PUBLIC RECORD

Dates: 19/8/2019 to 30/8/2019, 30/10/2019 to 01/11/2019 and 11/02/2020 to 14/02/2020

Medical Practitioner's name:	Dr Ali ISMAIL
GMC reference number:	6168323
Primary medical qualification:	Gydytojas 2006 Kauno Medicinos Universiteto

Type of case	**Outcome on impairment**
New - Misconduct	Not Impaired

Summary of outcome

Warning

Tribunal:

Legally Qualified Chair	Mr Colin Chapman
Lay Tribunal Member:	Mr Keith Moore
Medical Tribunal Member:	Dr Keith Dunnett

Tribunal Clerk:	Ms Angela Carney

Attendance and Representation:

Medical Practitioner:	Present and not represented 19/8/2019 to 30/8/2019 and 30/10/2019 to 31/10/2019 Not present and not represented 01/11/2019 Present and represented 11/02/2020 – 14/02/2020
Medical Practitioner's Representative:	Mr Adam Watkins, Counsel, directly instructed 11/02/2020 to - 14/02/2020
GMC Representative:	Mr Terrence Rigby, Counsel 19/8/2019 to 30/8/2019, 30/10/2019 to 31/10/2019 and 11/02/2020 to 14/02/2020 Ms Emma Cocks 01/11/2019

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly in private.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 01/11/2019

Background

1. Dr Ismail qualified in 2006 in Lithuania and prior to the events which are the subject of the hearing he worked as a Locum Trust Grade Doctor in Trauma and Orthopaedics. During 2017 he worked for the MyLocum recruitment agency at various hospitals in and around London.

2. The allegation that has led to Dr Ismail's hearing can be summarised as follows: on or around 23 July 2017, Dr Ismail consulted with a patient and made failures in relation to history taking, examination and record keeping and that Dr Ismail's handover for this patient was inadequate.

3. It is further alleged that, during a night shift on or around 2 August 2017, Dr Ismail was uncontactable and asleep. It is alleged that he then made dishonest statements about his actions during the night shift.

4. It is further alleged that, between 1 August 2017 and 3 August 2017, Dr Ismail worked 37 hours in a 44 hour period when it was unsafe to do so. It is also alleged that he acted dishonestly when submitting a timesheet for work done at West Middlesex Hospital.

The Outcome of Applications Made during the Facts Stage

5. The Tribunal granted the General Medical Council's (GMC) application, made pursuant to Rules 34(13) and (14) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that Dr D, a witness for the GMC be allowed to give evidence by video link due to his commitments as a Surgical Registrar in London. The Tribunal's full decision on the application is included at Annex A.

6. The Tribunal granted the GMC's application, made pursuant to Rules 34(13) and (14) of the Rules, that Dr C, a witness for the GMC, be allowed to give evidence by telephone, because of recent personal circumstances. These prevented him from attending the hearing or giving evidence by video link as he did not have internet access. The Tribunal's full decision on the application is included at Annex B.

7. The Tribunal granted the GMC's application, made pursuant to Rules 34(13) and (14) that Dr E be allowed to give evidence by telephone as he had made himself available

but was currently abroad and as such was unable to give evidence by video link. The Tribunal's full decision on the application is included at Annex C.

8. The Tribunal partially granted the GMC's application, made pursuant to Rule 17(6) of the Rules, to amend the Allegation to more accurately reflect the evidence before the Tribunal. The Tribunal's full decision on the application is included at Annex D.

9. The Tribunal refused Dr Ismail's application, made pursuant to Rule 29(2) to adjourn the hearing while he located a witness to support his case. The Tribunal's full decision on the application is included at Annex E.

The Allegation and the Doctor's Response

10. The Allegation made against Dr Ismail is as follows:

1. On or around 23 July 2017 you consulted with Patient A and you:

    a. failed to take a history from Patient A;
    To be determined

    b. failed to examine Patient A;
    To be determined

    c. told Patient A that he may have gangrene to his penis *or his groin*, when this was not clinically indicated;
    To be determined (as amended)

    d. failed to make an adequate record of your consultation in Patient A's records.
    To be determined

2. On 24 July 2017 your handover of Patient A was inadequate in that you told your orthopaedic colleagues the wrong mechanism of Patient A's injury.
To be determined

3. On or around 2 August 2017, during a night shift, you were:

    a. not contactable by telephone or bleeper;
    To be determined

    b. asleep.
    To be determined

4. On 2 August 2017, following the night shift you:

    a. told Dr B that you had not been asleep during your shift when this was untrue;
    To be determined

b. then told Dr B that:

i. you had been asleep during your shift;
To be determined

ii. the reason for you being asleep during your shift was because you had worked 72 hours straight as you had done shifts at Kings College Hospital, when this was untrue.
To Be determined

5. You knew the statements you made as set out at paragraph 4 were untrue.
To be determined

6. Your actions at paragraph 4 were dishonest by reason of paragraph 5.
To be determined

7. Between 1 August 2017 and 3 August 2017 you worked at:

a. West Middlesex Hospital on:
i. 1 August 2017 from 20:00 until 10:00 on 2 August 2017;
To be determined

ii. 2 August 2017 from 20:00 until 09:00 on 3 August 2017;
To be determined

b. Homerton Hospital on:

i. 1 August 2017 from 13:00 until 18:00;
To be determined

ii. 2 August 2017 from 13:00 until 18:00.
To be determined

8. You worked 37 hours in a 44 hour period as detailed in paragraph 7, when it was unsafe to do so.
To be determined

9. You submitted a timesheet dated 3 August 2017 for work done at West Middlesex Hospital which was:

a. not signed by a consultant;
Admitted and found proved

b. completed to give the impression that it had been approved by Dr C.
Admitted and found proved

10. You knew that prior to submitting the timesheet described at paragraph 9 above:

a. a consultant had to:

i. sign it;
To be determined

ii. approve it;
To be determined

b. that it contained a false signature.
Admitted and found proved

11. Your actions as described at paragraph 9 were dishonest by reason of paragraph 10.
Admitted and found proved in relation to paragraph 10b

The Admitted Facts

11. At the outset of these proceedings, Dr Ismail made admissions to some paragraphs and sub-paragraphs of the Allegation as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

12. In light of Dr Ismail's response to the Allegation made against him, the Tribunal is required to determine whether Dr Ismail consulted with Patient A and made failures in relation to history taking, examination and record keeping and whether his handover was inadequate. The Tribunal must also determine whether, during a night shift in August 2017, Dr Ismail was uncontactable and asleep and whether he made dishonest statements about his actions during the night shift. The Tribunal must further determine whether between 1 August 2017 and 3 August 2017, Dr Ismail worked 37 hours in a 44 hour period and whether it was unsafe to do so. It is also alleged that he acted dishonestly when submitting a timesheet for work done at West Middlesex Hospital.

Factual Witness Evidence

13. The Tribunal received evidence on behalf of the GMC from the following witnesses:

- Patient A, in person
- Dr D, Specialist Registrar, Trauma and Orthopaedics, formerly of Chelsea and Westminster Hospital NHS Foundation Trust, by video link
- Dr E, Associate Specialist Orthopaedic and Trauma Surgeon, Chelsea and Westminster Hospital NHS Foundation Trust, by telephone

- Dr B, Consultant Orthopaedic Surgeon, Chelsea and Westminster Hospital NHS Foundation Trust, in person
- Dr C, Specialist Registrar, Trauma and Orthopaedics, Chelsea and Westminster Hospital NHS Foundation Trust, by telephone

14. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Dr F, Consultant Orthopaedic Surgeon, Chelsea and Westminster Hospital NHS Foundation Trust
- Dr G, Consultant in Emergency Medicine, Chelsea and Westminster NHS Trust
- Dr H, Corporate medical Director and Consultant Critical Care, King's College Hospital NHS Foundation Trust
- Mr I, Head of Temporary staffing and Rostering, Chelsea and Westminster Hospital NHS Foundation Trust
- Mr J, Senior Recruitment Consultant, at MyLocum

15. Dr Ismail provided his initial response to the Allegation (undated) and an opening statement dated August 2019 and also gave oral evidence at the hearing.

Expert Witness Evidence

16. The Tribunal also received oral evidence from the GMC expert witness, Dr L, Consultant Orthopaedic Surgeon. Dr L provided a report dated 10 April 2018 and a supplemental report dated 2 June 2019.

Documentary Evidence

17. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to:

- Images of Patient A's injuries
- Patient A's A&E incomplete records
- Patient A's in-patient medical records
- Email dated 15 August 2017 containing Dr D's Trust statement
- 'On take' list
- Email exchange between Dr B and Mr J regarding Dr Ismail's performance
- Email exchange between Dr B and Ms K regarding timesheets
- Dr E's Trust statement
- Email exchanges between Dr C and Ms K
- Dr Ismail's incomplete timesheet
- Dr Ismail's timesheet
- Details of Dr Ismail's shifts provided by his Responsible Officer
- Printouts of Dr Ismail's shifts
- Investigation Report Chelsea and Westminster Hospital NHS Foundation Trust

The Tribunal's Approach

18. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Ismail does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

The Tribunal's Analysis of the Evidence and Findings

19. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Paragraphs 1a to 1d

20. The Tribunal noted Patient A's GMC witness statement dated 16 February 2018.

> *'4. I suffered a motorcycle accident, in Italy on 21 July 2017. I attended a hospital in Italy with serious injuries; my left arm was shattered, and my penis felt like it was ripped off and had a haematoma. I didn't know what was happening and was in a really bad state.*
>
> *5. Due to the language barrier, I was not comfortable being treated in Italy and flew back to England on 23 July 2017.*
>
> *6. I attended West Middlesex Hospital (the Hospital) at around 10-10.30pm on 23 July 2017.*
>
> *7. At the hospital, I first saw a triage nurse who didn't check anything. I had notes from my Italian doctor but was told by the staff that they couldn't upload them into the NHS system in case there was a bug.*
>
> *8. I then saw Dr Ismail who similarly, didn't check my bleeding but said I may have gangrene on my penis. Dr Ismail did not examine me or take a history of my injuries. Dr Ismail saw me for a very short period of time and told me to go home. Dr Ismail had eyes which were bloodshot red and was asking the nurses for advice on what to do. I had been living on paracetamol for three days and didn't expect this response.*
>
> *9. I refused to leave as I knew my injuries were serious. I waited around and demanded to see Dr Ismail again. Dr Ismail told me again to go home and I eventually left at 2am on the morning of 24 July 2017 …*
>
> *10. Dr Ismail did not carry out any scans and did not provide a casket [sic]. I feel like they did nothing to help me.'*

21. In his oral evidence, Patient A told the Tribunal that on 21 July 2017, in Italy, he had a head on collision with a car which was on wrong side of road. He stated that he knew his arm was injured and his groin was *'in a bad way'*. He said that he was treated by a surgeon at a local hospital in Italy but had been unhappy with the treatment. For example, he said that the sling for his arm was made out of a bedsheet, his groin injury

was treated with a bag of ice and he was only given paracetamol for pain relief. He said that, due to the language barrier, he chose to return to the UK and flew back on 23 July 2017 and went straight to the Accident & Emergency Department (A&E).

22. Patient A said that he was triaged in A&E and put in a treatment bay. It was Patient A's account that, when he arrived in A&E, he was bleeding and his boxer shorts were covered in blood. His arm was in a temporary cast and a sling made from a bedsheet. He said that because there was so much blood he had to wrap his penis in tissues. He said this was the condition in which he had flown back to the UK from Italy.

23. Patient A said he was seen by two nurses who said that Dr Ismail was coming. He said he was waiting for approximately half an hour when Dr Ismail arrived and introduced himself. He said that he explained about the motorbike crash. He was told that he had *'gangrene in the groin'* and `*there is nothing we can do'.* He said that he was in a very poor state and not feeling good. He said that his wife insisted that he should be seen again.

24. Patient A said he was seen again by Dr Ismail but told the same thing. His evidence was that he was not sent for an x-ray, and that the doctor did not examine him or make notes. He said there were no investigations at all and he left hospital in the same state as he had arrived. Patient A said that he left the hospital and returned home about 1.45am.

25. Patient A's evidence was that, apart from two nurses, Dr Ismail was the only doctor he saw and confirmed again that he received no treatment. When referred to the medical notes, which state *'Surgical SHO'*, Patient A again stated that Dr Ismail was the only doctor he had seen. Patient A confirmed he had no blood tests or x-rays taken.

26. Patient A was asked by Dr Ismail whether, given that the events were two years ago, he remembered him. Patient A said that Dr Ismail had been introduced when he entered the hearing room but he may not have recognised him if he saw him in the street. When asked by the Tribunal about Dr Ismail, Patient A stated that he took notes as he knew the way he was treated was poor and when he was re-admitted the next day Dr Ismail's name was *'bandied around the hospital'*. When asked by Dr Ismail how did he get the name 'Dr Ismail', Patient A said that he introduced himself at the hospital using this name.

27. Patient A was clear and emphatic in his evidence to the Tribunal that he was seen by only one doctor, the doctor was Dr Ismail and no investigations or tests were carried out.

28. However, the Tribunal was able to carefully consider Patient A's hospital records. These demonstrated that Patient A had been examined fully by an A&E doctor, who the Tribunal inferred was Dr M, Senior House Officer (SHO), and the Surgical SHO on call. Witnesses confirmed that the records showed that when Patient A was in A&E he had x-rays and blood tests, all of which had been denied by Patient A. They also contain a note made by the A&E SHO which indicates that there was no active bleeding. They also show a Surgical SHO's entry that Patient A was seen by the Surgical Team, which, the Tribunal

heard, included two female doctors and that he was seen by at least three doctors in total.

29. The Tribunal noted that GMC witnesses, Dr D, Dr E, Dr B, and Dr C all confirmed that Dr Ismail usually introduced himself and was known as 'Dr Ali', and not 'Dr Ismail' as described by Patient A. The Tribunal heard evidence that, as Dr Ismail was a locum doctor, he would not have had his name on his ID badge.

30. Dr D confirmed in oral evidence that his witness statement concerning what had happened on the night in question, was entirely based on what Patient A had told him sometime after he was admitted on 24 July 2017. Dr D told the Tribunal that Patient A had not referred to Dr Ismail by his name.

31. It was Dr Ismail's evidence that he had been dealing with a patient with a 'neck of femur' fracture in A&E when he was approached by a Dr M, the A&E SHO who he had met previously at Ealing Hospital when they worked there together. He stated that Dr M asked him to review an x-ray. Dr Ismail stated that he reviewed the x-ray and wrote in the 'nursing notes' section of Patient A's A&E medical notes the following:

> *'24/7/17 00.19*
> *Ortho SPR*
>
> *X-ray R/V*
> *Hx noted closed injury RTA motorbike*
> *Distal Radius Comminuted fracture*
> *Distal N/V intact*
> *Plan: discuss in trauma meeting*
> *Surgical vs conservative management*
> *Will contact patient mane @ 9am for update'*

32. Dr Ismail's evidence was that this was his only involvement with Patient A, and that he had not directly consulted with or met Patient A. His evidence was that Patient A may have seen him at the hospital because he was present near the bay in which Patient A was treated. He stated that, had he examined Patient A, he would have written 'O/E' (on examination) in the notes.

33. The Tribunal noted Dr L's initial opinion was based on the assumption that Dr Ismail was responsible for Patient A's care and was based on the witness statement of Patient A. Regrettably he did not have the full clinical notes when he wrote his first report. Dr L was later provided with two pages of Patient A's hospital records from which he concluded '*I therefore cannot see any evidence that Dr Ali Ismail examined or took a history from this patient that night.'* Dr L's evidence did not assist the Tribunal as to whether or not Dr Ismail was the doctor who consulted with Patient A.

34. The Tribunal would have been greatly assisted if it had been provided with a full set of Patient A's hospital records of his attendance at A&E on 23 July 2017 at the outset of the hearing. Even after further parts of the records were produced during the course of the hearing, they were still not complete. The Tribunal decided that the absence of the

full record prevented it from obtaining a complete picture of Patient's A's treatment on the night in question. However, the records which were produced and which were not challenged wholly undermined Patient's A's evidence of events on the night in question, the tests undertaken in investigating his injuries, who he was treated by, and that he had only been seen by one doctor.

35. For these reasons, the Tribunal decided that it could not rely on Patient A's account that he was only seen by Dr Ismail or that he was seen by Dr Ismail at all. The Tribunal considered Dr Ismail's evidence to be consistent with the medical records and preferred it to that of Patient A.

36. Therefore, on the balance of probabilities, the Tribunal was not satisfied that Dr Ismail consulted with Patient A at all. The Tribunal considered it was more likely than not that Dr Ismail's only involvement with Patient A was simply to review and comment on the x-ray results at Dr M's request as he explained in his evidence.

37. Accordingly, the Tribunal found paragraphs 1a to 1d not proved.

Paragraph 2

38. The Tribunal heard consistent evidence from several witnesses that, each morning at around 8.00am, a trauma meeting took place attended by various members of the orthopaedic department when the overnight on-call team handover to the day team, presenting details of the patients they had seen overnight so that any necessary further treatment or surgery could be arranged. The handover is based on brief details of the patients, any treatment given overnight, and any plan for further treatment as recorded on an electronic handover sheet. The Tribunal was told that this was the only documentation considered and discussed at these meetings as patient notes were not always available.

39. The Tribunal was shown both a redacted and an unredacted version of the handover sheet for the night of 23 July 2017. Patient A's clinical history was recorded as *'Left mid/distal shaft radius fracture RTA 50 miles close injury'* and his plan as *'Discuss in trauma meeting'* along with his mobile telephone number.

40. The Tribunal noted that in Dr D's original email to Dr B dated 4 August 2017, he stated:

> *'Ali told one of the doctors the patient was caught in a fight and that is how he injured it.'*

41. In his GMC witness statement dated 31 December 2017 Dr D stated:

> *'Dr Ali told me and other doctors at this handover that Patient PD* [Patient A] *had been involved in a fight and this is how he suffered a distal radius fracture.'*

42. In his GMC witness statement dated 13 May 2019 Dr D stated:

> *'I got the impression from Dr Ismail that he had seen Patient A as Dr Ismail referred to Patient A's x-ray at the handover meeting in the morning.'*

43. In his oral evidence, Dr D said he could not clearly remember the handover given by Dr Ismail and he could not remember being given a copy of the handover sheet which showed that Patient A's injury had been caused in an RTA (road traffic accident) and not in a fight. He said he left the meeting confused but under the impression that the patient had been in a fight. Dr D accepted that he could not reconcile his recollection with what was recorded on the electronic handover sheet which was provided to everyone at the trauma meeting.

44. The Tribunal noted that Dr D had later seen Patient A on the ward after he had been admitted the following day. Patient A had complained about the poor treatment he had received the previous night. Dr D he confirmed that Patient A had not mentioned Dr Ismail by name and stated that he had no reason to doubt Patient A at all.

45. It was Dr Ismail's evidence that he completed the electronic handover sheet with Patient A's details, printed a number of hard copies of the sheet to hand out at the trauma meeting, and that he presented Patient A's case at the trauma meeting in accordance with what was written on the sheet. Dr Ismail said that he had included Patient A on the handover sheet, even though he had not seen him, because he was concerned that Patient A had a fractured wrist due to high energy trauma which most likely needed surgery. By presenting Patient A to the trauma meeting, and including his telephone contact details on the handover sheet, he was trying to ensure that his fracture would be followed up and not missed.

46. The Tribunal decided that there was a degree of inconsistency in Dr D's statements about the handover meeting and that his recollection of the meeting was not very clear. The Tribunal noted that Dr D accepted without question what Patient A told him the following day, which the Tribunal has decided is not consistent with the hospital records. The Tribunal considered that Dr D's recollection of events may have been influenced by the account given to him by Patient A. The Tribunal therefore decided that it could not rely on Dr D's recollection of the handover meeting.

47. On the other hand, the Tribunal decided that Dr Ismail's recollection of the meeting was clearer and more coherent and supported by the evidence of the existence of an accurate description of Patient A's injury and his telephone contact details on the handover sheet. The Tribunal therefore preferred Dr Ismail's evidence to that of Dr D about the handover meeting. The Tribunal was not satisfied that Dr Ismail's handover was inadequate or that he gave the wrong mechanism of injury.

48. Accordingly, the Tribunal found paragraph 2 not proved.

Paragraphs 3a

49. It is not in dispute that Dr Ismail was working a night shift as a locum SHO covering on call Trauma and Orthopaedics at the West Middlesex Hospital on the night of 1-2 August 2017, and that his 12-hour shift commenced at 8pm. Dr E was the associate

specialist orthopaedic and trauma surgeon at the hospital at that time. He was not required to be present at the hospital overnight but was available by telephone should the SHO or anyone else need to contact him regarding an orthopaedic matter.

50. Dr E's evidence was that he received a call around 11.00pm from someone in the Urgent Care Centre (UCC) who needed to refer a patient. He was told that the on-call SHO was not answering his bleep. Dr E called the switchboard who told him they had bleeped Dr Ismail several times but that he did not answer. While Dr E was on the telephone to the switchboard, Dr Ismail called in answer to the bleep and Dr E was able to speak to him. Dr E obtained Dr Ismail's mobile number at that point.

51. Dr E's further evidence was that, around 4.30am, he received a call from Syon ward complaining that Dr Ismail was not answering his bleep as they needed him urgently. Dr E was told that security had been sent to find Dr Ismail but they had been unable to do so.

52. Dr Ismail confirmed that he had a hospital bleep and his personal mobile phone. He told the Tribunal that there were three ways that he was contactable: via the bleep (on which he could receive text messages to contact an extension number); also via the bleep but by a voice message; and via his mobile phone. Dr Ismail told the Tribunal that he received a text message on the bleep following which he contacted the switchboard and had spoken to Dr E. Dr Ismail told the Tribunal that, after seeing the patient, he went to the switchboard reception and asked them to check his bleep. He was told there were no replacement bleeps and that, as he had already answered one message, the bleep must be working. He therefore left his mobile number with the switchboard and personally gave the number to the persons in charge of the wards, A&E and the UCC. Dr Ismail said that he was not contacted again either by his bleep or personal mobile. He added that the following week he received calls from the switchboard on his mobile phone, which confirmed that they had been given his mobile number.

53. In his oral evidence Dr B accepted that it was plausible that the bleep was not working but said it was Dr Ismail's responsibility to ensure he was contactable. Dr B said he was not aware that Dr Ismail had reported any problem to the switchboard.

54. The Tribunal noted that there were only two instances when Dr Ismail was said not to be contactable, at around 11.00pm and around 4.30am. The Tribunal noted that with regard to neither was there any direct evidence presented as to what efforts had been made to contact Dr Ismail. There was no evidence from anyone who was trying to make contact with him, of the way in which they had sought to do so, how many attempts had been made, or over what time period. The Tribunal was not presented with any evidence to suggest that there was a time limit imposed on an SHO as to when a response to a call should be made, and the Tribunal considered that this would depend largely on what the SHO was doing at the time. For example, if involved in another emergency he may not be able to respond immediately or quickly. The Tribunal also noted that the evidence presented about the inability to contact Dr Ismail was largely hearsay evidence of complaints made the following day by unknown individuals who have not given evidence to the Tribunal.

55. Regarding the first incident, the Tribunal noted that Dr Ismail was contactable. Contact was, in fact, made with him because he did respond to the bleep message and contacted the switchboard at the same time as Dr E.

56. Regarding the second incident, the Tribunal noted that there were differing explanations given as to why Dr Ismail was needed. For example, it heard from Dr B that Dr Ismail was needed to resuscitate a patient, from Dr E that a patient needed a catheter, and there was also a suggestion that he was needed for a cannula. The Tribunal noted the evidence that there was a great deal of speculation at the hospital the following day about whether Dr Ismail had been asleep on duty. The Tribunal considers that the same speculation may have resulted in the complaint that he was not contactable.

57. The Tribunal decided that, in the absence of direct evidence from someone having tried unsuccessfully to contact Dr Ismail, and in the light of Dr Ismail's evidence, it was unable to find on the balance of probabilities that he was not contactable by telephone or bleep.

58. Accordingly, the Tribunal found paragraph 3a not proved.

Paragraph 3b

59. Having found the previous allegation not proved, the Tribunal cannot, and does not, draw any inferences with regard to the suggestion that because Dr Ismail was not contactable, he was asleep.

60. The Tribunal noted that it is accepted by the GMC that there was no direct evidence from any witness that Dr Ismail was asleep. The Tribunal noted that during the Trust investigation, it was recorded that the security manager confirmed, after checking records and having discussions with staff involved, that there was no record or recollection of any incident of finding Dr Ismail asleep.

61. The Tribunal also noted the evidence about the Dr Ismail's duties in the period before his locum shift on 2 August 2017. These were provided by Mr J, Senior Recruitment Consultant at MyLocum, and were not disputed by either party. They show that Dr Ismail worked the following hours and provide the context in which he worked his shift on the night in question:

19 July 2017	2000 - 0900	West Middlesex University Hospital
20 July 2017	2000 - 0900	West Middlesex University Hospital
21 July 2017	2000 - 0900	West Middlesex University Hospital
22 July 2017	2000 - 0900	West Middlesex University Hospital
23 July 2017	2000 - 0900	West Middlesex University Hospital
1 August 2017	1300 - 1800	Homerton University Hospital
1 August 2017	2000 - 1000	West Middlesex University Hospital
2 August 2017	1330 - 1830	Homerton University Hospital
2 August 2017	2000 - 0900	West Middlesex University Hospital

62. The records show that, following his shift on 2 August 2017, Dr Ismail did not work again until 7 August 2017 at Princess Alexandra Hospital.

63. The evidence that Dr Ismail was asleep comes from what occurred at the handover meeting which took place on the morning of 2 August 2017. Dr B was present at that meeting.

64. The Tribunal therefore noted Dr B's email dated 4 August 2017. This was an e-mail which Dr B sent to the locum agency. It states:

> *'2/8/17*
> *Night shift, found asleep with phone and bleeps switched off overnight by security as ward and emergency dept could not contact him. Patient bleeding on ward early morning had to be resuscitated when we all came in at 8am.'*

65. The Tribunal noted Dr B's GMC witness statement:

> *'5. In respect of the shift of 2 August 2017; I arrived at the Trust in the morning and it was chaos. Before the handover meeting began I was approached by a nurse, Nurse N, who told me that during the night shift the staff could not get hold of Dr Ismail for most of the night and they had a very sick patient that needed resuscitating. Indeed when I arrived in the morning the patient had still not been seen to. Nurse N told me that they had tried bleeping Dr Ismail and in the end had sent a security guard to go find him. I was informed by Nurse N that the security guard found Dr Ismail in the staff room asleep.*
>
> *6. I attended the handover meeting at 8am where we discuss the patients that had been admitted the previous night in order that we can organise follow up treatment and surgeries etc. for the day. I let Dr Ismail present the handover and it was immediately clear that he didn't really know what he was talking about. By this I mean that he could not give details about the patients' histories and examinations and he appeared to be very tired.*
>
> *7. I told Dr Ismail what Nurse N had told me and asked him what happened. Dr Ismail initially denied that he was asleep and said that his bleep was not working. Dr Ismail then changed his story and said that he was asleep. Dr Ismail then went on to say that the reason he was asleep was because he had worked 72 hours straight as he had done shifts at Kings College Hospital.'*

66. During his oral evidence Dr B confirmed that Dr Ismail appeared tired, sleepy and disorientated at the handover meeting, and that after initially denying he had been asleep, Dr Ismail admitted it. Dr B said that the issue for him was that Dr Ismail kept changing what he had said, saying different things, but that he clearly said that he had worked 72 hours straight at Kings College Hospital. However, Dr B accepted that his memory may not have been correct and that there may have been a misunderstanding

about what was said. Dr B said he was not aware that Dr Ismail had been working in A&E but fully accepted that this was possible as the Orthopaedic SHO may have been asked to provide cover in A&E.

67. The Tribunal noted Dr E's GMC witness statement:

> *'3. The next morning at our x-ray meeting, I met Dr Ismail for the first time. There were other SHOs, registrars and a consultant. I have stated in my trust statement that Dr Ismail admitted to being asleep and that this was because he had worked continuously 72 hours. I believe my Trust statement will be an accurate account.'*

68. The Tribunal noted that in his Trust statement, which was in the form of an e-mail dated 30 August 2017, Dr E had said:

> *'I did not see him asleep but he was not answering his bleep and mobile calls from urgent care centre, ward and switchboard so presumed he was asleep. Next day, in the x-ray meeting he admitted that before he started his on call, he worked continuously for 72 hours at a different hospital.'*

69. In his oral evidence Dr E insisted that Dr Ismail said, in front of colleagues at the handover meeting, that he had been asleep because he had worked for three days and was tired.

70. Dr Ismail's evidence was that he was not asleep and denies that the following morning he said he was asleep. Dr Ismail told the Tribunal that it was quiet in orthopaedics that night and he had been assisting in A&E which was significantly understaffed. He stated that, as a locum, he had only been issued with a temporary pass which only gave him access to certain limited areas of the hospital. He said that he was not aware that there was an area in the hospital where an on-call SHO could sleep but, in any event, his pass would not allow him access to that area.

71. Dr Ismail also gave evidence about his personal circumstances leading up to his shift that night. XXX. The Tribunal noted that this was not contested or challenged. Dr Ismail said that, at midday on 30 July 2019, he was picked up by his friend who he later had dinner with. Dr Ismail said he did not work on 31 July 2017. He then worked on 1 August 2017 in the afternoon at Homerton Hospital and then did the night shift at West Middlesex.

72. The Tribunal also had the benefit of Dr Ismail's work record. This showed that he had neither worked at Kings College Hospital in the period leading up to this allegation, nor had he worked for 72 hours straight. The Tribunal considered that this cast some doubt on the recollections of Dr B and Dr E about what had been said at that morning meeting.

73. The Tribunal also noted that, whilst Dr E was somewhat insistent about what had been said, the first time he had been asked to recall what had been said was some time later on 30 August 2017. Dr B had recorded his own recollections much closer in time to the conversation, but in his evidence, he accepted that what had been said may have

been mistaken or misunderstood. The Tribunal heard evidence that there was a considerable amount of general discussion at the hospital about Dr Ismail on that morning because of the allegations that he had not been contactable, and that there appear to have been several different allegations being made, as the Tribunal has noted above. For example, in Dr B's witness statement he said he was told that Dr Ismail was found asleep in contrast to the documentary evidence that security had no record or recollection of such an incident. The Tribunal considers that both Dr B and Dr E may have been unduly influenced by some of what was being said and that this may have impacted on their recollections.

74. The Tribunal decided that it was entirely plausible that Dr Ismail spent much of the night in question in A&E. This was accepted by Dr B and the Tribunal noted there is no evidence to the contrary. The Tribunal also noted Dr Ismail's open and frank explanation of the how he spent the days before he went on duty that night. It decided that it was not inevitable that Dr Ismail would be so tired that sleep whilst on duty was likely. The Tribunal therefore found that it could not be satisfied, on the balance of probabilities, that Dr Ismail was asleep as alleged.

75. Accordingly, the Tribunal found paragraph 3b, not proved.

Paragraphs 4a, 4b(i) and 4b(ii)

76. The Tribunal's findings about these allegations followed from its findings relating to the previous allegation.

77. The Tribunal has found it not proved that Dr Ismail was asleep. It follows that his denial that he was asleep was not untrue.

78. Accordingly, the Tribunal found paragraph 4a, not proved.

79. For the same reasons given in paragraph 3b, the Tribunal was not satisfied on balance that Dr Ismail told Dr B that he was asleep.

80. Accordingly, the Tribunal found paragraph 4b(i), not proved.

81. For the same reasons given in paragraph 3b, the Tribunal was not satisfied, on the balance of probabilities, that Dr Ismail told Dr B the reason for him being asleep during his shift was because he had worked 72 hours straight as he had done shifts at Kings College Hospital. The Tribunal could not find this to be untrue when it was not satisfied it had been said.

82. Accordingly, the Tribunal found paragraph 4b(ii) not proved.

Paragraph 5

83. As the Tribunal has found paragraph 4 not proved it follows that paragraph 5 could not be found proved. Accordingly, the Tribunal found paragraph 5 not proved.

Paragraph 6

84. As the Tribunal found paragraph 4 not proved it follows that paragraph 6 could not be found proved. Accordingly, the Tribunal found paragraph 6 not proved.

Paragraphs 7a(i), 7a(ii) and 7b(i)

85. The Tribunal noted that there was no dispute between parties that Dr Ismail had worked at both Homerton and West Middlesex Hospitals between 1 August and 3 August 2017.

86. The Tribunal noted the document (referred to under paragraph 3b of the Allegation above) produced by Mr J, which confirms the shifts Dr Ismail was booked for. The Tribunal was satisfied, and the parties agreed, that the 'list of shifts' document was an accurate reflection of Dr Ismail's locum shifts.

87. The Tribunal noted that the list of shifts document confirmed that Dr Ismail worked:

- at West Middlesex Hospital on 1 August 2017 from 20:00 to 10:00 comprising 13.30 hours work (allowing for a half hour break);
- at the same hospital on 2 August 2017 from 20:00 to 09:00 comprising 12.30 hours (allowing for the break); and
- at Homerton Hospital on 1 August 2017 from 13:00 to 18:00 comprising 4.30 hours work (allowing for the break).

88. The Tribunal accepted Dr Ismail's evidence that his agency insisted that he took a 30 minute break during each shift. The thirty-minute break is also indicated on Dr Ismail's timesheets.

89. Accordingly, the Tribunal found paragraphs 7a(i), 7a(ii), 7b(i) proved.

Paragraph 7b(ii)

90. The Tribunal noted that it is alleged in paragraph 7b(ii) that Dr Ismail worked at Homerton Hospital on '2 August 2017 from 13:00 to 18:00'. However, the Tribunal noted the list of shifts document states that Dr Ismail worked from 1.30pm to 6.30pm, equalling 4 hours and 30 minutes, after allowing for a thirty minute break.

91. The Tribunal bore in mind that the GMC did not make an application to amend the times in paragraph 7b(ii) to reflect the information in the list of shifts document.

92. The Tribunal and parties accepted that the list of shifts is an accurate reflection of the hours that Dr Ismail worked at Homerton Hospital on 2 August 2017. The hours listed are from '13.30 to 18.30'.

93. Accordingly, the Tribunal found paragraph 7b(ii) not proved.

Paragraph 8

94. The Tribunal found that the period in which Dr Ismail worked was from 13.00 hrs on 1 August 2017 until 09.00 hrs on 3 August 2017. This is a 44 hour period. Taking into account the 30 minute breaks, the Tribunal found that the total hours Dr Ismail worked in this period over the four shifts was 35 hours. This is not the 37 hours alleged and therefore factually paragraph 8 was not proved.

95. In any event the Tribunal then considered whether working either 35 or 37 hours in a 44 hour period was unsafe. The Tribunal noted that it has not been provided with any criteria which shows the maximum numbers of hours it is safe for a doctor to work. The Tribunal noted the evidence from Dr Ismail and some of the other witnesses that it is not uncommon for doctors to work very long hours.

96. The Tribunal did not consider working 35 hours in a 44 hour period to be inherently unsafe. Dr L was not asked to comment specifically about this. He was only asked to comment about working 72 hours straight, which the Tribunal considered significantly different from what this paragraph alleges.

97. The Tribunal then considered the question of safety in the context of what Dr Ismail was doing around the period in question. His evidence, which was not significantly challenged, was that he had not worked for several days prior to working the 35 hours. The Tribunal also accepted his evidence that when he did feel tired after working on 1 and 2 August, he cancelled his next shift. The Tribunal concluded that Dr Ismail was aware of the limits of what hours he should work and when it was safe or unsafe to do so.

98. For these reasons, the Tribunal could not conclude on balance that it was unsafe for Dr Ismail to have worked either 35 or 37 hours in the 44 hour period alleged.

99. Accordingly, the Tribunal found paragraph 8 not proved.

Paragraph 9a and 9b

100. Dr Ismail admitted paragraphs 9a and 9b and the Tribunal found them proved.

Paragraphs 10a(i) and 10a(ii)

101. The Tribunal accepted Dr Ismail's evidence that timesheets could be signed by either a consultant or a rota coordinator, and did not have to be approved by a consultant. This was confirmed by Dr C. In submissions, Mr Rigby accepted this explanation.

102. Accordingly, the Tribunal found paragraphs 10a(i) and 10a(ii) not proved.

Paragraph 10b

103. Dr Ismail admitted paragraph 10b and the Tribunal found it proved.

Paragraph 11 in relation to paragraphs 10a(i) and 10a(ii)

104. The Tribunal found paragraphs 10a(i) and 10a(ii) not proved therefore paragraph 11 falls in relation to these paragraphs.

Paragraph 11 in relation to paragraphs 10b

105. Dr Ismail admitted paragraph 11 in relation to paragraph 10b and the Tribunal found it proved.

The Tribunal's Overall Determination on the Facts

106. The Tribunal has determined the facts as follows:

1. On or around 23 July 2017 you consulted with Patient A and you:

   a. failed to take a history from Patient A;
   Not proved

   b. failed to examine Patient A;
   Not proved

   c. told Patient A that he may have gangrene to his penis *or his groin*, when this was not clinically indicated;
   Not proved (as amended)

   d. failed to make an adequate record of your consultation in Patient A's records.
   Not proved

2. On 24 July 2017 your handover of Patient A was inadequate in that you told your orthopaedic colleagues the wrong mechanism of Patient A's injury.
Not proved

3. On or around 2 August 2017, during a night shift, you were:

   a. not contactable by telephone or bleeper;
   Not proved

   b. asleep.
   Not proved

4. On 2 August 2017, following the night shift you:

   a. told Dr B that you had not been asleep during your shift when this was untrue;
   Not proved

b. then told Dr B that:

i. you had been asleep during your shift;
Not proved

ii. the reason for you being asleep during your shift was because you had worked 72 hours straight as you had done shifts at Kings College Hospital, when this was untrue.
Not proved

5. You knew the statements you made as set out at paragraph 4 were untrue.
Not proved

6. Your actions at paragraph 4 were dishonest by reason of paragraph 5.
Not proved

7. Between 1 August 2017 and 3 August 2017 you worked at:

a. West Middlesex Hospital on:

i. 1 August 2017 from 20:00 until 10:00 on 2 August 2017;
Determined and found proved

ii. 2 August 2017 from 20:00 until 09:00 on 3 August 2017;
Determined and found proved

b. Homerton Hospital on:

i. 1 August 2017 from 13:00 until 18:00;
Determined and found proved

ii. 2 August 2017 from 13:00 until 18:00.
Not proved

8. You worked 37 hours in a 44 hour period as detailed in paragraph 7, when it was unsafe to do so.
Not proved

9. You submitted a timesheet dated 3 August 2017 for work done at West Middlesex Hospital which was:

a. not signed by a consultant;
Admitted and found proved

b. completed to give the impression that it had been approved by Dr C.
Admitted and found proved

10. You knew that prior to submitting the timesheet described at paragraph 9 above:

a. a consultant had to:

i. sign it;
Not proved

ii. approve it;
Not proved

b. that it contained a false signature.
Admitted and found proved

11. Your actions as described at paragraph 9 were dishonest by reason of paragraph 10.
Not proved in relation to paragraph 10a
Admitted and found proved in relation to paragraph 10b

Determination on Impairment - 13/02/2020

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Ismail's fitness to practise is impaired by reason of misconduct.

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

3. The Tribunal reminded itself that at the facts stage Dr Ismail admitted, and the Tribunal found proved, that he submitted a timesheet dated 3 August 2017 for locum work done at West Middlesex Hospital. It was not signed by a consultant and was completed to give the impression that it had been properly approved, that he knew that prior to submitting the timesheet that it contained a false signature, and that these actions were dishonest. The Tribunal has referred to these findings as 'the 2017 allegations'.

4. In addition, the Tribunal received further evidence as follows. On behalf of the GMC from the following documents:

- Impairment and Sanction determinations from Dr Ismail's MPT hearing in January 2018
- Transcript of Day two of Dr Ismail's MPT hearing dated 30 January 2018
- Record of Determinations from Dr Ismail's MPT Review hearing in November 2018

5. Dr Ismail provided his own statement of reflection dated 25 January 2020.

6. The Tribunal also received in support of Dr Ismail a number of positive testimonials from colleagues, all of which it has read. The Tribunal had regard to the documentary evidence provided by Dr Ismail. The documents included, but were not limited to:

- Dr Ismail's statement of reflection dated 25 January 2020
- Dr Ismail's Curriculum Vitae
- Email from Mr J, MyLocum dated 14 August 2017
- Page 31 of the transcript from Dr Ismail's MPT Hearing dated 29 January 2018
- Certificates from courses Dr Ismail had completed
- MMDUS Course *'Professionalism: fulfilling your duties as a doctor'* on 21 January 2020
- Email from Ms O, Course Administrator, confirming Dr Ismail's attendance on the *Professionalism: fulfilling your duties as a doctor'* course on 21 January 2020
- Patient feedback forms
- Email from Dr Ismail to Dr P dated 18 December 2019

7. The Tribunal noted that there had been a Medical Practitioners Tribunal (MPT) hearing in January 2018 at which Dr Ismail admitted and the Tribunal found proved that on or around 7 October 2016 he submitted time sheets for work done at Whittington Health NHS Trust which were not signed by a consultant but gave the impression that they had been approved by a consultant. Dr Ismail also admitted, and the same Tribunal found proved, that on or around 11 October 2016 he completed a false reference. Dr Ismail also admitted, and the Tribunal found proved, that his actions were dishonest. The Tribunal has referred to these findings as 'the 2016 allegations'

8. The Tribunal noted that the January 2018 Tribunal found Dr Ismail's fitness to practise was impaired and imposed a suspension of nine months.

9. The Tribunal further noted that at a hearing in November 2018, an MPT reviewed Dr Ismail's suspension and found that his Fitness to Practise was no longer impaired. The November 2018 Tribunal revoked Dr Ismail's suspension with immediate effect, which was around four weeks before the time when it would have otherwise expired.

10. The Tribunal noted that Dr Ismail's statement of reflection set out the steps he has taken, both during and following the period of suspension imposed in January 2018, to remediate and to show that he has developed insight into his dishonest behaviour.

11. The Tribunal was not presented with any oral evidence. The parties indicated that they wished to make submissions only.

Mr Rigby's Submissions

12. On behalf of the GMC, Mr Rigby submitted that Dr Ismail's Fitness to Practise remains impaired based on the facts admitted and found proved in this case but also the previous matters determined in January 2018, for which Dr Ismail's registration was suspended. Mr

Rigby reminded the Tribunal of the two-stage process the Tribunal should adopt when considering impairment.

13. Mr Rigby stated that when the 2018 Tribunal considered the 2016 allegations, the Tribunal was not aware of the 2017 allegations which are the subject of these proceedings, nor was the November 2018 Tribunal aware of the 2017 allegations when it reviewed the suspension. This was because the 2017 allegations were still under investigation and had not proceeded to a hearing at that time. Mr Rigby stated that it cannot be known whether the January 2018 Tribunal would have imposed a more serious penalty had they known of the additional matter of the 2017 allegations, or if the reviewing Tribunal would have found that Dr Ismail's Fitness to Practice was no longer impaired if it had been able to take into account that additional matter.

14. Mr Rigby submitted that the gravamen of the 2017 allegations are that Dr Ismail deliberately falsified a signature on a timesheet, the contents of which may have been otherwise true, but they were not properly authorised, and that the timesheet was then submitted for payment. He submitted that the circumstances of the 2016 allegations were very similar in that they related to the dishonest submission of a timesheet which was not properly authorised, as well as the submission of a false reference. He pointed out that initially Dr Ismail did not admit the 2016 allegations, although at the January 2018 hearing he did admit the actions and that he had been dishonest.

15. Mr Rigby submitted that both sets of allegations involve the same activity and the same dishonesty. Mr Rigby submitted that these actions demonstrate a potential to be dishonest especially when under stress.

16. Mr Rigby noted that the January 2018 Tribunal had referred to paragraphs 65 and 68 and 71 of Good Medical Practice (the GMP), which are relevant to the matters now being considered by the Tribunal. These paragraphs state:

> *'65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> *68 You must be honest and trustworthy in all your communication with patients and colleagues….*
>
> *71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.*
>
> *a You must take reasonable steps to check the information is correct.*
>
> *b …'*

17. Mr Rigby noted that the January 2018 Tribunal found that honesty was a fundamental tenet of the profession. He submitted that it is almost presumptive that dishonesty results in a finding of impairment. He referred the Tribunal to *General Medical Council v Dr Iheanyi*

Chidi Nwachuku [2017] EWHC 2085 (Admin), ("*Nwachuku*") which, he said involved a similar case in which dishonesty about timesheets was involved. He pointed out that the Court in *Nwachuku* found that the Tribunal was wrong to find that doctor's Fitness to Practice was not impaired.

18. In particular, Mr Rigby referred the Tribunal to paragraphs 45-50 in *Nwachuku* which state:

> *'45.Dishonesty encompasses a very wide range of different facts and circumstances. Any instance of it is likely to impair a professional person's fitness to practise: R (Hassan) v General Optical Council [2013] EWHC 1887 per Leggatt J at paragraph [39].*
>
> *46. Dishonesty constitutes a breach of a fundamental tenet of the profession of medicine: PSA v GMC & Igwilo [2016] EWHC 524. A finding of dishonesty lies at the top end in the spectrum of gravity of misconduct: Patel v GMC Privy Council Appeal No.48 of 2002.*
>
> *47. A finding of impairment does not necessarily follow upon a finding of dishonesty. If misconduct is established, the tribunal must consider as a separate and discrete exercise whether the practitioner's fitness to practise has been impaired: PSA v GMC and Uppal [2015] EWHC 1304 at paragraph [27].*
>
> *48. However, it will be an unusual case where dishonesty is not found to impair fitness to practise: PSA v Health and Care Professions Council & Ghaffar [2014] EWHC 2723 per Carr J at paragraphs [45] and [46].*
>
> *49. The attitude of a practitioner to the allegations made and any admissions of responsibility for the misconduct will be taken into account as relevant factors in determining whether or not fitness to practise has been impaired: Nicholas-Pillai v GMC [2009] EWHC 1048 per Mitting J at paragraph [18].*
>
> *50. The overarching concern is the public interest in protecting the public and maintaining confidence in the practitioner and medical profession when considering whether the misconduct in question impairs fitness to practise: Yeong v GMC [2009] EWHC 1923 per Sales J at paragraphs [50] and [51]; Nicholas-Pillai (above) at paragraph [27]:*
>
> > *"In cases of actual proven dishonesty, the balance ordinarily can be expected to fall down on the side of maintaining public confidence in the profession by a severe sanction against the practitioner concerned. Indeed, that sanction will often and perfectly properly be the sanction of erasure, even in the case of a one-off instance of dishonesty."*

19. Mr Rigby submitted that public confidence in the profession, which is central to the Tribunal's decision, would be undermined if a finding of impairment was not made.

Mr Watkins Submissions

20. On behalf of Dr Ismail, Mr Watkins agreed that the Tribunal had to adopt a two-stage process. He accepted that Dr Ismail's conduct amounted to serious misconduct and was a departure from paragraphs 68 and 71 in the GMP. Mr Watkins submitted that it is important to note that the second stage is concerned with whether the doctor's fitness to practise is impaired now. He submitted that Dr Ismail's fitness to practise is not currently impaired.

21. Mr Watkins also referred the Tribunal to the case of *Nwachuku*. He submitted that the case did not state that there is a presumption of impairment when dishonesty is involved. Although it was said that any instance of dishonesty is *'likely to impair a professional person's fitness to practice"* , and that "*it will be an unusual case where dishonesty is not found to impair fitness to practise'*, it was also confirmed that a *"finding of impairment does not necessarily follow upon a finding of dishonesty'.*

22. Mr Watkins referred the Tribunal to the case of *The Professional Standards Agency and Social Care v The General Medical Council, Mr Andrew Hilton [2019] EWHC (Admin)* (*Hilton)* in which it was decided that a Tribunal had not acted unreasonably in finding that dishonesty did not amount to impairment. Mr Watkins acknowledged that each case is fact sensitive and that there was nothing in *Hilton* to suggest that the principles set out in *Nachukwa* are not to be applied.

23. Mr Watkins submitted that this was an 'unusual' case in which impairment need not be found because of the cumulative effect of three factors: the nature of the misconduct; the chronology, involving the overlap of the previous proceedings with these and the passage of time since the misconduct; and the impact of the proceedings on Dr Ismail as shown by his insight and efforts to remediate.

24. Regarding the misconduct subject of these proceedings, Mr Watkins submitted that there was a discrete limited act of dishonesty rather than a course of conduct and it was not for financial gain. He said that the dishonest conduct was essentially an administrative shortcut taken by Dr Ismail with the view to getting paid earlier than might have been the case, and not to obtain monies to which he was not entitled.

25. Mr Watkins stressed the circumstances at the time which were that Dr Ismail had financial difficulties, and was under considerable personal stress. XXX His relationships with colleagues were strained and he was accused of being asleep on the morning he was due to have the timesheet signed. It was against this backdrop that Dr Ismail's had falsified the timesheet. This was not a dishonest act impacting directly on the public which would directly endanger the public's trust. Nevertheless, Mr Watkins accepted that Dr Ismail's dishonesty amounted to serious misconduct. Mr Watkins reminded the Tribunal that Dr Ismail admitted his dishonesty at the outset of this hearing.

26. Regarding chronology, Mr Watkins reminded the Tribunal that the misconduct took place two and a half years ago in August 2017, at a time when Dr Ismail was not aware of the nature of the GMC's investigations into the 2016 allegations. He first became aware of those earlier allegations on or around 18 August 2017 when he received an introductory email from Ms Q, GMC Legal Advisor, explaining she would be the contact for the

proceedings into the 2016 allegations. This was after the misconduct on 3 August 2017 which this Tribunal is now dealing with.

27. Mr Watkins reminded the Tribunal that there were then two Tribunal hearings concerning the 2016 allegations, in January 2018 and November 2018. At neither did GMC inform the Tribunal of the then outstanding 2017 allegations even though Ms Q was the GMC caseworker for both cases.

28. Mr Watkins submitted that the chronology of these matters works in Dr Ismail's favour. Firstly, he used the suspension period well by doing voluntary clinical work in Lebanon as shown by the positive reference and the oral evidence given by Dr R at the review hearing. Secondly, he has used the time since the suspension was removed productively by working and undertaking continuing professional development as shown by the evidence which has been presented in the form of positive references, evidence of Continuing Professional Development (CPD) and patient feedback.

29. Regarding the impact of the proceedings on Dr Ismail, Mr Watkins referred the Tribunal to Dr Ismail's statement of reflection, in which he accepts that he has let his colleagues and the profession down. He has attended a professional ethics course *'Professionalism: fulfilling your duties as a doctor'* and received positive feedback from the course administrator, Ms O. Mr Watkins also referred the Tribunal to the various references which have been provided which show that Dr Ismail has been candid with his colleagues about these proceedings.

30. In conclusion, Mr Watkins acknowledged that any dishonesty raises concern, but he submitted that the facts of the dishonesty, the previous sanction, Dr Ismail's response to that sanction, his subsequent conduct, and his remorse and reflection, are all factors which cumulatively demonstrate that this is an 'unusual' set of circumstances such that it is not necessary in the public interest to find Dr Ismail's fitness to practise impaired.

The Relevant Legal Principles

31. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

32. The Tribunal reminded itself that it's over-arching role is the protection of the public, of which there are three limbs:

- protecting the safety and well-being of the public,
- maintaining public confidence in the medical profession, and
- upholding proper professional standards and conduct for members of the profession.

33. The Tribunal reminded itself of the two-stage process to be adopted. First, whether the facts proved amount to serious misconduct. Second, whether the doctor's fitness to practise is currently impaired by reason of the serious misconduct.

34. In considering current impairment, the Tribunal reminded itself that it must take into account the conduct in question in these proceedings, and any other relevant factors, such as conduct in the past, whether the misconduct is remediable, has been remedied, and the likelihood of repetition.

35. The Tribunal reminded itself that conduct involving dishonesty can be difficult, although not impossible, to remediate. It reminded itself that in caselaw (including *Nachukwa* to which it was referred) it has been stated that (i) it will be an unusual case where dishonesty is found not to impair fitness to practice and (ii) in dishonesty cases, it is particularly important for the Tribunal to place the second and third limbs of the overriding objective in the balance.

Misconduct

36. The Tribunal noted that Dr Ismail accepted that his dishonesty amounted to misconduct which was serious.

37. The Tribunal considered that Dr Ismail's dishonesty, in signing and submitting a timesheet, breached the trust of his colleagues at the hospital where he was working at the time, and his locum agency. The Tribunal noted that Dr Ismail was under significant personal stress and financial pressure at the time and that these factors may have had an impact on his judgement.

38. The Tribunal was satisfied that Dr Ismail's primary motivation was not to obtain payment for work to which he was not entitled. The circumstances at the time were that Dr Ismail had been asked to leave the hospital immediately. Because of his strained relationship with his colleagues that morning, he felt unable to approach them to approve his timesheet. There was also a requirement for him to submit the timesheet to the locum agency by lunchtime, if he was to be paid by that week.

39. In doing so, he chose to put his own interests above the interests of others and above his professional duties as a medical practitioner. Dr Ismail now accepts that his actions were completely unacceptable.

40. The Tribunal considered that Dr Ismail's conduct represented a departure from the expected standards of conduct and behaviour relating to honesty and integrity referred to in paragraphs 65, 68 and 71 of GMP.

41. The Tribunal concluded that Dr Ismail's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct.

Impairment

42. The Tribunal having found that the facts found proved amounted to serious misconduct, went on to consider whether, as a result of that misconduct, Dr Ismail's fitness to practise is currently impaired.

43. In doing so, the Tribunal considered the context in which the misconduct occurred as demonstrated by the chronology of significant events which, on the evidence before it, was as follows.

44. XXX

45. In October 2016, Dr Ismail dishonestly submitted the timesheet and a reference which resulted in the 2016 allegations.

46. In December 2016, XXX. He was informed by the GMC that they were taking action against him for failing to engage with the GMC appraisal and revalidation process. The Tribunal considered this to be a reflection of the personal and domestic pressures Dr Ismail was under at the time.

47. XXX

48. In August 2017, Dr Ismail dishonestly submitted the timesheet which is the subject of these proceedings. Shortly afterwards, he became aware that proceedings were being taken for the 2016 allegations.

49. In September 2017, Dr Ismail had a hearing concerning his GMC appraisal. He voluntarily agreed to come off the GMC Register until he had completed the GMC appraisal process.

50. On an unknown date between August 2017 and the Tribunal hearing in January 2018, Dr Ismail spoke to an employee at the GMC, possibly Ms Q, GMC Legal Advisor. He enquired whether the 2017 allegations could be heard by the January 2018 Tribunal at the same time as the 2016 allegations. He was told that the matters would be considered separately.

51. In January 2018 at the MPT hearing, Dr Ismail admitted the 2016 allegations, his fitness to practise was found to be impaired and he was suspended for nine months. The 2018 Tribunal did not order a review of the suspension. The 2018 Tribunal was not made aware of the 2017 allegations.

52. Between March 2018 and November 2018, Dr Ismail worked voluntarily as a doctor in Lebanon.

53. On 9 November 2018, the Tribunal reviewed Dr Ismail's suspension. This was at the request of the GMC. The 2018 Review Tribunal decided that Dr Ismail was no longer impaired and revoked the suspension with immediate effect. The Tribunal was not made aware of the 2017 allegations.

54. The 2018 Review Tribunal heard oral evidence from Dr R in Lebanon about the role Dr Ismail had undertaken there. It was satisfied that Dr Ismail had undertaken a clinical attachment diligently every week, for five days each week, including observations of ward rounds, theatres and clinics. The 2018 Review Tribunal noted that Dr R described himself as impressed with Dr Ismail's knowledge and of his articulation of his skills, and

that Dr R considered Dr Ismail to be fit to practise. The 2018 Review Tribunal also noted that Dr Ismail had completed a large amount of formal CPD training.

55. The 2018 Review Tribunal determined:

> *'18. Reflecting upon these matters, while the Tribunal considered that misconduct remained engaged in relation to Dr Ismail, it considered that this practitioner had complied with the period of suspension, and the public and the profession would find this sufficient. Consequently, the Tribunal determined that his fitness to practise was not currently impaired by reason of this.*
> *…*
>
> *23. Overall, therefore, having considered all the evidence, the Tribunal determined that Dr Ismail has kept his clinical skills and knowledge up to date, and his return to medical practice would not put patients at an unwarranted risk of harm. The Tribunal therefore determined that Dr Ismail's fitness to practise is not currently impaired by reason of his misconduct.'*

58. In June 2019 Dr Ismail began to practise again, following the completion of DBS checks. Since then he has worked as a locum doctor in different locations. The Tribunal has received several positive references relating to this work from referees who are aware of the 2016 and 2017 allegations and the proceedings before this Tribunal. The Tribunal accepted that he has been candid and open about them. The Tribunal identified a theme running through all the testimonial which shows Dr Ismail to be open, reliable, conscientious and a good hard working doctor.

59. The central issue in this case is the public interest in the promotion and maintenance of public confidence in the medical profession and the promotion and maintenance of proper professional standards and conduct in that profession. Doctors occupy a position of privilege and trust. They are expected to act in a manner which maintains public confidence in them and in the medical profession and to uphold proper standards of conduct.

60. In Bolton v Law Society [1994] 1 WLR 512 at [519], and in the Sanctions Guidance it is made clear that the reputation of the profession is more important than the interests of any individual doctor. In Bolton reference was made to the *'need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness'.* This equally applies to doctors.

61. The Tribunal recognises that dishonesty is a breach of a fundamental tenet of the profession. Being honest and trustworthy and acting with integrity are at the heart of medical professionalism. Dishonesty is difficult to remediate. In Nicholas-Pillai v GMC [2009] EWHC 1048 (Admin) it was said that the normal consequence of a finding of dishonesty is a severe sanction, often erasure, even in the case of a one-off instance. *Nwachuku*, to which this Tribunal has already referred confirms this approach.

62. Nevertheless, case law does envisage circumstances in which a finding of impairment need not necessarily follow a finding of dishonesty in unusual or exceptional cases. This was apparent in both *Nwachuku*, and *Hilton* to which the Tribunal was referred and, for example, PSA v Nursing & Midwifery Council [2017] CSIH 29, in which the Court stated at paragraph 27:

> *'Not every case of misconduct will result in a finding of impairment. An example might be an isolated error of judgment which is unlikely to recur, and the misconduct is not so serious as to render a finding of impairment plainly necessary. On the other hand, misconduct may be so egregious that, whatever mitigatory factors arise in respect of insight, remediation, unlikelihood of repetition, and the like, any reasonable person would conclude that the registrant should not be allowed to practise on an unrestricted basis, or at all. In such a case, to have been guilty of misconduct of such a nature is itself clear evidence that the practitioner should not be allowed to practise, or to practise unrestricted; and the public interest will point to a finding of impairment, and the imposition of an appropriate sanction. On the other hand, as one judge observed:*
>
> > *'[T]he [practitioner's] misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct." (Cheatle v General Medical Council, Cranston J, para 22).*

63. The Tribunal has borne in mind that Dr Ismail was dishonest on two separate occasions relating to his timesheets, almost one year apart from each other, and that this might be seen as an aggravating feature of his misconduct. On the first occasion, in 2016, there was a second element to the dishonesty in that a false reference was submitted as well as false timesheets, but in 2017 there was only one allegation relating to a single timesheet.

64. The Tribunal considered, however, that on both occasions, the context in which the dishonesty occurred were similar, namely the domestic and financial pressures being faced by the doctor. XXX In addition, on the morning the dishonest timesheet was completed, he was also facing serious professional allegations from his colleagues at the hospital. These allegations were those before this Tribunal at the facts stage and none were proved.

65. The Tribunal does not suggest that these external pressures excuse his dishonest conduct on either occasion, nor, indeed, does Dr Ismail. They do, however, provide the context in which the dishonesty occurred, a context which the Tribunal considered that Dr Ismail has now resolved and put behind him. The Tribunal considered this to be a factor in reducing the risk of repetition.

66. The Tribunal considered the degree of insight demonstrated by Dr Ismail. It noted his full admissions and accepted that Dr Ismail's apology was genuine.

67. The Tribunal noted Dr Ismail attended an MMDUS Course *'Professionalism: fulfilling your duties as a doctor'* on 21 January 2020. The course content consisted of:

> *'This training course focusses on key areas of professionalism which doctors encounter daily, both at work and in their private lives. The aim is for delegates to develop a greater understanding of their medico-legal responsibilities and the common areas in which doctors can find themselves in difficulty throughout their career.*
>
> *Increase awareness of responsibilities in relation to professionalism. Understand how to identify and mitigate personal and professional regulatory risks including: personal and professional boundaries; ending professional relationship; personal conduct; raising concerns about self and others; and regulatory, contractual and legal duties of candour.*
>
> *Participants are able to identify, assess and manage scenarios where demonstrating professionalism is important to avoiding regulatory or legal scrutiny.'*

68. The Tribunal took account of the email dated 27 January 2020 from Ms O, Course Administrator, in which she stated:

> *'Ali attended the full course which ran from 10am-4pm. He actively participated across all of the topics which included candour, raising and responding to patient safety concerns, professional conduct, boundaries and ending patient doctor relationships. The course included group discussion and Ali, along with other delegates, reviewed cases within each area of the course content, where a doctor had found themselves in difficulty. He shared anonymised personal examples which were helpful in widening out the issues being discussed. On several occasions Ali reflected on how he responded to similar scenarios, but would approach these situations differently as a result of the learning. Speaking to Ali at the breaks I believe he has obtained new insight into some of the pitfalls doctors can find themselves in trying to maintain professional and ethical integrity across their working and personal lives.'*

69. The Tribunal noted Dr Ismail's statement of reflection in which he acknowledges the damage to the reputation of the profession and the risk to patients if they are not able to trust doctors.

70. The Tribunal considered that Dr Ismail has reflected on his conduct and behaviour. Even though the 2018 Review Tribunal found that Dr Ismail had sufficient insight, he has continued to reflect on his behaviour and its impact on public confidence in the profession. He has continued to develop his insight, which is now at a high level.

71. The Tribunal considered it unlikely that Dr Ismail would act dishonestly in the future and the risk of repetition is low. Indeed, by the time of the 2018 Review Tribunal, Dr Ismail had developed a workable strategy to enable him to deal with pressures in a completely different way.

72. The Tribunal went on to consider other factors of the case, as follows.

73. The similar nature of Dr Ismail's dishonesty and the similar nature of the personal domestic and financial pressures which existed at the time of both instances of dishonesty. Dr Ismail received no money to which he was not entitled in either case. The dishonesty was at the lower end of end spectrum of the dishonesty.

74. Dr Ismail's admission of dishonest conduct in both sets of proceedings at the earliest opportunity.

75. The 2018 Review Tribunal determined that Dr Ismail's original dishonest misconduct had been sufficiently remediated to revoke the suspension with immediate effect.

76. At the January 2018 Tribunal there was an opportunity to bring both sets of allegations to the attention of the Tribunal so that they could be considered together. This opportunity was not taken by the GMC, notwithstanding that Dr Ismail had asked it to consider doing so. In November 2018, at the instigation of the GMC, the 2018 Review Tribunal again considered the 2016 allegations in isolation, whilst the investigation into the 2017 allegations was still ongoing.

77. In summary, the Tribunal considered the cumulative effect of: Dr Ismail's admissions of the 2016 and 2017 allegations; his acceptance of personal responsibility for them; his remediation during and since his period of suspension; his continuing personal development; and his clinical work since June 2019. The Tribunal considered it to be significant that these all occurred after the 2017 allegation. The Tribunal determined the cumulative effect to be unusual because of the nature of the misconduct, the chronology of events and the extent of the remorse, reflection and remediation.

78. The Tribunal considered whether, in any event, a finding of impairment is required to uphold the wider public interest. The Tribunal therefore considered whether the public interest is best served by a further finding of impairment for Dr Ismail, or allowing him to continue to practise as a fully remediated, insightful, and clinically competent doctor.

79. The Tribunal determined that this is one of those unusual cases where a finding of impairment is not required. This is not a case where the trust of patients, the public and the medical profession would be undermined by not finding Dr Ismail's fitness to practise to be impaired.

80. Accordingly, the Tribunal determined that Dr Ismail's fitness to practise is not impaired by reason of his misconduct.

Determination on a Warning - 14/02/2020

1. As the Tribunal determined that Dr Ismail's fitness to practise was not impaired it considered whether in accordance with s35D(3) of the 1983 Act, a warning was required.

Mr Rigby's Submissions

2. On behalf of the GMC, Mr Rigby reminded the Tribunal that there were two acts of dishonesty. Dr Ismail's misconduct was dishonest and it would dismay the profession and the public if a second act of dishonesty was not marked in some way. He reminded the Tribunal of paragraph 16, 19 and 20 of the GMC's *'Guidance on Warnings'*, (the Guidance) which state:

> *'16 A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:*
>
> - *there has been a significant departure from Good medical practice,*
>
> *or*
>
> - *there is a significant cause for concern following an assessment of the doctor's performance.*
>
> *19 Once the decision makers are satisfied that the doctor's fitness to practise is not impaired, they will need to consider whether the concerns raised are sufficiently serious to require a formal response from the GMC or MPTS tribunals, by way of a warning.*
>
> *20 The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.*
>
> *a There has been a clear and specific breach of Good medical practice or our supplementary guidance.*
>
> *b The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor's fitness to practise has not been found to be impaired.*
>
> *c. A warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely relating to a doctor's health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.*

d There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).'

3. Mr Rigby submitted that factors a, b, c and d apply in this case and that this is a case that falls 'close to the border' of impairment.

4. Mr Rigby referred the Tribunal to paragraph 24 of the guidance which states:

'Dishonesty
24 There is a presumption that the GMC should take some action when the allegations concern dishonesty. There are, however, cases alleging dishonesty that are not related to the doctor's professional practice and which are so minor in nature that taking action on the doctor's registration would be disproportionate. A warning is likely to be appropriate in these cases. An example of this might include, in the absence of any other concerns, a failure to pay for a ticket covering all or part of a journey on public transport.'

5. Mr Rigby referred the Tribunal to paragraph 118 onwards in the case of *Hilton* (to which it had been referred at the impairment stage), in which it was found that a warning should have been given because it was lenient to allow that doctor, who had also been dishonest, to escape without some record of his misconduct. He submitted that in this case, unlike in *Hilton,* there was an element of repetition the dishonest conduct which required the imposition of a warning to maintain public confidence.

Mr Watkins Submissions

6. On behalf of Dr Ismail, Mr Watkins submitted in the particular facts of this case it is not necessary to direct a warning. He reminded the Tribunal that the guidance on warnings is just guidance and each individual case must be decided on facts.

7. He submitted that the unusual features of this case are the 2018 proceedings, when Dr Ismail was suspended for misconduct very similar to that before this Tribunal. Mr Watkins acknowledged that paragraphs 20a, 20b and 20c of the guidance are engaged. In relation to paragraph 20d, Mr Watkins stated that it is not necessary or proportionate to record the further dishonesty by issuing a warning. He stated that Dr Ismail's fitness to practise history is available on the GMC website and disclosable to future employers.

8. Mr Watkins stated that Dr Ismail leaves this hearing with the very clear endorsement from the hearings in 2018. He submitted that the public would not be *'let down'* or *'deceived'* if this single act of dishonesty does not result in a warning. He submitted that it is not necessary or proportionate to issue a warning.

The Tribunal's Determination on Warning

9. In considering whether or not to issue a warning, the Tribunal followed the Guidance. The Tribunal noted in particular, those paragraphs referred to by the parties.

10. The Tribunal was not in a position to determine what the 2018 Tribunals might have done had they known about Dr Ismail's second act of dishonesty. The 2018 Tribunals were not aware of the second act of dishonesty and took no account of it. It is only this Tribunal, that has been in a position to consider Dr Ismail's further instance of dishonesty.

11. The Tribunal was mindful of its determination that Dr Ismail's fitness to practise is not impaired and the various factors it considered in reaching that conclusion, for example, the high level of insight, the low risk of repetition and the various testimonials provided.

12. Nevertheless, the Tribunal was of the opinion that Dr Ismail's misconduct was serious. In considering a warning the Tribunal was of the view that the aggravating factor in this case is that Dr Ismail's misconduct was a second separate act of dishonesty.

13. The Tribunal was satisfied that all of the factors in paragraph 20 are engaged in this case. The Tribunal determined that marking the seriousness of Dr Ismail's dishonesty is appropriate and proportionate. Whilst the Tribunal accepted the risk of repetition was low, that risk cannot be entirely ruled out, and the consequences of any repetition by Dr Ismail would be likely to result in a finding of impaired fitness to practise.

14. The Tribunal was satisfied that it is appropriate to mark Dr Ismail's second act of dishonesty by issuing a warning. The Tribunal was of the view that it is necessary and proportionate to do so in order to promote and maintain public confidence and standards in the profession.

15. Accordingly, the Tribunal determined to issue the following warning to Dr Ismail:

> *'Dr Ismail*
>
> *On 3 August 2017 you dishonestly submitted a timesheet for locum work which contained a false signature and was not properly approved.*
>
> *This conduct does not meet the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good Medical Practice and associated guidance. In this case, you breached the principles in paragraphs 65, 68 and 71, which state:*
>
> > *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
> >
> > *68 You must be honest and trustworthy in all your communication with patients and colleagues….*
> >
> > *71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.*

a You must take reasonable steps to check the information is correct.

Whilst your failing to meet these standards is not in itself so serious as to require any restriction on your registration, it is necessary to issue this formal warning.

This warning will be published on the medical register in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy.'

16. That concludes this case.

Confirmed
Date 14 February 2020 Mr Colin Chapman, Chair

ANNEX A – 20/08/2019

Application for video link evidence Rule 34(13) and (14)

GMC submissions

1. Mr Rigby made an application for GMC witness, Dr D, to give evidence by video link. He told the Tribunal that Dr D is currently working as a Surgical Registrar at Kingston Hospital, London. He told the Tribunal that due to work commitments it would be very difficult for Dr D to attend the hearing in person. Mr Rigby reminded the Tribunal that Dr D made himself available on the first day of the hearing (19 August 2019) to give evidence by video link but, due to the circumstances which transpired in the hearing, he was unable to do so.

2. Mr Rigby submitted that Dr D is an important witness and stated that if video link is the only way in which it is possible for him to give evidence, then it is in the interests of justice for the application to be granted.

Dr Ismail's submissions

3. Dr Ismail agreed that Dr D is an important witness. He stated that if Dr D cannot attend the hearing in person then he is content for him to give evidence by video link with the proviso that he is given the opportunity to question Dr D without time constraints.

The Tribunal's Decision

4. The Tribunal bore in mind Rules 34(13) and 34 (14) of the Fitness to Practise Rules 2014 (as amended), which state:

> *'34 (13) A party may, at any time during a hearing, make an application to the Committee or Panel for the oral evidence of a witness to be given by means of a video link or a telephone link.*
>
> *(14) When considering whether to grant an application by a party under paragraph (13), the Committee or Panel must—*
>
> > *(a) give the other party an opportunity to make representations;*
> > *(b) have regard to—*
> >
> > > *(i) any agreement between the parties, or*
> > >
> > > *(i) in the case of a Panel hearing, any relevant direction given by a Case Manager; and*
>
> *(c) only grant the application if the Committee or Panel consider that it is in the interests of justice to do so.'*

5. The Tribunal was concerned that the application for a witness to give evidence by the video link has been made today and considered that it should have been made to the MPTS Case Manager in advance of the hearing, regardless of whether or not Dr Ismail was engaging with the hearing process at that time.

6. The Tribunal notes that Dr D indicated that it would be difficult for him to attend the hearing in person. The Tribunal is of the opinion that Dr D is an important witness in this case and considers that it is preferable for him to give evidence by video link rather than not at all. The Tribunal is satisfied that it is in the interests of justice for Dr D to give evidence by video link. Accordingly, the Tribunal granted the application for Dr D to give evidence by video link.

7. The Tribunal assures Dr Ismail that he will be given the opportunity to question Dr D fully.

ANNEX B – 21/08/2019

Application for telephone evidence Rules 34(13) and (14)

GMC submissions

1. Mr Rigby made an application for GMC witness, Dr C, to give evidence by telephone. He told the Tribunal that Dr C's circumstances are such that he is unable to travel to the hearing centre. Mr Rigby told the Tribunal that Dr C is unable to give evidence by video link as there is no internet connection where he is. Mr Rigby accepted that giving evidence by telephone was not ideal, but submitted that it is in the interests of justice for the application to give evidence by telephone be granted.

Dr Ismail's submissions

2. Dr Ismail made no objection to the application.

The Tribunal's Decision

3. The Tribunal bore in mind Rules 34(13) and 34(14) of the Fitness to Practise Rules 2014 (as amended), as stated in Annex A.

4. The Tribunal accepts that due to Dr C's personal circumstances it is not possible for him to attend the hearing in person or by video link. The Tribunal considers that it is preferable for witnesses who cannot attend the hearing in person to give evidence by video link. However, it accepts that in this particular circumstance it is not possible. The Tribunal is of the opinion that Dr C is an important witness in this case and considers that it is preferable for him to give evidence by telephone rather than not at all. The Tribunal is satisfied that it is in the interests of justice for Dr C to give evidence by telephone and accordingly, grants the application.

ANNEX C – 22/08/2019

Application for telephone evidence Rules 34(13) and (14)

GMC submissions

1. Mr Rigby made an application for GMC witness, Dr E, to give evidence by telephone. He reminded the Tribunal that Dr E was scheduled to give evidence on 20 August 2019, but due to circumstances which transpired in the hearing, was unable to do so.

2. Mr Rigby told the Tribunal that Dr E is not available to give evidence by video link. Mr Rigby accepted that giving evidence by telephone was not ideal but submitted that it is in the interests of justice for the application to give evidence by telephone be granted.

Dr Ismail's submissions

3. Dr Ismail made no objection to the application.

The Tribunal's Decision

4. The Tribunal bore in mind Rules 34(13) and 34 (14) of the Fitness to Practise Rules 2014 (as amended), as set out in Annex A.

5. The Tribunal accepts that Dr E was due to give evidence earlier in the week. He cannot be available other than by telephone. The Tribunal considers that it is always preferable for witnesses who cannot attend the hearing in person to give evidence by video link rather than by telephone. However, it accepts that in this particular circumstance it is not possible.

6. The Tribunal is mindful that Dr E is an important witness in this case and considers that it is preferable for him to give evidence by telephone rather than not at all.

7. The Tribunal is satisfied that it is in the interests of justice for Dr E to give evidence by telephone and accordingly, grants the application.

Annex D - 24/08/2019

Application to amend the Allegation under Rule 17(6)

GMC submissions

1. Mr Rigby made an application pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to amend paragraphs 1a and 1c as follows:

'1. On or around 23 July 2017 you consulted with Patient A and you:

a. failed to take an adequate history from Patient A;

c. told Patient A that he may have gangrene to his penis or his groin, when this was not clinically indicated;'

2. Mr Rigby submitted that this amendment to paragraph 1a reflected the oral evidence given by the GMC expert, Dr L, when he was asked whether the history was adequate. He submitted that the amendment in relation to paragraph 1c is made in the light of Patient A's oral evidence.

Dr Ismail's submissions

3. Dr Ismail made no objection to the proposed amendments.

The Tribunal's Decision

4. The Tribunal noted Rule 17(6) states:

'(6) Where, at any time, it appears to the Medical Practitioners Tribunal that—

(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and
(b) the amendment can be made without injustice,

it may, after hearing the parties, amend the allegation in appropriate terms.'

Paragraph 1a

5. The Tribunal noted that it is Dr Ismail's case that he did not consult with Patient A.

6. The Tribunal considered that the application to amend paragraph 1a with the addition of the words *'an adequate'* changes the meaning of the paragraph substantially. The Tribunal considered that not taking a history at all is very different from taking an inadequate history.

7. The Tribunal has also noted that the GMC's allegations are on the basis that that Dr Ismail failed to take a history of Patient A rather than 'an adequate' history. The Tribunal is of the opinion that Dr Ismail has been presenting his defence during the cross examination of witnesses on that basis and therefore does not now have the opportunity to question them about the adequacy of the history taking.

8. The Tribunal has also noted that paragraph 1d includes the words 'an adequate record'.

9. The Tribunal was satisfied that agreeing to the amendment of paragraph 1a has the potential to cause an injustice to Dr Ismail. Accordingly, the Tribunal rejects the application in relation to paragraph 1a.

Paragraph 1c

10. The Tribunal was satisfied that in his oral evidence when Patient A referred to his 'groin' he was talking about the whole of his genital area. The Tribunal noted that Dr Ismail made no objection to the amendment. Therefore, it considers that there is no potential for injustice to Dr Ismail in amending paragraph 1c of the allegation. Accordingly, the Tribunal accedes to the application in relation to paragraph 1c.

ANNEX E- 29/08/2019

Application to adjourn under Rule 29(2)

Dr Ismail's submissions

1. Dr Ismail made an application pursuant to Rule 29(2) of the General Medical Council Fitness to practice Rules 2004 (as amended), to adjourn the hearing so that he might locate a potential witness to provide evidence in support of his case. The witness is a doctor (identified in the documents as Dr M) who was working in A&E at the West Middlesex Hospital at the time of the events relating to Patient A.

2. Dr Ismail stated that Dr M was the only witness who could support his assertion that he never consulted with Patient A. He said he was not aware that it was his responsibility to provide defence witnesses. He stated that he had raised concerns about Dr M on several occasions with the GMC Investigation Officer, Ms S. He stated that he first raised this in an email to Ms S in April or May 2018. Dr Ismail accepted that he could provide no evidence to support this, for example in the form of emails. He confirmed that he had not made any efforts to contact Dr M at any time.

3. Dr Ismail stated that following his suspension in January 2018 he could not work in the United Kingdom, so he went to Lebanon in March 2018 and returned to the United Kingdom in November 2018. When the suspension was revoked, he concentrated on successfully completing his appraisal in order to regain his licence to practise. He did this while living at his aunt's home in Brussels from 9 November 2018 to 13 March 2019. He

told the Tribunal that in March 2019 he went to work in Dubai and returned to the United Kingdom in June 2019 and completed his first locum job at Kings College Hospital.

4. Dr Ismail stated that he had met Dr M at Ealing Hospital prior to the events at the West Middlesex Hospital. He stated that he did not know what work Dr M is doing now. He confirmed that he had not contacted either Ealing Hospital or West Middlesex Hospital to see whether Dr M was still working there or whether they knew where he may be working now.

5. Dr Ismail confirmed that he was present for the MPTS case management telephone conference on 25 March 2019. He accepted that he was advised that he needed to obtain statements from any witnesses and was given a timescale of 5 July 2019 to do so. He was given the date for another case management conference in June 2019 but he did not participate and could not be contacted. A further case management conference was held on 4 July 2019, Dr Ismail did not participate. Dr Ismail acknowledged that he did not engage with the all of MPTS pre-hearing conferences.

GMC submissions

6. Mr Rigby submitted that at this late stage it might be difficult to identify and locate Dr M. He submitted that it would be unlikely that Dr M would remember these events in July 2017 and that it was unlikely he would be available in the near future.

7. Mr Rigby informed the Tribunal that the GMC's Rule 7 letter and hearing bundle was sent to Dr Ismail on 4 May 2018. Mr Rigby accepted that the bundle did not include the pages now made available in document C4. He told the Tribunal that Dr Ismail responded to the GMC in a letter dated 12 June 2018 in which he mentioned Dr M.

8. Mr Rigby informed the Tribunal that Dr Ismail was present at an MPTS Case Management telephone conference on 25 March 2019. He said that a pre-hearing telephone conference was initially scheduled for 20 June 2019 but was cancelled as Dr Ismail had not responded. This was rescheduled and took place on 4 July 2019. Dr Ismail did not participate in this conference call.

9. Mr Rigby objected to the adjournment and submitted that it would be unreasonable and disproportionate to adjourn the hearing.

The Tribunal's Approach

10. The Tribunal noted that the general power to adjourn a hearing is a discretionary one provided in Rule 29 of the General Medical Council (Fitness to Practise) Rules 2004,

and that the Rules do not give any guidance as to the circumstances in which an adjournment may or may not be appropriate.

11. The Tribunal noted that guidance on the proper approach to adjournments has been provided in: *GMC v Adeogba and Visvardis [2016] EWCA Civ 162*, *GMC v Hayat [2018] EWCA Civ 2796* and *Nabili v GMC [2018] EWHC 3331 (Admin)*. The key principles are:

- The Tribunal must strike a balance between fairness to the doctor and the public interest.

- The public interest must be seen in the context of the overriding objective, namely the protection, promotion and maintenance of the health and safety of the public.

- The fair, economical, expeditious and efficient disposal of allegations made against medical practitioners is of very real importance.

- There is a burden on medical practitioners, to engage with their regulator, both in relation to the investigation and ultimate resolution of allegations made against them.

- It runs counter to the protection, promotion and maintenance of the health and safety of the public that a practitioner can effectively frustrate the fair, economical, expeditious and efficient disposal of allegations when the practitioner has failed to engage in the process.

12. In short, the Tribunal should strike a proper balance between fairness to the doctor and the public interest, having regard to the whole history of the proceedings.

The Tribunal's Decision

13. The Tribunal noted that it has only received evidence from two witnesses to the events on or around 23 July 2019, Patient A and Dr Ismail.

14. The Tribunal considered that potentially Dr M could assist the Tribunal as, according to Dr Ismail, he was a witness to the events on or around 23 July 2019.

15. The Tribunal noted that both parties have known about the possible relevance of Dr M's evidence for over a year. It noted that Dr Ismail referred to Dr M in his response to the GMC in June 2018. The Tribunal noted that Dr Ismail was present at the Case Management conference on 25 March 2019, when he made aware of need to obtain witness statements and the timescale in which to do so, but chose not to engage with the

hearing process thereafter. It noted that Dr Ismail accepts that he failed to engage and has made no efforts to locate Dr M.

16. The Tribunal is satisfied that Dr Ismail has had ample opportunity to engage in the hearing process and to obtain evidence from Dr M.

17. In making its decision, the Tribunal has balanced fairness to Dr Ismail against the public interest. Whilst the Tribunal considers that Dr M might provide relevant evidence, it cannot be satisfied that Dr M can be located, nor that he will agree or be available to give evidence in the future.

18. In these circumstances, the Tribunal considered that Dr Ismail's interests are outweighed by the public interest in the expeditious and efficient disposal of allegations, particularly given Dr Ismail's limited engagement in the proceedings before the hearing started.

19. Accordingly, the Tribunal rejects Dr Ismail's application to adjourn.