The legal fallacies about 'if it was not written down it did not happen', coupled with a warning for 'GDC experts'

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Key points

- It is a legal fallacy that 'if it was not written down it did not happen'.
- A dictaphone is a useful, traditional and acceptable way of summarising all the important and available information immediately after the consultation.
- 'Pseudo-experts', acting for the GDC, can be imprisoned for up to two years if they stray beyond their remit or make false, rash or inappropriate allegations in their report,when this is accompanied by a statement of truth.

Abstract

It is a fallacy that 'if it was not written down it did not happen'. The expression has become something of a mantra among certain dental 'educationalistas' and has been recited so often by some plaintiffs' tame 'experts' and by some lawyers that many people now believe that it is true. As a matter of law, it is not. This article challenges the correctness of that oft-repeated assertion – because it is not a law of evidence and neither is it even a law of logic.

A lot of truly important diagnostic information can be gleaned by listening carefully to a patient with both of an interested clinician's eyes and ears being fully open and being 'fully present', rather than furiously scribbling notes. In fact, overtly concentrating on writing or typing notes, rather than sympathetically engaging face-to-face with a patient, can often detract from the chances of that patient being open and honest enough to reveal the bits of information that are so vital in getting the full diagnostic picture. A dictaphone is a useful, traditional and acceptable way of summarising all the important and available information immediately after the consultation.

The second part of the article draws attention to the potential for imprisonment for up to two years of 'pseudo-experts' who stray beyond their remit – or who make false, rash or inappropriate allegations in their report when this is accompanied by a statement of truth.

Introduction

For many dentists, the General Dental Council (GDC) is now a byword for threatening, bullying and intimidating behaviour with labyrinthine, inefficient processes which often appear inherently unfair to dentists.

For over 45 years, I had been lucky not to get caught up in the GDC's Kafkaesque processes, although I had written an article outlining these titled 'Regulators and regulations – who will guard the guards?' (2015).[1] That paper was prompted in part by my ten years on the Board of Dental Protection, during which time I had noted serious problems in many GDC approaches, not least with respect to fairness.

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I had also previously written in *Dental Update* an article titled 'The paradoxes of phantom bite syndrome or occlusal dysaesthesia', along with my esteemed colleagues Rasanatnam and Djemal.[2]

As I will explain, those articles proved to be prophetic.

The main purpose of the first part of this article is to illustrate how a professional expert witness, instructed by the GDC, was seduced by the adage 'if it is not written down it didn't happen'.

The details of the relevant case law are expressed very elegantly in the submissions prepared by Stewart Duffy, a partner at RadcliffesLeBrasseur, who is a highly regarded expert in the medico-legal minefield.

The second section of this article relates to a recent judgement which highlights the possibility of imprisonment of 'experts' who make false, rash or irresponsible statements in their reports to a court.

As the judgement makes clear, the prospect of imprisonment arises regardless of whether the inappropriate claims were made intentionally, or unintentionally, or for direct or indirect gain – or for no gain at all. The severity of the penalty reflects the importance that the court attaches to an expert's report. That judgement should serve as a stark warning to those who put themselves forwards as experts for the GDC not to stray into any areas beyond their competence or experience and not to make ill-considered, irrational or speculative claims.

The GDC might wish to alert potential experts to this at the time they are instructed, as some appear to have little current knowledge of the practical realities of contemporary dental practice in the UK.

The original problem

A few years ago, I was the subject of a complaint to the GDC. The complainant had made no attempt at local resolution. The patient had been referred to my NHS clinic and I made a diagnosis of 'phantom bite syndrome' (occlusal dysaesthesia) over two visits.

The patient attended our busy NHS postgraduate teaching clinic and completed a 12-page facial pain questionnaire which raised some concerns.

At my suggestion, the patient was seen by an experienced dental core trainee under my direct supervision. I was watching throughout the whole of that appointment in an open clinic. The trainee made four pages of detailed handwritten clinical notes which included the statement 'S/B Mr Kelleher', which is shorthand for 'seen by Mr Kelleher'.

While waiting for radiographs to be uploaded to the computer, I had discussed the case with the trainee and I had annotated the 12-page facial pain questionnaire in my own handwriting – ('?PBS' meaning 'phantom bite syndrome?'). We also reviewed the high-quality colour printouts of all the patient's occlusal contacts on the teeth in both jaws, which were included with the referral letter.

While I examined the patient, I had shown the trainee a technique for marking any possible occlusal contacts on the ceramic restoration to which the patient attributed her problems. This involves drying the tooth and using a combination of copal ether varnish and appropriate articulating paper. That fact was clearly written in the handwritten notes by the attending nurse as both the trainee and I were wearing surgical gloves for the examination.

The patient insisted that all of her problems 'were being caused by her bite', which she was adamant were due to the restoration being high and that this was causing her chronic obscure pain elsewhere.

There were no obvious radiographic findings.

The patient had a number of occlusal devices which had been made for her by various people whom she had consulted. I examined those carefully. I spoke with the patient, discussing her history and the relevant aspects of her facial pain questionnaire, as well as the clinical findings. I showed her the colour pictures of the occlusal contacts which confirmed that there were no contacts on that ceramic restoration, but that there were even contacts on all the other teeth – a fact which would not have been possible if the inlay had been high. According to the patient's history, the ceramic restoration had been placed after previous restorations were deemed to have failed.

In light of my findings, I explained that I thought she probably had phantom bite syndrome, which I told her was a very difficult problem to treat.

She was adamant that she wanted to see me again, which I agreed to do, once she had been wearing whichever of her occlusal devices she found to be most helpful. Following those discussions, I immediately dictated a letter to her dentist which was copied to her.

The second consultation took place some months later, again in an open clinic and accompanied by a very experienced nurse. I asked the patient to complete another 12-page facial pain questionnaire. I then carefully compared those findings and complaints about her bite with those of the previous 12-page facial pain questionnaire. I also checked the clinical details in the previous notes and colour printouts of the patient's occlusal contacts (about 30 pages of information in all).

The patient was accompanied by her husband. She was tearful and, according to her newly completed hospital anxiety and depression scale, more depressed than at the first consultation. She pleaded with me to change the ceramic restoration yet again.

I explained that further intervention would be unwise. It seemed clear to me that the diagnosis was primarily one of phantom bite syndrome, possibly with some TMD. That is a subject about which I had published a large case series in a peer-reviewed journal (Kelleher, Rasananatnam and Djemal in *Dental Update*).[2] Incidentally, that article was written and accepted for publication well before I met this particular patient.

I sought to explain to the patient that, because there was nothing clinically wrong with the tooth or its contacts, further aggressive removal of the ceramic inlay or other destructive dental interventions, such as equilibration, would be futile. I explained the problems of phantom bite/occlusal dysesthesia sympathetically and gently suggested that she should try some appropriate antidepressant medication and try to get some psychological help support from another medical practitioner.

I dictated another letter/report immediately after that consultation, which was then word processed, checked and sent to the patient and her dentist.

Importantly for what follows, both my letters/reports were dictated immediately after each consultation and each was checked by me before being sent to both the patient and her referring dentist.

My assessment and advice was not well received and a complaint to the GDC followed – including accusations that I had been intimidating. It was also alleged that I was in collusion with the referring dentist, despite the original referral having been addressed to a different female consultant. As it happens, I had never met the referring dentist, either before or since. My only knowledge of them is through this referral.

As the investigation progressed and the GDC disclosed documentation to my solicitors, it became apparent that the patient had complained about a number of other practitioners on her clinical journey. In spite of multiple requests to the GDC for disclosure of that highly relevant material which indicated a pattern of repeated complaint, the GDC withheld that material while never offering a plausible explanation for their persistent failure to disclose it.

The patient sought further treatment for her bite problems from a number of other practitioners in different disciplines and locations, who used a variety of treatments. Eventually, she did take some antidepressant medication with some limited improvement. Later evaluation by another restorative specialist arrived at the same diagnosis as me as the problem being phantom bite syndrome. That is a condition with a dominant psychological component, originally described by Marbach as a monosymptomatic hypochondriacal psychosis.[2] The specific complaints raised by the patient could easily be rebutted. My adviser's assessment was that they were certainly not career-threatening. The real story here is what happened next. It was only when the GDC instructed a retired professor to provide an expert report that matters took a serious and unexpected turn for the worse, with that expert advancing allegations of dishonesty against me, an allegation which was conjured from nowhere but which the GDC adopted uncritically, thus radically altering the seriousness of the allegations against me.

The subsequent problems at the GDC

The core of the problem rested with the expert's approach to the patient records and his thesis that the clinic letters were not part of the patient records, despite being disclosed by the hospital as part of the patient records and having been dictated by me at the time

of the two consultations. That thesis was the platform for the expert's bizarre assertion that any matters addressed in the letters but not also expressly referred to in the other clinic documentation were 'not supported by' the records and were consequently 'untrue' – leading to the inevitable conclusion, in the expert's mind, that those clinic letters were a dishonest fiction. I should stress that the expert never suggested that those letters were not prepared immediately following the consultation. However, as preposterous as the expert's analysis may seem to you, the GDC readily accepted it as the basis for advancing allegations of dishonesty against me – that I had not examined the patient and that assertions to the contrary in my clinic letters were a lie.

It is important to emphasise that the expert did not assert that anything in the clinic letters was contradicted by the patient's 'records', as defined by him. It was also apparent that he had not turned his mind to the question of whether the content of the clinic letters was corroborated by other material. Had he done so, he would have noted that the patient's own letter of complaint referred to the examination which I conducted and that the trainee's handwritten notes included express reference to the patient being seen by me ('S/B Mr Kelleher'). He also ignored the fact that those letters had been copied directly to the patient – a high-risk strategy if their content was simply a fabrication. Despite those matters, the GDC adopted the expert's allegations of dishonesty and formally advanced those allegations, while also informing my employer.

In theory at least, the complaint that I was rude and intimidating (which the nurses present both testified I had not been) could have been dealt with under Crown Indemnity. That was because she was an NHS patient, who was seen on both occasions on NHS premises in an open clinic. However, as my reputation was at stake, I asked Dental Protection Limited for their help because I was a longstanding member.

Stephen Henderson read the correspondence and listened carefully. When he realised the identity of the expert, his reaction suggested that their involvement in the case was a cause for concern. However, he calmly suggested that Dental Protection might be able to instruct a solicitor, Stewart Duffy of RadcliffesLeBrasseur, to help to deal with the matters on my behalf.

When I met Stewart, he was reassuringly calm, highly knowledgeable and brilliant to deal with. Following prolonged correspondence seeking clarifications from multiple people at the GDC and from the expert, with lots of worryingly long and inefficient delays at the GDC, once he had all the information he had exhausted from those enquiries, he quickly made formal submissions to the GDC on my behalf.

The following extract from those submissions is particularly pertinent to the central concern which this article seeks to raise:

'It has been Mr Kelleher's practice over many years to prepare his report of consultations in the form of a letter to the referring clinician. Such letters are dictated usually while the patient is still present, or during the clinic later on between other patients, or at the very latest immediately after the end of the clinic in question. In dictating the letters, Mr Kelleher relies upon his own recollection of those very recent events, aided by the records made by him, or his trainees, during the course of the consultation. Such an approach is entirely permissible. Prof X has not pointed to any authoritative source which prohibits such an approach. It is self-evident that a clinician preparing a letter to a referring colleague is just as entitled to rely on his own recollection of his discussions with, and assessment of, a patient as he is entitled to rely on any record made while the patient was present and to avail of any other available materials such as any clinical photographs sent, completed facial pain questionnaires, written details provided by the patient, or details in the referral or corresponding letters.

As for the purported distinction between "the records" and the clinic letters, that distinction exists only in the mind of Prof X. As will be evident from the papers in this case, the clinic letters formed part of the complainant's records. They were disclosed to the Council by the hospital in response to a request for such records. Indeed, the GDC's own request makes it clear that the records to be provided include clinic letters. In short, the distinction which Prof X seeks to make between those letters and "the records" is entirely arbitrary and is wholly irrational.

However, even if there were some merit in the distinction advanced by Prof X, and there is not, he relies on that distinction to build the second limb of his analysis, namely that only matters reflected in handwritten records made in the patient's presence are capable of being true. For reasons developed below, the adoption of the premise "if it's not written down it didn't happen" is liable to lead into error. Prof X does not limit himself to adopting that erroneous principle but takes it to the most extreme form which we have ever encountered. Prof X's analysis does not even admit the possibility that something which is not recorded by the clinician while the patient is present could be true.

We begin our analysis by looking at the flaws of the more benign version of the heuristic "if it's not written down it didn't happen" before assessing the wholly irrational way in which Prof X seeks to apply an extreme version of that premise in this case.

"If it is not written down it didn't happen" – an evidential fallacy.

The saying "if it's not written down it didn't happen" has become something of a mantra among certain members of the health and care professions and, particularly, among claimant's lawyers. It is not a rule of law or of evidence. It is not even a rule of logic. At its most attractive, it serves as a terse form of encouraging the making of fuller notes. In many respects, it is a counterpart to the adage that "the absence of evidence is not evidence of absence".

Each of the expressions is of limited utility and neither merits a significant role in the assessment of allegations of professional misconduct, particularly bearing in mind that the GDC bears the burden of proving the allegations which it advances.

The issue has been succinctly and robustly addressed by the Court of Appeal in the context of professional regulatory matters in the recent case of Miller and Another vs The Health Service Commissioner for England (2018) EWCA Civ 144: "It is also conceded that the ombudsman's evidence from one of her most experienced Directors, Mr Kellett, contained an unfortunate use of language when he said 'if it is not written down it didn't happen unless there is other corroborating evidence'. I do not accept that this was an erroneous use of language: it reflected the practice of and language used by officials in the documents to which this court was taken; that is, unless the doctor had noted something in the clinical records, poor practice is assumed. Aside from reinforcing an impression of predetermination, that is an

inappropriate way to conduct an investigation; it merely engenders defensive note-taking by doctors rather than clinical good practice. It is important to look for corroborating contemporaneous notes and also for evidence of good recording and safeguarding practices, but it is also important to listen to what a professional says."

This approach is entirely consistent with the Court of Appeal's earlier rejection of the proposition in a somewhat difference context in the case of Powys Teaching Local Health Board vs Dr Piotr Dusza, Dr Hako Sobhani (2015) EWCA Civ 15.

Those cases are also consistent with the observations of the NHSLA in their decision in NHS Commissioning Board vs Bargaindentist.com NHSLA/16765. Addressing the evidential value of the observation that examinations were not recorded in the clinical records, supporting claims for payment, the adjudicator observed:

"4.13: The Contractor has provided me with the records relating to each patient. England criticises the quality of the records, arguing that they do not properly record an examination. That may be so but the issue before me is whether or not examination, assessment and treatment planning was carried out and not whether these actions have been adequately recorded.

4.14: NHS England refers to the Faculty of General Dental Practice (UK) publication *Clinical examination and record-keeping: good practice guidelines* as the standards for record-keeping. This may inform any consideration of whether or not a contractor has complied with obligations under a contract to keep appropriate records, but I have not found it of any assistance in determining the issues which I have had to address as set out above."

Those examples are a reminder of the requirements of logic and common sense to look at the totality of the evidence in the round. They illustrate that it is not permissible, as a matter of law, to rely on the concept "if it is not written down it didn't happen".

However, the Case Examiners will note that the Court of Appeal in [the Miller case] were critical of the adoption of that concept even when it was qualified by the additional words "unless there is other corroborating evidence". That is telling in the context of Prof X's attempt to extend the concept in this case to exclude the possibility of corroborating evidence. Prof X's approach appears to be that if it is not written in "the records" then corroborating evidence in other contemporaneous documents, such as the clinic letters, is "unsubstantiated" by "the record" with the inescapable conclusion (in his mind) that it (1) "is not based on fact" and (2) "is therefore untrue".

The unadorned irrationality of Prof X's approach is not difficult to expose.

Prof X's willingness to adopt an irrational analysis of the available evidence, to wilfully close his mind to most of the copious and readily available evidence in the notes and to fail to even articulate or entertain any alternative possibility to the logical fallacy which he has crafted, all detract substantially from the opinions which he has advanced in relation to the matters which are the subject of the allegations of dishonesty. Indeed, Prof X's fundamental error as an expert was to descend into advancing opinions on the truth or otherwise of factual contentions. Prof X is a dentist. He was not present at any of the relevant consultations. He is not a witness of fact. It is simply no part of his role to opine on issues of fact. He ought not to have done so. The declaration which he has signed includes his confirmation that he does "not require further information" and that he has "made clear which facts and matters referred to in this report are within his own knowledge and which are not." That declaration did not prevent Prof X from stating, among other matters, "it is my opinion, based on the records provided, that the registrant did not examine the patient at either appointment".

His opinion is contradicted emphatically by the patient herself. In her complaint, [the complainant] expressly refers to Mr Kelleher examining her ("after his examination, he said 'I think you have a condition which is really hard to treat'").

Furthermore, Prof X has declared that the opinions in that report "represent [his] true and complete professional opinions on the matters to which they refer."

Absent the wholly unwarranted and irrational contentions advanced by Prof X, there is simply nothing whatsoever to support the allegation of dishonesty. In failing to properly apply their minds to the contentions advanced by Prof X, the GDC have simply adopted his irrational reasoning and have, quite improperly, advanced allegations of dishonesty against a distinguished practitioner with an unblemished professional record when there is not a scintilla of evidence in support of those allegations.'

Outcome

This GDC case was dismissed at the case examiner's stage with no further action being taken.

While this case was thrown out quickly once it reached the case examiners, there were unacceptable delays in reaching that point and the most serious allegations ought never to have been advanced by the GDC as they had no proper foundation. Nonetheless, our elegant submission demonstrated the profound flaws in relying on the frequently repeated trope that 'if it was not written down it did not happen'.

Reflections

This crazy case involved over two years of serious stress, multiple sleepless nights and serious sense of humour failure, as well as wasting hundreds of hours of valuable clinical time.

It involved hundreds of pages of correspondence and the expenditure of many thousands of pounds in legal fees because a retired professor, who has probably never run an NHS postgraduate teaching clinic – and has certainly not done so routinely for 35 years – went on an evidential and logical frolic whether through lack of competence or application and, perhaps more remarkably, the regulator simply adopted his transparently defective assessment.

The many esteemed consultants and real experts, as well as the trainee and the nurses, who all wrote to the GDC supporting me – for which I am extremely grateful – all confirmed the merit in my approach to record-keeping, including contemporaneous dictation of detailed clinic letters.

While the GDC should respect the independent opinions of experts whom they instruct, that should only be if those opinions are properly reasoned and can withstand logical scrutiny. Registrants must be able to have confidence that allegations of dishonesty against them will not be advanced by 'experts' or by the GDC without the most careful consideration. My experience highlights the decisive role which experts play in the fitness to practise process and the importance of the regulator who instructs those experts, choosing experts with appropriate experience and expertise and scrutinising the reports which they produce for obvious defects. The role of experts is important and they bear a

heavy weight of responsibility, perhaps not appreciated by the expert in my case but which was made abundantly clear in a recent Court of Appeal decision.

Part two

Legal consequences for an expert witness who recklessly makes a false statement in a report or witness statement when this is verified by a statement of truth

The second section of the article relates to recent judgement about the likelihood of imprisonment of 'experts' who make false, rash, irresponsible or misleading claims or statements, regardless of whether this is intentional or unintentional. That is because of the importance that the court attaches to the expert's report. That Court of Appeal judgement should serve as a stark warning to those putting themselves forwards as experts not to stray into any areas beyond their remit because, if they do, they can risk imprisonment as well as being totally discredited.

In Liverpool Victoria Insurance Co. vs Zafar (2019) EWCA Civ 392, the Court of Appeal warned of severe consequences for an expert witness making a false statement.

In their judgement, the Court of Appeal observed:

'The appropriate punishment for a person, who had deliberately or recklessly made a false statement in a document to be used in court proceedings, which was verified by a statement of truth, would usually be immediate committal to prison. That was especially the case when the statement was made by an expert witness'.

The Court said that the deliberate or reckless making of a false statement in a document verified by a statement of truth would usually be so inherently serious that nothing other than an order for committal to prison would be sufficient.

In the case of an expert witness, the fact that he or she was acting corruptly and made the relevant false statement for reward would make the case even more serious, but it would be a serious contempt of court even if the expert witness acted from an indirect financial motive (such as a desire to obtain more work from a particular solicitor or claims manager) or without any financial motivation at all.

This was so because of the reliance placed on expert witnesses by the court and because of the corresponding importance of the overriding duty that experts owed to the court. As that form of contempt of court undermined the administration of justice, it was always serious.

Without seeking to lay down an inflexible rule, the court took the view that an expert witness who recklessly made a false statement in a report or witness statement verified by a statement of truth would usually be almost as culpable as an expert witness who did so intentionally.

This was so because the expert witness knew that the court and the parties were dependent on his or her being truthful and had made a declaration which asserted that he or she was aware of his or her duties to the court and had complied with them

To abuse the trust placed in an expert witness by putting forwards a statement which was in fact false, not caring whether it was true or not, was usually almost as serious a contempt of court as telling a deliberate lie.

Moreover, the culpability of a condemnor who acted recklessly would be increased if he or she knew of circumstances that cast doubt on the accuracy of the relevant statement, but nonetheless made it without caring whether it was true or false. It goes without saying that the GDC ought to expect any expert witness who, in the course of preparing a report, advances an allegation of dishonesty against a professional colleague will have given the most careful consideration to the available evidence and will have specifically considered evidence which casts doubt on the allegation.

As to the appropriate length of sentence, the court had to have in mind that the two-year maximum sentence term had to cater for a whole range of conduct and had to seek to impose a sentence which sat appropriately within that range.

Further details of the case were published in the Law Report of *The Times* on Monday, 10 June 2019.

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