proceedings progressed. They were discovered as a result of an audit actioned at the request of Dr B.

252. Ms Barlow submitted that the evidence as it stands at the close of the case by the GMC, and fully taking into account the evidence of Dr Lee, was that whilst there is an icon, Ms D was unaware of it and Dr Lee was entirely silent about it. Moreover, Dr Lee does not suggest that the amendments were clear and plain for all to see, rather that they were not, and he accepts that they should have been.

253. In summary, Ms Barlow submitted that:

- There are admitted amendments to the medical records.
- Unless a person was aware of the icon, these amendments were not clear on the face of the records.
- Dr Lee himself in his most recent statement does not suggest that he was either aware of the icon or that others should/would have been.
- Ms D was not aware of either the icon or what it could reveal.
- The amendment to include a prostate scan was a retrospective entry and no corresponding action appears on the records for the 27 November 2017.
- The records, as they were at the 27 November 2017, support the evidence of Patient A that no telephone consultation took place.
- There is no mention of elevated PSA or any discussion about a scan of the prostate with Patient A in the record of the 13 February 2018, as one might expect had this been the subject of previous discussion and/or the need for a scan.
- The amendments took place at key moments in the clinical history of Patient A:
    - When he attended for a face-to-face consultation with Dr Lee in February of 2018.
    - Following the receipt of a letter of complaint from Patient A on the 11 May 2020.
    - Whilst no material amendment was apparently made, the audit shows that the records were accessed on the 21 October 2020, shortly after the request from Garrets Solicitors for those records.
- The amendments were not drawn to the attention of anybody by Dr Lee as the complaint/legal action progressed, they had to be discovered by others in 2023.

- The case of Dr Lee is that the amendments were made for clarity. This explanation is unsatisfactory given the complaint and the subsequent legal proceedings.

254. Ms Barlow stated that dishonesty was almost always proved by inference, she submitted that in this case the Tribunal had amendments to medical records made at key times in the history of Patient A that do not accord with the evidence of the patient himself. However, the original records do accord with the evidence of Patient A. Ms Barlow submitted that based on the evidence as it stands it would be more than reasonable to infer that the intention behind the amendments was a dishonest one.

255. Ms Barlow submitted that the evidence in relation to paragraphs 2(b) and 4(e) of the Allegation did not pass the *Galbraith* test. However, she submitted that in relation to the evidence in respect of the remaining paragraphs of the Allegation, there was evidence upon which a properly directed Tribunal could safely find the allegations proven.

Relevant Legal Principles

256. The Legally Qualified Chair ('LQC') gave legal advice to the Tribunal.

257. The LQC referred the Tribunal to the test as set out in the criminal case of *R v Galbraith*, which has been applied to and affirmed in regulatory proceedings such as these. When applying the *Galbraith* test to regulatory proceedings the Tribunal should ask itself:

- Is there no evidence before the Tribunal upon which it could, at the appropriate time, find the allegation proved? (If there is no such evidence, then the no case submission should be allowed).
- If there is some evidence, the Tribunal should ask itself whether it is of such an unsatisfactory character, that the Tribunal, properly directed as to the burden and standard of proof, could not find the matter proved. Is the evidence, for example, of a tenuous character, perhaps because of inherent weakness, or vagueness or because it is inconsistent with other evidence? If the Tribunal is satisfied that the GMC evidence taken at its highest is such that a properly directed Tribunal could not go on to find the allegation proved, then the no case submission should be allowed.
- Is there some evidence, the relative strength, and weakness, of which may be dependent upon the Tribunal's view of the reliability of a witness or other matters, which is within the province of the Tribunal to determine? Where, on one possible view, the Tribunal considers the facts capable of being proved

to the requisite standard by a properly directed Tribunal it should allow the allegations to remain and the proceedings to continue.

258. It was clear that the answers to the questions that the Tribunal is asked to determine under rule 17(2)(g) would revolve around what a Tribunal, properly directed as to the burden of standard of proof, might find proved. It was germane therefore to briefly consider certain key directions that might be made. However, at this stage the Tribunal was not required to determine whether the Paragraphs of the Allegation had been found proved, but whether the facts were capable, on the basis of the evidence adduced, of being proved to the requisite standard.

259. In regard to the issue of the impact of the seriousness of the allegations, the LQC referred the Tribunal to the case of *Byrne v GMC*. This case confirmed the principle that there is only one standard of proof in civil and regulatory cases; and that is proof that the facts in issue more probably occurred than not.

260. The seriousness of an allegation did not, of itself, require more cogent evidence. The inherent probability of the relevant conduct was a matter which could be taken into account in deciding whether the event or conduct occurred; this goes to the quality of the evidence.

Hearsay Evidence

261. The LQC reminded the Tribunal that Patient A's statement has been admitted into evidence as hearsay. However, the Tribunal must have in mind that it must treat hearsay evidence with caution. The Tribunal would have to consider carefully what weight, if any, can be attached to it insofar as such evidence is relevant to the allegations and the findings it has to make. Plainly a hearsay account could not be given the same weight as if the witness had appeared before the Tribunal and had given oral evidence on oath and been subject to questioning.

262. In estimating the weight, if any, to be given to the hearsay evidence the Tribunal should have regard to any circumstances from which any inference can reasonably be drawn as to the reliability or otherwise of the evidence. Factors that might influence the weight to be attached to hearsay evidence included whether it is supported by other evidence and whether it is consistent with that. The Tribunal might also wish to have regard to when a statement was made in relation to the incident or event in question, whether the evidence

involves multiple hearsay and whether any person involved had any motive to conceal or misrepresent matters.

263. The Tribunal was also entitled to consider the nature of the hearsay evidence relied upon, including when it was produced. A signed witness statement accompanied by a statement of truth was likely to be considered preferable, for example, to notes by one person of what they were told by another.

264. Factors that might undermine the reliability of hearsay evidence, in addition to the Tribunal's inability to make its own assessment of credibility, were inconsistencies in the hearsay account, either inconsistencies with an account given by the same witness or with any other evidence. This was not an exhaustive list but an indication of the kind of factors that may be relevant to the Tribunal's assessment of reliability and weight.

Dishonesty

265. It was alleged that one or more of Dr Lee's actions and/or his conduct was dishonest. · The LQC referred the Tribunal to the legal test for dishonesty as set out by the Supreme Court in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017) UKSC 67*. The Tribunal must:

- first ascertain (subjectively) the state of Dr Lee's own knowledge or belief as to the facts. The question is not whether the belief he holds is reasonable - the question is whether it is genuinely held. (The reasonableness of the belief is a matter of evidence going to whether he genuinely held the belief, but it is not a requirement that the belief itself must be reasonable.); and
- then consider whether that conduct was dishonest by the (objective) standards of ordinary decent people. (There was no requirement that Dr Lee must appreciate that what, he had done was, by those standards, dishonest.)

266. In the case of *Lawrance v GMC*, a case on dishonesty the judge stated that the legal assessor should have directed that the panel should only find dishonesty established if there was cogent evidence. He went on to make it clear that the civil standard applied, but where dishonesty, or particularly a serious offence is alleged, the decision makers must be aware of the need for such cogent evidence.

267. In *Soni v GMC*, a case on drawing an inference of dishonesty, the court stated that, although the GMC only needed to prove the allegation on the balance of probabilities *"the*

principle must nonetheless apply that before an inference could properly be drawn, the panel had to be able safely to exclude as less probable other explanations of Mr Soni's conduct".

268. In *Sharma v GMC* the judge adopted the principle set out in Re H by Lord Nicholls:

> '*in assessing the probabilities the court will have in mind as a factor, to whatever extent it is appropriate in the particular case, that the more serious the allegation the less likely it is that the event occurred and hence the stronger should be the evidence before the court concludes that the allegation is established on the balance of probabilities*'.

Analysis and conclusion

269. In coming to its conclusions on the application, the Tribunal was cognisant of the fact that it was not coming to a determination as to whether any of the allegations have been proved. Rather, in accordance with the legal advice received, it was considering whether the facts were capable of being found proved to the requisite standard by a properly directed Tribunal acting reasonably.

270. The Tribunal first addressed a number of issues raised in the submissions the resolution of which would inform its decision as to whether there was a case to answer on a number of the allegations.

Patient A's evidence

271. The Tribunal was particularly mindful of the legal advice received as to the issue of the weight that may or may not be attributed to Patient A's evidence that had been admitted as hearsay. It addressed a number of issues raised by Ms Tanchel that in her submission undermined the weight that could be placed upon it.

Date of statement

272. The statement was signed some six years after the key events to which it relates. This was correct. However, the Tribunal noted that the statement largely repeated, and indeed exhibited, the letter of complaint the patient had written in April 2020. His statement was in the Tribunal's view consistent with the terms of that letter of complaint.

Shocking diagnosis/significant ongoing traumatic treatment

273. There was no evidence before the Tribunal to persuade it that because Patient A had had a shocking diagnosis and was undergoing treatment, his evidence as to the events of September 2017 was therefore inherently unreliable. Indeed, the Tribunal was of the view that if Patient A had received information about a significantly elevated PSA level which might be indicative of a cancer diagnosis, that was something that arguably he would have been very likely to remember.

Legal proceedings in train at the time of statement

274. It is not clear on the evidence available to the Tribunal when legal proceedings were commenced and what stage they had reached. In any event, unless there were some suggestion of a fraudulent attempt to secure compensation (which does not appear to be being advanced on behalf of Dr Lee) it is not clear why the existence of legal proceedings should impact the reliability of the statement.

Not a complaint against Dr C and Dr Lee

275. Ms Tanchel asserts that the Letter was not a complaint against Dr Lee. Whilst it is not a formal complaint against him it does raise questions about his actions and indeed specifically references the November 2017 blood test which showed an elevated PSA level.

Erroneous recollection of the purpose of ultrasound

276. Whilst Ms Tanchel asserts that Patient A erroneously recollects that the ultrasound was for his kidney, in fact, the referral form includes amongst other things a request for a kidney scan and the medical notes of the consultation with Dr C reporting on the scan referred to kidney stones.

The contemporaneous November 2017 entry

277. The contemporaneous entry on the 27 November 2017 refers to the need for a routine appointment. However, it makes no reference to the raised PSA level or a discussion of its implications, nor to a telephone conversation with Patient A, nor to a discussion about a digital rectal examination, nor to the need for a scan. As such, the contemporaneous entry could well be argued to be consistent with Patient A's statement.

Legal action not commenced in early 2020

278. There may have been some confusion on Patient A's part as to what constituted legal action particularly as it appears that the letter of complaint sent in late April 2020 was drafted by his solicitors. Furthermore, there had been a mistaken understanding on the

GMC's part as to when legal action had been commenced. However, the Tribunal was of the view that it was important not to overstate the importance of the distinction between a letter of complaint and legal action for the purpose of these proceedings. A serious letter of complaint relating to an undiagnosed potentially terminal cancer was likely to have been of considerable concern whether or not it referenced or led to legal proceedings. The Tribunal noted that paragraph 4(c) of the Allegation references concerns having been raised by Patient A rather than legal action having been commenced.

General comments

279. The Tribunal was of the view that the issues in dispute relate significantly to whether a particular telephone conversation took place. The Tribunal further took into consideration that in the period following 27 November 2017, there was no evidence in the contemporaneous records of any discussions around the raised PSA level.

280. In light of all the above, the Tribunal was satisfied that Patient A's statement carried a degree of weight which Dr Lee will have the opportunity to seek to rebut.

Mediscan

281. As submitted by Ms Tanchel, the evidence around the February/March 2018 referral clearly demonstrated that, notwithstanding Mr E's assertion that no fax referrals were accepted after 2016, that was not the case. Further, Ms Tanchel was justified in asserting that the need for repeat referrals in 2018 demonstrated that certain (particularly fax) referrals could fall through the gaps and not be actioned.

282. Thus, the Tribunal was satisfied that it was plausible that a fax referral could have been sent in November 2017 which was not actioned or registered on the Mediscan system. Moreover, it was possible that through an administrative error at Dr Lee's Practice, a fax referral that a doctor had requested might never have been sent.

283. However, it seemed to the Tribunal that another plausible conclusion that a panel could reach was that, consistent with Patient A's evidence, Dr Lee had never made the referral. The Tribunal noted that the 13 and 27 February and 5 March 2018 referrals were all reflected by Docman entries in the Mediscan records whereas there is no such Docman entry for the referral which Dr Lee states was made in November 2017. Moreover, there is no evidence on the medical records of any subsequent chasing up or conversations as to why the November 2017 referral had not been actioned.

Ms D's evidence and the clinical records

284. It became an agreed fact between the parties that an icon indicated that a particular day's record had been subsequently altered and that clicking on that icon would take a user through to the details and timing of such amendments. Ms Tanchel submitted that this demonstrated a lack of dishonest intent on the part of Dr Lee on the basis that it would be obvious that he had amended the records subsequently and therefore was not attempting to mislead. The Tribunal's view was that this was not the end of the matter, and the question of dishonesty was still arguable for a number of reasons.

- It was not clear from when Dr Lee had been aware of the significance of the icon. He made no mention of it in his witness statement and indeed had expressed his regret for not making it clearer that he amended the records retrospectively.
- It was not clear that all users would understand the significance of the icon. Indeed, Ms D, the Practice manager did not.
- The allegation of dishonesty could still be made out even if the Tribunal found that the retrospective nature of the amendments was clear to users. If the statements in the retrospective entries were untrue to Dr Lee's knowledge and made dishonestly that would be sufficient without the need to prove that their retrospective nature had been concealed.

285. In the light of the above analysis, the Tribunal addressed the specific paragraphs of the Allegation remaining to be determined and whether sufficient evidence had been presented by the GMC for the facts as alleged to be found proven (i.e. whether there was a case to answer).

Paragraph 2(b)

286. The GMC had indicated that it did not intend to pursue this paragraph of the Allegation.

Accordingly, the Tribunal granted the application under Rule 17(2)(g) made on behalf of Dr Lee in respect of Paragraph 2(b).

Paragraph 4(a)(i)

287. For the reasons stated in paragraph 71 above relating to Mediscan, a panel could reasonably conclude that Dr Lee had not requested an ultrasound of Patient A's prostate on 27 November 2017 and that he therefore knew that.

Accordingly, the Tribunal refused the application under Rule 17(2)(g) made on behalf of Dr Lee in respect of Paragraph 4(a)(i).

Paragraphs 4(a)(ii) to (iv) and 4(b)

288. Whilst there is a contemporaneous reference to the need for a routine appointment, there is no contemporaneous note of the telephone conversation. There was no mention of the telephone conversation when the notes were amended in February 2018 and the first mention of the conversation was in May 2020 after the written complaint had been received. Patient A's statement however is clear, that in his recollection no such conversation took place. The Tribunal is therefore satisfied that it would be open to a panel based on the evidence presented by the GMC to find the facts proven.

Accordingly, the Tribunal refused the application under Rule 17(2)(g) made on behalf of Dr Lee in respect of Paragraphs 4(a)(ii) to (iv) and 4(b).

Paragraph 4(c)

289. The concerns were raised by Patient A in his letter of complaint of late April 2020 and Dr Lee wrote the Letter on 9 June 2020 in response to the complaint. The Tribunal is therefore satisfied that Dr Lee knew that the concerns had been raised at the time he wrote the Letter.

Accordingly, the Tribunal refused the application under Rule 17(2)(g) made on behalf of Dr Lee in respect of Paragraph 4(c).

Paragraph 4(d)

290. It follows from the reasoning referred to at Paragraph 4(a)(i) of the Allegation that there is a case to answer. If an ultrasound of Patient A's prostate was not requested on the 27 November 2017, it would therefore follow from the evidence that the February 2018 referral was the first time Dr Lee had referred Patient A for an ultrasound scan of his prostate.

Accordingly, the Tribunal refused the application under Rule 17(2)(g) made on behalf of Dr Lee in respect of Paragraph 4(d).

Paragraph 4(e)

291. The GMC had indicated that it did not intend to pursue this paragraph of the Allegation.

Accordingly, the Tribunal granted the application under Rule 17(2)(g) made on behalf of Dr Lee in respect of Paragraph 4(e).

Paragraph 5(a)

292. The Tribunal has found that a panel could arguably conclude based on the GMC's evidence that Dr Lee knew that he had not requested an ultrasound of Patient A's prostate on 27 November 2017. On that basis, the first element of the *Ivey* test (subjective knowledge) would be satisfied. If despite the note he made Dr Lee knew that he had not requested an ultrasound on that date, a panel could also conclude that he had acted dishonestly by the standards of ordinary decent people.

Accordingly, the Tribunal refused the application under Rule 17(2)(g) made on behalf of Dr Lee in respect of Paragraph 5(a).

Paragraph 5(b)

293. The Tribunal has found that a panel could conclude that, notwithstanding his subsequent note, Dr Lee knew that he had not had the telephone consultation he alleged with Patient A. On that basis, the first element of the *Ivey* test would be satisfied. If he knew that despite his note, he had not had a telephone conversation with Patient A a panel could also conclude that he had acted dishonestly by the standards of ordinary decent people.

Accordingly, the Tribunal refused the application under Rule 17(2)(g) made on behalf of Dr Lee in respect of Paragraph 5(b).

Paragraph 5(c)

294. Again, the Tribunal has found that a panel could conclude that Dr Lee knew that he had not discussed a digital rectal examination (DRE) with Patient A and that Patient A had therefore not declined the DRE. On that basis the first element of the *Ivey* test would be satisfied. If he knew despite his note that he had not had such a conversation with Patient A, a panel could also conclude that he had acted dishonestly by the standards of ordinary decent people.

Accordingly, the Tribunal refused the application under Rule 17(2)(g) made on behalf of Dr Lee in respect of Paragraph 5(c).

Paragraph 5(d)

295. Paragraph 5(d) links to Paragraph 2 of the Allegation. Paragraph 2(b) of the Allegation is not being pursued. Paragraph 2(a) of the Allegation is simply the confirmation of the completion of the referral for the February 2018 ultrasound scan. This did indeed occur and there is no suggestion of dishonesty pertaining to it.

Accordingly, a panel could not reasonably find paragraph 5(d) of the Allegation proven and therefore the Tribunal granted the application under Rule 17(2)(g) made on behalf of Dr Lee in respect of Paragraph 5(d).

Paragraph 5(e)

296. The Tribunal has found that it would be open to a panel based on the GMC's evidence to find that Dr Lee knew that he had not had the telephone conversation, discussed the results, discussed and/or recommended a DRE and that the patient had not declined a DRE as per paragraphs 4(a)(ii), 4(a)(iii), 4(a)(iv) and 4(b) of the Allegation. On this basis the first element of the *Ivey* test would be satisfied. If despite the notes that he made, the panel were to conclude that he knew all these things, it could also conclude that he had acted dishonestly by the standards of ordinary decent people. However, the Tribunal was not satisfied that there was any logic to the suggestion that the Letter was dishonest because he knew that Patient A had raised concerns.

Accordingly, the Tribunal granted the application under Rule 17(2)(g) in respect of the cross reference to Paragraph 4(c) but refused the application in respect of the remainder of Paragraph 5(e).

Paragraph 5(f)

297. The actions admitted in Paragraph 1 of the Allegation were the addition of the notes on 13 February 2018 (U/S prostate), 12 May 2020 (telephone consultation) and 13 May 2020 (Patient A declining a DRE). The 13 February 2018 note preceded any complaint by Patient A. However, the Tribunal was of the view that a panel could conclude that one possible explanation for the retrospective addition of the note was to forestall potential criticism of

his not having made a referral following the November 2017 PSA results. The May 2020 notes followed shortly after the receipt by the Practice of Patient A's letter of complaint and again a panel could conclude that they were designed to avoid potential criticism. The Tribunal was satisfied that such a complaint (particularly one relating to an alleged non diagnosis of a potentially terminal illness) would be taken very seriously, notwithstanding that it did not constitute or threaten a legal claim.

298. With respect to the reference to Paragraph 2 of the Allegation the GMC are no longer pursuing Paragraph 2(b) and there is no evidence to suggest that the referral for the February 2018 scan as per Paragraph 2(a) was for the purpose of avoiding criticism. It arose from a consultation with Patient A about his painful groin albeit that the ultrasound scan request covered other medical issues.

299. With regard to Paragraph 3 of the Allegation, the Letter was in response to the letter of complaint. The suggestion that the patient had declined to cooperate in an investigation into his condition could be viewed by a panel as an attempt to shift blame and hence avoid criticism of the care and treatment provided.

In the light of the above analysis the Tribunal granted the application under Rule 17(2)(g) in respect of the cross reference to Paragraph 2 but refused the application in respect of the remainder of Paragraph 5(f).

Conclusion

300. The Tribunal granted the application under Rule 17(2)(g) in respect of:

- Paragraph 2(b);
- Paragraph 4(e);
- Paragraph 5(d);
- Paragraph 5(e) in respect of the cross reference to Paragraph 4(c) only;
- Paragraph 5(f) in respect of the cross reference to Paragraph 2 only;

301. The Tribunal refused the application under Rule 17(2)(g) in respect of:

- Paragraph 4(a)(i);
- Paragraph 4(a)(ii);
- Paragraph 4(a)(iii);
- Paragraph 4(a)(iv);
- Paragraph 4(b);

- Paragraph 4(c);
- Paragraph 4(d);
- Paragraph 5(a);
- Paragraph 5(b);
- Paragraph 5(c);
- Paragraph 5(e) except in respect of the cross reference to Paragraph 4(c);
- Paragraph 5(f) except in respect of the cross reference to Paragraph 2.