

Humayun Kabir

Appellant

v.

The General Medical Council

Respondent

FROM

THE PROFESSIONAL CONDUCT COMMITTEE
OF THE GENERAL MEDICAL COUNCIL

REASONS FOR REPORT OF THE LORDS OF
THE JUDICIAL COMMITTEE OF THE PRIVY
COUNCIL OF THE 12TH JANUARY 1994,
DELIVERED THE 27TH JANUARY 1994

Present at the hearing:-

LORD TEMPLEMAN
LORD GOFF OF CHIEVELEY
LORD NOLAN

[Delivered by Lord Goff of Chieveley]

There is before their Lordships an appeal by Dr. Humayun Kabir from the determination and direction of the Professional Conduct Committee of the General Medical Council of 22nd March 1993 that the appellant was guilty of professional misconduct and that his name should be erased from the Medical Register.

The appellant was responsible for the general medical care of Mr. J. Hill, then living in Charlton, London S.E.7, who was a patient registered on his list of National Health Service patients. The charge against the appellant comprised the following three allegations:-

1. On 27th May 1988, when the appellant visited Mr. Hill at his home, he culpably failed to undertake an adequate medical examination of him and therefore failed to place himself in a position to enable himself to make a reasonable professional judgment on, and a proper assessment of, his patient's condition.
2. On 10th June 1988, he failed to visit Mr. Hill when
 - (a) he was requested to do so by the patient's wife;

(b) he received information about the patient's condition from his wife which should have indicated to him that a visit was necessary,

and he prescribed additional medication for Mr. Hill, for a nervous condition, without taking appropriate steps to ascertain his current need for such medication.

3. At an enquiry into the foregoing matters conducted on 4th May 1989 by the Medical Service Committee of the Greenwich and Bexley Family Practitioner Committee he sought to mislead that Committee by presenting false evidence, including entries in the patient's medical records, in his day book and in his visit book, as to his actions on 27th May and 10th June 1988.

In relation to the facts so alleged the appellant was charged with serious professional misconduct.

On 19th and 22nd March 1993, the Professional Conduct Committee inquired into the charges against the appellant. On that occasion the appellant, like the Council, was represented by counsel. Having heard the evidence and the submissions of counsel, the Committee determined that all the facts alleged against the appellant had been proved to their satisfaction. Counsel for the appellant then addressed the Committee in mitigation. The Committee then determined that the appellant was guilty of serious professional misconduct in relation to the facts proved against him, and directed that his name should be erased from the Register. It is against that determination and direction that the appellant now appeals.

At the conclusion of the hearing, their Lordships agreed humbly to advise Her Majesty that the appeal should be dismissed for reasons to be given later and the appellant was ordered to pay the respondent's costs. Their Lordships now set out their reasons for reaching that conclusion.

Evidence was given before the Committee by Mr. Hill's widow Mrs. Olive Hill (Mr. Hill having died since the events in question); by another general practitioner, Dr. Zoe Kenyon, who called at Mr. Hill's house on 14th June 1988 (having been contacted by Mr. Hill's daughter earlier that day) and who, having examined Mr. Hill, caused him to be admitted to Greenwich District Hospital on the same day; and by Mr. Stoker, a consultant surgeon, who was responsible for the care of Mr. Hill at the Hospital.

The evidence of these witnesses was to the following effect. In March 1988, Mr. Hill had been brought home from work with a bad right leg, which had been painful for 3-4 months. The appellant was called in on 8th April. He examined Mr. Hill; but his examination was very limited. He asked Mr. Hill to roll up his trouser leg and roll down his sock, and then to walk round the coffee table. Having felt Mr. Hill's right knee, he diagnosed osteoarthritis. Mrs. Hill told the appellant that her husband always had a cold

right foot, and asked him "if it was circulation"; but the appellant said that it was "all right". The appellant made no comparison between Mr. Hill's two legs. He did not ask Mr. Hill to remove his trousers or socks, nor did he examine his ankle or groin. He prescribed a painkiller and an anti-inflammatory cream.

On about 15th May, Mr. Hill grazed his right shin. The wound did not bleed, but it turned black. On 27th May 1988, the appellant made a second visit to Mr. Hill's house, at Mrs. Hill's request. The appellant examined Mr. Hill's shin, and felt his right knee; but once again he did not get him to remove his trousers or socks, nor did he examine his right ankle or groin or make a comparison between his two legs. He prescribed an antibiotic and a painkiller.

By 10th June 1988 Mr. Hill was suffering from severe pain in his right leg, and he asked his wife to get medical help. Mrs. Hill called on the appellant at his surgery, and told him that her husband's condition had deteriorated. She asked him either for a home visit, or for a referral to hospital, because her husband was in such pain. The appellant said that neither was necessary, and gave Mrs. Hill a prescription for an antibiotic, an antibacterial cream, and tablets for anxiety.

Four days later, on 14th June 1988, Dr. Kenyon called in response to a request from Mr. Hill's daughter. She obtained a full medical history from Mr. Hill. She carried out a full examination, and she noted a discoloured, cold right leg with a necrotic area on his right shin. She could find no pulses in his right leg, and she observed a marked difference in temperature and colour between his two legs. She diagnosed a blockage in the arterial system, high in the right leg, and she arranged for Mr. Hill to be admitted that day to Greenwich District Hospital. On examination of Mr. Hill in the Hospital, Mr. Stoker found that Mr. Hill suffered from generalised vascular disease which affected the supply of blood to his leg. His right leg was cold below the knee, and he had an ulcer on his right shin which was not healing due to poor blood supply. The femoral pulse on the right side (in the groin) was absent; and an aortogram confirmed a complete obstruction on the iliac artery and a block to the main femoral artery on the right. On 24th June 1988 Mr. Hill underwent a femoral bypass graft.

The appellant gave evidence before the Committee. He agreed that he first visited Mr. Hill on 8th April; but he said that he was asked to see Mr. Hill about a pain in his left knee. He claimed to have carried out a full examination, and in particular to have examined both knees. He found the joint of the left knee to be tender and swollen, and he diagnosed bronchitis. He also claimed to have seen Mr. Hill at his surgery on 15th April, when he provided him with a sick certificate. He

claimed to have examined his left knee again on that occasion, and to have found it to be still painful. According to Mrs. Hill, her husband did not leave his home after returning there from work in March. It was she who collected his certificates from the surgery, receiving them from the receptionist.

The appellant agreed that he visited Mr. Hill at his home on 27th May, because he had suffered a laceration to his right shin. After examining the wound, he examined "the other system" as well. He claimed to have checked Mr. Hill's pulses in both legs, taking "the pulses of both dorsum in the leg and popliteal". He claimed to have taken Mr. Hill's femoral pulse, which he detected, "so that there was no defect of any pulse anyway on any side of his body on that occasion".

He also agreed that on 10th June Mrs. Hill called on him at his surgery. At her request, he provided tablets for Mr. Hill's nerves, and another certificate. He said that he inquired after Mr. Hill's leg, and was told that it was improving slowly. Mrs. Hill did not ask for a home visit, nor for a referral to a hospital.

In support of his evidence, he relied on entries in his notes relating to Mr. Hill.

Their Lordships have set out in summary the different accounts given by Mrs. Hill and the appellant, because they revealed a serious conflict of evidence. The Committee, having heard the evidence and studied the relevant documents, plainly decided that they preferred the evidence of Mrs. Hill to that of the appellant. This, on the material before them, they were fully entitled to do. Indeed, having regard to the diagnosis of Dr. Kenyon made after a full examination carried out by her little over a fortnight after the appellant's visit on 27th May, it is difficult to see how the Committee could have reached any other conclusion. Dr. Kenyon's evidence demonstrated very clearly that a full examination of Mr. Hill, properly carried out, would have revealed the serious vascular problem from which Mr. Hill was suffering; and Dr. Kenyon's diagnosis was confirmed when Mr. Hill was examined following his admission to hospital. Mr. Hill was suffering from a chronic condition, as a result of which he had suffered severe pain; and, as events showed, his condition required his immediate admission to hospital for examination and treatment. The appellant never diagnosed what was really wrong with Mr. Hill. Furthermore, it is plain that the Committee were satisfied that the appellant had falsified entries in his notes, in particular his clinical notes relating to his actions on 27th May and 10th June, which he relied upon in an attempt to exonerate himself before the Medical Service Committee and again before the Professional Conduct Committee itself.

Faced with the conclusions of the Committee, and their foundation in the evidence before them, Mr. Siddiqi (who

said everything that could be said on behalf of the appellant before their Lordships) was reduced to advancing a number of specific criticisms of the conduct of the hearing before the Committee. First, he complained that certain diaries which the appellant wished to place before the Committee were excluded. The appellant had wished to rely on those diaries to rebut the allegation that he had falsified entries in his clinical notes; he claimed the diaries showed, in particular, that he habitually overwrote entries in documents maintained by him, and therefore that no significance should be attached to similar overwriting in his notes. Their Lordships can see no merit in this point. The appellant had in any event placed before the Committee medical records of other patients, which provided more pertinent evidence of the kind which he wished to derive from the diaries, which the Committee appear to have accepted. The real problem for the appellant was that the Committee plainly preferred Mrs. Hill's evidence to his own, and that the medical evidence was inconsistent with his account and indeed with the record revealed in the notes; from this it followed that the notes must have been altered after the event. In particular, the references to Mr. Hill's left leg in the notes for both 8th April and 15th April were inconsistent with Mrs. Hill's evidence, and with the fact that subsequently nothing was found to be wrong with that leg; indeed, the left leg was found to be normal, whereas there was a chronic problem with the right leg. Furthermore, a marginal note on 27th May that Mr. Hill's pulses were intact was inconsistent with the other medical evidence. In these circumstances, the diaries could have added nothing of relevance.

Next, Mr. Siddiqi claimed that there were serious inconsistencies between the evidence of Mrs. Hill and other evidence in the case. Their Lordships do not find it necessary to go through these alleged inconsistencies *seriatim*. They were all of minor importance; and in any event on examination they proved either to be illusory or to be susceptible of reasonable explanation. Other specific complaints were made by Mr. Siddiqi. In particular, he complained that no express warning was given by the Legal Assessor that, in so far as it was being alleged that the appellant had falsified his notes, the Committee should apply the criminal burden of proof. However, as appears from the transcript, counsel for the General Medical Council advised the Committee that, having regard to the conflict of evidence in the case, they should be satisfied so that they were sure with regard to the allegations made; and that this was understood was plainly accepted by counsel for the appellant in his closing submissions, in relation to the falsification of the notes in particular.

Their Lordships are satisfied that there is no substance in any of the points made by Mr. Siddiqi on the appellant's behalf. On the evidence before them, the Committee were fully entitled to reach the conclusion

