Neutral Citation: [2024] UKFTT 00048 (TC)

Case Number: TC09030

**FIRST-TIER TRIBUNAL**
**TAX CHAMBER**

George House, Edinburgh

Appeal reference: TC/2020/01588

*VALUE ADDED TAX – Exemptions – Health and welfare – Article 132 Principal VAT Directive 2006/112/EC – Item I, Group 7 Schedule 9, Value Added Tax Act 1994 – aesthetic medicine – whether medical care – No – whether services provided by a cosmetic clinic were exempt – No - Appeal dismissed*

**Heard on:** 14-17 November 2022
**Judgment date:** 12 December 2023

**Before**

**TRIBUNAL JUDGE ANNE SCOTT**

**Between**

**AESTHETIC-DOCTOR.COM LTD**

**Appellant**

**and**

**THE COMMISSIONERS FOR HIS MAJESTY'S REVENUE AND CUSTOMS**

**Respondents**

**Representation:**

For the Appellant: Melanie Hall KC, and Ciar McAndrew instructed by Azets for the Appellant

For the Respondents: Neale Tosh, of counsel, instructed by the General Counsel and Solicitor to HM Revenue and Customs

## DECISION

**INTRODUCTION**

1. The appellant is a private medical clinic which trades as the Dr Darren McKeown Aesthetic Medicine Institute ("the Clinic"). It provides a wide range of cosmetic treatments.

2. The Notice of Appeal dated 22 April 2020 appeals the decision issued by the respondents ("HMRC") on 2 April 2020 to the effect that the appellant is required to register for VAT from 1 June 2010 in accordance with Schedule 1 of the Value Added Tax Act 1994 ("VATA") because the VAT threshold of £70,000 had been breached in April 2010.

3. It is common ground that that decision letter should be read in the context of:-

   (a) A letter from HMRC dated 25 November 2019 which stated that the appellant's supplies did not constitute exempt medical care and thus HMRC intended to compulsorily register the appellant for VAT. That letter requested details of rolling turnover.

   (b) A letter from HMRC dated 17 January 2020 which stated that the effective date of registration was 1 July 2010.

   (c) A Review Conclusion letter dated 26 March 2020 which cancelled the letter (and registration) of 17 January 2020.

4. The decision dated 2 April 2020 confirmed the decision that the appellant was liable to register for VAT on the basis set out in the letter of 25 November 2019 but amended the date for registration for VAT. On 3 December 2020, HMRC issued an assessment under section 73(1) VATA in total of £1,635,614 covering VAT periods from 1 June 2010 to 31 March 2020. Further assessments were issued subsequently.

5. HMRC's position is that almost all of the services supplied by the appellant should have been standard rated on the basis that the purpose of those services is purely cosmetic. If they are wrong about that and there is more than one purpose, then the principal purpose is purely cosmetic even if there are other ancillary therapeutic purposes.

6. The Grounds of Appeal accept that "where there is no medical purpose behind a treatment, and it is carried out for purely cosmetic purposes, the supply is taxable" but goes on to say that "However such treatments are not routinely carried out by the business, and any turnover from such cosmetic procedures are therefore comfortably below the threshold required for VAT registration. [The] business is therefore, at best, partially exempt, and not wholly taxable as HMRC have determined or liable to register for VAT".

*The Pleadings*

7. There had been a Case Management Hearing on 16 September 2022 and in accordance with Directions, HMRC had lodged an Amended Statement of Case and an Amended Supplementary Statement of Case. The appellant had lodged an Amended Reply to HMRC's Statement of Case. The parties had been unable to agree a List of Issues for the hearing and therefore each lodged their own.

8. Following the hearing, the appellant sought permission, which was granted, to lodge submissions on the decision of the Court of Appeal in *Mainpay Ltd v HMRC* [2022] EWCA Civ 1620 ("Mainpay"). Those were received on 17 July 2023 and HMRC's submissions in response were received on 31 July 2023.

9. On 14 August 2023, the appellant lodged an unsolicited submission in relation to Judge Fairpo's decision in *Epem Limited v HMRC* [2023] UKFTT 627 (TC) ("Epem"). On the same

day HMRC lodged a vigorous objection on the basis that it was a First-tier Tribunal ("FTT") decision and therefore not binding and the appellant had distinguished it on the facts.

10. On 26 October 2023, the appellant lodged a further unsolicited submission in relation to the Court of Appeal judgment in *Mercy Global Consult Ltd (in liquidation) v Adegbuyi-Jackson and others* [2023] EWCA Civ 1073 ("Mercy Global") on the basis that the Court had summarised what it regarded to be the ratio of *Mainpay* and made further observation on the medical care exemption. On the following day HMRC vigorously objected on the basis that the issue in *Mercy Global* was whether *Mainpay* was binding on the Court of Appeal which is not an issue that is in dispute in this appeal. It is not.

**The hearing**

11. I had the benefit of a hearing Bundle extending to 1,768 pages and an authorities Bundle extending to 653 pages. I also had a Bundle submitted by the appellant relating to the Joint Council for Cosmetic Practitioners ("JCCP") which extended to 49 pages and included Dr McKeown's Certificate, the Code of Practice, Definitions for Members of the Public and a 2021 paper entitled "What constitutes a medical, medically related or cosmetic procedure?".

12. The sole witness was Dr McKeown. I accept Mr Tosh's criticism that much of Dr McKeown's evidence strayed into opinion and advocacy. I am mindful of Mrs Justice Proudman in *HMRC v Sunico* [2013] EWHC 941 (CH) at paragraph 29 where she states:

> "29. … As I have already noted, to the extent that the witnesses expressed their opinions on the documents they discussed I have discounted their evidence."

That principle also holds good in relation to oral evidence. Dr McKeown was a witness of fact only.

13. I had Skeleton Arguments for both parties. In the course of the hearing Mr Tosh produced the full Swedish text of *Skatteverket v PFC Clinic AB* Case C-91/012 ("PFC") and Google Translate translations of paragraphs 18, 20 and 29 in *PFC*. I do not speak Swedish and it transpired no-one else did either!

14. I had transcripts because at the Case Management Hearing I had agreed to authorise them, in the face of HMRC's opposition, not least because Ms Hall made it explicit that any adverse decision would be appealed and the Upper Tribunal would benefit from transcripts. Unfortunately, the transcripts were not in conventional format, had no index and at certain points they were not in the least coherent; I go so far as to say incomprehensible. Fortunately I had noted the evidence in the usual way. The transcripts were only provided to the Tribunal on 20 December 2022 and required quite a lot of time, by reference to my notes, to render them of some utility.

**The Burden and Standard of Proof**

15. The appellant bears the burden of establishing that it qualifies for exemption.

16. In relation to disputed matters, the standard of proof is the usual civil standard which is on the balance of probability, namely whether something is more likely than not.

**The appellant's list of issues**

17. Do the supplies made by the appellant fall within the scope of Article 132(1)(c) of the Council Directive 2006/112/EC (The Principal VAT Directive) ("the PVD") as implemented by Item 1 of Group 7 of Schedule 9 VATA ("Item 1")?

18. Having failed to lay down legislative conditions, pursuant to Article 131 of the PVD, which exclude from exemption all care provided for cosmetic reasons, regardless of the

underlying purpose of that care, is it permissible for HMRC to create such a condition by administrative fiat or to otherwise rely upon such a condition as a basis for denying exemption to the appellant?

**HMRC's list of issues**

19. Was the purpose or principal purpose of the supplies made by the Clinic the prevention, diagnosis, treatment or cure of a disease or health disorder or the protection, maintenance or restoration of health (as the appellant contends) or were those supplies made for purely cosmetic reasons (as HMRC contend)?

20. Were the services supplied by the Clinic wholly performed or directly supervised by a person registered or enrolled in the register of medical practitioners or the register of qualified nurses and, if so, did those services fall within the scope of that person's qualifications?

21. Were the services provided by the Clinic exempt supplies of medical care under Item 1 of Group 7 of Schedule 9 VATA?

**The four legal principles**

22. At the outset of the hearing, Ms Hall stated that, although the parties could not agree a composite list of issues, if the various issues were read with the pleadings and the Skeleton Arguments, four core legal principles could be identified. Resolution of those would enable the Tribunal to determine the central question as to whether the services supplied by the appellant were exempt supplies of medical care under Item 1. Mr Tosh did not demur.

23. Those principles were identified as being:-

(1) Whether for the purpose of the VAT exemption the Tribunal should consider only the purpose of the services provided by the Clinic or should it also seek to identify the principal purpose and treat that principal purpose as determinative as HMRC contend.

(2) Looking at the concept of whether supplies are made for "purely cosmetic reasons", which was a concept which first appeared in *PFC*, does it apply only to plastic surgery or does it apply to all cosmetic treatments as HMRC argue.

(3) What is the legal significance of the fact that in providing its services the Healthcare Professionals ("HCPs") employed by the Clinic use their medical skills, qualifications and training.

(4) Whether, in light of Parliament's failure to exercise their power under Article 131 to exclude not just cosmetic services but also cosmetic services provided by medical professionals from the scope of the exemption, it is open to HMRC to now do so on the basis that the nature of the services provided by the Clinic is cosmetic. In summary, if Parliament did not do so, can HMRC do so by administrative fiat.

**Areas of common ground**

24. It is not disputed that:-

(a) The Tribunal is concerned only with Article 132(1)(c) as implemented by Item 1. It is not directly concerned with Article 132(1)(b) as implemented by Item 4 although the comparisons between Article 132(1)(b) and (c) inform the correct approach to interpreting the latter because of the differences between the two (*Future Health Technologies v HMRC* C-86/09 ("Future") at paragraph 29*)*.

(b) Item 1(c) includes services provided by surgeons, GPs and nurses and that all of the persons administering the treatments provided by the appellant were registered

under the Health Professions Order 2001 SI 2002/254. The principal issue therefore is the extent to which, if at all, the services provided by the appellant consist in the provision of medical care.

(c) The purpose of the service determines whether the medical care exemption applies but the only dispute is how that is identified and, in particular, whether it is the principal purpose or does it suffice to be identified as the purpose.

(d) The exemption cannot be claimed unless the purpose of the service is to diagnose, treat, and insofar as possible, cure diseases or health disorders including the protection, maintenance or restoration of health.

(e) The provision of medical care in Article 132(1)(c) is an autonomous, independent concept of EU law. That was established in *d'Ambrumenil and Another v CCE* C-307/1 and *Unterpertinger v Penfionsversicherungsanstalt der Arbeiter* C-212/01 ("d'Ambrumenil"). The Courts routinely refer to it as having a therapeutic aim or therapeutic purpose and that encapsulates a long list of activities including psychological treatment.

(f) The subjective understanding of the patient with regard to the purpose of the service is not determinative although it may be relevant. The findings of the HCP may also be relevant but is not necessarily determinative (*PFC* at paragraphs 33 to 36).

(g) Some cosmetic treatments can qualify as medical care.

(h) The task for the Tribunal is to evaluate the evidence to determine whether the services provided by the appellant fall within the concept of medical care.

**The Legal Framework**

25. There is no dispute about the relevant legislation.

26. Whilst the UK is no longer a member of the European Union ("EU"), the VAT exemptions continue to be derived from retained EU law. The purpose of the VAT exemptions is expressed in Chapter 2 of the PVD as being "Exemptions for certain activities in the public interest".

27. Article 131 provides that:-

"The exemptions provided for in Chapters 2 to 9 shall apply without prejudice to other Community provisions and in accordance with conditions which the Member States shall lay down for the purposes of ensuring the correct and straightforward application of those exemptions and of preventing any possible evasion, avoidance or abuse."

28. Article 132 of the PVD provides that:-

"Member States shall exempt the following transactions

…

(b) hospital and medical care and closely related activities undertaken by bodies governed by public law, or under social conditions comparable with those applicable to bodies governed by public law, by hospitals, centres for medical treatment or diagnosis and other duly recognised establishments of a similar nature;

(c) the provision of medical care in the exercise of the medical and paramedical professions as defined by the Member State concerned; …".

29. The PVD is implemented in domestic law by VATA. Part II of VATA provides for (amongst other things) certain exemptions from VAT.

30. Section 31(1) provides that:-

"A supply of goods or services is an exempt supply if it is of a description for the time being specified in Schedule 9."

31. Item 1 Group 7 of Schedule 9 VATA provides, insofar as relevant for these purposes, that:-

"The supply of services consisting in the provision of medical care by a person registered or enrolled in any of the following –

(a) The register of medical practitioners

(b) …

(c) The register kept under the Health Professions Order 2001 …

(d) The register of qualified nurses, midwifes and nursing associates maintained under article 5 of the Nursing and Midwifery Order 2001."

32. Note 2 to Group 7 provides:-

"Paragraphs (a) to (d) of Item 1 … includes supplies of services made by a person who is not registered or enrolled in any of the registers or rolls specified in those paragraphs with the services that are wholly performed or directly supervised by a person who is so registered or enrolled."

***Mainpay***

33. Both parties are agreed that the Court of Appeal's overall approach in *Mainpay* is consistent with, and reaffirms, well-established principles that govern the scope of the medical care exemption.

34. Both parties are agreed that *Mainpay* does not provide a strong analogy on the facts. It was an appeal concerning the provision of staff to the NHS through an agency and the issue was whether that supply of staff was an exempt supply of medical care.

35. The latter part of the decision in *Mainpay* was divided into five sections and the second was "The meaning of medical care". Paragraph 61 reads:-

"61. The FTT considered a number of cases relating to medical care for the purposes of Article 132(1)(b) and (c) at FTT [10]-[17]. The UT encapsulated much of that case law in a series of propositions set out at UT [89]. No challenge is raised to the content of any of those paragraphs, which accurately set out the law. Indeed, by his helpful note produced for the Court, Mr Firth echoes much of what the FTT and UT said in these paragraphs. But Mainpay's arguments have moved on; before I turn to them, I record three basic propositions of law which are not in dispute:

i) First, the exemptions constitute independent concepts of community law which must be placed in the general context of the common system of VAT (*Kügler* [25]).

ii) Secondly, the exemptions are to be interpreted strictly (but not restrictively) since they constitute exceptions to the general principle of taxation (*Kügler* [28]).

iii) Thirdly, the analysis of what is being supplied depends, in any given case, on economic realities of the transaction, that being a "fundamental criterion" for the application of the common system of VAT (see *Airtours Holiday Transport Ltd v HMRC* [2016] UKSC 21; [2016] 4 WLR 87 at [48], citing Case C-53/09 and C-55/09 *Revenue and Customs Commissioners v Loyalty Management UK Ltd and Baxi Ltd* [2010] ECR I-9187; [2010] STC 2651 at [39]-[40]); the contracts are the most useful starting point in that exercise, but not necessarily the end point: see *WHA Ltd v Revenue and Customs Commissioners* [2013] UKSC 24; [2013] 2 All ER 907. The UT recognised this approach in terms at UT [96], see paragraph 33 above, and their encapsulation of the approach was not subject to any challenge in this appeal."

36. The UT decision to which reference is made is that of Mellor J and Judge Guy Brannan and it is reported at [2021] UKUT 0270 (TCC). Paragraph 89 of that decision reads:-

"89.The scope of the exemptions for medical care contained in Article 132(1)(b) and (c) of the Directive (and its predecessor Article 13A(1)(b) and (c) of the Sixth Directive) have been the subject of a number of decisions by the CJEU. The main principles can be summarised as follows:

(1) The exemptions envisaged in Article 13 of the Sixth Directive are to be interpreted strictly since they constitute exceptions to the general principle that VAT is to be levied on all services supplied for consideration by a taxable person: e.g. *Kügler* C-141/00 (" *Kügler*") at [35].

(2) Those exemptions constitute independent concepts of Community law whose purpose is to avoid divergences in the application of the VAT system from one Member State to another (*Card Protection Plan* C-349/96 at [15], *Commission v France* C-76/99 at [21] and *Kügler* at [52]).

(3) As regards the place where the services must be supplied, in contrast to Article 132(1)(b) which concerns services encompassing a whole range of medical care normally provided on a non-profit-making basis in establishments pursuing social purposes such as the protection of human health, Article 132(1)(c) applies to services provided outside hospitals and similar establishments and within the framework of a confidential relationship between the patient and the person providing the care, a relationship which is normally established in the consulting room of that person: *Kügler* at [35] and *EC Commission v United Kingdom* C-353/85 at [33]

(4) Article 132(1)(b) and (c) have separate fields of application and are intended to regulate all exemptions of medical services in the strict sense. Article 132(1)(b) exempts all services supplied in a hospital environment while Article 132(1)(c) is designed to exempt medical services provided outside such a framework, both at the private address of the person providing the care and at the patient's home or at any other place: *Kügler* at [36].

(5) The application of Article 132(1)(c) is not dependent on the legal form of the person supplying the medical care. Thus, a limited company supplying medical care through medically qualified staff fell within the exemption: *Kügler* at [41].

(6) The concept of 'provision of medical care' does not lend itself to an interpretation which includes medical interventions carried out for a purpose other than that of diagnosing, treating and, in so far as possible, curing diseases or health disorders: *W v D* C-384/98 at [18].

(7) Although the provision of medical care must have a therapeutic aim, it does not necessarily follow that the therapeutic purpose of a service must be confined within an especially narrow compass. Thus, medical services effected for prophylactic purposes may benefit from the exemption under Article 132(1)(c). Even in cases where it is clear that the persons who are the subject of examinations or other medical interventions of a prophylactic nature are not suffering from any disease or health disorder, the inclusion of those services within the meaning of provision of medical care is consistent with the objective of reducing the cost of health care, which is common to both the exemption under Article 132(1)(b) and that under (c) of that Article: *d'Ambrumenil* C-307/01 ("*d'Ambrumenil*") at [58].

(8) It is the purpose of a medical service which determines whether it should be exempt from VAT. Therefore, if the context in which a medical service is effected enables it to be established that its principal purpose is not the protection, including the maintenance or restoration, of health but rather the provision of advice required prior to the taking of a decision with legal consequences, the exemption under Article 132(1)(c) does not apply to the service: *d'Ambrumenil* at [60].

(9) Article 132(1)(b) does not include any definition of the concept of activities 'closely related to hospital and medical care'. That concept does not, however, call for an especially narrow interpretation since the exemption of activities closely related to hospital and medical care is designed to ensure that the benefits flowing from such care are not hindered by the increased costs of providing it that would follow if it, or closely related activities, were subject to VAT: *Commission v France* C-76/99 at [22]-[23].

(10) The provision of medical care which does not meet all the requirements laid down in order to benefit from the exemption from VAT under Article 132(1)(b) is not, as a matter of principle, excluded from the exemption laid down in Article 132(1)(c). It is not apparent from the wording of Article 132(1)(b) that that provision is intended to limit the scope of Article 132(1)(c). Article 132(1)(b) covers all services supplied in a hospital environment while Article 132(1)(c) covers services provided outside such a framework, both at the private address of the person providing the care and at the patient's home or at any other place, in the context of the exercise of medical and paramedical professions as defined by the Member States: *Peters* C-700/17 at [21], [27] and [28].

37. The Court of Appeal in *Mainpay* went on to analyse *Kügler* and found that:-

(a) "mere involvement in medical services by qualified personnel" is not sufficient to qualify for the exemption [64] and [66],

(b) "exemptions are to be construed strictly as exceptions to the general rule …, and that words of extension cannot be read in (see eg Case C-366/12 *Finanzamt Dortmund-West v Klinikum Dortmund GmbH*…" [66],

(c) "medical care" is defined as "diagnosing, treating and, in so far as possible, curing diseases or health disorders", [67], and

(d) "*Kügler* confirms that the supply in question must be of medical care, coming within the established meaning of that term, from *D* and other cases, which requires that the services have a therapeutic aim, that they consist of the diagnosis, treatment or cure of disease or ill-health. That is what the phrase 'medical services must be involved' in the English version of *Kügler* [27] means."[69]

38. At paragraph 72 the Court quoted from paragraphs 33 and 34 in *Finanzamt Kyritz v Wolf-Henning Peters* Case C-700/17 ("Peters") which read, in so far as material here:

> "33. It does not in any way follow from the wording of that provision that, in order for the provision of medical care to be exempt, it must be supplied within the framework of a confidential relationship between the person providing the care and the person being treated.
>
> 34. Moreover, to add such a condition is unwarranted in light of the objective of that provision of reducing the cost of medical care and making that care more accessible to individuals … to the extent that those services are of sufficient quality … without the existence of a confidential relationship between the patient and the person providing the care being decisive in that regard."

39. I observe that paragraph 42 of *Peters* stated that:-

> "It follows that the answer to the second question is that Article 132(1)(c) of Directive 2006/112 must be interpreted as meaning that the exemption from VAT that it provides for is not subject to the condition that the medical care in question is supplied within the framework of a confidential relationship between the patient and the person providing the care."

40. At paragraphs 73 to 78 of *Mainpay* the Court went on to consider arguments advanced by Mr Singh KC for HMRC in relation to other CJEU cases to the effect that the outcome of the cases upon which *Mainpay* relied depended on the facts in those cases.

41. The section of the judgment dealing with the meaning of medical care concluded at paragraph 78 with a finding that:-

> "I accept Mr Singh's answer on the CJEU cases. None of them carries Mainpay home. The facts of each are important to the CJEU's confirmation that the medical exemption applied (or, in the case of *Klinikum Dortmund*, did not). It is the facts of the case judged through the lens of commercial and economic reality, which determines whether Mainpay was making supplies of medical care, or not".

42. In paragraphs 79 to 80, the Court then went on to consider the commercial and economic reality in that case where, as the Court in *Mercy Global* pointed out at paragraph 20, Whipple LJ focussed on issues of control in the context of whether there was a supply of staff or a supply of medical services. That was an issue for both *Mainpay* and *Mercy Global* but is not an issue here. I am not concerned with the framework of control.

43. I do not require to consider the argument advanced in *Mainpay* to the effect that the purpose of the exemption is to prevent VAT increasing the cost of healthcare. However, for the avoidance of doubt, in this appeal, as in *Mainpay,* I adopt the Court's finding at paragraph 85:-

> "…the issue at the heart of this appeal is one of interpretation and application of the medical exemption; if particular supplies are not exempt applying the terms of Article 132(1)(c), properly construed, they cannot come within exemption simply because not to do so would increase the cost of medical care."

44. At paragraph 28 of *Mercy Global* the Court made it explicit that "The issue before the Court of Appeal in *Mainpay* was as to the proper interpretation of Item 1 and its application to the facts". I am concerned with the interpretation and application of the medical exemption in the light of the facts of this appeal.

45. The submissions for the appellant, in relation to *Mainpay*, drew attention to the judgment of the Eighth Chamber of the CJEU in *CIG Pannónia Életbiztosító Nyrt v Nemzeti Adó- és Vámhivatal Fellebbviteli Igazgatósága* C-458/21 "CIG") which was handed down on 24 November 2022. It was argued that in that case it had been necessary to have regard to the principal purpose of supplies because, as in *d'Ambrumenil* and *Mainpay*, there were competing or extraneous commercial purposes. Ms Hall argues that, by contrast, the central issue of principle in this appeal is whether, in the course of confidential consultations the services provided by the Appellant can be described as medical care and in that context the "principal purpose" cannot be the right approach.

46. Mr Tosh's submissions for HMRC also referenced *CIG* arguing that it reinforced his argument that if there is more than one purpose of a supply, it is the principal purpose which is determinative.

47. I observe that at paragraph 24 of *CIG* the Court stated that "It is the purpose of a medical service which determines whether it should be exempt from VAT pursuant to Article 132(1)(c)…". At paragraph 30, the Court found that even although services of various types were provided "the expert report remains the main purpose of those services, their therapeutic implications being merely indirect, so that those services cannot be regarded as having a therapeutic aim."

48. Both parties advanced arguments on four FTT decisions on the scope of the medical exemption. The most recent is *Illuminate Skin Clinics Ltd v HMRC* [2023] UKFTT 547 (TC) ("Illuminate") where Judge Christopher McNall and Mr Duncan McBride reviewed the other three earlier decisions and addressed submissions on *Mainpay.* (The Counsel and solicitors for the appellant in *Illuminate* were the same as in this appeal and the Notice of Appeal is exactly the same.)

49. Like that Tribunal at paragraph 24, I find that the approach to the law adopted by the Court of Appeal (and the Upper Tribunal) in *Mainpay* was not one which was limited to the facts in *Mainpay*. I also agree that the legal guidance articulated was intended by both appellate jurisdictions - the Court of Appeal and the Upper Tribunal before it - to be of general application.

50. Both parties in this appeal agree that the supplies that were under consideration in *Illuminate* were "substantially similar" to those in this appeal but disagree only as to whether that Tribunal applied the guidance in *Mainpay* correctly. Therefore there is no need for me to narrate the factual matrix in *Illuminate.* None of these Tribunal decisions is binding upon me, so in arriving at my decision I refer to them only where I wish to adopt their reasoning.

51. For completeness, since I have also considered the other three decisions and I agree with the analysis of them in *Illuminate*, with thanks to Judge McNall and Mr McBride, I adopt and quote from their paragraphs 31 to 36.

> "31. Finally, the scope of Items 1 and 4 have been considered by this Tribunal on at least three occasions over the last decade or so: (in date order) *Ultralase Medical Aesthetics Ltd v HMRC* [2009] UKFTT 187 (TC) (Judge David Porter and Ms Ann Christian); *Skin Rich Ltd v HMRC* [2019] UKFTT 0514 (TC) (Judge Jeannette Zaman and Mrs Rayna Dean); *Window to the Womb (Franchise) Ltd v HMRC* [2020] UKFTT 201 (TC) (Judge Jonathan Cannan).
>
> 32. In *Ultralase* the taxpayer provided surgical and cosmetic treatments for patients in hospitals and in its own private clinics. Most of the treatments were cosmetic, based around enhancing a patient's appearance, such as face lifts, hair removal and anti-cellulite treatment. It was held that the relevant test was the purpose for which the supplies were

made. If cosmetic intervention was required in circumstances where it did assist 'health disorders', then, the Tribunal held, that assistance should be available in a hospital and so ought to be exempt. The appeal was allowed in part.

33. In *Skin Rich* the taxpayer supplied Botox treatments and dermal fillers (together characterised as 'injectables') and nail fungus treatment (done using a medical-grade laser) at a skin culture and aesthetics clinic. Those were not exempt, because they were not carried out for a principal purpose of diagnosing, treating, and, so far as possible, curing diseases or health disorders. The injectables were given as an end in themselves, and were not given as ancillary to another (medical or surgical) treatment….

34. *Window to the Womb* concerned packages of ultrasound scans for pregnant women in the 16-40 week gestation period. Packages included a "Well-being scan", which provided confirmation of single/multiple pregnancy, heartbeat check, detection of some abnormalities, growth check, position of baby and placenta, and a well-being report. All franchisees were registered with the CQC to carry out a 'regulated activity' at specified premises and were required to use qualified sonographers registered with the Health and Care Professions Council. The scans were carried out in addition to NHS scans and were not clinically indicated.

35. The Tribunal held that the question was, looking at the supply, whether the principal purpose for which a typical customer purchased a scan package was the diagnosis, monitoring, treatment or prevention of illness. That was the case in relation to the different packages of scans, which were not just reassurance, but were the women herself choosing to monitor her medical condition. The supplies were exempt.

36. None of the First-tier Tribunal decisions are formally binding on us, but should be taken into account. They traverse similar ground, albeit with differing levels of intensity. We have found the more recent discussions in *Skin Rich* and *Window to the Womb* more helpful than the significantly earlier discussion in *Ultralase*."

**Overview of the background**

52. Following an enquiry into the Corporation Tax affairs of the appellant, on 12 April 2018, HMRC wrote to the appellant referencing that enquiry and opened a VAT enquiry. Shortly before the VAT enquiry was opened the appellant had engaged Campbell Dallas to advise on what medical records should be kept. It is not in dispute that their intervention significantly altered the format of the medical records.

53. After the VAT enquiry was opened Campbell Dallas were then engaged in relation to all tax matters. They are now known as Azets and hereinafter I refer to them as Azets throughout.

54. On 12 June 2018, both enquiries were escalated to a Code of Practice 9 ("COP 9") enquiry into not only the appellant but also other business ventures with which Dr McKeown had been involved. On 27 June 2018, Dr McKeown accepted the offer to make a full disclosure under the contractual disclosure facility ("CDF") and made an Outline Disclosure.

55. On 29 June 2018, Azets provided information that had been requested by HMRC in the original VAT enquiry.

56. As part of the CDF, on 10 January 2019, Azets wrote to HMRC saying that Dr McKeown had "started work on collating the requested patient files". They sent HMRC what were described in the covering letter as "…the first 100 sets of patient notes". They were later described to HMRC as being a sample of 100 patient records for April, August and November 2015 ("the Samples").

57. Dr McKeown attended a COP 9 meeting with HMRC and Azets on 13 May 2019. The Notes of the meeting ("the Notes") were signed by both of the Azets personnel who had been present and by Dr McKeown. In cross-examination, he stated that he signed the Notes (in July 2019) because Azets had said that they were accurate.

58. In the course of the meeting, in referencing the Samples, which were described as patient records, Dr McKeown was asked if he held any other records. He said that each patient had a file which "includes details of their GP, any allergy information and consent forms". He was asked what information was completed at the time of treatment and he conceded that the summary sheet that he had sent to HMRC for each Sample had been completed by him before he sent the Samples to HMRC and had been compiled based on his "personal knowledge and registration documents held".

59. It was agreed that more complete records for three samples of a mix of old and new cases would be provided and that Sample patient 60 would be included in that.

60. Following the COP 9 meeting, Dr McKeown provided documentation for a patient from each of 2011, 2015 and 2018. Sample patient 60 was the 2015 patient.

61. On 13 December 2021, HMRC wrote to Azets, referring to the COP 9 meeting, the Samples and the sample records from 2011, 2015 and 2018 ("the 2011 Patient", "the 2015 Patient" and the "2018 Patient" respectively) and asked for sight of consent forms and the registration documents.

62. In an email dated 17 February 2022, Azets confirmed to HMRC that the latter records comprised "3 full sets of notes…where the entire patient file was provided…" and that the "registration documents" was just the consultation form (I will refer to that as the "Patient questionnaire"). They also stated that prior to the records being stored electronically much of the patient information was fragmented and often there was not a single patient file. They offered to produce "Full File notes" for patients 20 to 40 of the Samples. (HMRC had asked for full records for all of the Samples).

63. On 14 April 2022, Azets produced the 20 Full File notes to HMRC and confirmed that they were the full records for patients 20 - 40 of the Samples but excluding patients 26, 28, 33 and 34. Therefore the Full File notes also included the next sequential numbers being patients 40 - 44 of the Samples. (They cannot count!).

64. On 30 June 2022, HMRC wrote to Azets stating that they had reviewed the "terms of the full patient records" and their position had not changed. They argued that:

> "(i) Patients have sought treatment to address cosmetic concerns rather than to address any disease or health disorder (either psychological or otherwise).
>
> (ii) There is no record of any clinical diagnosis of any disease or health disorder having been made or any treatment plan having been directed towards addressing it.
>
> (iii) In some instances, there is reference to a diagnosis of 'psychological concerns relation [sic] to appearance' but there is no adequate specification of the nature of those concerns or any diagnosis of any psychological disorder. These references do not amount to a clinical (or other professional) diagnosis."

**Approach to the evidence**

65. Unfortunately, finding the facts was a far from straightforward exercise notwithstanding Dr McKeown's 36 page witness statement and oral evidence.

66. The facts are absolutely crucial. As can be seen I am concerned with whether or not the appellant should have been registered for VAT since as long ago as 1 June 2010. In all of his evidence, Dr McKeown tended to focus on the very recent past and there were inaccuracies even in that.

67. The appellant has the onus of proof and has been professionally advised in this matter since 2018.

68. I was not referred to it but I agree with Judge Amanda Brown, KC and Member Duncan McBride in *Cry Me A River Limited v HMRC* [2022] UKFTT 182 (TC) where they state at paragraphs 11 to 14 as follows:-

> **"Approach to evidence**
>
> 11. There are a number of cases which, over the last decade, have considered the approach to be taken in respect of oral evidence received, particularly concerning facts and matters which occurred sometime before the giving of the evidence. These cases have been comprehensively reviewed in the judgment of Judge Brooks in *Hargreaves v HMRC* [2019] UKFTT 244.
>
> 12. So far as material in the present appeal the Tribunal notes, from that judgment, that a certain degree of caution is to be taken because:
>
> "26 …
>
> - memories are fluid and malleable, being constantly rewritten whenever they are retrieved …
> - the process of … litigation … subjects the memories of witnesses to powerful bias …
> - witnesses, especially those who are emotional, who think they are morally right, tend very easily and unconsciously to conjure up a legal right that did not exist …".
>
> 13. The judgments summarised by Judge Brooks conclude that:
>
> 'The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts. "This does not mean that oral testimony serves no useful purpose … But its value lies largely … in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth."'
>
> 14. This approach is particularly relevant in the present appeal."

68. It is also particularly relevant in this appeal.

69. I am in no doubt that Dr McKeown passionately believes that he takes a holistic approach to his patients, that they are not customers but are patients and that everything that he does is in the patient's best interests and for the benefit of the patient's psychological health.

70. He was emotional about the Clinic, how HMRC perceived aesthetic medicine and what he believed was the only possible approach to the services provided by the appellant, namely that it was the provision of medical care.

71. However, there are numerous discrepancies between the contents of his witness statement, his oral evidence and the documentation that had been lodged with HMRC and the Tribunal. There are also, what appear to me to be, a number of omissions or gaps.

72. The primary documentary evidence consisted of:-

(1) The Samples. In each case it was a two page document. In the hearing they were generally referred to as the "patient notes" because it had become clear, as I will explain, that the first page was not part of the patient records and the document accompanying that was, in most cases, simply a note of the treatment.

(2) The documentation for each of the 2011 Patient, the 2015 Patient and the 2018 Patient.

(3) The Full File notes.

(4) The Notes of the COP 9 Meeting ("the Notes").

(5) A screenshot of the appellant's website that was discussed at the COP 9 meeting. (the "Screenshot").

(6) The JCCP documentation.

73. In addition, although not a document, in the Notes there was reference to a 2016 BBC documentary in which Dr McKeown had participated ("the Documentary"). The BBC had spent nine months filming it. Dr McKeown referred to it and relied upon it in a letter to HMRC dated 22 August 2019 ("the 2019 letter"). The Documentary was not referred to in the hearing, but, having already largely written this decision, I checked the jointly agreed Bundle to ensure that nothing had been missed and I found it. It transpired that HMRC had produced it at number 32 in their List of Documents and they had produced a link to it (and to a number of other documents on the List) in the agreed Bundle. It cast light on a number of issues. It is relevant and far more contemporaneous than much else. It did not change my decision but it filled in a number of gaps and explained rather a lot. I had to recast the findings in fact.

74. In the 2019 letter Dr McKeown not only quoted from the Documentary but said that:-

> "The reason I agreed to participate in this documentary was to challenge the public perception of aesthetic medicine and help the public understand what we do in aesthetic medicine, what the motivations of our patients are and how our speciality helps improve our patients (sic) health and quality of life. I wanted to dispel the myth that aesthetic medicine is a trivial fashion or beauty trend, and show what happens in a 'real life' aesthetic medical practice".

It did and therefore I refer to it where it is relevant.

75. The 2019 Letter was from Dr McKeown to Officer Compston who had led for HMRC at the COP9 meeting. It was either in response to what was said at the meeting or to paragraph 328 of the Notes which read that HMRC "…pointed out the lack of reference to a medical diagnosis and treatment (sic) care plan and also, no reference to diagnosis and treatment of psychological conditions".

76. It commenced by stating:- "I understand you had concerns regarding the psychological aspect of the work I do, and specifically what qualifies me to make a psychological diagnosis…". Dr McKeown went on to explain at some length that he did not offer "trivial beauty procedures" and that the "complex interaction between the physical and psychological aspects of health lies at the crux of my aesthetic medical practice…".

77. He then went on to say:-

> "Historically, as you have seen, my medical records have focused on documenting the key pieces of information required for patient safety: the patients (sic) details, medical history, drug history, allergies, mental health history, environmental factors affecting their skin health, drug details, batch numbers and doses of drugs used."

I cite that quotation because, as will be seen from my findings in fact about the patient records, whilst there were usually details of the drugs, batch numbers and doses, prior to 2018 there was minimal detail of the medical and or mental health history of the patients.

**The Facts and my observations thereon**

***The Clinic***

78. Dr McKeown is the sole director and owner of the Clinic. The Clinic has evolved over time.

79. Since my interest starts in 2010, I needed to find some facts about the early years but the available information is surprisingly limited and largely either contradictory or lacking in relevant detail.

80. In his witness statement Dr McKeown stated that, having had a small private practice exploring his interest in minimally invasive aesthetic medicine, he had "created" the Clinic in 2009 and worked from "small premises". He was working for the NHS elsewhere and travelled to Glasgow working in the Clinic at the weekends.

81. He went on to say that in 2011 he had left the NHS to focus on the Clinic full time; at that point he was the only employee of the Clinic. However, there are a number of problems with those statements and it seems to be an inaccurate account.

82. On 28 June 2018, Azets wrote to HMRC stating:- "It [the Clinic] has been in operation since 2008". In the Notes there are at least three references to accounts for the APE (Accounting Period Ending) 31 August 2008, one of which shows a deduction claimed for the use of Dr McKeown's home as an office.

83. I therefore find that the appellant has been trading since 2008.

84. I also observe that the Notes state, in response to a question about what he was doing in 2011/12 and 2012/13, that he "definitely thought he had been working during this period - possibly leaving the NHS around that time". He also said that "When the business originally started he was working in the NHS and worked every Saturday and Sunday in 2012. For some time he would take every Wednesday off but would take phone calls at home." Earlier in the meeting it is recorded that "He previously worked for the NHS in the South and used to travel to Glasgow every weekend". I observe that the 2011 Patient had a consultation, and treatment, on Sunday 20 November 2011.

85. On the balance of probability, at least before 2011 and almost certainly for one or two years later, Dr McKeown was a sole practitioner in the Clinic working limited hours. Nevertheless there is no doubt that from 2010 the Clinic's turnover was above the VAT threshold, albeit he argues that VAT was not due.

86. In the Notes, Dr McKeown had confirmed that he had rented an office in London but he had last practised there six years previously, ie 2013. He still maintained that Harley Street address, paying £50 per month to remain registered at that address. The Documentary stated explicitly that he had a clinic in London in addition to his practice in Glasgow. I observe that the documentation for the Clinic consistently states "London | Glasgow" and carries the Harley

Street address followed by the Glasgow address with an 0800 telephone number and the website details. I have assumed that all of that may simply be "advertising".

87. In relation to the Clinic and those who worked there, when and what they did, in his witness statement dated 12 January 2022, Dr McKeown stated that:- "Since that time [2011], the Clinic has grown from a single practitioner into a team of colleagues who provide comprehensive aesthetic medical care to our patients." Obviously, he has not commented on the period before 2011.

88. In oral evidence Dr McKeown said that *** ("Surgeon 1") had joined the Clinic in 2013.

89. The Notes record that until 2015, Dr McKeown's mother had been the only receptionist. She had started work in April 2014. She made all of the appointments. (In other evidence it was established that at that time all enquiries were offered an appointment but I do not know when that stopped). At that time only paper records were maintained. Some computerised records were introduced in 2016 but paper records were also kept.

90. The undisputed evidence was that surgical treatments were only offered from 2015. In his witness statement Dr McKeown said that those treatments were initially provided by Surgeon 1. I have no information as to how often Surgeon 1 worked at the Clinic prior to surgery being introduced in 2015 or what percentage of his work after that time was non-surgical.

91. Accordingly, although he was a surgeon, Surgeon 1 would have provided non-surgical treatments prior to 2015. One of the Samples (Patient 99) which was explored with Dr McKeown in cross-examination related to a non-surgical treatment and he said that the handwriting and notes were that of Surgeon 1. I will revert to that Sample.

92. The Notes record that Dr McKeown's then (in 2019) partner, and now husband, Tom Cronin, had previously worked in the financial sector until 9 December 2016. He had initially been employed by the Clinic as a sub-contractor but became an employee. Dr McKeown's oral evidence was that he prepared the rotas for the employees, ensured that stock levels are appropriate and generally saw to the smooth running of the business. I note from the Documentary that in 2016, Dr McKeown' mother was described as the office manager but clearly, at some unspecified date, Mr Cronin became the office manager.

93. In his witness statement, having stated that Surgeon 1 had initially provided the surgical treatments, Dr McKeown had said:- "Since 2017, a consultant plastic surgeon, [***Surgeon 2] has taken over the surgical practice at the Clinic". I have added emphasis since, I can see from the Notes that even in May 2019, Surgeon 1 was still working for the Clinic.

94. I observe that in the letter from Azets to HMRC dated 29 June 2018, one of the matters that was confirmed was that all treatments were carried out either by qualified medical professionals or under their supervision. It stated that: "The majority of treatments" were carried out by Dr McKeown, *** ("GP 1"), and the two surgeons. I do not know when Surgeon 1 ceased to work for the Clinic.

95. In his witness statement Dr McKeown had stated that GP 1 had worked for the Clinic between 2017 and 2021. In oral evidence, he said that GP 1 was a qualified GP and had worked for two mornings per week and on a Saturday. I have limited information as to what precisely she did (see paragraph 154).

96. The Clinic has been a registered independent clinic regulated and inspected by Healthcare Improvement Scotland ("HIS") since 9 March 2017.

97. Independent clinics are defined in the National Health Service (Scotland) Act 1978 at section 10F(2) as being:

"'independent clinic' means, subject to subsection (2A), a clinic which is not comprised in a hospital and in or from which services are provided by a medical practitioner, dental practitioner, registered nurse, registered midwife or dental care professional;"

98. The appellant's Certificate of Registration is dated 10 October 2018. Only one announced inspection of the Clinic has taken place and that was in March 2019. The outcome of that has not been produced.

99. The conditions of registration include:-

(a) "The service will treat service users aged 18 or over".

(b) "The service shall ensure that staff possessing the appropriate skills, training and experience are provided in sufficient numbers to ensure the safety and welfare of all service users."

(c) "The service will provide non-surgical treatments and minor surgical treatments."

(d) "No Follicular Unit Transplantation (FUT) strip hair transplants will be carried out".

(e) "The service will only provide treatments to individuals aged 17 for medically diagnosed conditions."

100. The Notes record that:-

(1) In May 2019, the employees were Dr McKeown, his mother, who was a receptionist, his partner who had a managerial role, GP 1 and two ladies, one of whom was a part-time receptionist and part-time laser therapist and the other was a receptionist. Another employee who had been a surgical assistant had been paid cash bonuses "…as an incentive for her to follow up patients after their initial consultation". It seems that she may have left in 2018. It is of note that there is no mention of any nurses or patient co-ordinators and Dr McKeown referred to both of those in his witness statement and oral evidence.

(2) When asked if any self-employed individuals worked for the Clinic he said that he sub-contracted work to two surgeons but they were not employees. They did not provide invoices as there was an agreed payment structure. They used the Clinic premises and the fees were split 50/50.

(3) In recent years there had been major changes in the treatments offered and growth in the appellant's business including taking on a breast surgeon, Surgeon 2. I observe however, that the context is that Dr McKeown confirmed that the payments to Surgeon 1 in the APE to 28 February 2016 amounted to £101,025. (The appellant's year end changed from 31 August to 28 February with effect from APE 28 February 2014.) That is relevant because if it was Surgeon 2 who achieved major growth, it must have been on quite a significant scale. I have no details.

(4) The breast surgery was carried out by Surgeon 2 at BMI Kings Park Hospital with follow up appointments held at the Clinic. There is no mention as to where Surgeon 1 performed surgery but it is clear from the Documentary that he certainly did so at the Clinic. Whether it was all or only part of his work after 2015 is not known.

(5) Each patient of the Clinic had a file which would include details of their GP, any allergy information and consent forms. Later in the interview Dr McKeown said that he had a record of the patient's past medical history. Whilst I can occasionally see references to medical history I have seen very little detail of the type I would expect to see in a GP's notes. I will expand upon that in due course. (I had made it very clear at the Case

Management Hearing and in the hearing itself that I have extensive experience of reading medical notes, both those used in hospitals and GP notes).

(6) He was asked about the Samples and asked to confirm what information had been available at the time of treatment and what he had added before sending the Samples to HMRC. He said that at the time of treatment a fact sheet was prepared for each patient detailing the purpose of the treatment and the procedure carried out. For patient safety, details of the drugs used were recorded including the batch number. The Notes have been manually altered to say "fact" sheet but I believe that the original is correct being "face"; hence my references to "Face Pages" when discussing the records. It is the one consistent type of record, albeit it was in a much smaller format prior to 2013.

(7) He said that "…each patient would have a pre-treatment assessment. There would be consultation notes and then a post (sic) treatment assessment.". As can be seen from my findings in relation to the Samples and other records there are very few consultation notes and minimal, if any, records of post treatment assessment. There are a few examples of a note at a subsequent treatment that the patient was happy, or not, following the previous treatment.

(8) The initial appointments and follow up appointments would not incur any charges and if a patient came in for treatment which was not ultimately carried out, because it was unsuitable, there would be no charge.

(9) In relation to the APE ending 28 February 2016, he estimated that there would have been approximately 6,000 appointments and no payment was received for 50% of those (but, of course, as the preceding sub-paragraph makes clear there was only payment for treatments and not for consultations).

(10) Approximately 20% of appointments were "no shows" and so they had moved to sending an electronic text message reminder two days before the appointment.

(11) When asked whether he had ever received or made referrals to a psychiatrist, he said that he had not. He did not suggest that he had ever made a referral to a psychologist.

(12) He did not routinely get referrals from GPs. (Azets explained that the NHS was not permitted to refer to the private sector).

(13) The website had a list of all of the treatments that were available. In oral evidence Dr McKeown confirmed that there was a price list for treatments but that has not been produced. In cross-examination he confirmed that it would have said, for example, "Botox" or "face and neck lift" etc.

(14) Having taken advice from Azets, the records held for patients were now more extensive but the work done was the same.

(15) He said at paragraph 111 that he "…might use friends of family for models…and would not charge for any of that work".

(16) Dr McKeown stated that "patients research the treatments that they are looking for themselves and they then find him".

101. I observe that in the patient questionnaire in use in 2018, there were tick box questions which asked "How did you hear about us? My doctor, A friend or family member, Search engine, Social media platform, Other".

102. In the course of the COP 9 meeting Dr McKeown had confirmed that the Outline Disclosure had correctly stated that:- "The company has grown significantly as a result of media exposure and is automating its processes to help deal with this." Presumably that was a

reference not only to the website and social media but also to the Documentary. In the Documentary, a patient is seen telling Dr McKeown that following treatment earlier that day she had had numerous responses to her posts on Facebook.

103. The Notes record that having been referred to the Screenshot, Dr McKeown advised that:-

> "…his patients want to feel better about the way they look but 'Kardashian' clones go somewhere else for treatment and other clinics must be advertising for these people. He initially refused to take part in the BBC documentary but took part to illustrate that his work involved normal people who wanted to feel better about themselves".

104. That is very much the tenor of the Documentary where he, and patients, talked about the fact that it was so good that normal people had access to treatments which had previously been the preserve of Hollywood actors and rich people only. Botox and other treatments were becoming more mainstream and readily accessible; it was getting more popular and becoming the norm. Everyone had some form of insecurity. They wanted to hold back the ageing process. One patient described it as being like going for a dental check-up or as part of a beauty routine. Of course, I place no particular stress on those views since that is not determinative but it sets the scene. Another talked of popping out for groceries and getting Botox done. Surgeon 1 described patients wanting to feel better and said "This is what they want - it is not what they need".

105. Dr McKeown said that coming to the Clinic was not like being "in a normal doctor's surgery where you are giving people bad news. We are doing something that is positive, that is having a positive impact on people's life."

106. The (undated) Screenshot of the website for the Clinic which was discussed at the meeting states that:-

> "Prescribing the power to be beautiful"
>
> My passion in life is to help men and women feel better about themselves through the way that they look. I aim to give people the power to become the best version of themselves by providing the right information and the right cosmetic treatments at the right times."
>
> "But no one wants to look tired or old before their time. That's where I come in."
>
> "In my clinics we do much more than simply sell treatments. Our focus is on helping you to really understand the ageing process and make the right decisions that suit you now, but also are right for you in the future as well. Sometimes it will be simply lifestyle changes, sometimes it will be the use of a particular product and sometimes, when appropriate, it may be to have a cosmetic treatment. Regardless of what I recommend for you however, you can be sure that my goal for you is always the same: to make you look and feel your very best for now, and the future."

107. Dr McKeown explained that some of the phrases used on the website were used for search engine optimisation repeating certain phrases so that the site will appear on google search engines. He argued that the patients know that their psychological issues will be reviewed. Azets argued that HMRC should not get too "hung up" on the wording on the website.

108. There is no evidence about what the website looked like at the time that the enquiry commenced or before that. The years with which I am concerned start in 2010 so there is no information about where the emphasis lay in previous years. I have not seen a current website.

109. In his witness statement Dr McKeown stated that the Clinic had employed *** ("GP 2") in 2019. In oral evidence, he said that she was a GP who had worked part-time until 2021 but

is now working full time for the Clinic on a Tuesday to a Saturday. He explained that GP 2 has no nursing assistant. She sees fewer patients than Dr McKeown and is involved in audits and other clinical governance issues as well as telephone consultations but those apparently only commenced a few months before the hearing.

110. He went on to say that:-

> "In late 2021 I hired *** ("GP 3") as [GP 1's] replacement" and "…we now have four doctors in the Clinic who regularly see each other's patients….".

In fact, although the appellant's Skeleton Argument also stated that the Clinic employed two GPs that is not accurate. In oral evidence, it transpired that GP 3 had not commenced work. Dr McKeown explained that she had not completed the mandatory training referenced in the witness statement as the Clinic had had different priorities. Therefore only one GP was employed in 2021 and 2022.

111. Like much else, the whole issue of the staffing of the Clinic, and when, could best be described as lacking in clarity, or indeed in some cases, accuracy.

112. In his witness statement Dr McKeown said that "When patients undergo surgical procedures, [Surgeon 2] is always assisted by one scrub nurse and another assistant". The inference is that that had always been the case but he did not tell HMRC in 2019 that he employed any nurses. Of course in 2019, Surgeon 2 did not operate in the Clinic but Surgeon 1 appears to have done so. Furthermore, the Documentary shows Surgeon 1 being assisted by a man whilst doing a face lift. There was no male employee, apart from Mr Cronin, identified to HMRC in the Notes.

113. He went on to say that "In addition to our doctors, the Clinic uses three qualified nurses. All three nurses work primarily in the NHS and do one or two days per month at the Clinic on a rota basis. They principally assist [Surgeon 2] with the surgical procedures." In oral evidence Dr McKeown said that they also get the patient ready for surgery, deal with them after surgery, and make sure that they have the written after care instructions, any medication and emergency contact details.

114. There is a 24 hour emergency telephone number for dealing with any unexpected complications and out of hour calls are diverted to Mr Cronin's mobile telephone number. Dr McKeown is usually available "on call" to deal with emergencies. Any emergencies relating to surgery are dealt with by Surgeon 2 or one of his NHS colleagues. Dr McKeown confirmed that there were very few calls. I do not know when that service started.

115. He also stated in his witness statement that:- "I will normally have a nursing assistant to help me." In oral evidence when asked about her and what she did he said that she was a former dental nurse who is employed for five days each week. Her role was to assist during treatments and to act as a chaperone when he was consulting. Dr McKeown sees between 15 and 20 patients each day of whom two thirds would have a treatment. There was no evidence of a nursing assistant in the Notes.

116. In the Documentary, when performing a hair transplant (a topic to which I will revert in more detail), he can be seen being assisted by someone who might have been a nurse. Pertinently, in the Documentary, four "technicians" can be identified assisting with the hair transplant.

117. In his witness statement he said that "We also have a small number of laser therapists who carry out laser treatments under supervision". In oral evidence when he was asked to identify precisely which staff he employed there was no mention of laser therapists. I know from the Notes that one receptionist had also worked as a laser therapist in 2019. In response

to a question from me, Dr McKeown said "If it looks as though they may be a candidate for some sort of laser treatment, then they will generally be booked for an appointment with [GP 2]". He went on to say that if the treatment was likely to be injectables then the appointment would be booked with him. Either the witness statement is inaccurate or he suffered a lapse of memory.

118. Another difficult area was his statement that "Most new patient enquiries are made on the telephone or by e-mail and are responded to by our patient co-ordinator team…". There was no mention of patient co-ordinators or a team of them in the Notes.

119. In oral evidence, Dr McKeown identified by name, one of the patient co-ordinators and I observe that she was one of the ladies identified in the Notes as being the full-time receptionist as opposed to the part-time receptionist.

120. He explained that one of the dedicated receptionists sometimes doubles up as a patient co-ordinator and two other members of staff act as patient co-ordinators. They share an office with Mr Cronin. The patient co-ordinator talks to the patient in order to obtain an initial understanding of what the patient is hoping to achieve.

121. Dr McKeown described it as an information gathering process. He conceded that even new patients often know what treatment they want, although they may be incorrect. He said that the patient is asked to send in some photographs of the relevant feature which concerns them (for example, their nose or forehead). That may be the case for telephone enquiries and some of the email enquiries for new patients but, as I explain later, in 2022 there was a standard enquiry form.

122. He also said that training of patient co-ordinators, who normally come from a customer service background, had been done "recently" by Mr Cronin. He expanded on that stating that that had been in the last three or four years; that is since the HMRC enquiries. Dr McKeown said that he had trained Mr Cronin who does have some patient contact in that he will answer the telephone or emails if the receptionist and / or patient co-ordinators are busy.

123. Unfortunately, one of the many gaps in the information provided was any level of detail as to how many enquiries were received and how many were translated into appointments. In his witness statement Dr McKeown said that "The majority of our patients are regular patients who visit the Clinic once or twice a year". I have no information as to the quantity of that majority.

124. What I do know is that in February 2020 there were 55 new patients. Given that the clinic is open for six days each week that would mean between two and three new patients each day. I also do not know if that was a typical month. Nor do I know when the requests for photographs commenced. The only photographs that have come to my attention are those that are redacted in the standard enquiry forms in 2022.

*The physical space in 2022*

125. The premises extend to approximately 1,600 square feet. The reception area is simply a desk with some chairs. There is a waiting room with chairs and sofas and a small recovery room with some chairs for patients after they have had treatment. The staff share an office. The toilet facilities are for both staff and patients.

126. Surgeon 2 has a small office which he uses for consultations and a separate room for surgery. The latter contains a dental couch and a stool for the surgeon. There is a scrub trough, operating light, trolleys for instruments and a storage facility. There is mechanical ventilation in that room as it is a regulatory requirement.

127. Dr McKeown and GP 2 have rooms that are both very similar. They consult and administer treatments in their rooms. They have a dental couch, seating and a desk for the doctor and laser equipment with its ancillary equipment. There are lockable fridges for the Botox, fillers, local anaesthetics, disinfectants and other necessary paraphernalia. There are clinical sinks with clinical taps. The doctors use "regular soap".

128. Their rooms are at the front of the building and have windows so there is natural ventilation. All surfaces are designed to be easily cleaned.

129. I do not know when the appellant moved to these premises.

*The profile of the Clinic*

130. Clearly this has changed over time and again I have little detail.

131. Over the lifetime of the practice, the Clinic has had approximately 12,000 patients who have been registered. I was surprised and explored the detail of that with Dr McKeown pointing out that, as I understood it, the average GP practice would be very busy if it had 6,000 registered patients. He then stated that the Clinic saw "most patients once every six months". Some patients would only attend every two years and some would return after five or six years. As can be seen from the documentary evidence that may be accurate for some patients but it seems that many attend more regularly.

132. Ultimately, he said that there would be approximately five and a half thousand patient visits in each year but that would include the pre-consultation, treatment and aftercare visits. Each of those would be recorded as a separate visit. Not every patient has each of those three visits. That is relevant because in his witness statement Dr McKeown said that patients (ie the undefined majority) who returned for repeat treatments would not require these three visits. I have seen no evidence of aftercare visits other than to observe that at a subsequent treatment, at least one patient expressed satisfaction with the previous treatment.

133. In oral evidence, Dr McKeown conceded, that on occasion, treatment might be administered with no gap between the pre-consultation meeting and treatment. I will revert to that but certainly I observe that that was the case for the 2011 Patient and also the patient in Full File note 3.

134. Although HMRC had sight of appointment records in 2019, nothing of that sort was produced to the Tribunal.

135. Dr McKeown stated that some 91% of the Clinic's patients identify as women who are in their 40's, 50's or 60's. The majority had suffered sun damage and nicotine exposure. Dr McKeown said that he estimates that approximately 10% or 15% of the patients have a diagnosis of depression and often coexisting anxiety. What certainly was not clear was who had diagnosed that and/or whether it was clinical depression. There was no distinction in the records that I have seen.

136. Mr Tosh asked Dr McKeown about diagnoses and the use of ICD codes (International Classification of Diseases). There is not a single ICD code in the records. Whilst I fully accept that it is not uncommon for a doctor to treat a patient without specifying an ICD code or indeed making, for example, a decision whether the patient has schizophrenia or bipolar affective disorder, nevertheless I would expect clinical findings such as, in those examples, that there had been a psychotic episode. Depression presents across a very wide spectrum and the psychological impacts are very different. There was extremely little clinical detail in the records.

137. Dr McKeown did not address the profile of the Clinic in the period before 2015, which is unfortunate. He stated that in 2015, when surgery was introduced, 90% or 95% of treatments were injectables, 5% to 10% were surgery and probably less than 1% were lasers.

138. By 2022, he thought that the profile was 60% injectables, 20% surgery and 20% lasers. Those were approximate estimates and there was no evidence beyond his oral response to my questions.

139. Dr McKeown relied upon his published article for PRS Global Open which explored the impact on psychological health of injectable procedures (where he properly disclosed that he has been a consultant for a manufacturer of injectables and that the cost of the statistician's services were met by the manufacturer).

140. He said that in an audit of 55 new patients in February 2020, two were from overseas and so were not offered follow up visits. Of those 55 patients who were asked to complete psychological tools (questionnaires) before they had their first consultation, and the same questionnaires some weeks later after their initial treatment, only 35 completed the latter questionnaire.

141. They ranged in age between 20 and 71 with an average age of approximately 45. Some 40% had previously been treated elsewhere. 17% had both Botox and filler treatment, 17% had only Botox and 66% had only fillers. Dr McKeown confirmed that it was an accurate reflection of the profile of the Clinic (in relation to non-surgical procedures) in 2021 which is after the period with which I am concerned. What the profile at any other time might have been is unknown.

*The Services offered by the Clinic*

142. So how do the patients find the Clinic? I was mildly bemused by Dr McKeown's choice of heading in his witness statement which was "Patient acquisition process". He stated that:

> "When new patients register with the Clinic, they most commonly find us via a recommendation from a friend or from online research and self-referral".

Clearly, it is important to ascertain what they research.

143. I have already addressed the website and the Documentary. As can be seen from paragraph 100(15) above, Dr McKeown told HMRC that he used friends and families as models but I have no information as to when and where. I do know from the Documentary that he hosted a drinks party for patients and potential patients. He has produced no evidence in relation to social media presence notwithstanding the fact that in some of the more recent Patient questionnaires there is a question that reads: "I consent to my photographs being displayed on the clinic social media sites". Clearly there are more than one.

144. In his witness statement Dr McKeown stated that:-

> "As the Clinic has grown, I have brought into the team other doctors with different areas of interest and expertise both surgically and non-surgically, and invested in a number of technologies such as laser and energy-based devices".

I have been provided with limited detail of those areas of interest or expertise whether surgical or non-surgical. On the contrary Dr McKeown's evidence was that little had changed over the years. As will be seen that is not correct.

145. In fact, a major issue was trying to identify what services were delivered by the Clinic, and when. In cross-examination, Mr Tosh had explored with Dr McKeown precisely what it was that the Clinic had offered.

146. In his witness statement, Dr McKeown had stated that:-

> "The type of non-surgical treatments offered by the Clinic has remained broadly the same since 2011 although of course the available techniques and products have advanced considerably during that period."

That does not assist in relation to the period before 2011.

147. In oral evidence Dr McKeown confirmed that the Clinic has delivered, what he described as, three modalities for non-surgical treatments. Those are minimally invasive treatments being "injectables" of botulinum toxins (commonly known as "Botox" which is the description that I will use although I acknowledge that only one of those toxins is licensed as Botox ®) and facial volumising fillers such as dermal fillers ("fillers") and laser treatments. The fillers add volume to the face and/or to the lips. The laser treatments are primarily used for repair of sun or sunbed damage. Of the non-surgical treatments the majority has always been the injectables.

148. He said that over the period, the method of delivery had changed because more sophisticated products had become available and, particularly in the field of laser technology, the range of treatments offered had improved.

149. In his oral evidence, Dr McKeown, stated that the surgical interventions, which have been offered since 2015, are eyelid surgery to remove fat or skin from around the eyelid and face and neck lifts which tightened or lifted the loose skin around the face and neck. Those treatments had remained "broadly the same since 2015".

150. However, when I read the Notes, I observed that HMRC had questioned payments made to "Marius" in April and May 2015. Dr McKeown had explained to HMRC that Marius was a "hair transplant technician". Dr McKeown suggested that other payments in March and May 2015, which had been questioned by HMRC, related to his own "hair transplant training".

151. As can be seen, the HIS Certificate excludes strip hair transplantation and yet the Documentary demonstrates that in 2016, Dr McKeown was, and had been, performing such hair transplants. The surgery took up to 12 hours, was performed in the Clinic and cost approximately £6,000. There was a team of four technicians who assisted. I therefore find that, certainly in 2016, and possibly before and afterwards, the Clinic was offering hair transplants. Whilst the subjective view of the patient is not determinative, I also observe that one of the patients in question seemed to view it as a purely cosmetic procedure.

152. The next and far more crucial inaccuracy or omission relates to the other surgical treatments that were apparently offered. I am not in a position to opine as to what constitutes "minor surgical treatment" for HIS purposes. However, I can see clearly from the patient questionnaire that was in the records for both the 2011 Patient, who was also the patient in Full File note 4, and the 2018 Patient that the second half of one of the pages asked the patient to circle the treatment(s) that were of interest in the following table:-

| **Facial Improvement** | **Skin enhancement** | **Body contouring** | **Other** |
|---|---|---|---|
| Facial fillers | Skin injectables | Fat reduction | Laser hair removal |
| Wrinkle relaxers | Skin products | Breast enlargement | |
| Face lifting | Laser treatment | Breast correction | |
| Ear correction | Chemical peels | Tummy tuck | |
| Fat reduction – chin | Skin tightening | Arm lift | |
| Eyelid correction | Pigmentation | | |

153. I say one of the pages because in the records for the 2018 Patient there is a two page "New Patient Registration Form" which is a questionnaire completed by the patient (I only know that is called that because an identical form was exhibited elsewhere by Dr McKeown and the heading had not been redacted). There appears to be attached to that a further two page questionnaire and the table is on the second page of that. In the records for the 2011 Patient, only the second page of the latter questionnaire is included for the 26 February 2019 record but both pages are included for the 11 October 2018 record.

154. I note that "Fat reduction" appears in this table but was never mentioned by Dr McKeown as being a treatment that was offered. When writing this decision I was surprised to note that in her CV, GP 1 said that under the tutelage of Dr McKeown she had performed Botox, filler and laser treatments. However, she stated that she was the "Clinical Lead for Coolsculpting cryolipoysis" which is a form of fat reduction which I observed being performed by Dr McKeown in the Documentary. I do not know how many of those treatments were delivered or when.

155. I should say that very few of the earlier records are dated and hand-written post-it notes of unknown vintage abound. Since I observe from the Notes that HMRC reviewed what they described as the "appointment sheets" I can only assume that in preparing the documentation for HMRC, Dr McKeown had cross-referenced those to the records; hence the post-it notes.

156. Furthermore, as I have indicated at paragraph 100(3) above, the Notes show that Dr McKeown "confirmed major changes in the treatments and growth in the business…including taking on a Breast Surgeon [ie Surgeon 2] to carry out breast surgery….". Beyond knowing that breast surgery was offered, and for a time was performed elsewhere, I know nothing about it.

157. Whilst I note Dr McKeown's argument that he signed the Notes because he was stressed and Azets had told him that they were accurate, the fact is that they had been lodged in process and if he had identified any inaccuracies he could have corrected those in his witness statement or in evidence-in-chief. He did not. The only correction of note was that he corrected the witness statement to state that the patient questionnaire that he had exhibited had never been in use and had been sent to Azets in error.

158. That raises another issue because he then told the Tribunal that the actual "form" used was at page 993 of the Bundle. That is Full File note 1. I can see from other records that the patient questionnaire starting at page 993 is actually the questionnaire that was in use from approximately 2013 to 2018 and thus before the HMRC enquiry.

159. The records for the two patients where the table was found show that a very different questionnaire was in use for the 2018 Patient who completed it on 20 June 2018 and for the 2011 Patient who completed it on 11 October 2018 and again on 26 February 2019. The New Patient Registration Form or questionnaire still seems to have been in use in early January 2020 since Dr McKeown exhibited those two pages. What I do not know is whether the other questionnaire with the table was still in use from early 2020. I do not know anything about the surgery.

160. His witness statement then goes on to exhibit a blank online questionnaire which he stated had been used "Following the computerisation of the Clinic's records in 2020". Of course he had told HMRC that records had been computerised in 2016 (paragraph 89 of the Notes). One problem with that is that there is no example of a completed questionnaire like that in the Bundle yet some of the records are later than 2020.

161. The alleged post 2020 questionnaire does not include "Body contouring treatments". I do not know when they were introduced, or when, or if, they ceased to be offered, albeit the

Documentary did show patients being provided with "fat reduction" for the stomach, a face lift and fillers being injected into hands. I do not know which were done in the Clinic but I assume that breast surgery and tummy tucks were provided in the hospital used by Surgeon 2.

162. Dr McKeown also exhibited what he described as a "sample new patient enquiry form received in January 2021". It was not. There were two in the Bundle. They were dated 2 January 2022 and both were extensively redacted. However, they are obviously a standard form. They are headed "Consultation Enquiry". There are five headings before there is an option to upload an image and then the following pages are redacted.

163. Dr McKeown states in his witness statement that the first patient was offered a consultation and the latter was "told that, on the basis of the information provided, the Clinic would be unlikely to be able to help her". Unfortunately nothing to that effect was included in the Bundle. The following document in the Bundle is the questionnaire that was apparently never used. Given that, and all the other conflicts in the evidence, I attach limited weight to that statement by Dr McKeown.

164. The questions asked were "Age, Please tell us in your own words what bothers you about your appearance, Please tell us what in an idea (sic) world you would like us to achieve for you, Would you prefer to explore surgical or non-surgical options? and Please tell us which specific concerns you have using the following boxes".

165. The enquiries were from people aged 34 and 21 respectively, so, if Dr McKeown is correct about the profile of his patients they are atypical. There are only three boxes and two have been redacted; only the first being "Lip volume" is shown.

166. The source of the Enquiry Form has not been identified but it is possibly the website. I do not know whether it was from part of the website dealing with lips only but that seems probable. I say that because Lip volume is the first box and in oral evidence Dr McKeown told Mr Tosh that comparatively few fillers were used on lips.

167. Those forms tell me very little about what was on offer in 2022 which, in any event, is 21 months after the end of the period with which this appeal is concerned. I have seen no evidence of any questionnaire before 2011.

168. I said at the outset that it was very difficult to identify the services that were supplied and when. What I have identified is that both Dr McKeown's witness statement and his oral evidence were riven with inaccuracies and neither addressed the position between 2010 and the opening of HMRC's enquiries with any material degree of relevant information.

169. That is unfortunate since the appellant bears the burden of proof. It is particularly unfortunate since I have been furnished with no evidence about the breast surgery which apparently drove a major growth in the appellant's business. The fact that until 2018 a surgical co-ordinator was paid cash incentives to follow up patients after their initial consultation is indicative of the provision of purely cosmetic treatment.

*The patient journey*

170. Another major problem area was to identify what exactly happened. I have mentioned enquiry forms and the patient "acquisition" but that is all in recent times. Dr McKeown's witness statement and most of his oral evidence focussed on 2022 which was not helpful.

171. I accept that on the balance of probability most patients self-referred from the outset. Dr McKeown stated in his witness statement that some patients are occasionally referred by other doctors but that is in conflict with the Notes where his accountant said explicitly that GPs did not refer patients.

172. I was told that originally every enquiry was offered an appointment. I do not know when that stopped. Presumably, when that stopped, as the Clinic grew, the patient co-ordinator, or I assume up until at least the COP 9 meeting, the receptionist would give the doctor the information and at a high level the doctor would say whether treatment could be offered, or not, and what the options might be.

173. Until GP 2 commenced working on a full-time basis it was Dr McKeown who did that screening. More recently, if the doctor considered that the appellant could help the patient they would recommend an initial consultation with the doctor who was best matched to the patient's needs. In the months before the hearing the system evolved further and it is GP 2 who now speaks to the patient rather than the patient co-ordinator.

174. Since the time of the HMRC enquiries, Dr McKeown states that when a patient is offered, and accepts a consultation, an email is sent to the patient to confirm the appointment and provides information about the most likely treatment options and an approximate indication of the costs. Since 2020, the patient has been provided with an online questionnaire asking questions about their health and lifestyle history.

175. A range of different paper questionnaires have been used over the years. Initially they were extremely brief (see the 2011 Patient). Dr McKeown changed them in late 2012 or early 2013 and again in approximately 2018 and in 2020 when the Clinic moved to a computer based system. He described "experimenting with a number of form designs over the years". He conceded that the form exhibited to his witness statement had never been used and had been lodged in error. What every questionnaire includes is asking the patient what the patient wants to have done.

176. If the patient does not complete the questionnaire prior to the consultation then the patient is asked to do so in the waiting room prior to the appointment. If a patient refuses to complete the forms then they do not have a consultation.

177. Once the necessary documentation is in hand the doctor collects the patient from the waiting room and conducts the consultation.

178. The consultation lasts for approximately 20 minutes when looking at cosmetic treatment with a low risk profile but for surgical procedures, the initial consultation is a mandatory 45 minutes followed by a second 30 minute consultation two weeks later.

179. Dr McKeown stated that following the consultation a cooling off period of two weeks is mandatory for all non-surgical complex minimally invasive treatments. It has not been explained to me what amounts to such a treatment but as I explain in relation to the patient in Full File note 5, I would have expected there to have been a cooling off period for her and there was not.

180. Dr McKeown states that in the consultation, after assessing the psychological aspects of the patient's health, the physical health is also considered. A "thorough review" of the patient's medical history is undertaken and finally there is a physical examination of the patient. As will be seen from the patient's records, I have no evidence to that effect. I revert to that at paragraphs 427 and 428.

181. The treatments are carried out in the doctors' rooms for non-surgical procedures.

182. Currently, and I do not know for how long that has been the case, for surgical procedures the surgeon is assisted by one scrub nurse and a nursing assistant. Following surgery, patients remain in the recovery room where they normally have something light to eat and drink before being taken home by a responsible adult.

183. On leaving the Clinic the patient is provided with written aftercare instructions. If a patient wishes to avail themselves of the service then they can book a two week follow-up appointment. An automatically generated email is issued two weeks after the treatment and that is aimed at checking on the patient's progress and asking them to arrange a follow-up appointment if the outcome does not match their expectations or if they have experienced any unexpected complications.

184. In his witness statement Dr McKeown said that when patients have had a more complex minimally invasive procedure or an invasive procedure, follow-up appointments are scheduled before they leave the clinic. For most non-surgical treatments those would take place two weeks after the treatment. For patients who have had an invasive surgical procedure, they have a follow-up appointment (presumably by telephone given the surgeon's working hours) the day after treatment to check for any issues and a further appointment after one week. They are then seen at one month, three months and six months in order to assess progress.

185. I have seen no evidence of anything relating to surgery so I cannot attach much weight to that given the numerous other discrepancies in the evidence.

186. In his witness statement Dr McKeown stated that:

> "…with the most psychologically complex patients, we may refer the patient to a psychologist before treatment. This is not particularly common, and has only happened around 5-10 times over the lifetime of the Clinic. Such referrals are more common with patients who are being considered for surgical interventions …".

187. I explored that statement with Dr McKeown in the context of one of the Samples where it was recorded that the patient had mental health problems and had had a previous admission to a psychiatric unit. I asked whether or not that should have been a patient who was referred to psychology and Dr McKeown conceded that, on reflection, potentially that should have been considered. He then explained that referrals only really started after Surgeon 2 joined the Clinic in 2017.

188. In his witness statement Dr McKeown made a reference to a suggested referral for psychology "recently" which was turned down by the patient. On the balance of probability, I do not accept that there were referrals to psychology prior to 2017 by Surgeon 2 and by others until after HMRC's enquiries.

189. There is nothing in the Bundle to suggest that the appellant made referrals to other Clinicians although it was argued in Opening Submissions that, although not in the majority, there were numerous examples of referrals to specialists. There is no evidence beyond that assertion which, of course, is not evidence.

***Dr McKeown's qualifications***

190. Dr McKeown is a qualified doctor registered with the General Medical Council ("GMC") and holds a current and valid licence to practise medicine in the United Kingdom. He graduated in medicine from the University of Glasgow in 2005. His undergraduate training followed the standard pattern and included hospital placements across different areas of medicine in the later years. For one of those placements, known as "rotations", he spent six weeks in the psychiatric unit of a hospital. He undertook two periods of study abroad known as "electives" and the first was between his second and third years in medical school and he spent that time in a private practice in California which provided aesthetic plastic surgery. Between his third and fourth years at medical school he completed a second elective in craniofacial surgery at a private hospital in Michigan where face lift surgery was provided.

191. Following graduation, like every other UK qualified doctor he completed the two Foundation Years ("FY1 and FY2") of post-graduate training. For FY1 he spent six months each in general medicine and general surgery wards. FY2 included rotations in general medicine, general surgery and four months in psychiatry. The psychiatry rotation was in a general adult ward but involved attendance at Accident and Emergency on a rota. At that time, doctors held full registration with the GMC on completion of FY1; currently it is only after completion of FY2. He spent no time in a General Practice ("GP") rotation.

192. From August 2007 he embarked on specialist training in plastic surgery. He qualified as a Member of the Royal College of Surgeons.

193. In 2012 he joined the British College of Aesthetic Medicine ("BCAM") as an associate member. BCAM is a GMC Designated Body which means that it is an organisation that provides members with regular appraisal and supports, in this case, doctors with revalidation.

194. All licensed doctors who practise medicine must revalidate and the norm is to do so every five years. Like other doctors he must complete a minimum of 50 hours of accredited continuous professional development ("CPD") each year. In 2021, as part of his CPD, he did a four hour online course in the psychological aspects of aesthetic medicine.

195. Dr McKeown became a full member of BCAM in 2021 (which entails passing an examination).

196. He registered with the Joint Council for Cosmetic Practitioners ("JCCP") with effect from 21 October 2022 and membership is for one calendar year. He did so by submitting an application to BCAM in order to "grandfather" onto the JCCP list of "Practitioners Registered to Provide Cosmetic Medical Treatments". That application was approved by a letter dated 9 September 2022 on the basis that he had provided proof of treatment specific training in skincare, the clinical use of Botox and fillers and complications management, lasers and light sources. His four month rotation in psychiatry in FY2, his CPD, and GMC appraisals were deemed to map to the competencies for registration.

197. I have narrated his qualifications at length because in her Skeleton Argument, Ms Hall argued that Dr McKeown's qualifications and experience make him as well equipped to provide psychological treatments as General Practitioners ("GP"). Mr Tosh argued that he was not qualified to offer psychological treatments.

***GPs***

198. Dr McKeown has no GP training. Whilst he does employ a GP, I heard no evidence from her or from GP 1. I did have information about Dr McKeown's own training and his CPD and appraisals, but I was only provided with CVs for the two GPs. The CV for GP 2 appeared to have been produced prior to her appointment to the Clinic. The CV for GP 1 is undated but appears to have been produced before she left the Clinic.

199. Beyond Dr McKeown's statement that every new doctor receives training, I do not know what that comprises or when that commenced. GP 1 only started with the Clinic in July 2017 and her CV says that she worked under Dr McKeown's tutelage. I do not know if GP 2, or either surgeon, had such training. I know very little about the training.

200. As I pointed out in the course of the hearing, and in the Case Management Hearing, I have relatively extensive knowledge of the medical profession and how it is regulated. In order to become a GP a doctor has to complete a degree recognised by the GMC followed by the foundation course of general training which takes two years but, crucially, general practice specialist training which takes a minimum of a further three years. A GP must join the GMC GP register and for most doctors this means completing the speciality training on a GMC

approved programme, passing the Member of the Royal College of General Practitioners examination and gaining a Certificate of Completion of Training ("CCT").

201. It is very different to the training for surgeons. For the avoidance of doubt, Dr McKeown's rotation in psychiatry was in an adult ward in a hospital dealing with general psychiatry so it is very different to the provision of community mental health treatment such as that provided by GPs.

202. In his witness statement, when arguing that the Clinic provided treatments that were similar to those provided by other doctors both privately and through the NHS, Dr McKeown said that the only purpose of those treatments was to achieve a positive psychological outcome for patients by improving their appearance. For completeness, the examples he gave were as follows:-

(a) Acne vulgaris which, as he correctly says, is an extremely common condition of the skin. Where patients are psychologically affected by the appearance of acne, GPs and dermatologists often prescribe a number of medications including exfoliates, antibiotics and retinoids. Those treatments serve no other purpose than to promote the psychological wellbeing of the patient because the appearance of their skin has improved.

(b) Hemifacial spasm which is a condition which involves involuntary twitching of the muscles on one side of the face and is normally caused by pulsation of an artery adjacent to the facial nerve. It does not impair physical function but the appearance of twitching muscles can cause considerable distress to patients. GPs will refer those patients for treatment and neurologists will treat the condition with medication and sometimes operate. That surgery is performed for the purpose of alleviating the psychological distress of the patient.

(c) Breast reconstructions are frequently offered after cancer surgery. Dr McKeown's argument was the absence of a breast causes no physical health impact but the psychological impact can be significant. The only purpose of reconstructions is to relieve psychological suffering.

(d) Neurologists regularly prescribe implants for testicular cancer patients who have had one or more testicles removed. The implants have no physiological function but alleviate symptoms of psychological distress.

(e) The appearance of prominent ears can be very distressing for young children and surgery is often performed to correct that.

(f) He said that as a medical student he had "regularly" observed rhinoplasty operations (to change the shape of the nose) or injections to combat hyperhidrosis (excess sweating).

203. He stated categorically that "In my view, there is no material difference between these treatments and the treatments which are prescribed by the Clinic".

204. The Samples and other patient records are the only documents that I, or HMRC, have that give any detail about treatments prescribed by the Clinic and, of course, I have nothing in relation to surgery.

**The Samples and other patient records**

205. Mr Tosh urged me to proceed with particular caution in relation to the records that had been produced on the basis that he argued that the records had been tailored to achieve a particular fiscal outcome. There is no doubt that the more recent types of medical records were formulated on the basis of advice from Azets who were engaged in 2018 when it was known that HMRC were taking an interest in the Corporation Tax affairs of the appellant and were likely to look at the VAT issues.

206. In evidence, Dr McKeown agreed that the format of the records had been amended to focus on the psychological aspects. In particular in cross-examination, Dr McKeown confirmed that he had been advised to add tick boxes and specifically boxes for "Is there a medical aspect to this treatment plan, Is there a psychological aspect to this treatment plan" and "Is this treatment purely cosmetic".

207. I can also certainly understand why Azets are seen to have conceded in the Notes at paragraph 348 "that the information supplied to date was insufficient to evidence that DM's services qualified to be treated as being exempt from VAT".

208. At that point HMRC had the Samples.

209. At no stage have HMRC changed their view that the patient records which had been produced then and more recently did not suffice to justify the exemption. It was argued for the appellant that HMRC had imposed too high a standard for records. Given the facts that I now find, I cannot agree.

210. Since the Samples were the first information of note provided to HMRC, and they are referred to in the Notes they provide a good starting point for ascertaining the context for the treatments provided by the Clinic in 2015. I will then turn to the later documentation that the appellant has furnished both to HMRC and to the Tribunal.

211. For production of the Samples, Dr McKeown had created what I call a "Cover Form" for each patient summarising the information that, I can see from the Notes, he said was derived from "his personal knowledge and registration documents held". It transpired that by registration he meant the patient questionnaires, in their various forms, that are completed at the first consultation and sometimes thereafter.

212. Each Cover Form had five headings, namely Patient concerns, Diagnosis, Treatment, Duty of care and Opinion.

213. Behind the Cover Form, with the exception of Patient 99, there were also sheets headed "Treatment Records". I shall call them "Face Pages". Those had a *pro forma* drawing of a female face and the sites for the injectables were marked on it. There were boxes which showed the batch of eg Botox, the concentration, lot number and expiry date. There were also boxes headed "Consultation summary notes" and "Procedural notes". Neither of those boxes contained any information about distress, anxiety or details of discussions about psychological issues in any of the Samples.

214. Of the 100 Samples, 70 had no information in those boxes. Four simply had details of the cost of the treatment ranging from £400 to £1,500 and stating in two cases that it was simply a consultation. One, Patient 73, simply recorded a failure to attend. In many cases it only recorded that it was, or would be, a "top-up". A number simply recorded a detail about the injectable(s). One recorded that "Only do forehead every second time, more natural".

215. The Cover Form was missing for Patient 98 and only the Face Page was included.

216. Patient 99 did not include a Face Page but was simply a piece of headed paper with a handwritten date, an observation that the patient "lives at home, non smoker, reading glasses, lower eyelids, lower eyelid". There is a minimalist sketch of what I take to be a lower eyelid, two entries reading "PMH" and "DH" (being shorthand for past medical history and drug history respectively) against which it says "Nil" and "Nil, NKA" respectively. There is then a signature. In cross-examination when identifying Surgeon 1 as the author, Dr McKeown said that that would have been the totality of the documentation for that patient on that date but there would have been a patient questionnaire. He said that his own notes "are typically fewer than that" in 2015. I accept that and, indeed, it is obvious from the Full File notes.

217. In every Cover Form the "Opinion" was "Medical treatment". In almost every case the Duty of Care section included statements such as:-

> "Address the patients concerns
>
> Psychological support
>
> Restore anatomical concerns
>
> Not to be dismissive of the patient
>
> Protect and maintain the health of the patient, including the psychological health".

218. When I asked why Dr McKeown had included "Not to be dismissive of the patient", he said that he had been trying to point out the significance of the patient's concerns.

219. HMRC had prepared a spreadsheet which incorporated the information from the Cover Forms and added two further columns being "Layman Explanation/Treatment Sheet" and "HMRC Opinion". In every case HMRC's opinion was that the treatment was cosmetic.

220. HMRC's analysis of the Samples was that:

> "Dr McKeown has provided 100 sets of patient records. All of the treatments listed appear to be cosmetic. Examples of the "conditions" treated include the following:
>
> i. Botox for wrinkles on forehead
> ii. Botox for wrinkles on eyes
> iii. Use of "fillers" for lips
> iv. "Hump in nose"
> v. Wrinkles on upper face
> vi. Volume loss around cheek region….
>
> In relation to every single one of his patients he has noted the presence of psychological concerns."

They were criticised by Ms Hall for recording the treatment as being Botox when sometimes it was a different toxin. I do not accept that criticism. HMRC used Botox in the same way as I have done in this decision and pertinently included it in the column headed "Layman Explanation /Treatment Sheet".

221. Dr McKeown conceded that almost all of the entries were for Botox or fillers. There were no laser treatments or surgical procedures and the recorded Duty of Care was essentially the same for every entry.

222. Mr Tosh put it to Dr McKeown that in the Cover Form for Patient 1, the patient's concerns were wrinkles and active acne and there was no reference to psychological issues. Dr McKeown argued that because he had said under "Diagnosis" that she had premature

rhytids (wrinkles) and under the heading "Treatment" he had included not only Botox and discussing acne management but also "Psychological concern/support", he had demonstrated that the patient had psychological needs.

223. On being questioned as to what "Psychological concern/support" meant, he said:-

> "So that means talking sympathetically with the patient, understanding what their concerns are, and generally being a caring and supportive doctor towards the patient. I think it's an important part of every consultation that a doctor does, whether it be in the context of cosmetic treatments or not."

224. The patient had asked for and paid for Botox treatment. The Clinic had given lifestyle advice about acne and listened sympathetically to the patient.

225. The problem that I had when I was writing this decision, was that I noted that at paragraph 32 of his witness statement, Dr McKeown had said in relation to initial screening that:

> "Sometimes, the photographs provided by these patients show that they still have active acne which needs to be cleared up before we can begin to treat the scaring. In these circumstances, our doctor would recommend that the patient first see a dermatologist, and we usually refer that patient to a local dermatologist with an interest in treating acne."

226. The evidence in relation to this sample is that 15 Botox injections were provided.

227. Mr Tosh then took Dr McKeown to the records for the second patient and again the patient had not expressed a psychological concern but the Diagnosis stated that the patient had skin damage due to exposure to sunbeds and smoking and was at risk of early skin cancer because of lifestyle factors. Dr McKeown had again diagnosed "Psychological concerns regarding skin changes". Mr Tosh enquired what the difference was between concern about skin changes and psychological concerns about skin changes. The answer was that if a patient was worried about something, then it was a psychological symptom.

228. Dr McKeown argued that "… the overwhelming majority [of patients] have lifestyle history factors that have resulted in their appearance that they find distressing". Accordingly, the first topic of conversation in a consultation with a patient is about using sunscreen or stopping sunbeds and smoking. He argued that it was the same as a patient going to the GP to complain about a lesion on their forehead and the GP will take a history of sun exposure in order to come to the correct diagnosis.

229. With respect, I disagree. Quite possibly a GP will ask about sun exposure but the type of lesion, colour, shape and growth would be the clinical findings. There would almost always be photographs and/or measurements and those would be dated.

230. During the hearing, Dr McKeown conceded that the Cover Forms were "a sort of artificial exercise". They were largely generic and he said that they had been produced by him expressly for the benefit of HMRC to try and point out aspects "that are important in a cosmetic consultation". A number of the Cover Forms use the terminology like "he/she" and appear to be a "cut and paste" exercise.

231. An example is one where the patient had been prescribed a drug which is used for psoriasis. I put it to Dr McKeown that I was startled to see his "usual" wording under the heading "Treatment". It said "Advice on lifestyle-avoiding excessive UV light and sun protection". I pointed out that my understanding was that Dermatologists not infrequently prescribe that drug in conjunction with very regular UV light treatment and that is monitored by the hospital. He agreed that I was correct.

232. His argument was that he had found it stressful compiling the Cover Forms and "…the reality is that most of the patients that I see have some of our clinical findings. It's like if you've gone to a cardiology clinic, most of the patients there will have chest pain". That is a sweeping statement and, whilst accurate for a chest pain clinic, in my experience, it does not reflect cardiology clinics in general.

233. It is clear that it was because HMRC had concerns about the Cover Forms, and the stress placed on psychological issues in those, that he had been asked at the COP 9 meeting what part of the Samples was contemporaneous documentation. The Cover Forms certainly were not. Clearly, Dr McKeown had realised that concern and that is the reason that he sent HMRC the 2019 Letter.

234. The information for the 2011, 2015 and 2018 Patients was more illuminating.

235. I start with Patient 60 since it gives a good snapshot of the records kept and the *modus operandi* in 2015 until early 2018 before Dr McKeown changed his style of record keeping after taking advice from Azets.

*Patient 60 who is the 2015 Patient*

236. The original Sample consisted only of the "Cover Form" and the "Face Page" which was undated. I will revert to both.

237. What was produced after the COP 9 meeting, and described as the full records, for the 2015 Patient started with another Cover Form which was headed "Patient record summary". That narrated that the patient had first attended on 5 March 2015 and stopped attending in February 2018. Like the earlier Cover Forms it was compiled by Dr McKeown in 2019 for the benefit of HMRC.

238. He fairly conceded that the notes from the initial consultation were brief but he stated that he would have relied on the patient questionnaire and a thirty minute consultation where the reasons why the patient wished treatment would have been discussed. Unfortunately, neither the initial consultation note nor the terms of the patient questionnaire provide any contemporaneous evidence. He stated that he would have assessed the patient's suitability for treatment according to his "standard protocols" described in the 2019 letter.

239. He stated that the "significant findings" in this case were a history of smoking and tanning "which <u>would</u> have resulted in physiological changes to the condition of her skin". I have emphasised the use of the word "would" because there is no evidence that it had done so.

240. The patient questionnaire appears to have been completed at the consultation in March 2015. The most relevant entries include:-

(1) The patient did not wish her GP to be informed.

(2) "What is the reason for your consultation today?" - "botox for forehead".

(3) "What bothers you most about your appearance?" - "forehead"

(4) "What would you like to achieve by having cosmetic treatment?" – "smooth forehead"

(5) "How long have you been thinking about having treatment?" – "six months"

(6) The patient described regularly wearing sunscreen on a day to day basis. She had sunbathed on holiday and went on two foreign holidays each year. She had previously lived in a warm country. She did not use sunbeds although she had done so in the past for two years (when that had been was not identified). She said that she rarely smoked, albeit she had smoked in the past when she had smoked approximately 10 cigarettes per

day. She had smoked "on and off" for 10 years but currently she only smoked twice per week.

(7) She had never had cosmetic work done in the past.

(8) She had no health issues other than eczema.

241. Whilst on other similar patient questionnaires in the Bundle, at the end under a heading "Consultation Summary Notes" there are a few lines completed by the Doctor noting symptoms etc, there was nothing on this questionnaire. Incidentally those Notes should be signed and dated and I noted none that had been completed so it is difficult to know the date in many cases. Azets stated in a letter to HMRC that they would have been completed contemporaneously. That is an assertion and not evidence.

242. Dr McKeown had produced a new Face Page with a post-it note dated 5 March 2015 which only contained a note in the Consultation box stating that the patient had lines on her forehead and a frown, so toxin and filler had been discussed (two words are illegible) and he would see her two weeks later.

243. The Face Page that had been produced as Patient 60 was also included but this time I can see that it was dated 9 April 2015 because a post-it note to that effect has been added. The treatment was Botox as was the case with the next Face Page, which was dated 5 October 2015, and the sites (19) for the injections were identical.

244. A consent form was signed on 9 April 2015 by Dr McKeown and the patient. No consent forms were furnished for the second treatment. There was no entry in the Consultation box for the next treatment either.

245. The final record is a Face Page dated 1 February 2018 and the only information is the *pro forma* drawing with the sites for 13 Botox injections; there is nothing in the Consultation box. There is no consent form.

246. If those records are the complete records, as they were claimed to be, then there are significant deficiencies.

247. It is difficult to equate those records with the Cover Form completed by Dr McKeown for the Sample. On that it said that:-

(1) The Patient's concerns were upper facial rhytids (ie wrinkles) and she feels that she looks tired.

(2) The Diagnosis was photo damage secondary to previous use of sunbeds, she was a current smoker so had nicotinic damage, she was at risk of early skin cancer due to her lifestyle and she had "psychological concerns" about skin changes and wrinkles.

(3) The Treatment was specified as being "Psychological concern/support", advice on lifestyle changes (such as avoiding excessive UV light, using sun protection and stopping smoking) and (I summarise) Botox to "address the patients (sic) psychological concerns and reduce the signs".

(4) The Duty of Care was described as being "Recognise and address health issues, Address the patients (sic) concerns, Not to be dismissive of the patient, Protect and maintain the health of the patient, including the psychological health."

(5) The Opinion was that it was Medical treatment.

248. Whilst I note that his evidence was that he relied on his knowledge of his patients, I find that he compiled the Cover Form almost four years after the event. He did so entirely for the

benefit of HMRC and it is not underpinned to any material extent by the contemporaneous documentation.

249. As can be seen, the records for this patient can only be described as minimalist. The key information was simply the request for Botox and the prescription for and provision thereof.

250. In cross-examination, Dr McKeown conceded that Azets had told him that he required to include in the medical records what he described as "intent statement" which was a statement as to whether or not a treatment was purely cosmetic. Hence he changed the format of the records. Since in some regards there are significant changes, but much remained very minimalist, I narrate the records for the 2011 Patient in detail since that shows the evolution of the records with my observations thereon.

*The 2011 Patient who is also "Full File note 4"*

251. These records are far more revealing. The records span the period 20 November 2011 until 14 June 2019 which is a letter of referral to psychology. I observe from that letter that Dr McKeown stated that she had been a patient for ten years. That is either incorrect or no records have been produced for the period 2009 to 2011.

252. That letter also states that the patient has always had symptoms of BDD ("Body Dysmorphic Disorder") which has escalated in recent years and had now reached crisis point.

253. The "Patient record summary", being the Cover Form is the same in both the 2011 Patient records produced in 2019 following the COP 9 meeting and the Full File notes produced in March 2022. That states that the patient had attended the Clinic for eight years.

254. Dr McKeown reports that the patient had a history of generalised anxiety but that anxiety escalated significantly in 2019 because two other surgeons had confirmed his decision that she should not have surgery on her eyelids; hence the referral to psychology.

255. Mr Tosh put it to him that the earliest referral to psychology was the 2011 Patient and the referral was only made one month and a day after the COP 9 meeting where he had been asked about whether he made referrals (to a psychiatrist). Mr Tosh also took him to the 2019 Letter where Dr McKeown attempted to explain to HMRC why psychological concerns were at the heart of what he did. I accept that it is possible that the timing could simply be a coincidence but I consider that to be unlikely given that referral was apparently not even discussed for the 2018 Patient (see paragraph 305). What is not known is the outcome of that referral.

256. The records for this patient, as produced, start in 2019. Dr McKeown uses the new form of paperwork. There are tick boxes. Dr McKeown accepted that the format was devised with Azets and the notes are much more detailed. For the first time there was a question on a page headed "Review of Previous Treatment" ("the Review Page") that reads: "Did the treatment improve patients (sic) self confidence?"

257. In response to the headings "Complications" and "Any changes in medical history" he narrates the eyelid issue and notes that the patient accepted a referral. Unfortunately Dr McKeown has redacted the date. As I have indicated, the referral letter is included in the file.

258. The next item is the part of the questionnaire with the table to which I refer above with a post-it note stating that it was dated 26 February 2019.

259. The questionnaire asked, on a scale of 1-9 how much her appearance bothered her, whether it interfered with her life and how often she thought about that to which the answer was 9 in each case. She confirmed that she had had mental health issues in the past. The second

half of the page asked the patient to circle the treatment(s) that interested her in the table that I have reproduced at paragraph 152 above.

260. She had circled four items in each of the first two columns and one in the third. Below the table there were tick boxes asking if the patient would like to discuss surgical, non-surgical or both options. She had not ticked any of the boxes.

261. Below that there are tick boxes that she had not completed which asked about how she had found the Clinic.

262. The next record is a Review Page dated 26 February 2019. Dr McKeown had ticked the box for self-confidence. There were two drawings of a face, one headed examination and the other treatment. He had completed both and details of the Botox and fillers were noted.

263. The next two pages relate to treatment and the second page is signed and dated 11 October 2018 but that page shows that there appears to have been treatment on 25 October 2018. On the first page which is headed "Medical Record" there is a drawing of a face headed "Examination" which Dr McKeown has completed. He has filled in information under headings which included "Patient concerns", "Past medical history", "Excess sun" and four questions:

(a) Does the cosmetic defect cause the patient psychological distress?

(b) Does the issue interfere with personal relationships, ability to work or social life?

(c) How often does the patient think about this?

(d) Is there a history of psychological problems, periods of anxiety, depression or low mood?

Interestingly, although the past medical history stated "anxiety" and the answer to the first question states "feels anxious at school gates", the last of these questions was answered "No". Details of an injectable that had been used was next to the Examination face.

264. On the next page, there were headings for "Diagnosis, Special notes and alerts, Clinical options and Treatment plan(s)". The Diagnosis was "sun damage FVL (shorthand for facial volume loss) + severe psychological symptoms". Under Special notes he has written "??BDD" to which I will revert. He recorded that she felt better after getting Botox. The treatment was filler and Botox.

265. There is a tick box for the question:- "Does the psychological benefit of the treatment outweigh the potential risks of the treatment?" The answer was "yes".

266. I note, in that context, that in his witness statement Dr McKeown had said that "Since around 2017, the form [patient questionnaire] has expressly stated that patients will only be offered a cosmetic treatment if it will result in a psychological benefit which outweighs the risk of the procedure". The Medical Record is not the questionnaire and it is completed by the Clinic.

267. The "Treatment record" is a drawing of a face and the sites for Botox and fillers are identified on that. The 25 October 2018 date is written there. There are details of the Botox and fillers, the label for the former of which is stuck on the previous page next to the Examination face.

268. There are then six tick box items which read (and I quote):-

(a) Is there a medical aspect to this treatment plan:

(b) Is there a psychological aspect to this treatment plan:

(c) Is this treatment purely cosmetic?

(d) Consent issues discussed?

(e) Aftercare instructions

(f) Follow up appointment.

269. In cross-examination, in relation to another patient, Dr McKeown confirmed that he had never ticked yes for the third question "in circumstances where I have gone on to provide the treatment."

270. The next record is the patient questionnaire with a post-it dated 11 October 2018 and it includes the table with treatment options to which I have previously referred. The first question asked is "What is the main reason for your visit today?", to which the answer was "Botox under eyes to reduce crepeness (sic)".

271. The patient had not circled her areas of concern on the drawing of a face nor answered the tick box questions adjacent to that which were "How I can look better for my age, How can I change something that has been bothering me for years, How I can look more attractive" and "Other".

272. The second page of the questionnaire is identical to the one that I have described for 26 February 2019 but on this occasion she had ticked three items in each of the first two columns in the table and one in the third and that was a different option to that circled in 2019. She had also ticked a box stating that she would like to discuss surgical options.

273. The next record is an undated Face Page with details of two fillers and a very brief and partially indecipherable note of what was physically done.

274. The following record is a Face Page with relatively extensive notes dated 26 June 2018 recording that the patient had not attended because Dr McKeown had not provided the treatments that she wished so she had used a mobile nurse practitioner. He notes that she was very distressed about her appearance. There is no record of what, if anything, was done.

275. There is then an illegible and undated Face Page showing Botox and possibly fillers which I think is dated 18 July 2017. It is accompanied by a recent clinical history and that is clearly dated 18 July 2017. There is no mention of distress or anxiety and it records only complaints about puffiness, itchiness and pain and headaches.

276. The next record is a Face Page for Botox with no notes dated 21 March 2017. There are then two Face Pages which appear to relate to a consultation on 5 January 2017 and treatment with fillers on what appears to be 10 January 2017, although 2 February 2017 is mentioned in the largely illegible brief note.

277. There is an illegible Face Page for 22 December 2016 preceded by two Face Pages for 13 October 2016 (Botox only) and 10 June 2016 (Botox and fillers). There is a note on the latter Face Page which reads "30/6/16 top-up".

278. There is a Face Page with a post-it for 3 May 2016 which is possibly a consultation only and it says that treatment for "NLF" (that is not included in the list of abbreviations provided to HMRC) is "not indicated".

279. The Face Page with a post-it for 2 November 2015 seems to suggest that both Botox and fillers were provided on 13 November 2015.

280. The Face Page for 26 May 2015 notes physical complaints only and suggests that there was a top up of Botox on 9 June 2015. The Face Page for 25 September 2014 indicates that Botox was administered but the patient had asked about fillers for her jaw and neck and those

were “not indicated. Declined”. There is a Face Page for 20 March 2014 where Botox and fillers were administered. Those dates are all on post-it notes.

281. There are three pages relating to 6 and 13 September and 1 October 2013; two are notes and one (13 September) is a Face Page. The notes are dated contemporaneously but the Face Page has a post-it note. The notes for 6 September 2013 record that the patient felt much more confident. Treatment was clearly provided on the last occasion because the batches are identified. It appears that on the first visit there was treatment but it was not an invasive treatment. There is a Face Page for 24 May 2013 but it seems likely that that did not involve invasive treatment.

282. There are then very different records. Firstly, the Logo for the Clinic used in all of the other records is not utilised. Secondly, the records comprise six very small diagrams of faces with the sites of the injectables identified. The date is inserted to the right and below that there is space for 8 small lines of comments. Those simply amount to minimal details of treatments administered on 20 November and 4 December 2011, 22 July and 5 August 2012 and 17 March and 16 May 2013.

283. Lastly, there is a patient questionnaire dated 20 November 2011 and it is a very simple two page document. On the first page there were the following questions and answers, namely:-

> (1) “Tell us what areas you are interested in having treated? - Jowls, nek (sic) area, sagging from bottom of mouth to chin”
>
> (2) “How long have you been thinking about having a non-surgical treatment? - Already had it done”
>
> (3) “What do you hope to achieve by having a non-surgical treatment? – Feeling more confident in myself”
>
> (4) “Are you aware that non-surgical treatments carry a risk of side effects and complications? – Yes”
>
> (5) “How do you think you would feel if you were to develop complications? – Shocked and devastated”

284. The second page asked seven basic questions, to which the answer in each case was “No”. They read:-

> (1) Have you ever had any cosmetic medical or surgical procedure in the past? Please provide details.
>
> (2) Do you suffer from any medical conditions? For example heart disease, high blood pressure.
>
> (3) Have you ever suffered from any psychiatric problems in the past? Please provide details.
>
> (4) Are you currently taking any medications? Please provide a list.
>
> (5) Do you have any allergies that you are aware of?

(6) Have you ever had a local anaesthetic injection? Did you suffer any side effects?

(7) Is there any risk you could be pregnant or are you currently breast feeding?

285. Given that on the previous page the patient had said that she had already had non-surgical treatment, clearly she did not consider Botox or fillers to be medical treatment.

286. I can see from the relevant Face Page that she had treatment that same day to her forehead, eyelids, lips and chin which is what she had requested. If that was her first visit to the Clinic, there was no cooling off period and no pre-treatment assessment visit. There is no record of a post-treatment assessment.

287. Lastly, the records included two one page "informed consent" documents explaining fillers and Botox on which it states that they were signed by the patient and doctor on 20 November 2011. There is also a copy of a two page information leaflet that was given to the patient on that day.

288. If this is indeed a full record of the patient's medical records it is deficient in a number of respects. Firstly, there are no other consent forms. Secondly, although in the letter of referral Dr McKeown states that the patient "has had significant psychological concerns related to her appearance for the duration of the time she has attended my clinic…" and that in 2017 he had noted that she had become increasingly "paranoid" about her appearance, it is only in October 2018 that there is any mention of anything of that nature or of BDD. There is no record of the "extreme anxiety" that he told the psychologist that the patient had experienced in the "earlier years" and nor is there a record of the "talking therapy" he also mentioned.

289. The GMC guidelines to which I will refer later makes it explicit that clinical records should include relevant clinical findings. If those were his findings they were not recorded for almost seven years.

290. It was only when writing the section in this decision relating to BDD that I identified the fact that this patient is also Sample Patient 23. Unfortunately, the Face Page for that Sample was not included in either the Full File note or the 2011 Patient records.

291. On the balance of probability, looking at those records I find that:

(a) It was only in mid-2013 that the Patient questionnaires and the Face Pages that are seen elsewhere in the records were introduced. That is consistent with the other examples of Patient questionnaires in the records dating from 23 May 2013. It is also consistent with the inference from the facts that I have found earlier that actually the Clinic really only became a full time activity for Dr McKeown in approximately mid-2013 and Surgeon 1 joined him at or about that time.

(b) The patient's medical history was never relevantly updated until 2018, and

(c) Clearly, this is not a full record of the patient file, as it is claimed to be, or if it is, it is seriously deficient.

*The 2018 Patient*

292. The Cover Form states that the patient came to the Clinic in October 2018 shortly "after we introduced the new system of recording our notes to capture more of the information related to the psychological aspects of treatment".

293. The New Patient Registration Form, which is dated 20 June 2018, states that the patient does not wish his GP to be contacted. He said that he did take an antidepressant medication. That medication is prescribed for Post Traumatic Stress Disorder (PTSD). He stated that he did

suffer from a mental health disorder and identified it as PTSD. The question "Have you ever seen a psychiatrist? Yes/No" has not been answered.

294. Although a post-it note has been put over the signature and date, I can see that the second questionnaire was dated "31st OCT 2018". In answer to the question on the first page of the questionnaire as to the main reason for the visit he said "To see Darren McKeown about dermal fillers for my lower eye bags."

295. He ticked the boxes for (a) stating that he wished to be advised how to look better for his age and (b) how he could look more attractive. He did not tick the box "How I can change something that has been bothering me for years". He ticked the box confirming that he had had a consultation or treatment previously and the three boxes asking about changes since his last consultation at the Clinic. Regrettably, if there were any notes from that previous consultation beyond the form dated 20 June 2018, they have not been produced.

296. On the second page he answered the "Psychological" questions with a 9, 8 and 9 respectively and confirmed that he had had mental health problems in the past. He circled "Facial fillers" in the table and said that he would like to discuss both surgical and non-surgical options. He had found the Clinic using a search engine.

297. The Medical Record dated 31 October 2018, which was completed by Dr McKeown, records under the heading "Past medical history" "Depression? PTSD-partner died 4 yrs ago". Under the heading "Cosmetic history" it states that the patient had seen a surgeon and had been refused surgery. He had then recorded "?BDD". On the rest of the page he noted that the patient was significantly distressed and "Said if he doesn't get help he will attempt surgery himself".

298. It also records that the patient had seen a psychiatrist and was on antidepressants. On the next page he notes that there are "substantial psychological symptoms". He states under "Clinical options" that "psych/psychology – already tried". What is not recorded is when or in relation to what, ie PTSD, BDD, depression or facial appearance.

299. Under the heading "Treatment plan(s)" he states that the patient is extremely distressed and "I believe he may follow through his threat to self-operate". He was offered fillers on the basis that that would improve but not cure the bags under his eyes. The decision was not to proceed with treatment that day and to see him one month later.

300. Dr McKeown had noted the dosage of the antidepressant at 100 mg. I am aware that 25mg would be an initial dose for PTSD and the maximum for any reason would be 200mg.

301. The first page of the next record is a Medical Record which is dated 28 November 2018 and states that there was a further long discussion. On the second page which was signed by Dr McKeown the Diagnosis was that "psychiatric + psychological concerns related to appearance" and the patient was "at risk of physical mutilation". The box for whether the psychological benefit of treatment outweighs the potential risks of the treatment was not ticked. Treatment was provided. Curiously it is dated 27 November 2018. The consent form was signed by Dr McKeown on 28 November 2018.

302. I found these records difficult. Comparatively few people with mental health issues have access to either a psychiatrist or a psychologist; obviously that means that those who do are the most unwell and vulnerable in our society. As I pointed out in the hearing, most mental health patients are treated in the community by a GP and/or a CPN (Community Psychiatric Nurse). Once discharged by a psychiatrist many will continue to have contact with a CPN. There is no detail of this patient's psychiatric history or the timing of that.

303. In any GP notes there would have been detail of the timing of any interventions and the titration of medication.

304. As can be seen there was scope for the medication to be titrated in order to alleviate distress and/or symptoms. I observe that at paragraph 53 of his witness statement Dr McKeown stated:

> "Whilst the fact that a patient is taking psychiatric medicine is not necessarily a contraindication to treatment, it is something that must be carefully explored during the consultation."

There is no evidence at all that that was explored beyond noting that the patient was on a specified dosage of medication.

305. A threat to attempt surgery on one's face is clearly serious and no referral was made and there is no indication that there was a discussion of that possibility or the possibility of altering the medication. Whilst the records argue the justification for the use of fillers, I find that there is a lack of a focus on anything other than using fillers.

*The Full File notes*

306. The quality of what were described as the Full File notes was another cause for concern. It was Dr McKeown who chose which 20 records should be provided and he compiled them. Because it had been argued that HMRC were imposing standards of record keeping that were too onerous and that Dr McKeown had complied with the GMC Guidelines, to which Ms Hall referred me, I quote the relevant sections on record keeping which read:

> "The GMC Good Medical Practice Published March 2013 Updated April 2014
>
> 19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.
>
> 20 You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection requirements.
>
> 21 Clinical records should include:
>
> a relevant clinical findings
>
> b the decisions made and actions agreed, and who is making the decisions and agreeing the actions
>
> c the information given to patients
>
> d any drugs prescribed or other investigation or treatment
>
> e who is making the record and when".

307. He had also produced "The Consultation draft of revised Good medical practice published April 2022" and the relevant sections read:

> **"**Record your work clearly, accurately, and legibly
>
> "12 Formal records of your work (including patients' medical records) must be clear, accurate, and legible. You must make records at the same time as the events you are recording, or as soon as possible afterwards.

13 When recording decisions in patients' medical records, you should take a proportionate approach to the level of detail you record. Clinical records should include:

a relevant clinical findings

b decisions made and actions agreed (including decisions to take no action), and who has made the decisions and agreed the actions

c any drugs prescribed or other investigations or treatments

d the information given to patients and relevant others

e who is making the record and when.

14 You must keep records that contain personal information about patients, colleagues or others securely and in line with any data protection law requirements."

308. I selected one of the Full File notes at random to read and having done so chose another, equally at random, to ensure that the first was not atypical. Sadly it was not. I narrate the detail at what is some length but that is necessary to make explicit the numerous deficits. The detail of these records explain how the Clinic operated. It was the appellant's choice to produce these and state that they were full records. Sadly, for the reasons that I narrate, I find that they are not as there are omissions or alternatively I find that they are simply deficient.

*Full File note 3*

309. This Full File note related to a patient who had first consulted the clinic in 2015. The Cover Form dated 14 March 2022 stated that she ceased to attend in 2018; Dr McKeown stated that that form had been prepared based on the patient's records and his own recollections of the patient.

310. The patient questionnaire was dated 28 March 2015 and indicated that the purpose of the consultation was "to receive botox" and she wanted to "feel and look better". The very brief consultation notes which were neither dated nor signed did say that she was very anxious but did not say why. Botox and fillers were prescribed. There are eleven Face Pages, one of which is undated but that may be because of the redaction. There are nine consent forms all of which are dated.

311. There is a signed consent form for Botox dated 28 March 2015 so she must have been given treatment on her first appointment. There is no Face Page dated for that date. The undated Face Page for Botox shows an expiry date for the Botox that was used of October 2019 so it seems unlikely that that relates to that consultation since the expiry date for Botox treatment in the summer of 2015 was November 2016 and for treatment in September 2016 was November 2018. Therefore it seems that there is at least one Face Page that is missing. In fact there are many more.

312. There is a Face Page and a consent form for fillers dated 2 April 2015.

313. There is a further consent form for Botox dated 26 June 2015. The problem with that is that the Face Page with that date of treatment had that date scored out and 30 July 2015 was substituted. There is no written comment beyond recording the treatment given.

314. Chronologically, the next Face Page for Botox is dated 15 December 2015 and although the box is ticked for written aftercare instructions being provided and there is an indecipherable

squiggle next to "Follow up appointment", the entries for the brand of Botox, the Lot number and the expiry date have not been completed. Like most of the Face Pages for this patient the Consultation summary notes and Procedural notes have not been completed. There is no consent form for this treatment nor for any of the other Botox treatments except treatment on 13 July 2017.

315. There are Face Pages for fillers in different areas of the face dated 5 and 26 February 2016 but a consent form only for the latter treatment.

316. The Face Page for Botox treatment on 6 September 2016 has marked on it, in a different colour ink, what appears to be filler treatment below the eyes on 27 September 2016. There are no consent forms for either. There is both a Face Page and a consent form for fillers above the eyes on 18 October 2016. There is a Face Page for Botox on 2 February 2017 but with no details beyond the Lot number etc. The Face Page for treatment on 13 July 2017 shows sites for both Botox and fillers but in different ink a date is given for 31 August 2017. There are consent forms dated 13 July 2017 for both Botox and fillers. Possibly the filler was done on the latter date but that is not consistent with the Face Page for 20 November 2017 which shows both Botox and fillers on the same day. There are no consent forms for either 31 August or 20 November 2017.

317. Lastly in relation to this patient, there are consent forms for fillers on 3 May 2016, 5 April and 18 October 2018 and there are no Face Pages.

318. As can be seen, far from fitting the profile suggested by Dr McKeown where a patient attended the Clinic approximately twice a year, this patient attended far more frequently. In 2015 she attended at least three times for Botox and once for fillers. In 2016 it would appear that she had at least five treatments for fillers and one for Botox. In 2017 she appears to have had at least three Botox treatments and two treatments with fillers. There are no face pages for 2018 so all I know is that there are two consent forms and she left the Clinic in 2018.

319. This patient is also Sample 22. The Cover Form for that said that the patient had borderline BDD and anxiety (amongst other things). It did not say who had diagnosed that. The Face Page is the one for fillers on 2 April 2015. In cross-examination, Dr McKeown said that the Cover Form "summarises the information that is contained elsewhere within the patient records".

320. The Cover Form for the Full File note made no mention of BDD but said that the patient had significant anxiety that was out of proportion to defects. That could be construed as BDD but is certainly not explicitly so. That Cover Form was also produced for HMRC.

321. The Consultation summary notes on the Patient questionnaire made no mention of BDD. It did say that she was very anxious but did not say why. There is no mention of anything on the Face Pages; just the details of the sites of the injections. There is no contemporaneous evidence of BDD.

*Full File note 7*

322. Sample 40 was also Full File note 7 ("the Note"). The Face Page in the Sample was dated 25 April 2015 and was for fillers and it was the first Face Page in the Note. The Cover Form for the Sample stated that the patient had had chemotherapy for breast cancer, whereas the Patient questionnaire states that she had had a wide local excision and radiotherapy. It is not material in regard to the treatment provided by the Clinic but it is a significant inaccuracy in the records.

323. There is a Face Page for Botox and fillers dated 26 June 2015 and a Face Page for Botox dated 15 December 2015 but only the expiry date for the Botox but not the type or batch number have been included. There is only a consent form for the June treatment.

324. There are no consent forms for either Botox or fillers in 2016.

325. The Face Page for 14 April 2016 shows Botox and fillers but the only detail for the Botox is the type and concentration. The Face Page for 4 October 2016 shows the sites for Botox and the details but in different coloured ink and dated 28 October 2016. There are two sites for, possibly fillers, but no details. There are Face Pages for fillers dated 10 November 2016 and 2 June 2017. However, there are consent forms for both Botox and fillers on 2 June 2017 so a Face Page must be missing.

326. There is a Face Page for both Botox and fillers dated 11 July 2017 and there are consent forms. There is a Face Page for Botox dated 7 December 2017 but the consent form is dated 11 December 2017.

327. There are consent forms for both Botox and fillers dated 28 March 2018 but no Face Pages. There is a consent form for Botox dated 23 April 2018 but the Face Page is dated 24 April 2018. There is a consent form for Botox dated 19 September 2018 but no Face Page.

328. There is a Review Page dated 19 March 2019 where the box for self confidence has been ticked and there are details of three treatments with fillers. There is a consent form. However, there are consent forms for fillers dated 5 April and 23 May 2019 but no Review or Face Pages.

329. There is a Review Page for 23 September 2019 for one treatment with fillers but no consent form. There is also a Review Page for Botox dated 19 September 2019 but no consent form.

330. Crucially the new electronic records dated 18 May 2021 state under "Treatment history" that the patient has been treated for Botox 12 times in the past and for fillers it was three times and in both cases the most recent occasion was on 1 February 2020. Firstly, there is a consent form for Botox dated 31 January 2020 but no consent form for fillers and there is no Face Page in 2020. Secondly, the cosmetic treatment history in the Patient questionnaire indicates that the patient had had Botox for the past seven years with the most recent being in January 2015 and she had also had fillers on that date.

331. Patently that Treatment history is inaccurate and the records are not complete.

*Full File note 17*

332. The patient in Full File note 17 suffered from what was described as "severe depression", was on the maximum dosage of medication and was noted as seeing a psychiatrist regularly (and there is no detail of that). She completed the Patient questionnaire on 27 April 2015 and signed the Botox consent form on that day. She appears to have had treatment that day. She also had a "top-up" on 5 June 2015 and at least one further treatment in December 2015 (there may have been another but the Face Page is undated).

333. An obvious point is that this patient would fall into the category where much more detailed patient records would have been expected, given the recorded mental health issues. More pertinently, I note that treatment on the day does not conform to the statement at paragraph 68 in Dr McKeown's witness statement that:

> "… I typically encourage my patients to think about their options before choosing to undergo treatment. … I occasionally prescribe and administer very minor interventions during the initial consultation (for example, where I have decide to prescribe a small dose of Botox® to alleviate the face wrinkles of a patient with a simple medical history and

who may have undergone similar treatment elsewhere or has undertaken detailed research before their consultation".

This patient most certainly does not have a simple medical history.

*Full File note 5*

334. Mr Tosh took Dr McKeown to Full File note 5. The Cover Form states that the patient's concern was a bump on her nose, Dr McKeown treated her once and had not seen her again. The Patient questionnaire stated that she wanted non-surgical nose reshaping, she had never had any cosmetic procedures and she had no mental health issues or medication. It was dated 7 April 2015. The Face Page showing the fillers is undated and the consent form is dated 7 March 2015. Either the questionnaire or the consent form is dated incorrectly but what is clear is that she was treated on the day of the consultation.

335. Pertinently, the Cover Form points out that this treatment is less invasive than surgery but because of the sites for the injections there is a risk of blindness and this needs to be given "special attention". The degree of anxiety suffered by the patient "needs to be high enough to justify accepting this risk". There is no mention of any anxiety in the Patient questionnaire and Dr McKeown has simply recorded that the patient is aware of the risk of sudden blindness.

336. In summary, she asked for fillers and she received treatment that day with no time for reflection.

*The JCCP and records*

337. Dr McKeown had produced the JCCP paper and I was taken to a number of paragraphs by both Ms Hall and Mr Tosh.

338. Firstly, and obviously, it is simply that Body's opinion on the law and, as Ms Hall pointed out, in some regards it is incorrect. Secondly, the JCCP is a voluntary organisation and it has no regulatory role.

339. I have added emphasis in the various quotations.

340. Under the heading "JCCP Statement" having stated that only HCPs can decide whether something is medical or medically related it states that:-

> "Having performed a diagnostic assessment of the patient, a practitioner should be able to <u>demonstrate</u> whether there is a physical, psychological or psycho-social therapeutic benefit arising from either the consultation and/or the treatment of that condition or its associated presentations. If there is a <u>demonstrable clinically determined</u> therapeutic benefit to the person then that treatment episode is deemed to be "medical" or "medically related".

341. It goes on to state that:-

> "The key determinant is that there has to be a <u>recorded</u> statement of therapeutic benefit/outcome (that includes reference to the presenting concern and the treatment plan that has been co-designed with the patient to offer relief or benefit to the person) that is recorded in the patient record and agreed during the consultation prior to treatment." (emphasis added)

342. It recommends that the HCP "…should undertake a full and holistic assessment of the patient to inform the formulation of <u>a written diagnosis</u> and produce a <u>written care treatment plan</u> that identifies also the benefits/risks of the treatment. Details of the patient's personal expectations of the outcomes of the procedure should also be documented".

343. Importantly it goes on to say:

"For aesthetic practice a 'good' medical record would also include examining a patient's concerns and reasons for seeking a procedure and psychological/emotional assessment screening for anxiety, Body Dysmorphic Disorder or for any other form of presenting mental health condition."

344. It makes it clear that although the "medical intention" in relation to a treatment should be identified and documented that:

"…applies to a single treatment episode with ongoing assessment required for future treatment episodes. The determination cannot be applied retroactively in the absence of documented evidence of medical intention. Furthermore, the patient should confirm their understanding of the 'medical' or 'cosmetic' nature of the intended procedure and agree and consent to the proposed clinical treatment plan. This cannot be applied retrospectively".

345. It points out that a treatment may be of therapeutic benefit whether or not it is classified as a medical or medically related treatment.

346. In Appendix 1 the JCCP "Stated Position" is that having said that cosmetic procedures performed by HCPs are not automatically "medical" or "medically related" and many fall outwith those definitions, it makes it explicit that "Rather, there must be a clearly defined, discernible and intended 'medical' evidenced benefit for the patient".

347. Earlier in that Appendix 1 under the heading "Legal position" it states that in order to:

"…prove that a service or treatment is medical and not purely cosmetic a practitioner needs also to show that the presenting reason for referral or 'complaint' has a specific medical element to it (i.e. physical, psychological, preventative, curative, etc) and that the purpose in performing the subsequent treatment is in response directly to the complaint. It is important to document this in the medical record as part of the clinician's duty of care…".

***BDD***

348. I have mentioned BDD. In his witness statement Dr McKeown referred to BDD stating that it was a mental health condition. He produced the treatment record to which I have referred above which included a diagnosis of BDD but that was in 2022 which is outwith the period with which I am concerned.

349. In Opening Submissions I was referred to the NHS information online in 2022 which described BDD as a mental health condition, which I accept that it is. However, given the alleged profile of the Clinic, I am surprised on the reliance thereon as what it said was that:

(a) Patients should see a GP if they thought they had BDD.
(b) It was most common in teenagers and young adults.
(c) It could lead to depression and in that regard mindfulness might help.
(d) Psychological therapies, like CBT, could help as could medication like SSRIs.
(e) If those did not work mental health clinics or hospitals might assist.

350. Botox and fillers are not mentioned. They are also not mentioned in the NICE Clinical guideline that was produced. The treatment options included in that are cognitive behavioural therapy and/or anti-depressant medication, neither of which were prescribed by Dr McKeown.

351. With the exception of the 2011 Patient there is no evidence of a referral to anyone else.

352. Ms Hall pointed to ten patient records where BDD was identified, one of which was the 2011 Patient and I have already discussed the point that BDD was only very latterly identified.

In fact, there was duplication because that patient was included twice, once being the referral letter and the other the Cover Form in the Sample. All of the other records to which I was referred were Cover Forms.

353. In cross-examination Dr McKeown confirmed, in relation to the number of patients with BDD, that "It is a very small proportion".

**Discussion**

354. Do I find that the purpose of the services provided by the appellant, in the round, is to diagnose, treat or cure health disorders or to protect, maintain or restore human health? In short the answer is no and that for the following reasons.

355. In the Amended Reply to HMRC's Statement of Case it was argued that:

> "The question is not whether the supplies are 'medical' in nature and therefore exempt or whether they are cosmetic in nature and therefore standard rated. One of the central questions is whether supplies which involve treatments which are cosmetic in nature can nevertheless be classified as medical care and therefore exempt."

356. The appellant's primary position was described as being that, on the facts of this case, the appellant's services clearly fall within the scope for the exemption because they have a therapeutic purpose. As Ms Hall put it succinctly in her Skeleton Argument "The purpose of the cosmetic medical care provided by the Appellant is to secure the relief or alleviation of the patient's physical and/or psychological health disorders".

357. I do accept that the health disorders covered by exempt transactions under Article 132(1)(c) of the PVD can encompass psychological issues but the simple fact is that the appellant has failed to prove the nature and extent of any such issues for individual patients even at a basic level.

358. As a reminder, as I have pointed out at paragraph 37(c) above, *Mainpay*, at paragraph 67, made it clear that "medical care" is defined as "diagnosing, treating and, in so far as possible, curing diseases or health disorders".

359. I do not have credible or coherent evidence (to use Ms Hall's words) to establish that in any year with which I am concerned in this appeal the appellant was dispensing medical care within that meaning.

360. As I have described, Dr McKeown's evidence was inconsistent and patently inaccurate in numerous respects. For the avoidance of doubt, I am not suggesting that Dr McKeown has lied. I have no doubt that he passionately believes in what our late monarch described as "his truth". That is precisely why I have described my approach to the evidence and set out the facts at such length.

361. The problem for the appellant is what it has proved is that it provided Botox and fillers at specific levels on given dates. It has not provided contemporaneous evidence that it was medical care.

362. It has provided no coherent evidence in relation to surgery and apparently the growth in the appellant's business was driven by breast surgery and media exposure (paragraphs 100 and 102 above). The information about media exposure is minimal and really amounts only to the Screenshot and yet there is obviously a great deal that could or should have been provided to HMRC and the Tribunal.

363. It is clear from the evidence that the patients chose the appellant's services because they wished to improve their appearance; the appellant's website encapsulates that thinking. The

Patient questionnaires show that to be the case. The patients have probably seen the price list on the website and photographs on social media sites.

364. The patients wanted to feel better and look less tired or old. That is not medical care.

365. Dr McKeown's evidence that all cosmetic care involves psychological treatment which provides therapeutic benefit just does not assist; there is a need, a crucial need, to identify both a health disorder and treatment, that for evidenced clinical reasons will provide a therapeutic result. The appellant has not done that.

366. Whilst latterly there are some high level notes about anxiety or depression it is not clear whether that was reported by the patient or diagnosed by the HCP.

367. I was not persuaded by the argument that the licensed use for Botox is only where wrinkles have "an important psychological impact in adult patients" and therefore all of the appellant's patients must have had psychological issues. Whilst that is what the Summary of Product Characteristics (SmPC) states is a therapeutic indication for its use, I do not accept that that means that it is always used in the treatment of a mental health disorder. Botox is widely available.

368. In oral argument it was suggested that "All of the notes record that the psychological profile of the patients was addressed and the intensity of the psychological concerns varies enormously…".

369. Whilst all of the Cover Forms do refer to the psychological profile, that was for HMRC's benefit and was not part of the patient's records until at least 2018. As can be seen there was almost no detail in the actual records.

370. In his oral evidence Dr McKeown said that all of the patients in the clinic had "some degree of anxiety relating to their appearance". That does not assist because by definition, given that the patients self-refer, they are dissatisfied with some aspect of their appearance and want to improve it. That does not mean that their health is affected or that they have a health disorder.

371. Furthermore, whilst I totally agree that the intensity of psychological concern can vary there is very little documentary evidence even as to variation over the years for an individual patient.

***Peripheral issues***

372. It was argued for the appellant that HMRC's *Notice 701/57 "Health professionals and pharmaceutical products"* adopts the wrong approach to the scope of the exemption and contradicts the jurisprudence of the European Court. I do not propose to address those arguments. Firstly, the Notice does not have the force of law. Secondly, it is simply HMRC's interpretation of the law. Like Judge Cannan at paragraph 100 in *Window to the Womb* I find that in the context of this appeal it does not add much to the submissions of the parties.

373. The appellant placed reliance on the *House of Commons Health and Social Care Committee Second Report* dealing with impact of body image on mental and physical health. There is no reason for me to address the arguments predicated thereon since this case turns on its own facts and the relevant law as applied thereto. However, I note that Ms Hall quoted therefrom as follows:

> "We recommend that the new licensing regime for non-surgical cosmetic procedures includes a commitment to a two-part consent process for anyone considering having a non-surgical cosmetic procedure, including, at a minimum, a full medical and mental health history, as well as a mandatory 48-hour cooling off period between the consent process and undergoing the procedure".

374. As can be seen, I have no evidence of full medical, let alone mental health, history. Consent is only partially documented and there is very little documentation of any cooling off period, let alone a mandatory period. That document does not assist the appellant.

375. For the avoidance of doubt, HMRC have accepted that although a charge is only made for the treatments, the consultations form part of the same supply. Had they not accepted that, I would have made a finding to that effect.

376. In his witness statement at paragraph 61 Dr McKeown said that

> "I do also see and treat a smaller number of other physical abnormalities. Most commonly, these include scarring both from previous trauma and/or skin disease processes such as acne. I also have a small number of patients that I treat for hyperhidrosis, hemifacial spasm (one sided facial twitching), blepharospasm (eye lid twitching) and Bell's Palsy (one-sided facial drooping). However, these cases form a relatively small proportion of my practice."

377. That was confirmed in cross-examination when he conceded that "…the overwhelming majority [of our patients] have lifestyle history factors that have resulted" in facets of their appearance that they find distressing and for which treatment was provided.

378. Dr McKeown has produced no evidence of patients with any of the conditions to which he refers.

379. HMRC would accept that treatment of physical abnormalities would constitute medical treatment and therefore would be exempt, as would I. However, the onus is on the appellant to identify and quantify that and that has not been done. In the absence of such evidence, the general rule applies and the services are to be treated as standard rated (see *PFC* at [23]).

380. If, there were diagnoses of BDD, and from the records, for the reasons that I have given there is doubt about that having been documented, the same principle applies; there is no clear identification or quantification.

381. In his witness statement, at paragraph 63, Dr McKeown said that "Occasionally, I diagnose certain physical conditions of which the patient was previously unaware". He has adduced no evidence of that and again the same principle applies.

382. On the contrary, the evidence is overwhelmingly to the effect that the patient has indicated precisely what treatment they wish to request, and why; for example, Botox for wrinkles. I accept that on occasion treatment was refused.

***PFC and the translation***

383. As I have indicated, in the course of the hearing, Mr Tosh produced the full Swedish text of *PFC* and Google Translate translations of paragraphs 18, 20 and 29. He did so in support of an argument that there were various differences in terminology between the official English language report and the Google Translate version. He did so in relation to the appellant's close textural analysis of paragraphs 18 and 29 in the context of the concept of "purely cosmetic".

384. Ms McAndrew argued that no weight whatsoever should be attached to the informal translation. She argued that:

> (1) HMRC had been aware of the appellant's case on *PFC* (ie that "purely cosmetic applied only to surgery) since the Skeleton Argument had been filed three weeks previously and had also been aware that the Authorities Bundle included only the official English translation.
>
> (2) The appellant had had no opportunity to test the accuracy of the informal translation or to decide whether it should seek an alternative translation.

(3) No one present spoke Swedish.

(4) There were only translations of three paragraphs and any paragraph in any judgment should be read in context.

385. I have had regard to the Overriding Objective and I agree with her on all counts. Accordingly I have disregarded both the translation and the arguments for HMRC predicated thereon.

***The Bundle and the JCCP Bundle***

386. In Closing Submissions, Mr Tosh objected to reliance having been placed on the letter to which I refer at paragraph 196. Ms Hall argued that as it was in the Bundle, which had been agreed, then the Tribunal was entitled to take notice of it. I had done so in pre-reading. I rejected the Objection on the basis that HMRC had notice of it and it was indeed in an agreed Bundle.

387. The same principle applies to the Notes and the Documentary.

***The Four core legal principles***

*Principal purpose or the purpose?*

388. Ms Hall argued that the concept of a "principal purpose" was unique to fact patterns such as those found in *d'Ambrumenil* where there are two competing purposes, one of which is extraneous to the exemption. An example would be servicing a third party litigation.

389. She had referred the Tribunal to a long list of authorities where the phrase "the purpose" rather than "the principal purpose" had been used. Mr Tosh took no exception to the passages to which she referred and wholly agreed that the Tribunal's task was to identify the purpose but he argued that if there was more than one purpose, there must be some way of identifying that. His argument was that it was artificial to try and distinguish between different types of competing purpose. On that basis identifying the principal purpose would be the correct approach.

390. In Closing Submissions, Ms Hall expanded upon "the purpose" arguing that it was the overall purpose, having regard to all of the facts and circumstances in which the services are provided.

391. I do not propose to address all of the arguments advanced. I am mindful of Judge Hetherington's exhortation to the First-tier Tribunal not to embark on a frolic of its own. The Court in *Mainpay* endorsed the approach of the Upper Tribunal and when considering the purpose of a medical service at paragraph 89(a) the Upper Tribunal refers to the principal purpose (see paragraph 36 above).

392. I accept that the Upper Tribunal does reference *d'Ambrumenil* but it does not qualify its argument to the effect that one should look for a principal purpose only where there are competing purposes one of which is extraneous to the exemption.

393. In any event, comparatively few things in this life have only a single purpose. The famous tax case of *Mallalieu v Drummond* makes that point very clear. To paraphrase, the House of Lords said that the barrister must have had a subconscious purpose of meeting her needs as a human being (ie being dressed) when she purchased her court dress although her purpose in doing was for use in court only.

394. In my view, correctly, in Closing Submissions, Ms Hall said that "There is no such thing as a single issue patient" and there is always more than one purpose when seeing a patient in consultation.

395. I have followed the Upper Tribunal and looked at whether the principal purpose of the services provided by the Clinic is the provision of medical care within the meaning of the exemption. As is clear, I have also considered all of the facts and circumstances that were brought to my attention or were in the Bundle. In any event, I find that the overall purpose is the provision of cosmetic treatments; it does not suffice that an ancillary or incidental effect of the supply of the service is therapeutic in that the patient feels more confident or happy.

*Purely cosmetic*

396. As can be seen, one of HMRC's issues is whether the Clinic's services were purely cosmetic in nature. It is common ground that that concept was first identified in the last sentence of paragraph 29 of *PFC.* However, that must be read in context and the paragraph reads:

> "Thus, services such as those at issue in the main proceedings, in so far as their purpose is to treat or provide care for persons who, as a result of an illness, injury or a congenital physical impairment, are in need of plastic surgery or other cosmetic treatment may fall within the concept of 'medical care' in Article 132(1)(b) of the VAT Directive and 'the provision of medical care' in Article 132(1)(c) thereof respectively. However, where the surgery is for purely cosmetic reasons it cannot be covered by that concept."

397. PFC provided cosmetic and reconstructive plastic surgery and some skincare services including Botox, fillers and lasers. It is argued for the appellant that at paragraph 29 the Court was addressing only plastic surgery and not other cosmetic treatments.

398. I think that that is the natural reading of that paragraph since the decision was concerned with both surgery and other cosmetic treatments.

399. Of course in this appeal after 2015, an unidentified proportion of the appellant's supply of services was surgery.

400. In any event, in the same way as I find that there will rarely be a single purpose, I would have thought that there would rarely be a purely cosmetic purpose in that an incidental result may well be greater self-confidence etc.

*Qualifications*

401. I deal with this principle as the first issue under the heading of The Evidence but in summary, qualifications may be relevant but are not determinative.

*Is there an Administrative Fiat imposed by HMRC?*

402. It is argued for the appellant that the legislation is silent on cosmetic treatment, psychological care and psychosocial aspects of care and that HMRC, in adopting a granular approach and imposing far too high a standard of record keeping, are effectively legislating by the back door or imposing an administrative fiat.

403. I do not accept the suggestion that HMRC are close to saying that if a taxpayer is practicing aesthetic medicine then the exemption would not be available. I agree with Mr Tosh that what HMRC have done is to look at the purpose of the supplies of services made by the appellant and endeavoured to decide whether or not those constitute the provision of medical care. The Notes make that clear. That is why HMRC wanted more information from the appellant and wanted to understand how the appellant operated.

404. In order to claim an exemption from VAT (or indeed make any claim in relation to VAT) a taxpayer must keep relevant and appropriate records to vouch the claim. Incidentally, for that reason alone, I reject the suggestion that it was somehow inappropriate of the appellant to seek advice from Azets in relation to its records.

405. For the reasons that I set out below under the sub-heading Records, I do not accept that HMRC are imposing any particular standard of record keeping. In summary, what I do accept is that HMRC have been, and are, seeking to apply the provisions of VATA and have not gone beyond that.

***The Evidence***

406. As I have indicated, it is common ground between the parties that the views of the HCP are not determinative but are relevant. At paragraph 36 of *PFC* the Court stated that:

> 36. It follows that the fact, referred to in the fourth question, that services such as those at issue in the main proceedings are supplied or undertaken by a licensed member of the medical profession or that the purpose of such interventions is determined by such a professional, **may** influence the assessment of whether interventions such as those at issue in the main proceedings fall within the concepts of 'medical care' or 'medical treatment' within the meaning of art 132(1)(b) and (c) of the VAT Directive respectively."

407. I have added emphasis because Ms Hall argues that I must attach great weight to Dr McKeown's assessment of the purpose of the treatments as seen by his witness statement, the exhibits thereto, the other documents and his oral evidence.

408. Before turning to that, I point out that, as I have indicated at paragraph 37(a) above, *Mainpay* makes it explicit that "mere involvement in medical services by qualified personnel" is not sufficient to qualify for the exemption.

409. Mr Tosh confirmed that it was not part of his case that Dr McKeown was not qualified to administer cosmetic treatment but argued that Dr McKeown is neither a psychiatrist nor a psychologist nor qualified as such and he relied upon paragraph 30 of *H.A. Solleveld & Anor v Staatssecretaris van Financiën* ("Solleveld") Cases C-443/04 and C-444/04. Dr McKeown placed considerable emphasis on his qualifications and had stressed that he had done four months training in a psychiatric ward. However, firstly, that was simply part of Foundation training. Secondly, it was established in oral evidence that it was in a general adult ward where typically one would expect to be dealing with acutely ill patients with, for example schizophrenia or bipolar disorder with, say, psychotic symptomology. It is not psychology.

410. Neither argument is persuasive. Dr McKeown is not a psychiatrist nor a psychologist but I do not agree with HMRC that he would require to have had specific training in psychiatry or psychology. I do not take the view that the appropriate tax treatment should depend on whether the person delivering it has psychological training or experience. Dr McKeown did have a few hours of such training in 2021.

411. As I have pointed out, in this country, most diagnoses of mental health disorders are made by GPs.

412. Ms Hall made it explicit that the appellant does not compare itself with psychiatrists or psychologists but the comparison is with GPs. The appellant argues that the appellant delivers "comparable quality" and that is in the public interest which, of course, is the objective of the exemption. I will revert to the principle of fiscal neutrality.

413. Ms Hall argues that the fact that the HCP is qualified matters in the context of deciding whether there is a therapeutic purpose and "quality" is the relevant criteria. For that, *inter alia,* she relies upon paragraph 40 of *Solleveld* which states that "…In fact, where it [medical care] is not identical, medical care can be regarded as similar only to the extent that it is of equivalent quality from the point of view of recipients".

414. The patients attending the Clinic do not do so to see a psychiatrist or psychologist; they do so in the hope and expectation of purchasing a cosmetic procedure.

415. The qualifications of the HCPs involved might be relevant but are not determinative. If the HCP diagnosed depression or, for example, BDD the qualifications would be relevant.

416. Although the service provided may be provided by an HCP who can engage with the patient's emotional or psychological needs and might be a good listener, that does not alter the position.

417. I have set out the detail of the records at such length because that demonstrates what is not in the records. Given that there are so many discrepancies in relation to other matters, such as what surgical treatments were offered and when, it was necessary to carefully scrutinise the contemporary documentation.

418. This is the appellant's appeal and, unlike in *Epem* where there was a paucity of records, the documentation was extensive. Ms Hall asked me to "review the patient summaries…and look at not just the treatment, but all of the other notes behind them and form [my] own assessment. I have.

***The records***

419. At the heart of the appellant's case was the assertion that the patient records provide the evidence that the services delivered by the appellant had a clear therapeutic purpose. I was told that I would see diagnoses, treatment, an attempt to cure, health disorders identified, and a quest to protect, maintain and restore health.

420. As can be seen, I am afraid not.

421. Until, in Closing Submissions, Ms Hall addressed Mr Tosh's argument that the JCCP documentation encapsulated HMRC's position in a nutshell, I had not understood why Dr McKeown had produced the JCCP documentation since it seemed to me that it undermined the appellant's case. It was then argued that that documentation had been produced to give a complete picture and that I should focus on the GMC guidelines for records.

422. It is not for me to determine whether or not the appellant's record keeping was GMC compliant. My only interest in the patient records is to try and ascertain if they assist in establishing whether or not medical care, within the meaning of the exemption, was provided during the consultations between the HCPs and the patients and whether the service (not just the treatment) that was provided had a therapeutic purpose.

423. I fully accept that the JCCP guidelines are voluntary but I certainly do not accept that I should focus on the GMC guidelines and attach little weight to these. I consider them to be very relevant and I have highlighted various words and phrases because, as can be seen, as Mr Tosh argues those aspects are precisely where the appellant has not complied. I agree with him.

424. Why are they relevant? Of course they are recent and adherence is voluntary. That is not the point because, as I have indicated, I do not accept that HMRC have imposed any specific record keeping requirements. All that they have sought to establish, as I have done, is whether the appellant provided medical care and, as the JCCP documentation makes clear the records are a means of establishing that.

425. It was repeatedly asserted that HMRC had focussed purely on the treatments that were delivered and ignored the rest of the "package" including the consultations etc. I do not consider that to be a fair assessment.

426. Whilst, undoubtedly at every stage, in general, the appellant's records have included very precise details of the Botox and fillers used, I am afraid that, as can be seen, neither the records for the 2011, 2015 and 2018 Patients nor the Full File notes to which I have referred, can be described as accurate or complete.

427. At paragraph 62 in his witness statement, Dr McKeown stated:-

> "The next step in the consultation process is to conduct a thorough review of the patient's medical history. An understanding of the patient's previous illnesses, medications and allergies is important when evaluating a decision to prescribe any treatments or interventions. There are also some significant neurological and dermatological contraindications to treatments that we commonly offer, so any history of those must be noted."

428. As can be seen from my findings in fact on the documentary evidence, there is no evidence of a thorough review of any patient's medical history. At best, where there is any evidence, it could be described as cursory. Even basic information is notably absent.

429. At paragraph 71 in his witness statement, Dr McKeown suggested that where a patient has previously suffered from mental health issues "I take the time to go through these issues and gather further details". If he did that, it is most certainly not evidenced in the patient records that have been produced, and it should be. The 2018 Patient is a good example of that failure.

430. In passing, given the standard of the other record keeping, I noted with some concern the record for Sample Patient 53 where the Cover Form stated that the patient had anorexia nervosa (which had been treated by a psychiatrist), BDD and depression. Anorexia at that level is a very serious mental health issue. I do not have the Full File but she was given Botox. The "Treatment" section of the Cover Form contained no suggestion of a referral to, or liaison with other services etc but narrated that the "psychological impact of aesthetic medicine" was described as being discussed at length with the patient and her mother. She was given lifestyle advice on sun avoidance.

431. Whilst I accept Dr McKeown's statement that lifestyle advice is a "really important part of what I do" and I know that GPs dispense lifestyle advice routinely, nevertheless I find it surprising, that in a context of an apparent combination of three comorbid conditions the treatment options are lifestyle advice, Botox and a discussion about the limitations of aesthetic medicine.

432. In summary, I certainly accept Ms Hall's point that GP notes can be cryptic, but, they are usually very informative, detailed and extensive and give, in Dr McKeown's words, a holistic view of the patient. The same cannot be said of the patient information in the Bundle.

433. If one ignores the Cover Forms which were compiled, four and seven years after the event, for the benefit of HMRC, and which I have demonstrated were less than accurate, one is left with the contemporaneous records. If one then also ignores those Face Pages where there are no clinical findings or notes beyond the details of the Botox or filler delivered there are extremely few clinical findings or indeed factual information and thus diagnoses. In general, the Patient questionnaires are the only other evidence until after 2018.

434. It was argued for the appellant that:

> "The record keeping aspect of our case on Article 131 is also important….Parliament could have…laid down conditions with regard to vigorous record keeping. It chose not to. HMRC are imposing a standard on the appellant which is significantly greater than

they expect of GPs making medical assessments of a comparable quality. That is to say holistic medical assessments; looking at every aspect of the patient…".

435. I do find that until 2018, there were almost no clinical findings, there certainly was no record of an assessment at the time of each treatment, as the JCCP recommend, and both before and after 2018 there are significant omissions from the records. I can see very few examples of a diagnosis by the appellant being identified let alone a treatment or care plan beyond the location of the sites for Botox or fillers. What seemed to happen, repeatedly, is a request for Botox or fillers and then that is, or is not, delivered.

436. The style of the records before 2013 were such that it appears that the only record was the detail of the injectables and the Patient questionnaire, which, as I have observed (in the context of the 2011 Patient) was decidedly minimalist. The detail of the injectables was on a very small Face Page which really amounts only to a slip of paper with space only for that information.

437. I also do not find that the records support Dr McKeown's assertion in cross-examination that in general the patient records would indicate to someone reading them that the patients had psychological issues. To be fair, he did qualify that statement by saying that there is a psychological purpose in all cosmetic interventions. That is a sweeping and very general statement and should be considered in the context of paragraph 227 above where I record that he said that if a patient was worried about something that was a psychological symptom. Certainly he has always been very clear, as the Screenshot makes explicit, that the purpose of the appellant's business is to make the patients look and feel better.

438. In my view, the same could be said of a haircut, a visit to a spa, if so inclined, a laugh at a stand-up comedian or even a refreshing walk in the park! That aside, a psychological purpose does not necessarily equate with treatment of disease or improvement in health. I entirely agree with Judge Fairpo in *Epem* when she said that "Dissatisfaction with appearance does not automatically mean that the patient has a health disorder." I do not think that, in general, worrying that one is looking older is a health disorder.

439. In cross-examination, Dr McKeown stated that in the course of a consultation he would diagnose psychological conditions and "It is then recorded in their notes which they are free to take a copy of". As can be seen, there is very little of that nature in any of the patient records and what there is, is to be found after the HMRC enquiries. The copies that a patient would be able to obtain, in general, seem to amount simply to the Face Pages and, as I have indicated, in almost none of them is there any diagnosis or indeed record of anything other than the type of Botox and filler and the sites for injection.

440. I find that on the balance of probability, any patient having, as Dr McKeown states, researched the Clinic whether on social media or otherwise, has a consultation, asks for, and in most instances then gets, treatment whether on the day or not. The fact that on occasion treatment is declined does not detract from that. In all walks of life, both professionals and tradespeople will refer work to others and/or decline to act, provide, sell or buy.

441. By definition, all cosmetic treatments are provided, to some extent, for cosmetic purposes. I agree with HMRC that the supplies made by the appellant are not purely therapeutic. It is helpful to consider what therapeutic means and that is that it relates to the healing of disease. Whilst I note the American article produced by Dr McKeown which argues that ageing is a disease, that is not a widely held view and, in general, the appellant's patients are at most, middle aged. In any event, sun damage and nicotine damage are not part of the ageing process *per se*. They are self-inflicted damage as is moderate weight gain

442. The appellant argues that sun or nicotine damaged skin are health disorders and they can be in certain cases such as, for example, melanoma, but in general they are not health disorders treated by GPs.

**Fiscal neutrality**

443. One of the key arguments advanced for the appellant was that the EU concept of fiscal neutrality was engaged because the services provided by the Clinic are comparable with services provided by General Practitioners ("GPs"). Paragraph 32 of *L.u.P. GmbH v Finanzant Bochum-Mitte* Case C-106/05 defines fiscal neutrality as being a situation "whereby economic operators carrying on the same activities must not be treated differently as far as the levying of VAT is concerned". At paragraph 29 of *Peters* the Court referred to that pointing out that one has to look to equivalency from a qualitative point of view in the light of the professional qualifications of the service providers in question.

444. HMRC argued that the services provided by the Clinic and GPs are "fundamentally different" and that therefore the principle of fiscal neutrality is simply not engaged.

445. It was argued for the appellant that Parliament could have laid down conditions in regard to "vigorous record keeping" but had chosen not to do so. Accordingly, because HMRC were imposing a standard on the appellant that was significantly greater than was expected of a GP making medical assessments of comparable quality there was a breach of the principle of fiscal neutrality. Those medical assessments were defined as being "holistic medical assessments; looking at every aspect of the patient" sitting before the HCP.

446. I do not accept that for a number of reasons.

447. As I have indicated, I agree that the JCCP's recommended standard of record keeping is an indication of what would be helpful in establishing that a service is exempt. The records that have been produced for the appellant simply do not reach anything like that standard even after the introduction of new records from 2018. There is a dearth of clinical findings.

448. I do not find that HMRC are imposing any particular standard of record keeping. All that they are saying, and correctly so, is that it is for the appellant to prove that particular supplies are exempt. As I have pointed out in the section on the JCCP and records, the onus is on the practitioner to have records to prove that a procedure is medical and not cosmetic. In fact, the JCCP points out that:

> "It is important to note however that is not the case that a particular aesthetic procedure is always 'medical' by definition or determined by the rationale for electing to receive the treatment. For instance, a dermal filler lip augmentation could be regarded as a 'medical' procedure for one patient and 'cosmetic' in another based on the patient's reason for seeking to procure and to receive the treatment."

449. Of course, it is agreed that the subjective view of the patient is not determinative but is relevant and it is only one factor but the point is that, for example for the 2011 Patient, all that I, or HMRC, know is that on her first consultation she asked for and received Botox and fillers. As I have pointed out, the first mention of distress or anxiety was only in June 2018 but in October 2018, the answer to the question about a history of psychological problems including anxiety is "No".

450. Dr McKeown's argument was that all of the treatments that he described as comparators are regularly provided by the NHS and are akin to the services provided by the Clinic when treating skin that has been aged by sunlight or nicotine and which has resulted in wrinkles.

451. Well, he is entitled to his opinion that the treatments are basically similar but I disagree.

452. I have found that the appellant's records do not disclose very much about the patients let alone give a holistic picture. On the basis of the information with which I have been provided, whilst I accept that Dr McKeown listens empathetically and sympathetically to his patients and almost certainly has more time than a busy GP, I do not accept that the service provided is similar.

453. The common thread in the examples upon which the appellant relied was a variation on a theme of relieving psychological distress.

454. The appellant has chosen GPs as the comparator. *Frenetikexito – Unipessoal Lda v Autoridade Tributária e Aduaneira* C-581/19 identifies the importance of getting the right comparator at paragraph 32 which reads:

> "32. That interpretation does not contravene the fiscal neutrality principle, which precludes in particular two deliveries of goods or two supplies of services which are identical or similar from the point of view of the consumer and meet the same needs of the consumer, and which are therefore in competition with one another, from being treated differently with regard to VAT (see, to that effect, judgment of 17 December 2020, *WEG Tevesstraße*, C-449/19, EU:C:2020:1038, paragraph 48 and the case-law cited), since, in the light of the objective pursued in Article 132(1)(c) of Directive 2006/112, nutrition monitoring services provided with a therapeutic purpose and nutrition monitoring services without such an objective cannot be regarded as identical or similar from the point of view of the consumer and do not fulfil the same needs on the part of that consumer." (Emphasis added)

455. I simply do not accept that the appellant has established that it is in competition with GPs. I do not accept that the appellant has demonstrated that the patients would even begin to think that a GP practice would offer such cosmetic interventions. In his witness statement Dr McKeown, at paragraph 27 argued that "cosmetic care is rationed on the NHS and when it is provided, generally had very long waiting lists". Absolutely no evidence has been produced to suggest that the NHS, whether GPs or not, has ever offered Botox or fillers for wrinkles caused by sun damage and nicotine in middle aged women etc.

456. There is no evidence that the various patients would have either wanted or needed to have consulted a GP about their appearance; most indicated that they would have not wished their GP to have been told that they had consulted the appellant or be given details of the treatments.

457. The services provided by the appellant are not being provided for medical purposes. The fact that, as Dr McKeown argued in the Documentary, the patients leave the Clinic feeling happier unlike when having attended the GP, does not mean that the treatment (including the consultation) is medical or has a therapeutic aim.

458. I do not accept the argument on fiscal neutrality.

**CONCLUSION AND OUTCOME**

459. In summary, I do not have an accurate picture of the appellant's activities in any period, let alone the earlier periods.

460. For all the reasons given, whilst I accept that the appellant helps the patients achieve their goals in relation to their appearance and does so with kindness and supportively, that is not medical care within the established meaning of that term. The appellant is not "diagnosing, treating and, in so far as possible curing diseases and health disorders" and the fact that there are pre-treatment consultations does not change that.

461. The details with which HMRC and I have been provided in the documentary evidence to the effect that the patients hope to, and appear to, achieve greater self-esteem is not evidence of healthcare. Calling it holistic care does not make it medical. It does not change its tax status.

462. Shortly put, this appeal fails, on the basis of the facts found, on the evidence adduced. The appellant has not established that its services fall within Item 1 Group 7 Schedule 9 VATA. The appellant should have been registered for VAT and the supply of services should have been standard rated. HMRC were therefore correct to raise a best judgment assessment in terms of section 73(1) VATA.

463. Therefore the appeal is dismissed.

**RIGHT TO APPLY FOR PERMISSION TO APPEAL**

464. This document contains full findings of fact and reasons for the decision. Any party dissatisfied with this decision has a right to apply for permission to appeal against it pursuant to Rule 39 of the Tribunal Procedure (First-tier Tribunal) (Tax Chamber) Rules 2009. The application must be received by this Tribunal not later than 56 days after this decision is sent to that party. The parties are referred to "Guidance to accompany a Decision from the First-tier Tribunal (Tax Chamber)" which accompanies and forms part of this decision notice.

**ANNE SCOTT**
**TRIBUNAL JUDGE**

**Release date: 12th DECEMBER 2023**