SECOND DIVISION, INNER HOUSE, COURT OF SESSION

[2023] CSIH 13
XA42/22

Lord Justice Clerk
Lord Turnbull
Lady Wise

OPINION OF LADY DORRIAN, the LORD JUSTICE CLERK

in the appeal

by

DR MINA MOHIUL MAQSUD CHOWDHURY

Appellant

against

THE GENERAL MEDICAL COUNCIL

Respondents

Appellant: P Reid; BTO Solicitors LLP
Respondent: Lindsay KC; Anderson Strathern LLP

14 March 2023

Introduction

[1] Following a hearing by a panel of the Medical Practitioners Tribunal Service the appellant, a consultant in paediatrics and neonatology, was found to be impaired in terms of his fitness to practise and as a result his name was erased from the medical register. He submits that that decision should be quashed and a new Tribunal appointed to re-examine the facts on the basis of a diagnosis of Autism Spectrum Disorder made between the

impairment decision and the sanctions hearing. It is asserted that this diagnosis is *res noviter veniens ad notitiam* (newly discovered information), likely to have had a material bearing on the Tribunal's assessment of fact and decision on impairment (*Rankin* v *Jack* 2010 SC 642).

Background

[2] The appellant qualified in 1998 and held a number of paediatric posts culminating in his becoming a full-time consultant at NHS Forth Valley in 2013. The allegations against him relate solely to his activities while providing treatment at the Meras Clinic. This was a private clinic, set up by him in Glasgow in 2014 in order to provide private paediatric care. For that purpose he had established two companies, Meras Global Ltd and Meras Healthcare Ltd.

[3] The events giving rise to the complaints occurred between March and August 2017. It was alleged by the GMC that the appellant failed to provide proper clinical care to three children (Patients A, B and C) in that he made diagnoses which were not clinically justified and as a result caused anxiety and distress to the parents of the patients. It was also alleged he recommended certain tests or investigations for which there was insufficient clinical justification.

[4] Parents A, B and C all gave evidence in person in support of the allegations, which evidence is reflected in the Tribunal's findings noted below. The appellant provided a written statement, supplemented at the hearing by oral evidence. He maintained that he had given a measured and differential diagnosis in each case and sought to characterise the parents as overly anxious and suggested that they had misunderstood what he had said to them during the consultations.

The Tribunal's findings

Patient A

[5] Patient A, a teenage child, had been losing weight, feeling faint and suffering from headaches and dizzy spells with no clear explanation. The only diagnosis made by NHS doctors was possible postural hypotension. In August 2017 patient A's mother felt that her condition had declined so much that she needed to see someone urgently. She then made an appointment with the Meras Health Centre for 18 August 2017.

[6] The Tribunal found the following facts to be proven:

1. During a consultation with Patient A and her mother on 18 August 2017, the appellant failed to provide good clinical care in that he:

(a) created an unwarranted sense of concern, in that, without sufficient clinical justification to do so he:

(i) informed patient A's mother that patient A had a "neuroblastoma in her stomach which could spread if left untreated", or words to that effect;

(ii) said to the mother "we are now going to have a serious conversation. We are going to have the conversation that all parents dread. We are going to talk about the 'C' word", or words to that effect;

(iii) advised the mother that patient A needed to undergo a number of blood tests and travel to London for an MRI scan.

2. During a consultation with patient A and her mother on 19 August 2017, he failed to provide good clinical care in that he created an unwarranted sense of concern in that without sufficient clinical justification to do so at that time,

(a) he informed the mother that patient A needed to:

(i) have blood tests as soon as possible;

(ii) go to the Portland Hospital [London] for an MRI scan the next week, or words to that effect;

(iii) have blood tests costing £3,245.00 reduced to £1947.00; and

(b) refused to write a letter confirming his care and treatment for patient A to her GP.

3. That

(a) at all material times he was the Managing Director and shareholder of Meras Global Ltd and Meras Healthcare Ltd; and

(b) that his actions were financially motivated and dishonest.

Patient B

[7] Patient B was approximately 30 months old and had a history of problems with diarrhoea, poor weight gain, sweating during the night and recurrent chesty coughs/infections. An NHS Paediatrician advised that he be tested to rule out Cystic Fibrosis, for which there was potentially a 6 months waiting list on the NHS. To avoid such a wait parent B decided to have the test done privately and made an appointment with the Meras Health Centre. Blood tests were arranged. About a week later parent B called for the results. She was told by the receptionist that there was no genetic abnormality and that there was a high chance that the child did not have Cystic Fibrosis. The receptionist said that nevertheless the appellant wanted to arrange a follow-up consultation which took place by Skype on 13 June 2017.

[8] The Tribunal found the following facts to be proven:

1. During a consultation, conducted via Skype, with patient B's parents on 13 June 2017, the appellant failed to provide good clinical care in that he:

(a) created an unwarranted sense of concern in that without sufficient clinical justification to do so at the time, he:

(i) informed patient B's mother that a high level of B cells could be due to blood cancer or lymphoma;

(ii) stated that he knew a place in London which could provide treatment for patient B;

(b) stated that there were no places in Scotland where echocardiograms could be performed on children, or words to that effect.

(c) did not recommend immediate referral for patient B to the local NHS paediatric oncology service, based on the advice he had given and did not make such referral.

2. During a consultation with patient B, his mother and grandmother on 14 June 2017, the appellant failed to provide good clinical care in that he created an unwarranted sense of concern in that without sufficient clinical justification to do so at the time he

(a) stated that as he "had detected a heart murmur on two separate occasions, this was not an innocent murmur" or words to that effect; and

(b) suggested a course of private treatment/investigation that was disproportionately expensive without offering appropriate referral for NHS treatment/investigation.

Patient C

[9] In February 2017, parent C noticed a lump on the left thigh of her daughter, who was approximately 15 months old at the time and sought advice from her GP. The GP noted that patient C was overall well in herself, but due to the parent's concerns made a paediatric

referral with a waiting time of approximately 15 weeks. On 6 March 2017, the parent consulted the GP over a second lump on the thigh, when the GP noted a smaller lump evolving on the right thigh. Parent C was recorded as being "distressed" about the lumps and the GP therefore made an urgent referral for the child to have an Ultra Sound Scan (USS), with an approximate waiting time of four weeks.

[10] Parent C, wishing to avoid the wait, made an appointment with the Meras Clinic for 7 March 2017. A colleague of the appellant examined the child. He noted that the child had a cold and swollen lymph nodes which would need monitoring and/or re-examination. He thought that the lumps felt like lipoma but an ultrasound would be required to confirm this diagnosis. In light of this, parent C was happy to wait for the NHS ultrasound. On 14 March 2017, parent C and her husband took patient C back to the Meras Clinic for a consultation with the appellant. Parent C stated that the appellant had instigated this by calling her to say that "something had been flagged up in the notes" or words to that effect. The appellant denied this and said that the parent had contacted him.

[11] The Tribunal found the following facts to be proven:

1. During a consultation with Patient C and her parents on 14 March 2017, the appellant failed to provide good clinical care in that he

(a) created an unwarranted sense of concern in that, without sufficient clinical justification to do so at the time, he

(i) informed patient C's parents that the child had a lump attached to the bone in her leg which was a soft tissue sarcoma, or words to that effect;

(ii) stated that:

(a) he knew a doctor in London who could arrange for Patient C to get an ultrasound scan, an MRI scan and biopsy done in a couple of

days; (b) most patients stay in an apartment to get everything sorted quickly; stated that 'if things are happening it is best to get on top of them early', when patient C's mother asked whether they could wait until after their booked NHS scan, or words to that effect;

(b) said "it would be confusing to return back to the NHS", or words to that effect;

(c) made the diagnosis[of soft tissue sarcoma] on the basis of a clinical examination alone; and

(d) did not arrange an immediate referral to the local NHS paediatric oncology unit in light of that diagnosis.

2. In patient C's medical records he recorded, in the knowledge that such information was untrue, that

(a) Patient C's parents pressed him for a diagnosis;

and

(d) an audio consultation took place on 16 April 2017.

The Tribunal's assessment of the evidence

[12] In reaching its conclusions on the facts, the Tribunal concluded that parent A was a very clear and robust witness when clarifying her account of events under cross-examination and found her oral evidence to be broadly consistent with her written statement. She gave a clear explanation on the issue of referral to the NHS. The Tribunal found her evidence to be reliable and had no reason to doubt her credibility. Parent B gave her evidence with clarity. Her oral evidence was broadly consistent with her written witness statement. The Tribunal was assisted by her clarity in conveying that she had

attended Meras Healthcare for a specific purpose – Cystic Fibrosis testing - and not for any other treatment or tests. The Tribunal found her evidence reliable and had no reason to doubt her credibility. Parent C was a measured and credible witness. Her oral evidence was reliable and consistent with her written witness statement. The Tribunal noted that she had a scientific background and some medical knowledge. It was assisted by her recollection and explanation of what she did on 16 April 2017. She maintained her account under detailed questioning and made concessions when appropriate.

[13] The Tribunal addressed whether it was fair in the circumstances to consider the evidence of the parents as supporting the evidence of each other. In this regard it noted that there were three wholly independent complainants, none of whom knew each other, but who all made very similar allegations of events within a short timescale. There were common features. In each instance the appellant had diagnosed or suggested a cancerous condition without sufficient investigation, thereby alarming the parents, and had gone on in each case to suggest or make arrangements for expensive private testing or treatment in London. Despite this in all three cases he made no referrals to local oncology and had been reluctant to communicate his diagnosis to the relevant GPs.

[14] The Tribunal considered that it was very unlikely that the parents could have all been mistaken about their accounts of what happened during their consultations with the appellant or in their recollection of what he told them. In view of the similarities between each complaint and the unlikelihood that three independent complainants, each making complaints within a short period, would either invent their allegations or misunderstand the advice that they were given, the Tribunal determined that the evidence of one complainant could fairly be treated as supporting the evidence of another.

[15] The Tribunal had regard to testimonial evidence concerning the appellant's character, but could accord this limited weight because of its greater concerns about his documentary and oral evidence. In particular, the appellant was reluctant to provide further evidence in relation to the number of private patients he treated, the staff that he employed, and his financial accounts, and had to be asked several times before providing that information. When he eventually did so the material suggested that the companies were loss-making and that he employed fewer staff than had originally been indicated. In his oral evidence the appellant was at times less than candid and at times became unduly defensive.

[16] The Tribunal also had regard to the Meras Healthcare Ltd consultation notes for Patients A, B and C. In each case the consultation notes were in conflict with what each of the parents said they had been told by the appellant at the time. The Tribunal initially understood that the notes produced were printouts from Meras' in-house computer system. However, it transpired that this was not so and what had been supplied was a transcription of the notes carried out by appellant.

[17] The Tribunal noted that the appellant could have provided screen captures from the computer system. Given how the material was produced, the Tribunal had very serious concerns regarding the integrity, accuracy and honesty of the transcriptions. The notes of the appellant's "impression" of the patients and record of their discussions were written in a defensive style. It considered that the transcribed notes read as if they were an overly detailed and retrospective justification of the appellant's actions and not a contemporaneous record. The notes were difficult to accept as an accurate factual record, not least to the extent that the content differed so markedly from the accounts of the consultations given by the parents.

[18] Furthermore, the GMC had asked the appellant to provide an audit trail of any changes to the settings or the visual interface of the computerised patient records, in order to address the suspicion that notes have been amended retrospectively. The appellant's assertion maintained that it was not possible to provide such a trail was unconvincing, in light of evidence from a computer software expert that such a record should be available.

Diagnosis of ASD

[19] By the time of the sanction decision the appellant's diagnosis of ASD had been made. This had followed concerns expressed by counsel instructed to appear for the appellant at the sanctions hearing (who had not previously been instructed in the case), who had family experience of the condition, and by an occupational therapist. This led to investigation and ultimate diagnosis of the condition. It is not disputed that the diagnosis is a genuine one. The psychiatrist who made the diagnosis, Dr Premal Shah, produced several reports, and gave evidence at the sanctions hearing, where he stated that the appellant suffered from ASD to a "moderate" extent (having previously considered the extent to be "extreme").

[20] As to the effect of the diagnosis this is covered in the written reports which indicate that:

1. There were indications that the appellant's communication style has led, and continues to lead, to misunderstandings:

    (a) Parents described him as not very reassuring and matter of fact.

    (b) He was known, even outside his professional life, for being blunt in his delivery, undiplomatic and pedantic.

(c) In interview he did not engage in social pleasantries which made it difficult to form a rapport.

This summary is followed by an expression of opinion, thus:

> "It is very likely that [the appellant's] communication difficulties and his less than average ability to appreciate other people's perspectives produced a disproportionate negative effect with those involved with him, including the parents of patients, the Tribunal and both legal teams. It would likely have a disproportionately large negative influence both in the perception of parents, but also of the Tribunal and legal team members."

2. The primary utility of a diagnostic label is to help both the individual and associated family, friends, and associates to understand that individual, and to recognise the implications in terms of the person's strengths and weaknesses. Without such a label, both the individual and surrounding associates can be extremely negatively judgemental about the individual. Dr Shah also expressed the opinion that:

> "it is very likely that the Tribunal's and both legal teams' perception of [the appellant] may have been significantly different if the diagnosis of ASD was known at the time."

He considered that it would have influenced the method of communication with him, since those with ASD find vague, nondirective questions difficult to answer, and may appear evasive or defensive. A diagnosis would have allowed the Tribunal and the two legal teams to institute reasonable/ useful adjustments to the proceedings to allow a fair process from the perspective of the appellant. It is likely that this could have influenced the Tribunal's conclusions.

3. It is likely that he would not have read parents' concerns accurately and may have provided information in a way that he perceived as being factual but may have been perceived as being very alarming by recipients. He may not have been aware that parents

would have perceived it as such and would perceive that what he was recommending was logical without being aware of its impact on the parent.

4. The appellant described in great detail his view of risk (including clinical risk). He indicated that he would "chase" any possibility of a differential diagnosis, however improbable in order to ensure that he had done his best for his patient. He acknowledged that whilst "common things were common", it was important to him to ensure that he had not left any possibility out, as it would not feel like complete and satisfactory clinical care, particularly in those who had not had apparent satisfaction through the usual channels.

5. The report suggests that there is evidence suggesting that the appellant has had a long history of keeping excessively detailed records, in line with his excessively detailed way of thinking. His overly detailed style is to a degree that it was clearly recalled by those who had provided references, namely his previous teachers, his co-researcher, his judo co-instructor, his accountant and those who went to school with him.

[21] An expression of opinion is stated:

> "It is likely that, if the Tribunal were aware of [the appellant's] autism, a different interpretation may have been attributed to some of the points raised at stage 1 of the proceedings."

Impairment decision and sanction decision

[22] At the sanctions hearing it was acknowledged that the rules of procedure did not allow the Tribunal to re-open its determination on the facts, so the diagnosis of ASD was relied on in relation to the appropriate sanction, and in particular the issue of remediation. Having made a finding of impairment the Tribunal concluded that only the sanction of erasure would suffice.

[23] It is not disputed that on the findings made by the Tribunal the decisions it reached on impairment and sanction were reasonably open to it. It is not at this stage necessary to

say anything else about these decisions, save in one respect. The main thrust of the appeal is that the diagnosis is *res noviter*, the earlier absence of which could be satisfactorily explained, which would have been relevant and admissible before the Tribunal, and in respect of which there was a reasonable prospect that it would have made a material difference to the Tribunal's decision.

[24] It is nevertheless necessary to draw attention to certain paragraphs in the sanction decision, since they are central to the submissions for the appellant, who seeks to place a particular interpretation on them.

[25] The Tribunal was presented with two reports, and evidence, from Dr Shah. The submissions made to the Tribunal in respect of these included that:

> "While [the appellant] does not seek to go behind the decisions at stages 1 and 2 as has been made clear, he submits that the medical evidence along with his reflections are highly relevant and material to sanction, particularly where no submissions were made at stage 2." (Para 12)

Further, the reports were a "factual matrix" which "contextualised the position". The submissions thereafter were focussed on the issue of remediation, and the effect of the diagnosis thereon.

[26] The following excerpts from the decision are relevant:

> "19. As a result of the receipt of Dr Shah's psychiatric report, the Tribunal found itself in a constrained and difficult position in that it was unable to review the decisions it had made at stage one and stage two. For the avoidance of any doubt, Mr Powell on behalf of [the appellant], conceded that this Tribunal could not go behind the decisions at stage one and stage two. Mr Morwood on behalf of the GMC also confirmed this Tribunal did not have the power to review its decisions at stage one and stage two.
> …
> 21. The Tribunal was of the view that Dr Shah is a well-respected senior psychiatrist, with specialist experience in ASD since 2013 and it has accepted his diagnosis of ASD in respect of [the appellant]. Dr Shah clarified in evidence that he now thought this was to a '*moderate*' and not '*extreme*' extent.
>
> …

> 31. The Tribunal considered that [the appellant] has had the opportunity to remediate over the now two and a half years since the stage one findings and since the complaints were made. The Tribunal also considered [the appellant's] reflections carefully. It agreed that the issue of communication was now a factor in this case, as a result of considering and accepting the contents of Dr Shah's report. However, the Tribunal was unable to determine what impact and of what relevance [the appellant's] diagnosis of ASD had on his communications with the parents of the patients, given that it could not go behind its findings and rehear any evidence."

The legal test

[27] Parties were in substantial agreement about the legal test in a case such as this. The test in regulatory proceedings was the same as that which arose in any other civil context. Thus:

(a) It was for the party seeking to introduce the fresh evidence to satisfy the court that there is an acceptable explanation for the evidence not having been available at the time of the original proceedings;

(b) that party must satisfy the court that the fresh evidence would have been relevant and admissible before the original Tribunal; and

(c) the court must be satisfied that there is a reasonable prospect that the fresh evidence would have made a material difference to the Tribunal's decision.

[28] Even where relevant evidence was not available at the proof and its non-availability was not due to a failure to investigate the case properly, the court will not necessarily allow additional proof: the overall consideration is the interests of justice, in respect of which finality is an important element. Particular difficulties may arise where it is sought to lead additional evidence in order to persuade the court to alter findings in fact which were based upon the Lord Ordinary's assessment of credibility or reliability. The court will normally be slow to reopen the evidence. (*Rankin* v *Jack; Clark v Greater Glasgow Health Board* 2017 SC 297; *Ralston* v *Secretary of State for Scotland* 1991 SC 336). Reference was also made to the

guidance given in *Megrahi* v *HM Advocate* [2002] JC 99; and *Fraser* v *HM Advocate* 2008 SCCR 407, in the criminal context, where very similar considerations arise.

Submissions for the appellant

[29] The fact that the diagnosis was made only after counsel had suggested that there might be an issue of that kind was the reasonable explanation for the fact that the evidence was not available to be put before the Tribunal at the determination stage. It had been the appellant's new counsel expressing the view that the appellant exhibited autistic traits which started the chain of events leading to the diagnosis. Although the traits which support a diagnosis of ASD will be lifelong ones, it is nevertheless known that there is a rate of late diagnosis of the condition. The reason for the diagnosis not being known of, and thus the evidence not being available at an earlier stage, is reasonable.

[30] The Tribunal's observation in the sanction decision to the effect that it was "'in a constrained and difficult position" (para 19); its acceptance that the issue of communication was now a factor in this case, as a result of considering and accepting the contents of Dr Shah's report (para 31) and its recognition that it was unable to determine what impact and what relevance the appellant's diagnosis of ASD had on his communication with the parents of the patients, given that it could not go behind its findings and rehear any evidence (para 31) were all strongly supportive of the appellant's case. The Tribunal can only have viewed itself in a "difficult" position if it considered that the evidence of the appellant's diagnosis had a reasonable prospect of making a material difference to its findings at the earlier stage. In other words, the Tribunal accepted, amongst other things, that ASD would "likely have a disproportionately large negative influence" upon their perception of him. The Tribunal clearly accepted that this raised a new issue in the case. It was essentially

stating that had it been aware of this evidence it would have reached a different conclusion on the factual determination.

[31] The new evidence consisted in the diagnosis in the reports from Dr Shah and where the appellant sits on the spectrum of ASD. It was submitted, in very general terms, that there were aspects associated with a diagnosis of ASD which would have been likely to impact on the appellant's evidence to the Tribunal, and the Tribunal's assessment of the credibility and reliability of his evidence.

Submissions for the respondents

[32] It was submitted that the appeal should be refused because the diagnosis of ASD is not *res noviter veniens ad notitiam* and is immaterial in respect of the grounds upon which the Tribunal concluded that the appellant's fitness to practise was impaired.

[33] The diagnosis, with the exercise of reasonable diligence, could have been obtained in the advance of the hearing to determine the facts. Dr Shah's report suggests that the traits relevant for the diagnosis have been present in the appellant for a very long time.

[34] In any event, the evidence was unlikely to alter the factual findings of the Tribunal, especially given the cross-admissibility of the parents' evidence. It was very unlikely that all three parents could have been so mistaken about their accounts of what happened during their consultations with the appellant or in their recollection of what he told them.

[35] The demeanour of the appellant was not material to the Tribunal's assessment of his credibility. Rather, it was the acceptance of the credibility and reliability of the evidence of the complainants and serious concerns relating to the integrity, accuracy and honesty of the transcribed consultation notes that resulted in the Tribunal making adverse credibility findings in respect of the appellant. Both of these grounds are wholly unrelated to the

diagnosis of ASD as they were not decided upon the basis of the appellant's demeanour or the manner in which he understood and answered questions. Nor was the appellant's refusal to provide screen shots and/or an audit trail in any way connected to a diagnosis of ASD. Insofar as reasonable adjustments, there is nothing in the transcript of the hearing that gives rise to any reasonable or legitimate concerns that the Appellant did not understand the questions that he was being asked.

[36] It would not be in the interests of justice to allow the appeal.

Analysis and decision

General observations

[37] There is a clear flaw at the centre of the appellant's approach in this case. That is that the primary focus has been on the mere diagnosis itself, rather than on the manner in which certain features of the condition effect the appellant in specific ways related to the subject matter, conduct and outcome of the proceedings. The diagnosis itself, and a recital of common characteristics which may be, or even are, found in the appellant does not advance the issue. It is always important to bear in mind that the new evidence must be examined in the context of the whole proceedings, and the evidence led during the original process. To succeed with an appeal on the basis that this constitutes fresh evidence it is vital to link it closely to the conduct and outcome of the proceedings in a way which might persuade the court that it could have a material effect on the decision. A proper and detailed analysis from the viewpoint of the appellant should be the start of this, which may or may not lead to a detailed analysis of parts of the transcripts. This is necessary not only because of the need to establish materiality, but because, as Lord Reed noted in *Rankin v Jack* (para 40) a step in assessing whether the grounds advanced have merit is to examine the cogency of the

evidence advanced. In short, the diagnosis would not be capable of impacting on the original decision unless it manifested itself in ways which influenced or contributed to that decision.

[38] It is a striking feature of this case that the only evidence placed before the court in support of the appeal comes in the form of reports from Dr Shah. Of course, in the course of preparing those reports Dr Shah had recourse to statements of/interviews with the appellant, and others who knew him well or had dealings with him. He will reasonably have taken them *pro veritate*. However, none of that material is placed before the court and there is no mechanism offered by which it could be tested by the respondents or the court, particularly in relation to any potential effect on the proceedings in, and decision of, the Tribunal. The only evidence on which the appellant seeks to rely is that of Dr Shah. There is no suggestion that the appellant's evidence at any reconstituted Tribunal would differ from the evidence given at the original hearing. This is, to say the least, difficult to understand, but as we have noted below we have not been furnished with any statement or affidavit from the appellant. It seems highly likely that were this appeal to succeed the evidence of the appellant – and indeed possibly others – might be different or in addition to evidence given in the original proceedings. This, as much as anything, exposes the flaw in the approach of resting on the evidence of Dr Shah alone.

[39] The contents of Dr Shah's reports are for the most part stated at a level of generality in relation to the appellant and how the condition might generally manifest itself. This is not a criticism of Dr Shah, it is reasonable that he should take this approach in a diagnostic setting. It is for the appellant and his advisers to place before the court the material which makes the necessary link between the generality of how the condition impacts upon the appellant and the way in which he presented to the Tribunal, gave his evidence or was

assessed by it, in such a way as to persuade the court that had the Tribunal heard the evidence a door to a different result might have been opened. We should stress that we are not for a moment suggesting that all the material placed before Dr Shah and used as the basis of his diagnosis should be placed before the court. There is no dispute that the diagnosis is correct and that he was entitled to rely on the material as he did. However, it does not follow that material relevant to the making of the diagnosis is equally of materiality in relation to the issues of fact which the Tribunal had to determine. Sufficient material requires to be placed before the court, even if only in the form of an account from the appellant explaining for example, that he found certain questions difficult to answer, or that he realises retrospectively that he answered certain questions in such a terse way that it might have influenced the Tribunal's assessment. A great deal of material may not be required but there must be sufficient to provide the necessary link between the determination in the proceedings and the way the specific condition manifests itself in the appellant. It must be borne in mind that Dr Shah's supplementary report came with this rider at section 2.1:

> "It must be stressed that the nature of impairment in ASD varies between individuals and depends on individual circumstance. Those with significant ASD can be extremely productive individuals who contribute significantly in their chosen line of work."

The material must be capable of enabling the court to conclude that it was likely to have had a material bearing on or part to play in the determination of critical issues in the proceedings.

[40] This is not what has occurred in this case. Instead the submission was at a similar level of generality, namely that the condition was relevant in the following respects:

1. It explains why the appellant would have difficulty interpreting the parents' emotional state, thus justifying his assessment that they were overly anxious in terms of seeking a diagnosis, a proposition which the Tribunal rejected.

2. The condition means the appellant has a low tolerance to risk or uncertainty so he has to articulate or exclude those risks, hence explaining the discussions about other likely diagnoses.

3. The condition provides a prism through which the appellant's oral evidence must be seen and understood as affecting assessment of credibility and reliability:

- he has difficulties with social interaction;

- he may come across as abrupt and direct;

- he may have difficulty understanding the questions or unspoken meaning behind them.

This explains the demeanour which the Tribunal considered was a problem.

4. The condition explains the appellant's record-keeping – which the Tribunal considered "overly-detailed", and impliedly constituting retrospective justification. He has a long history of excessively detailed record-keeping.

5. It would have allowed those involved in proceedings to decide how to formulate questions in the knowledge that the appellant cannot interpret unspoken assumptions.

[41] There is no further attempt to link these factors with specific aspects of the appellant's evidence before the Tribunal; or decisions and assessments made by the Tribunal; and in particular to show how they might have impacted upon the Tribunal's determination of the stark conflicts of fact which arose in the case, some of which are discussed at paragraph [47] below. No affidavit or statement from the appellant seeking to address these issues has been provided, nor has there been an attempt to analyse the

transcripts to show where the condition may have impacted upon the evidence of the appellant, whether in relation to the kind of questions asked of him, comments from the Tribunal or his presentation generally.

[42] Counsel for the appellant sought to draw comfort from the wording of the expressions of opinion from Dr Shah referred to above. However, with great respect to Dr Shah, who we understand to be eminent in his field, it seems to us that in these passages he is doing little more than speculating; and moreover that he is at serious risk of trespassing on the function of the court. Again this is not a criticism of Dr Shah, because we note that he was specifically asked by the appellant's agents to comment on these matters.

[43] It may be that this approach was followed because of the erroneous interpretation placed on paras 19 and 31 of the Tribunal's sanctions decision. We are unable to read these comments as carrying the weight attributed to them on behalf of the appellant. The reports of Dr Shah had no bearing on any issues before the Tribunal other than sanction, and could never have done so. The Tribunal was simply acknowledging this. It is impossible reasonably to read these comments as implying that the Tribunal would have reached a different decision on the facts had it been aware of the diagnosis at an earlier stage.

Reasonable explanation

[44] Leaving aside the issue of deficiency in the nature of the material provided, we are not satisfied that the appellant has provided a reasonable explanation for the absence at an earlier stage of the evidence now sought to be placed before the Tribunal. The reports from Dr Shah are redolent of characteristics which have been obviously and markedly apparent for a very long period of time to a wide variety of individuals- colleagues; family; school teachers. One might have expected to see at the very least an affidavit from the appellant

and/or his wife stating that no-one had previously raised the possibility that he might have ASD. In the light of indications that significant traits have been exhibited since childhood it is not satisfactory to rely on an *ex parte* statement on his behalf that this was the case.

[45] In the case of *B* v *HM Advocate* 2014 SCCR 376 the court discussed the need for an appellant seeking to rely on additional evidence in an appeal against conviction to demonstrate that there was a reasonable explanation for the proposed new evidence not having been heard in the original proceedings. In that case the proposed additional evidence comprised statements which it was claimed had been made by one of the complainers in the case to relatives of the appellant in advance of the trial. In delivering the opinion of the court at paragraph [19] the Lord Justice Clerk (Carloway) said:

> "There is no evidence before the court, in the form of an affidavit or a statement from either the appellant or his former agents, that the conversation, whatever its content, was not known to the appellant or his legal advisers. There is no evidence about what consideration was given by agents, in consultation with the appellant or otherwise, about any enquires of members of the appellant's extended family. In the future, the court wishes to make it clear that it would expect that type of material to be made available."

This court endorses those comments and emphasises their applicability to any form of appeal based on the availability of new evidence.

Materiality

[46] We are not, in any event, persuaded that the new evidence would have made a material difference to the Tribunal's decision. The Tribunal's decision centred on the assessment of the evidence of the parents against that of the appellant. The issue was one narrowly focussed on the credibility and reliability of the competing accounts.

[47] A number of sharp conflicts arose between the evidence given by the respective parents and that of the appellant. In each case the Tribunal was able to resolve this conflict

for reasons which did not bear on the appellant's demeanour or method of communication, or other general factors which might be related to the appellant's ASD, and which was often based on extraneous evidence. Amongst the key such conflicts were the following:

(i) In relation to patient A there was a sharp dispute as to whether the appellant had given a diagnosis strongly indicating the presence of neuroblastoma; or whether he had offered this only as one of several differential diagnoses, which were described by him as unlikely.

The Tribunal resolved this in favour of the parent having regard to other medical notes. Patient A's condition had deteriorated to the extent that she was admitted to the Royal Hospital for Sick Children for a week in August 2017. Her mother said that she told the doctors she had received a diagnosis of cancer. This is recorded in her hospital records of 20 August 2017 which noted:

> "the doctor there recommended investigations, parents were not happy with and gave a diagnosis of cancer, asked for expensive blood tests. The doctors (*sic*) name is Mina Chowdhury".

On 21 August the notes record:

> "They were told after palpitation of the abdomen that she had a neuroblastoma which had likely metastasised to her upper spine and she should go to the Portland for an MRI today (Monday). When asked if her care would be transferred back to the NHS the doctor said no, because the NHS just dismisses our diagnoses".

(ii) In respect of patient B the assertions were that the appellant had created an unwarranted sense of concern by informing the parent that a high level of B cells meant that the child could have blood cancer; and had stated without justification that an echocardiogram was indicated, since he had heard a heart murmur on two occasions, meaning that the murmur was not innocent. The appellant did not in fact dispute that he said the former, although he maintained he said it was unlikely. As to the heart murmur,

his position seems to be that he only heard this once, and would not have recommended an echocardiogram on that basis.

The Tribunal noted from the records that the parent had reported to her GP that the specialist (ie the appellant) had definitely indicated that there was a heart murmur, which suggested a degree of anxiety on her part and was more consistent with her account than that of the appellant.

(iii) Whether the consultation on 14 March had been instigated by the appellant, or had been at the request of the patient C's parent.

The Tribunal resolved this dispute in favour of the parent. It noted that the consultation with the appellant's colleague, on 7 March, which had offered a likely diagnosis of lipoma had reassured the mother, and whilst this still required to be confirmed by ultrasound, such an intervention was to be carried out on the NHS in a matter of weeks. There was therefore no reason for the parent to contact the clinic for a further appointment or to have any ongoing concern.

(iv) Whether the appellant had given a positive diagnosis of soft tissue sarcoma or whether he had specified this only as a very unlikely differential diagnosis; and whether the parent had pressed for a diagnosis or whether the appellant had volunteered it.

The Tribunal again resolved this in favour of the parent. The finding that the appellant had instigated the meeting, not the parent, was relevant here, but of most significance were the medical notes at the hospital. The Tribunal noted that parent C gave evidence that she had been so worried that she had spoken to an oncologist friend, who expressed surprise that the appellant would give such a diagnosis without a scan or biopsy having been performed first. This led her to contact a paediatrician at the RHSC by e mail explaining that she had been told that one of the lumps was a soft tissue sarcoma. He advised her to contact A&E where

following an ultrasound the view was that the lump was likely to be fat necrosis. Blood tests were normal. The A&E records - within 2 days of the meeting with the appellant - noted the parent as stating that she had recently seen a private paediatrician who had advised that the lumps on the thigh were likely to be soft tissue sarcomas.

(v) The appellant maintained that there had been a telephone consultation with parent C on 16 April 2017. Parent C, having reviewed her diary noted that this was Easter Sunday. She knew clearly that she had attended a family lunch that day and had received no call from the appellant. She said that there had in fact been no communication during the month of April.

[48] The Tribunal accepted the parent's evidence on this, considering her explanation to be the more plausible account. The fact that the date was actually Easter Sunday would obviously make it memorable.

[49] In addition to these factors is the fact that these complaints were made by three people unknown to each other, in relation to behaviour over a short timescale, and with a striking degree of similarity.

[50] As to the notes, the fundamental concern of the Tribunal lay in the facts that (i) the content differed significantly from what the parents said; (ii) given their acceptance of what patient C said about 16 April 2017 that entry could not be true; (iii) that they had at no time been given screenshots of the entries, which should have been a relatively easy matter to arrange; (iv) that the material originally presented as the notes was in fact a purported transcription by the appellant from the source material, which the Tribunal was never shown; (v) the absence of an audit trail as to alterations on the recording system, which should have been possible to provide according to expert evidence.

[51] The expert reports paint an impression of the appellant being awkward or aloof in certain social situations, and of him perhaps being perceived as blunt or even rude. None of those features, in our view, contributed to the Tribunals' assessment of the appellant's evidence. The Tribunal was rightly concerned with credibility and reliability, rather than likeability. It is highly experienced in scrutinising witnesses' evidence and no issues were raised as to the appellant's comprehension of certain lines of questioning. Significantly, much of his evidence was placed before the Tribunal in a written statement.

[52] In appeals of this sort it is important to observe that there is a danger of ascribing to new evidence more significance than it would have had at the actual hearing. It is important to assess the new evidence in the context of the whole testimony adduced at that hearing. In this context it is of relevance to note that there was no submission on behalf of the appellant as to how the diagnosis of ASD would bear on the conflicts of fact which arose and which the Tribunal resolved in favour of the relevant parents.

[53] In these circumstances the appeal will be refused.