



Neutral Citation Number: [2024] EWHC 629 (Admin)

Case No: AC-2023-LON-001893  
CO/2269/2023

**IN THE HIGH COURT OF JUSTICE**  
**KING’S BENCH DIVISION**  
**ADMINISTRATIVE COURT**

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 26 March 2024

**Before :**

**MR JUSTICE SHELDON**

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**Between :**

**DR NITHYA SANTHANALAKSHMI**  
**SHUNMUGAVEL PANDIAN**

**Appellant**

**- and -**

**THE GENERAL MEDICAL COUNCIL**

**Respondent**

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**Sam Thomas** (instructed by **MDDUS**) for the Appellant  
**Rory Dunlop KC** (instructed by **GMC**) for the Respondent

Hearing dates: 5 March 2024  
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**Approved Judgment**

This judgment was handed down remotely at 10.30am on 26 March 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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**MR. JUSTICE SHELDON**

**Mr Justice Sheldon:**

1. Dr Nitha Shunmugavel Pandian appeals from the decision of the Medical Practitioners Tribunal (“the Tribunal”) of the General Medical Council (“the GMC”) to suspend her for a period of two months, following a finding that her fitness to practice was impaired by reason of misconduct.
2. The appeal is directed at the Tribunal’s finding that Dr Pandian had not conducted an examination of Patient A on 24 May 2019, even though she had written into Patient A’s notes various matters which indicated that an examination had taken place; and to the Tribunal’s finding that Dr Pandian had been dishonest in doing so. Dr Pandian submits that the Tribunal’s decision on the facts was wrong and/or was unjust because of serious procedural or other irregularity.
3. I have to consider whether or not to grant Dr Pandian an extension of time for her to bring the appeal, as her appeal was lodged out of time. If I do extend time, then it is necessary for me to consider the merits of her appeal.

Factual Background

4. Dr Pandian obtained her GMC registration in July 2018. She started working at Kettering General Hospital in November 2018. On 24 May 2019, Patient A attended the Accident and Emergency department of Kettering General Hospital presenting with concerns about her blood pressure. Patient A underwent an initial assessment and was transferred to the hospital’s Ambulatory Care Unit, where Dr Pandian was working as a Trust Grade Doctor, at Senior House Officer level. Dr Pandian’s duties involved detailed history taking, checking clinical vitals, carrying out relevant preliminary examinations, arranging initial investigations and presenting the case to a senior registrar or consultant for further assessments. After being assessed by Dr Pandian, Patient A was then seen by a consultant: Dr Khan. Dr Pandian has no recollection of seeing Patient A. Dr Khan did not give evidence to the Tribunal.
5. Patient A’s notes record that Dr Pandian carried out a physical examination. The notes record “S1 + S2 +” which relates to the patient’s first and second heart sounds. With respect to a respiratory examination, this is recorded as “clear” which means that no added sounds were noted. With respect to an examination of the abdomen, the notes record “soft and non-tender”.
6. Patient A complained to the Trust that Dr Pandian had recorded an examination that she did not perform. An investigation was carried out by the Trust. Patient A also made a complaint to the Ombudsman. Both closed their investigations with no further action.
7. The matter was referred to the GMC. After investigation, allegations against Dr Pandian were formalised as follows:

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

1. On 24 March 2019 you consulted with Patient A and wrote in her emergency assessment document in the box headed:

- a. cardiovascular, next to heart sounds, ‘S1 + S2 +’;
- b. respiratory, ‘clear’;
- c. abdomen, ‘soft, non tender’.

(These allegations were admitted).

2. You knew that you had not, at the time of your actions at:
  - a. paragraph 1a, listened to Patient ’s heart;
  - b. paragraph 1b, listened to Patient’s breathing;
  - c. paragraph 1c, examined Patient ’s abdomen.
3. Your actions at:
  - a. paragraph 1a were dishonest by reason of paragraph 2a;
  - b. paragraph 1b were dishonest by reason of paragraph 2b;
  - c. paragraph 1c were dishonest by reason of paragraph 2c.”

(The allegations at 2 and 3 were denied by Dr Pandian).

#### The Tribunal’s judgment

8. In its judgment, the Tribunal set out the evidence provided by the various witnesses: Dr Pandian, Patient A, and Mr B who is Patient A’s husband. The Tribunal set out the relevant legal principles, including the advice that

“Tribunals should be wary of placing too much reliance on the demeanour of individuals, however impressive, when assessing the accuracy of their recall of events, without being aware of the fallibility of memory and the importance and greater accuracy of contemporaneous documents”.

9. The Tribunal observed that Patient A stated that there were a number of “errors” in the medical notes written by Dr Pandian: that, contrary to what was set out in the notes, she did not have a cough at the time of the assessment, that she was not an HCA (a Healthcare Assistant), that she did not take Nurofen and that although she had discussed the medication Propranolol with her General Practitioner, she had not been prescribed it. Dr Pandian was reported to have told the Tribunal that she could only write down what the patient had told her. The Tribunal noted that Patient A was recalling events from four years ago when she commented on the notes. The Tribunal went on to say that it

“could appreciate that, while not ideal, the “errors” could perhaps be understandable. There were some parts in Dr Pandian’s notes that she had crossed out and then replaced with a correction and so this appeared to have been a developing

situation in which Dr Pandian was checking certain aspects with Patient A as she was writing and re-writing her notes. For example, under the heading “Presenting complaint”, Dr Pandian told the Tribunal that the words “chest pain” were obtained from the nursing notes, and crossed out by her subsequently and replaced with the word “palpitation” as this is what Patient A would have told her.”

10. At paragraph 35, the Tribunal observed that within Patient A’s medical records there was also a specialist review page that detailed the assessment conducted by Dr Khan at 11am on 24 March 2019, shortly after the assessment by Dr Pandian. The Tribunal noted that Patient A had stated that Dr Khan did not examine her either. The Tribunal commented that there is a reference within the specialist review page to the chest being clear. It reads: “O/E [that is, on examination] – alert, no tremors, lungs are clear”.
11. The Tribunal noted at paragraph 38 that on the specialist review page the words “anxious/anxiety” in Dr Pandian’s handwriting had been crossed out, and that Dr Khan had written “likely anxiety related symptoms” with an underline. The Tribunal commented that this was consistent with Patient A’s recollection of her assessment by Dr Khan. In her witness statement, Patient A had stated that during the course of her assessment by Dr Khan she saw the notes that he was writing. She could see that the consultant had written that her blood pressure was secondary to anxiety, and she saw him underline this twice. Patient A said in evidence that it bothered her that her symptoms were being put down to anxiety “especially as neither doctor ever physically examined me”. She also said that neither of the doctors “had actually listened to me”.
12. At paragraph 39, the Tribunal stated that it appreciated that Patient A would have been worried about her health when she attended hospital and that she had a headache which “felt like her head was exploding”. Nevertheless, the Tribunal was of the view that Patient A was

“very convincing in that the trigger for her complaint was when she saw the words “soft, non tender” in her medical notes and was aggrieved and immediately complained.”

The Tribunal went on to say that:

“The specific recollection of Dr [Khan] underlining certain words added credence to her account. The Tribunal was of the view that, despite being worried and upset, Patient A was in a position where she would have known whether she had been examined or not. The Tribunal did not find it to be credible that Patient A would have missed a physical examination on the account provided and the evidence before it as a whole.”

13. At paragraphs 40-42, the Tribunal discussed the evidence of Mr B. The Tribunal noted that when Mr B was asked whether he could have been mistaken that Dr Pandian had not examined Patient A, he had stated that he was not mistaken. The Tribunal mentioned that there were a number of matters that Mr B could not recall, including whether a consultant had seen Patient A. The Tribunal commented, however, that “crucially [Mr B] corroborates Patient A’s evidence that no examination took place by Dr Pandian”.

14. The Tribunal discussed Patient A's occupation at paragraphs 43-45. Dr Pandian's counsel, Mr Thomas (who also appears for Dr Pandian on this appeal) had argued that Patient A's occupation was irrelevant and should not be admitted by the Tribunal. The Tribunal decided that evidence about Patient A's occupation was admissible, but commented that "it placed limited weight on Patient A's occupation. The Tribunal was of the view that a patient did not have to be a healthcare professional to realise whether or not a physical examination had taken place."
15. The Tribunal referred to statements in support of Dr Pandian. At paragraph 58, the Tribunal commented that it was "clear that there were no other concerns or complaints about Dr Pandian's fitness to practise and there were a number of testimonials, including within the Rule 7 response, that referred to Dr Pandian's competence and integrity. The Tribunal took these into account".
16. The Tribunal concluded at paragraph 59 that:

"Dr Pandian could not specifically recall these events in relation to Patient A but was, nonetheless, adamant that she never makes mistakes of this nature. On the other hand, the Tribunal found Patient A's recollection to be persuasive for the above reasons and determined that it was more likely than not that Dr Pandian had not examined Patient A".
17. At paragraph 63, the Tribunal determined that Dr Pandian would have known that the examination had not taken place, but still made entries in Patient A's medical records to say that it had. At paragraph 66, the Tribunal determined that Dr Pandian knew that she had not, at the time of her actions in paragraph 1 of the Allegation, listened to Patient A's heart and chest or examined Patient A's abdomen. Accordingly, the Tribunal found paragraph 2 of the Allegation against Dr Pandian proved.
18. At paragraph 69, the Tribunal found that, in accordance with the test for dishonesty set out in *Ivey v Genting Casinos* [2017] UKSC 67, an ordinary decent person would, in the particular circumstances of this case, consider Dr Pandian's actions to be dishonest. A doctor should not complete entries within a patient's medical records stating that an examination has taken place when that had not occurred. That was dishonest.
19. The Tribunal went on to consider whether Dr Pandian's fitness to practice was impaired because of her misconduct. The Tribunal concluded that her conduct fell so far short of the standards reasonably to be expected of a doctor so as to amount to serious misconduct, and that Dr Pandian's fitness to practice was impaired. The Tribunal imposed the sanction of a two month suspension on Dr Pandian's registration.

### The Appeal

20. The Tribunal's determination was served on Dr Pandian on 12 May 2023 via email sent by the Medical Practitioners Tribunal Service. The email contained a letter stating that

"Any appeal must be lodged at the relevant court within 28 days of the date on which notification of this decision is deemed to have been served on you. Notification will be deemed to have

been served on 18 May 2023 and therefore any appeal must be lodged on or before 15 June 2023.”

21. Dr Pandian’s appeal was filed on 15 June 2023, but this was rejected by the Court Office because the bundle was not in the correct format. The appeal notice was subsequently sealed for service on 16 June 2023. The appeal should have been lodged on or before 9 June 2023.

### The Grounds of Appeal

22. The Grounds of Appeal are as follows:
- I. The Tribunal’s determination of fact, based upon the evidence, in relation to Allegations 2 and 3 was wrong, in that the Tribunal based its decision upon “persuasive demeanour” and memory which was clearly fallible. This was the incorrect approach based upon the authorities: (See: *Dutta v General Medical Council* [2020] EWHC 1974 (Admin) and *General Medical Council v Khan* [2021] EWHC 374 (Admin));
  - II. The GMC failed to present evidence from Dr Khan, the consultant supervising Dr Pandian, which contributed to the wrong decision by the Tribunal;
  - III. The Tribunal’s decision to allow Patient A’s employment to be elicited was procedurally incorrect. The fact was irrelevant and therefore inadmissible.

### The Statutory Framework and relevant legal principles

23. Section 40 of the Medical Act 1983 (“the 1983 Act”) sets out the statutory framework for an appeal from a decision of the Tribunal to the High Court. An appeal notice must be lodged within 28 days of service of notification of the decision: section 40(4). The statutory time limit can be extended in “exceptional circumstances” when to deny the power to extend time would impair the very essence of the right of appeal, so as to ensure compliance with the European Convention on Human Rights: see: *Stuewe v Health and Care Professions Council* [2023] 4 W.L.R. 7 at §49.
24. The test for an appeal is whether the decision of the Tribunal was “wrong” or “unjust because of a serious procedural or other irregularity in the proceedings”: see the Civil Procedure Rules (“CPR”), r.52.21.
25. The High Court has acknowledged the constraints on its role given that the Tribunal is the primary fact finder and will have the benefit of hearing directly from the witnesses. Recent descriptions of the High Court’s role have been provided by Warby J in *Dutta v General Medical Council* [2020] EWHC 1974 (Admin) at §§20-21, and Morris J in *Byrne v GMC* [2021] EWHC 2237.
26. In *Byrne*, Morris J was referred to a large number of authorities<sup>1</sup>. Morris J distilled the relevant legal principles as follows:

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<sup>1</sup> *Gupta v General Medical Council* [2001] UKPC 61 [2002] 1 WLR 1691 at §10 (citing *Thomas v Thomas* [1947] AC 484 [1947] AC 484 487-488 ); *E.I. Dupont de Nemours v S.T. Dupont* [203] EWCA Civ 1368 at §§84-98 esp at §84 and §98; *Assicurazioni Generali SpA v Arab Insurance Group* [2003] 1 WLR 577 at §§13-22, 197; *Chyc v*

“12. . . First, the degree of deference shown to the court below will differ depending on the nature of the issue below; namely whether the issue is one of primary fact, of secondary fact, or rather an evaluative judgment of many factors: *Assicurazioni Generali* at §§16 to 20. ...

13. Secondly, the governing principle remains that set out in *Gupta* §10 referring to *Thomas v Thomas*. The starting point is that the appeal court will be very slow to interfere with findings of primary fact of the court below. The reasons for this are that the court below has had the advantage of having seen and heard the witnesses, and more generally has total familiarity with the evidence in the case. A further reason for this approach is the trial judge’s more general expertise in making determinations of fact: see *Gupta*, and *McGraddie v McGraddie* at §§3 to ...

14. Thirdly, in exceptional circumstances, the appeal court will interfere with findings of primary fact below. (However the reference to “virtually unassailable” in *Southall* at §47 is not to be read as meaning “practically impossible”, for the reasons given in *Dutta* at §22.)

15. Fourthly, the circumstances in which the appeal court will interfere with primary findings of fact have been formulated in a number of different ways, as follows: - where “any advantage enjoyed by the trial judge by reason of having seen and heard the witnesses could not be sufficient to explain or justify the trial judge’s conclusions”: per Lord Thankerton in *Thomas v Thomas* approved in *Gupta*; - findings “sufficiently out of the tune with the evidence to indicate with reasonable certainty that the evidence had been misread” per Lord Hailsham in *Libman*; - findings “plainly wrong or so out of tune with the evidence properly read as to be unreasonable”: per in *Casey* at §6 and Warby J (as he then was) in *Dutta* at §21(7); - where there is “no evidence to support a ... finding of fact or the trial judge’s finding was one which no reasonable judge could have reached”: per Lord Briggs in *Perry* after analysis of *McGraddie* and *Henderson*. ...

16. Fifthly, I consider that, whilst noting the observations of Warby J in *Dutta* at §21(1), on the balance of authority there is

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*General Medical Council* [2008] EWHC 1025 (Admin) at §23; *Muscat v Health Professions Council* [2008] EWHC 2798 (Admin) at §83; *Mubarak v General Medical Council* [2008] EWHC 2830 (Admin) at §§5, 20; *Southall v General Medical Council* [2010] EWCA Civ 407 at §47 and §§50-62 (citing *Libman v General Medical Council* [1972] AC 217 [1972] AC 217 221F); *Casey v General Medical Council* [2011] NIQB 95 at §6; *O v Secretary of State for Education* [2014] EWHC 22 (Admin) at §§58 to 64, 66; *R (Dutta) v General Medical Council* [2020] EWHC 1974 (Admin) at §§21-22, 38-43; *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC 3650 (Comm) ; *McGraddie v McGraddie* [2013] UKSC 58 ; *Henderson v Foxworth* [2014] UKSC 41 at §§48 and 58-67; *Perry v Raleys Solicitors* [2019] UKSC 5 at §52, and the US case *Anderson v City of Bessemer* (1985) 470 US 564 at 574-57 ; and *Khan v General Medical Council* [2021] EWHC 374 (Admin). This list of authorities is set out in *Byrne* at §10.

little or no relevant distinction to be drawn between “review” and “rehearing”, when considering the degree of deference to be shown to findings of primary fact: *Assicurazioni* §§13, 15 and 23. *Du Pont* at §§94 and 98 is not clear authority to the contrary. Rather it supports the proposition that there may be a relevant difference when the court is considering findings of evaluative judgment or secondary or inferential findings of fact, where the court will show less deference on a rehearing than on a review.  
...

(2) The credibility of witnesses and corroborating evidence

17. First, the credibility of witnesses must take account of the unreliability of memory and should be considered and tested by reference to objective facts, and in particular as shown in contemporaneous documents. Where possible, factual findings should be based on objective facts as shown by contemporaneous documents: *Dutta* §§39 to 42 citing, in particular, *Gestmin* and *Lachaux*.

18. Secondly, nevertheless, in assessing the reliability and credibility of witnesses, whilst there are different schools of thought, I consider that, if relevant, demeanour might in an appropriate case be a significant factor and the lower court is best placed to assess demeanour: Despite the doubts expressed in *Dutta* §42 and *Khan* §110, the balance of authority supports this view: *Gupta* §18 and *Southall* at §59.

19. Thirdly, corroborating documentary evidence is not always required or indeed available. There may not be much or any such documentary evidence. In a case where the evidence consists of conflicting oral accounts, the court may properly place substantial reliance upon the oral evidence of the complainant (in preference to that of the defendant/appellant): *Chyc* at §23. There is no rule that corroboration of a patient complainant’s evidence is required: see *Muscat* §83 and *Mubarak* §20.

20. Fourthly, in a case where the complainant provides an oral account, and there is a flat denial from the other person concerned, and little or no independent evidence, it is commonplace for there to be inconsistency and confusion in some of the detail. Nevertheless the task of the court below is to consider whether the core allegations are true: *Mubarak* at §20.”

Extension of Time

27. Dr Pandian lodged her appeal on 15 June 2023. This meant that her appeal was brought out of time. It is clear that her appeal was lodged out of time because she had been misled as to the proper date by the Tribunal administration. The letter to Dr Pandian setting out her right of appeal was sent to her by email; it explained that any appeal must be lodged by 15 June 2023. That date would have been correct if the decision had



been notified to Dr Pandian by post, as the statute provides a deeming provision for service by post: see paragraph 8(5) of Schedule 4 to the 1983 Act. Service of the decision had been made by email, however, for which there are no deemed service provisions in the statute. Accordingly, time ran from the date of actual service, which in this case was 12 May 2023, and so the appeal should have been lodged within 28 days of that date.

28. It seems to me that, given that the late lodging of the appeal was caused by the Tribunal administration, it would be unjust to shut out this appeal for being out of time. These are exceptional circumstances which justify a reading down of the notice of appeal provisions<sup>2</sup>. The GMC did not object to this course of action.

### Ground 1

#### *Submissions on behalf of Dr Pandian*

29. On behalf of Dr Pandian, Mr Thomas submitted that the Tribunal made a wrong decision in this case, because it placed too much emphasis on the demeanour of Patient A, without taking into account the totality of the evidence and in particular the contemporaneous written evidence. Mr Thomas contended that the Tribunal should have taken the contemporaneous written evidence as the starting point of its analysis, and then assessed Patient A's evidence against that. In taking the approach that it did, the Tribunal misdirected itself, by failing to follow the principles set out in *Dutta* and *Byrne*. In *Dutta*, three fundamental errors were identified in the panel's reasoning process:

“First, the Tribunal approached the resolution of the central factual dispute by starting with an assessment of the credibility of a witness's uncorroborated evidence about events ten years earlier, only then going on to consider the significance of unchallenged contemporary documents. Secondly, the Tribunal's assessment of the witness's credibility was based largely if not exclusively on her demeanour when giving evidence. Thirdly, the way the Tribunal tested the witness evidence against the documents involved a mistaken approach to the burden of proof and the standard of proof.”

Mr Thomas submitted that the same criticisms could be made of the Tribunal in this case.

30. Mr Thomas argued that, if the Tribunal had taken the contemporaneous evidence as its starting point, it would have acknowledged that the notes of Dr Khan's assessment of Patient A supported Dr Pandian's version of events and undermined Patient A's reliability. Mr Thomas observed that Dr Khan came to the same conclusion as Dr Pandian – that Patient A's condition was “likely anxiety related” – and the consultant

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<sup>2</sup> I was told during the course of the hearing that the Medical Practitioners Tribunal Service has not amended the letter that is sent out to the parties. To avoid the same situation arising again, it would obviously be sensible for the wording of the letter to be amended.

could only have done so if he had examined the patient. This contradicted, and therefore undermined, Patient A's evidence, as the patient had told the Tribunal that she was not examined by Dr Khan.

31. Moreover, if Dr Khan had examined Patient A, then it would have been a "fluke" that Dr Pandian had come to the same conclusion about Patient A as Dr Khan had without examining her. The more likely interpretation of events, therefore, based on the contemporaneous evidence was that Dr Pandian's version of events was correct and the evidence of Patient A that there had been no examination could not be relied upon.
32. Mr Thomas also contended that it would defy logic for Dr Pandian to write down in the notes that she had examined Patient A if she had not done so, when Patient A was shortly going to be assessed by the consultant, Dr Khan.
33. In his Reply submissions, Mr Thomas argued that the documentary record relating to Dr Khan's assessment must be regarded as supporting the position that Dr Khan had examined Patient A. Patient A had said in evidence that she had told Dr Khan that she had not been examined by Dr Pandian. Patient A had also said in evidence that she had not been examined by Dr Khan. If both of those matters were correct, then it would mean that Dr Khan had provided his own opinion as to the cause of Patient A's symptoms and had agreed a plan of action for her in the knowledge that Patient A had not been examined at all. Mr Thomas submitted that that would be a very surprising thing for Dr Khan to have done. It was far more likely that Dr Khan had examined Patient A, and so Patient A's evidence that he had not done so undermined her reliability and credibility.
34. Mr Thomas also pointed to a number of discrepancies between Mr B's evidence and that of Patient A, and contended that these discrepancies were ignored by the Tribunal in its reasoning. For example, Mr Thomas submitted that it was Mr B's evidence that the complaint made by Patient A related to the fact that she queried the reference to her symptoms and experience being put down to anxiety in the notes. Patient A's evidence, however, was that her complaint was triggered by the reference in the notes to her abdomen being "soft, non-tender", implying that she had been physically examined, when she had not.
35. Mr Thomas contended that whilst the Tribunal concluded that Patient A was a credible witness, it did not find that Dr Pandian was not a credible witness. Mr Thomas also argued that the Tribunal appeared to have reversed the burden of proof within paragraph 39, where it stated that it "did not find it credible that Patient A would have missed a physical examination". Mr Thomas submitted that the factors identified on behalf of Dr Pandian, which placed Patient A in a state of unusual emotional and physical stress (such as her recent return to the United Kingdom and her mother's recent death) were either ignored or were not sufficiently convincing for Dr Pandian to have overcome that burden.

*Submissions on behalf of the GMC*

36. Mr Dunlop KC, on behalf of the GMC, contended that the Tribunal was entitled in this case to rely on its evaluation as to the credibility and reliability of Patient A's evidence, including her demeanour, in circumstances where there was no objective documentary evidence with respect to the alleged examination against which the oral evidence could

be tested. The documentary record prepared by Dr Pandian, which might in usual circumstances be regarded as objective evidence of what had taken place, could not be regarded as objective evidence as it was alleged to contain a false record of events. This falsification extended to the description of the examination of Patient A by Dr Khan on the specialist review page of the notes, as that description had been written by Dr Pandian as well.

37. Further, Mr Dunlop KC contended that the Tribunal did not merely rely on Patient A's demeanour. The Tribunal also relied on the reliability of Patient A's memory with respect to the fact that Dr Khan had underlined the words "anxiety". The Tribunal also relied on the fact that Patient A had made her complaint swiftly after the date of her alleged examination. Further, the Tribunal relied on Mr B's evidence, which corroborated that of Patient A that the examination by Dr Pandian had not taken place. The fact that Mr B's evidence was inconsistent with that of Patient A in a number of details was to be expected, as inconsistencies between witnesses will frequently arise. The Tribunal was not obliged to set out every point of inconsistency, and the fact that it did not deal with every piece of inconsistency does not mean that it got its decision wrong.
38. With respect to the argument raised by Mr Thomas in Reply, I gave Mr Dunlop KC the opportunity to respond. Mr Dunlop KC pointed out that this was not an argument that had been made by Dr Pandian before the Tribunal, so the panel could not be found to have reached a "wrong" conclusion for failing to address it. Further, it was not an argument that had been set out in, or foreshadowed by, the Grounds of Appeal or the Appellant's skeleton argument and it was unfair for it to be raised at the hearing before me. As to the substance of the argument, Mr Dunlop KC contended that the inference that Mr Thomas asked the Court to draw was not the only one available to it.
39. Mr Dunlop KC also argued that the Tribunal did not need to consider Dr Pandian's credibility as she had no memory of the patient in question. Mr Dunlop KC submitted that the burden of proof had not been reversed: Mr Thomas' arguments about this involved a misreading of the Tribunal's decision.
40. As for the alleged lack of logic for Dr Pandian to write down that she had examined Patient A when she had not done so, Mr Dunlop KC contended that regulatory panels regularly have to deal with cases – which are found proven – of medical professionals doing things which might make little sense. That does not mean that they did not occur.

#### *Discussion and analysis*

41. It is clear from the authorities that in the ordinary case where there is objective contemporaneous evidence available, the objective evidence should be considered first and the oral evidence should be tested against it. This approach makes considerable sense given the inherent unreliability of memory: see *Gestmin SGPS S.A. v Credit Suisse (UK) Limited* [2013] EWHC 3560 at §§15-17, per Leggatt J.
42. As explained by Morris J in *Byrne* at §19, where there is no documentary evidence available, the credibility and reliability of witnesses in their oral evidence is likely to be of real significance in the fact finding process, and this can include witnesses' demeanour in appropriate cases.

43. In the instant case, there was no objective contemporaneous documentary evidence as to whether or not Dr Pandian had examined Patient A. The only documentary record that was available was alleged to be falsified. There was also no objective contemporaneous documentary evidence as to whether or not Dr Khan had examined Patient A, as the notes about an examination on the specialist review page had been written by Dr Pandian herself.
44. With respect to the point made by Mr Thomas in Reply that it would be surprising if Dr Khan had not examined Patient A if he had been told that Dr Pandian had not examined her either, this argument was not made to the Tribunal, and so it would be wrong to criticise the Tribunal for failing to address it in its reasoning. In any event, I do not consider the point necessarily supports Dr Pandian. There are a number of possible explanations for why Dr Khan might not have examined Patient A even if he had been told by Patient A that Dr Pandian had not examined her. Dr Khan may not have heard Patient A say that she had not been examined by Dr Pandian. Dr Khan may not have understood what Patient A was saying. Dr Khan may not have believed what Patient A was saying, given that the notes explicitly referred to examinations of Patient A by Dr Pandian. It is not for this Court to speculate on what Dr Khan did or did not do, or why he did not do it. Accordingly, it cannot be said that Dr Khan must have examined Patient A, and that Patient A's evidence to the contrary cannot be reliable, thereby undermining her overall credibility.
45. Ultimately, therefore, there was no objective contemporaneous evidence of an examination by Dr Pandian or by Dr Khan against which the witness evidence of Patient A (and Mr B) could be tested. In the circumstances, the Tribunal's focus on the witness evidence was not wrong.
46. Furthermore, this is not a case where the Tribunal only relied on Patient A's evidence based on her demeanour. There were a number of other matters which bolstered the Tribunal's finding that Patient A was a convincing witness and so should be believed. The Tribunal was impressed by the fact that Patient A had recalled that Dr Khan had underlined the word "anxiety", and this was correct when the documentary evidence was looked at. There was also corroboration of her evidence by Mr B. Patient A's evidence was also supported by her relatively swift complaint that she had not been examined by Dr Pandian. The Tribunal also found that Patient A appreciated the significance of making a case against a doctor. There was, therefore, plenty of support for the Tribunal's conclusion that the examination by Dr Pandian had not occurred.
47. As for the discrepancies between Mr B's evidence and that of Patient A, it is correct that these are not specifically mentioned by the Tribunal. Nevertheless, the failure to mention these matters does not mean that the Tribunal's decision was wrong, as not all arguments made to a regulatory panel have to be addressed specifically in its decision. The fact that Mr B's evidence was inconsistent with Patient A on minor, or more tangential, matters does not mean that the Tribunal was wrong to accept Mr B's evidence as being reliable, and therefore corroborative, on the key question as to whether Patient A was examined by Dr Pandian.
48. Further, the Tribunal was not wrong in not making any finding as to Dr Pandian's credibility. It did not need to, given that Dr Pandian had no direct memory of Patient A and so did not give evidence as to what she had actually done. In addition, the arguable illogicality of Dr Pandian recording an examination which she had not done was

outweighed, in the Tribunal's judgment, by its finding that Patient A was credible and reliable. This is not an unreasonable conclusion for the Tribunal to have reached.

49. I also do not consider that the Tribunal reversed the burden of proof, as Mr Thomas had suggested it had done at paragraph 39. The Tribunal did not ignore the fact that Patient A was "worried and upset" when she attended hospital on 24 March 2019. The Tribunal make specific mention of this before finding, and stated that "despite" this, it was not credible that Patient A would have missed a physical examination had it in fact been conducted by Dr Pandian.

#### Ground 2

50. Mr Thomas contends that the Tribunal erred in not addressing the fact that the GMC did not call Dr Khan as a witness when the burden of proof was on the GMC. It was submitted that it would be entirely wrong in principle for the absence of Dr Khan to be held against Dr Pandian. Mr Dunlop KC submitted that there was no obligation on the GMC to call Dr Khan, and that the Tribunal did not need to say anything about the consultant's absence.
51. I agree with Mr Dunlop KC on this point. It was a matter for the parties as to who they should call as a witness. Dr Pandian could have called Dr Khan had she wished to, as could the GMC. The fact that Dr Khan was not called by either of the parties was not something which featured in the Tribunal's decision as having any relevance to its reasoning. It was not held against either party, nor was it regarded as favouring either party.

#### Ground 3

52. Mr Thomas maintained his argument that the Tribunal erred in allowing evidence about Patient A's employment to be admitted. In my judgment, the Tribunal did not go wrong in allowing the evidence in, as it had the potential to be relevant, depending on how the rest of the evidence developed. As it turned out, the Tribunal found the evidence about Patient A's employment to be of little weight. That evaluation was not wrong.

#### Conclusion

53. In my judgment, therefore, the appeal is dismissed.