PUBLIC RECORD

Dates: 06/06/2022 - 21/06/2022

Medical Practitioner's name:	Dr Amir FARBOUD
GMC reference number:	6115244
Primary medical qualification:	MB BCh 2005 University of Wales

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 8 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Julia Oakford
Lay Tribunal Member:	Mrs Rebecca Miller
Medical Tribunal Member:	Dr John Moriarty

Tribunal Clerk:	Mrs Anne Bhatti

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr James Buchanan, Counsel, instructed by MDU
GMC Representative:	Ms Kathryn Johnson, Counsel

Attendance of Press / Public

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

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 - 16/06/2022

Background

1. Dr Farboud obtained a degree in Science in 1999 from King's College, London. He obtained several qualifications in medicine which included: MBBCh from University of Wales College of Medicine in 2005; MRCS (2008) and FRCS (ORLHNS) (2016) from the Royal College of Surgeons of London. At the time of the events Dr Farboud was practising as a final year trainee ENT Surgeon (ST7/8) at Cardiff and Wales NHS Trust ('the Trust').

2. The allegation that has led to Dr Farboud's hearing can be summarised as, on 28 April 2017, Dr Farboud failed to obtain appropriate consent from Patient A and make adequate medical records. It is also alleged that, on 18 September 2017 and 21 September 2017, Dr Farboud failed to provide good clinical care to Patient B. It is further alleged that Dr Farboud was dishonest in statements made to both Patient B and Dr C, in relation to Patient B's care.

The Outcome of Applications Made during the Facts Stage

3. The Tribunal granted in part an application by Mr James Buchanan, Counsel, on behalf of Dr Farboud. Mr Buchanan submitted that the hearing be converted to a virtual hearing from stages two and if required stage three, due to Dr Farboud's personal circumstances. The Tribunal determined to allow parties to attend the hearing virtually for stage two and, if required, stage three of the hearing. The Tribunal would assess its position following the facts stage to decide whether it would sit virtually or at the hearing centre.

4. The Tribunal granted the application by Ms Kathryn Johnson, Counsel, on behalf of the GMC, that paragraph 2(b)(i) be withdrawn because Dr C had accepted that it was his responsibility to decide whether a facial monitor was used during the surgery and he was of the view that it was not required. It was not the practice at the Trust to use a facial monitor during the relevant procedure. Mr Buchanan had not opposed the application.

The Tribunal determined to grant Ms Johnson's application and paragraph 2(b)(i) was withdrawn.

The Allegation and the Doctor's Response

5. The Allegation made against Dr Farboud is as follows:

That being registered under the Medical Act 1983 (as amended):

Patient A

1. On 28 April 2017 you carried out Septoplasty and Bilateral Antral Washout ('BAWO') on Patient A and you:

    a. failed to:

        i. obtain consent from Patient A for the change in the procedure from Functional Endoscopic Sinus Surgery ('FESS') to BAWO; **Admitted and found proved**

        ii. inform Patient A of the complications associated with BAWO; **Admitted and found proved**

        iii. make an adequate record in Patient A's medical records of:

            1. the change in procedure from FESS to BAWO; **Admitted and found proved**

            2. the reasons for altering the procedure from FESS to BAWO; **Admitted and found proved**

            3. your discussion with Patient A regarding the complications associated with BAWO. **Admitted and found proved**

Patient B

2. On 18 September 2017 you carried out a cortical mastoidectomy ('the surgery') on Patient B and:

    a. you continued drilling:

        i. when it was not clinically indicated; **Admitted and found proved**

ii. after Dr C told you 'to finish the procedure and close up,' or words to that effect; To be determined

b. your surgery was inadequate in that you:

i. failed to:

1. ~~use a facial nerve monitor during the surgery~~; Withdrawn

2. recognise the:

a. short process of incus; Admitted and found proved

b. facial nerve; Admitted and found proved

c. labyrinth; Admitted and found proved

3. recognise that you had caused injury to:

a. short process of incus; Admitted and found proved

b. facial nerve; Admitted and found proved

c. labyrinth; Admitted and found proved

ii. caused injury to the:

1. short process of incus; Admitted and found proved

2. facial nerve; Admitted and found proved

3. labyrinth; Admitted and found proved

iii. upon becoming unsure where you were drilling in the ear you failed to:

1. stop drilling; To be determined

2. seek assistance from a more senior colleague; To be determined

c. following the surgery you failed to:

i. carry out an adequate and appropriate post-operative assessment of Patient B's:

1. facial nerve; **Admitted and found proved**

2. nystagmus; **Admitted and found proved**

3. hearing function; **Admitted and found proved**

ii. recognise that the head bandage would not have caused Patient B's:

1. vertigo; **To be determined**

2. facial nerve weakness; **Admitted and found proved**

iii. recognise the possibility that you had caused an iatrogenic injury to the facial nerve and labyrinth; **Admitted and found proved**

iv. discuss the serious complication as described in paragraph 2bii with Dr C or another senior colleague; **Admitted and found proved**

v. put in to place an adequate and appropriate management plan as you did not organise:

1. urgent high resolution CT scan of the temporal bones; **Admitted and found proved**

2. bone conduction audiogram; **Admitted and found proved**

3. the commencement of steroids to reduce oedema of the facial nerve; **Admitted and found proved**

4. the commencement of a vestibular sedative; **Admitted and found proved**

5. for Patient B's eye to be protected with lubricants; **Admitted and found proved**

d. you advised Patient B that the head bandage was the cause of her facial weakness and that it would improve. **Admitted and found proved**

3. On 21 September 2017 you:

   a. reviewed Patient B and you failed to:

      i. carry out an adequate and appropriate assessment of Patient B's:

         1. facial nerve; To be determined

         2. nystagmus; To be determined

         3. hearing function; To be determined

      ii. perform a tuning fork Weber test; To be determined

      iii. in the alternative to paragraph 3aii, to correctly interpret the result of the tuning fork Weber test; Admitted and found proved

      iv. make appropriate and adequate records in Patient B's medical records; Admitted and found proved

   b. texted Dr C and told him that 'she [Patient B]:

      i. hasn't got a dead ear, Webers lateralised to the operate ear'; Admitted and found proved

      ii. has no nystagmus or vertigo, just unsteady'. Admitted and found proved

4. You knew the statement you made at paragraph:

   a. 2d was untrue because you knew that a head bandage would not cause facial weakness; To be determined

   b. 3bi was untrue because of your omissions as described at paragraph 3aii; To be determined

   c. 3bii was untrue because of your omissions as described at paragraph 3ai. To be determined

5. Your actions at paragraph:

   a. 2d were dishonest by reason of paragraph 4a; To be determined

   b. 3bi were dishonest by reason of paragraph 4b; To be determined

c. 3bii were dishonest by reason of paragraph 4c. To be determined

The Admitted Facts

6. At the outset and during the course of these proceedings, Dr Farboud 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.

Witness Evidence

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

- Patient B, witness statement dated 9 December 2021, in person;
- Dr C, ENT Consultant, the Trust, witness statement dated 1 March 2020, in person;
- Ms D, Staff Nurse, Cardiff and Vale University Health Board, witness statement dated 22 December 2021, by video link;
- Dr E, Associate Specialist in ENT, the Trust, witness statement dated 31 August 2020, by video link.

8. Dr Farboud provided his own witness statement dated 4 April 2022 and also gave oral evidence at the hearing in person. In addition, the Tribunal received evidence from the following character witness on Dr Farboud's behalf:

- Mr F, ENT Consultant/Head and Neck Surgeon, character reference dated 30 May 2022, by video link.

Expert Witness Evidence

9. The Tribunal received evidence from an expert witness, on behalf of the GMC. Mr G, Consultant ENT Surgeon. He provided an expert report dated 8 July 2019 relating to Patient A.

10. The Tribunal also received evidence from an expert witness, on behalf of the GMC. Mr H, Consultant ENT Surgeon. He provided expert reports dated 12 October 2021 and 8 June 2022 relating to Patient B.

11. Both experts gave oral evidence in person.

12. Mr H was an ENT Surgeon with a tertiary adult and paediatric practice. He had undertaken fellowship training in neuro-otology at Toronto General Hospital and Hospital for Sick Children in Toronto, Canada. Mr H's NHS adult practice was at Bradford Royal Infirmary, Bradford and the Royal Hallamshire Hospital, Sheffield. His paediatric practice was at Sheffield Children's Hospital, Sheffield. He also had a private practice at Claremont Private Hospital and BMI Thornbury Hospital in Sheffield. Mr H was an Assigned Educational Supervisor (AES) for trainees in otolaryngology at Sheffield Children's Hospital. He also supervised trainees in the theatre and outpatient setting and on-call.

13. Mr G was the Medical Director and Responsible Officer of South Tees Hospitals NHS Trust from April 2015 to July 2016. This involved the leadership, oversight and governance of over 500 doctors within the organisation. Prior to this Mr G was Chief of Service for Surgery between 2011 and 2015; Clinical Director in ENT 2009 to 2011 and Associate Medical Director 2006 to 2009. He had been a practising Consultant ENT Surgeon of over 26 years' experience. During his training as a Registrar and Senior Registrar he was instructed in and practiced septoplasty techniques and Functional Endoscopic Sinus Surgery ('FESS') and subsequently undertook these procedures during his first 10 years as a consultant before sub-specialising solely in head and neck surgery.

Documentary Evidence

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

- Dr C's initial statement to the Trust dated 9 October 2017;
- Text messages between Dr C and Dr Farboud between 21 September and 4 October 2017;
- Dr E's initial statement to the Trust, undated;
- Ms D's initial statement to the Trust dated 24 October 2017;
- Patient A and Patient B's medical records, various dates.

The Tribunal's Approach

15. 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 Farboud 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.

16. The Tribunal had regard to *Byrne v GMC (2021) EWHC 2237*,

> *'(1) There is only one civil standard of proof in all civil cases, and that is proof that the fact in issue more probably occurred than not.*
>
> *(2) There is no heightened civil standard of proof in particular classes of case. In particular, it is not correct that the more serious the nature of the allegation made, the higher the standard of proof required.*
>
> *(3) The inherent probability or improbability of an event is a matter which can be taken into account when weighing the probabilities and in deciding whether the event occurred. Where an event is inherently improbable, it may take better evidence to persuade the judge that it has happened. This goes to the quality of evidence.*
>
> *(4) However it does not follow, as a rule of law, that the more serious the allegation, the less likely it is to have occurred. So whilst the court may take account of inherent probabilities, there is no logical or necessary connection between seriousness and probability. Thus, it is not the case that "the more serious the allegation the more cogent the evidence need to prove it''*

17. In assessing witness evidence, the Tribunal had regard to the case of *Dutta, R (On the Application Of) v General Medical Council (GMC) [2020] EWHC 1974 (Admin) (22 July 2020)* where the judge addressed errors in the approach of the Tribunal. The Tribunal will be mindful of starting with the objective facts as shown by authentic contemporaneous documents, independent of witnesses, and using oral evidence as a means of subjecting these to critical scrutiny. The Tribunal also notes that an assessment of a witness's credibility should not be largely or exclusively based on their demeanour.

18. Where relevant to its decision-making process, the Tribunal had regard to the test for dishonesty set out in *Ivey v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] UKSC 67 ('Ivey')*, which states at paragraph 74:

> *'When dishonesty is in question the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional*

requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'

19. The Tribunal considered the case of *Khan v The General Medical Council [2021] EWHC 374 (Admin)*. Tribunals should not assess a witness's credibility exclusively on their demeanour when giving evidence. Tribunal should consider all of the evidence before them before coming to a conclusion about witness's credibility. This could include conflicts in evidence with another witness, denials of the allegations and reasons why they could not be true or admission of lying (on oath or otherwise) on a previous occasion. It is open to Tribunals not to rule out the whole of a witness's evidence based on credibility; credibility can be divisible.

20. The Tribunal considered the case of *Towuaghanste v The General Medical Council [2021] EWHC 681 (Admin)*. It was important that the Tribunal should specifically state if it finds Dr Farboud has given dishonest evidence or deliberately sought to mislead the Tribunal as opposed to putting the regulator to proof as this could be relevant at a later stage.

21. The Tribunal was cognisant throughout that the doctor should be regarded as being of good character and this might support his credibility. Further the fact that he was of good character might mean that he was less likely to act as set out in the Allegation.

The Tribunal's Analysis of the Evidence and Findings

22. 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.

Chronology - Patient B's surgery

23. On 18 September 2017, Dr C had taken Patient B's consent for the cortical mastoidectomy ('the surgery') prior to the operation. The main purpose of the surgery was to explore Patient B's left ear to investigate the cause of her hearing loss. The surgery had two stages, part one and part two. Part one involved the use of an endoscope to look into Patient B's ear canal to assess what type of disease process was present, in particular whether there was cholesteatoma. Part two was to check whether

there was any further disease in the airspace contained in the mastoid bone, the bone behind the ear. Dr C's role was to supervise and advise Dr Farboud when necessary.

Part one

24. Dr Farboud looked in Patient B's ear using an endoscope. Dr C was present during the full duration of part one of the procedure. This part of the procedure does not form part of the Allegation.

Part two

25. Dr C was present when part two of the procedure commenced. Dr Farboud had started to prepare to use the drill. Dr C had left the operating room to make a telephone call. When Dr C had arrived back to the operating room, the drill was smoking. The issue with the drill was resolved and Dr C observed Dr Farboud for about 20 to 30 minutes, before he left the operating room for the second time. Whilst Dr C was present in the operating room, the camera on the operating microscope was taken by another member of staff, which resulted in Dr C not being able to observe the surgery on the television stack system. However, he was still able to use the side teaching arm of the microscope to visualise the operating field. He continued intermittently to observe the surgery by this means. Dr E was also observing the surgery and was present throughout part two of the surgery. Dr C left to see a child on the paediatric ward who he had to see as soon as possible and did not return to the theatre.

Paragraph 2(a)(ii)

26. The Tribunal considered paragraph 2(a)(ii) of the Allegation whether on 18 September 2017, Dr Farboud carried out the surgery on Patient B and he continued drilling after Dr C told him, '*to finish the procedure and close up'*, or words to that effect.

27. The Tribunal took into consideration Dr C's statement to the Trust dated 9 October 2017, *'I recommended that little more was done, and that Mr Farboud could finish the procedure and close up*'. The Tribunal also took into account Dr C's witness statement dated 1 March 2020:

> *'I can't recall word-by-word exactly what I said to Dr Farboud at the time, but the type of thing that I would have said to him is 'I think there's enough done now, you don't need to do anymore, are you happy to finish up and close?.'*

28. The Tribunal bore in mind that Dr C had confirmed that the words he had used, had not been exact but the '*type of thing'* he would have said to Dr Farboud at the time. The Tribunal also took into consideration that in Dr C's oral evidence he said he was not sure exactly what he said and '*I can't remember now'* but it was words to that effect that he would have used.

29. Dr E's statement to the Trust (undated) stated:

> *'[Dr C] agreed there was no cholesteatoma looking at the cavity and told [Dr Farboud] to finish the cortical mastoidectomy and close up. He then left the theatre a second time and to my knowledge did not return.'*

30. Dr E in her witness statement said that the statement she had prepared for the Trust was written '*fairly soon*' after 18 September 2017. In her oral evidence, she confirmed that the Trust's statement was written at least some days, if not weeks, after the surgery.

31. The Tribunal bore in mind that the written account by Dr C was written on 9 October 2017 and Dr E's account was written fairly soon after 18 September 2017. Both accounts were provided at a time when the incident was much fresher in their minds than the oral evidence given to the Tribunal and in their GMC witness statements.

32. The Tribunal considered Dr Farboud's witness statement dated 4 April 2022, in which he denied this paragraph of the Allegation:

> *'I deny this allegation. I did not understand that Mr C had told me to finish the procedure and close up. My understanding was that I was to continue and 'finish up' the procedure. I would have had no reason to continue drilling and ignore Mr C.'*

In his oral evidence Dr Farboud confirmed that he did not hear the words Dr C said he had used.

33. The Tribunal had to consider what the instructions had been by Dr C and whether it had been clear to Dr Farboud to finish the procedure and close up.

34. The Tribunal found that Dr C and Dr E's evidence was ambiguous. The Tribunal was of the view that there had been a misunderstanding of the meaning of what was said by Dr C. Dr Farboud's evidence was that he understood Dr C's instruction was to continue drilling, which he had done. Dr E's evidence was to, '*to finish the cortical mastoidectomy*

and close up'. Dr C had confirmed in written and oral evidence that the words in his witness statement were not the exact words that he would have used.

35. The Tribunal found that there had been some inconsistences in the evidence from Dr E and Dr C, particularly in relation to what Dr Farboud was told by Dr C to do when he left the theatre. Regardless, of the actual words said the Tribunal had to decide whether the instructions provided by Dr C to Dr Farboud were clear on the balance of probabilities for him to stop drilling. The Tribunal determined that the words used by Dr C had not been a clear instruction to stop the procedure. The Tribunal was of the view that in these circumstances the term, '*finish*' could have different meanings and was ambiguous. The Tribunal determined that finishing the procedure was to complete it and not simply stop and close up.

36. The Tribunal therefore found paragraph 2(a)(ii) of the Allegation not proved.

Paragraphs 2(b)(iii)(1) and 2(b)(iii)(2)

37. The Tribunal considered paragraphs 2(b)(iii)(1) and 2(b)(iii)(2) of the Allegation separately, but the conclusion it reached was based upon the same evidence of fact. The Tribunal considered whether on 18 September 2017, Dr Farboud carried out the surgery on Patient B and the surgery was inadequate in that, when he become unsure where he was drilling in the ear he failed to stop drilling and seek assistance from a more senior colleague.

38. The Tribunal considered the evidence from Dr Farboud dated 4 April 2022:

> *'Around three quarters of the way through the operation, Mr C returned, and I got up and went to the review the scans with Mr C. The end point was to find the mastoid antrum, and air space that communicates with the middle ear. This would have indicated ventilation of the middle ear had been achieved. I cannot recall the precise words used, but I understood Mr C's instructions to be to "keep going" and I recall that Mr C showed me the area on the scan that I needed to be heading towards, the mastoid antrum.'*

39. The Tribunal considered that during Dr Farboud's oral evidence, he accepted that he was not clear that he knew where he was drilling.

40. It also considered a text message which Dr Farboud had sent to Dr C dated 29 September 2017:

'I have to accept that I was in the wrong place when I was drilling. I have lost my landmarks and position'

41. The Tribunal considered that Dr Farboud in his oral evidence said that he had accepted that he was in the wrong place after the incident had occurred but had not known at the time that he was in the wrong place.

42. The Tribunal took into consideration that Dr Farboud in his oral evidence stated, *'I accept I should have realised and needed more help*'.

43. It considered the evidence from Dr E dated 31 August 2021:

'At paragraph 3 of Exhibit SK1, I stated that '[Dr Farboud] was concerned that there were no landmarks'. I have been asked to clarify how I formed this impression. Mr Farboud was saying that he couldn't identify the landmarks, including the short process incus (which is the tiny bone in the ear).'

44. The Tribunal considered Dr C's witness statement dated 9 October 2017:

'I recommended that little more was done, and that Mr Farboud could finish the procedure and close up. I checked he was happy, and he confirmed he was, and I left theatre to attend the ward to see a patient I had been contacted about.'

45. In Mr H's expert report dated 12 October 2021:

'According to the statement of Mr Farboud, he was concerned during the operation that he was drilling too deep into Patient B's ear and that he had seen no recognisable anatomical landmarks. At this point, if he was unsure as to where he was, he should have stopped and sought assistance from [Dr C]. By not stopping, this standard of care was seriously below that expected of a reasonably competent ST8 ENT trainee.'

46. The Tribunal considered Mr H's supplemental expert report dated 8 June 2022:

'Mr Farboud stopped drilling as he realised that he was too deep in the ear and had not found any recognisable anatomy. At this point, he should have asked [Dr C] for assistance in my opinion.'

47. Dr Farboud in his oral evidence stated that he had asked Dr C to look at the scans during part two of the procedure and he had a lengthy discussion with Dr C. In his written statement he said:

> *'I remember that I had a long discussion with Mr C away from the operative area looking at the scans of Patient B on a computer screen. I remember that I was struggling to complete the operation.'*

48. Dr E and Dr C had not said in their evidence that Dr Farboud had looked at the scans again during part two of the surgery. Although Dr E recollected a pause neither she nor Dr C described a long discussion.

49. The Tribunal therefore determined that Dr C and Dr Farboud had not looked at the scans or had a long discussion, whilst looking at the scans during part two of the procedure.

50. Dr Farboud stated in his written evidence, '*I remember that I was struggling to complete the operation*' before Dr C left, and accepted in his oral evidence that he should have realised that he needed more help. The Tribunal was of the view that the duty was on Dr Farboud to realise that he needed help and he had accepted in his evidence that he needed it. Mr H was of the view that when Dr Farboud was unsure where he had been drilling, he should have stopped and asked for help.

51. The Tribunal concluded that Dr Farboud was unsure where he was drilling in the ear and he failed to stop drilling and seek assistance from a more senior colleague.

52. Therefore, the Tribunal found paragraphs 2(b)(iii)(1) and 2(b)(iii)(2) of the Allegation proved.

<u>Paragraph 2(c)(ii)(1)</u>

53. The Tribunal considered paragraph 2(c)(ii)(1) of the Allegation, whether on 18 September 2017, Dr Farboud carried out the surgery on Patient B and following the surgery, he failed to recognise that the head bandage would not have caused Patient B's vertigo.

54. The Tribunal considered Dr Farboud's evidence that he was not aware of Patient B suffering from vertigo. In his statement dated 4 April 2022 he stated:

'I deny this allegation. Patient B did not report vertigo when I assessed her in the postoperative environment. I accept that Patient B was drowsy and uncommunicative and I should have returned when Patient B was more awake and asked her specifically about vertigo.'

55. Patient B was moved to the ward at 12:35 following the surgery undertaken by Dr Farboud.

56. Patient B's medical records dated 18 September 2017 at a time that was unclear in the medical notes but between 16:00 and 16:25 show:

'Pt. C/o feeling nauseous + vomited twice. OBS taken + recorded. News 2. Noted facial weakness to L sided + L eye is slightly drooping'

57. At 17:00 it was recorded that Dr Farboud and the anaesthetist attended Patient B:

'S/B SPR + Anaesthetist + reviewed pt.
Plan: > Stay – in overnight
- *Home tom if well (NLD)*
- *Removal of dressing tom.'*

58. The Tribunal bore in mind that the medical notes timed at around 16:00 and 17:00 had not mentioned vertigo and nor had it been recorded in the notes prior to that. The Tribunal took into consideration that vertigo was mentioned in the medical records at 18:15, however it was not Dr Farboud who had attended Patient B at that time.

59. The Tribunal also took into consideration Ms D's statement to the Trust dated 24 October 2017 (she was the nurse who had attended Patient B following the surgery). In it she stated:

'Patient complaining of nausea. Patient vomited a couple of time and states she feels so unwell. I advised the patient to stay in bed. I noticed the patient had a left facial droop. Patient had very bad vertigo. And continue to feel nauseated despite anti emetics given.

ENT on call contacted to review patient's facial droop'

60. The Tribunal took into consideration that the only mention of vertigo in the medical notes was after Dr Farboud had attended Patient B. When Dr Farboud attended Patient B in

the hours following the operation the concern in the medical notes and according to Ms D's statement to the Trust the issue she contacted the ENT on call about was the facial droop. The Tribunal was of the view that Dr Farboud had not been aware that Patient B had suffered from vertigo at the time he had attended her post surgery on 18 September 2017.

61. Therefore, the Tribunal determined to find paragraph 2(c)(ii)(1) of the Allegation not proved.

Paragraph 3(a)(i)(1) and 3(a)(i)(2)

62. The Tribunal considered paragraphs 3(a)(i)(1) and 3(a)(i)(2) of the Allegation separately, but the conclusion it reached was based upon the same evidence of fact. It considered whether on 21 September 2017, Dr Farboud reviewed Patient B and had failed to carry out an adequate and appropriate assessment of Patient B's facial nerve and/or nystagmus.

63. The Tribunal considered Patient B's medical notes dated 21 September 2017 at 8:10am:

'O/E L partial facial palsy remaining'

The Tribunal noted that there was no detail of a full assessment of the facial nerve and no mention of nystagmus.

64. The Tribunal also bore in mind, Mr H's expert report dated 12 October 2021:

'Following mastoid or middle ear surgery, it is standard practice to record facial nerve function, assess for nystagmus and to use a tuning fork to perform a Weber's tuning fork test to test for hearing function. As concerns about the patient had been raised by the day ward surgery staff regarding facial weakness and dizziness, it is imperative that Mr Farboud should have assessed fully to determine if there had been an iatrogenic injury to the labyrinth and facial nerve. Therefore, Mr Farboud did not undertake an adequate and appropriate post-operative assessment of Patient B. This standard of care was seriously below that expected of a reasonably competent ST8 ENT trainee.'

65. The Tribunal considered Dr Farboud's evidence that he had carried out these assessments, however he had accepted that he had not made a note in Patient B's medical records. In his statement dated 4 April 2022:

'I take these allegations together. I did complete an assessment of the facial nerve and nystagmus, but I accept I did not document them. I recall that I was feeling panicked by my growing suspicion that I had injured Patient B during the operation. I recall that I asked the nursing staff for a tuning fork, which could not be found during my assessment of Patient B. After completing my assessment of Patient B I continued with my Ward Round, and I recall that the tuning fork was found at the end of my ward round. I then went back to Patient B with the tuning fork to carry out the assessment. I completed the assessment, but in my haste I accept I did not document it.'

66. Dr Farboud in his oral evidence regarding the assessment of the facial nerve said '*I asked the patient to raise her eyebrow and blow her cheek*' but accepted he could not recall the result. In his oral evidence for nystagmus he said, *'nystagmus is not recorded I have no explanation and I do not recall seeing nystagmus'*. Dr Farboud also accepted later in his oral evidence that, '*nystagmus is important and part of a comprehensive examination'*. Dr Farboud had accepted in his oral evidence that he had not considered the nystagmus.

67. The Tribunal also took into consideration that even if Dr Farboud was in *'panic mode'* at the time, it was not a plausible explanation as to why he had not made a record of having carried out the assessments.

68. It also considered Dr Farboud's oral evidence, '*I have not fully appreciated the severity of the injury at that point. I failed on that front to elicit a full examination*'. The Tribunal was of the view that this evidence from Dr Farboud was akin to acceptance that he had not carried out adequate and appropriate assessments.

69. The Tribunal also bore in mind that in Dr Farboud had cancelled other engagements to attend to Patient B on 21 September 2017. In his oral evidence he confirmed he did this as '*this was a concern about whether Patient B had sustained a serious injury*'. The Tribunal was of the view that it was inconceivable that Dr Farboud would not have made a record of the assessments he had carried out, considering that there had been a possibility at that time that something had gone wrong.

70. The Tribunal accepted Mr H's evidence that Dr Farboud had failed to carry out an adequate and appropriate assessment of Patient B's facial nerve and nystagmus.

71. For the reasons set out above the Tribunal found paragraphs 3(a)(i)(1) and 3(a)(i)(2) of the Allegation proved.

Paragraph 3(a)(i)(3) and 3(a)(ii)

72. The Tribunal considered whether on 21 September 2017 Dr Farboud reviewed Patient B and had failed to: carry out an adequate and appropriate assessment of Patient B's hearing function; and/or perform a tuning fork Weber test. The Tribunal considered paragraphs 3(a)(i)(3) and 3(a)(ii) of the Allegation separately, but the conclusion it reached was based upon the same evidence of fact because hearing function was to be assessed by doing a Weber test.

73. The Tribunal bore in mind the evidence from Mr H's expert report dated 21 October 2021 that:

> *'The patient should have had their hearing function checked with a Weber tuning fork test. In his statement, Mr Farboud stated that he performed this and that the tuning fork lateralised to the operated ear, indicating a conductive hearing loss, which would be a normal result in a patient with ear packing in place. As the patient had a dead ear in the operated ear and normal hearing in the non-operated ear, the tuning fork test would have lateralised to the non-operated ear.'*

74. The Tribunal took into consideration that in Patient B's medical records there had been no record of a Weber test being carried out to determine hearing function. Dr C in his statement to the Trust dated 9 October 2017 stated that Patient B had told him that she had not had a Weber test done before:

> *'checked her hearing clinically using the Weber tuning fork test. She indicated she had not had this test done before, which surprised me because Mr Farboud had mentioned it in his text.'*

75. The Tribunal bore in mind that Patient B's account given to Dr C was made one week after the surgery.

76. It noted the text message Dr Farboud had sent to Dr C on 21 September 2021:

> *'She hasn't got a dead ear, webers lateralised to the operated ear and she has no nystagmus or vertigo, just unsteady'*

77. The Tribunal bore in mind that in Dr Farboud's written evidence he had stated that he had completed the Weber test by placing the tuning folk on Patient B's forehead and then in oral evidence he had stated that he had put the tuning fork on the top of the

head. Later in oral evidence he said he could not remember the specifics of how he carried out the Weber test with Patient B.

78. The Tribunal found that a Weber test was not carried out by Dr Farboud to assess Patient B's hearing function. It had evidence from Dr C that Patient B informed him that a Weber test had not been carried out. It had not accepted Dr Farboud's evidence as it was inconsistent and there was no record in Patient B's medical notes that the Weber test had been undertaken.

79. The Tribunal determined that Dr Farboud failed to carry out an adequate and appropriate assessment of Patient B's hearing function and failed to perform a tuning fork Weber test. Therefore, found paragraphs 3(a)(i)(3) and 3(a)(ii) of the Allegation proved.

Paragraph 3(a)(iii)

80. The Tribunal considered paragraph 3(a)(iii) of the Allegation, it noted that Dr Farboud had admitted this paragraph of the Allegation during the hearing. However, this paragraph of the Allegation was an alternative to paragraph 3(a)(ii), which the Tribunal found proved for the reasons set out above.

81. The Tribunal therefore determined that paragraph 3(a)(iii) of the Allegation could not be found proved.

Paragraph 4(a)

82. The Tribunal considered paragraph 4(a) of the Allegation whether Dr Farboud knew the statement he had made in paragraph 2(d), that he advised Patient B that the head bandage was the cause of her facial weakness and that it would improve, was untrue because he knew that a head bandage would not cause facial weakness.

83. The Tribunal bore in mind that Dr Farboud had admitted paragraph 2(d) of the Allegation. Dr Farboud said in his evidence that the tight bandage would have caused loss to facial mobility and admitted in oral evidence that head bandage would not cause facial weakness. The Tribunal was of the view that Dr Farboud knew that a head bandage would not cause facial weakness. Therefore, the Tribunal determined to find paragraph 4(a) of the Allegation proved.

Paragraph 5(a)

84. Having found that Dr Farboud knew the statement he made at paragraph 2(d) was untrue, the Tribunal went on to consider whether Dr Farboud's conduct was dishonest by the objective standards of ordinary decent people. The Tribunal had found that Dr Farboud knew that facial weakness was not caused by a tight head bandage. The Tribunal considered that there was no requirement that Dr Farboud must appreciate that what he had done was by the standards of ordinary decent people dishonest per *Ivey*. The Tribunal considered that ordinary decent people would consider Dr Farboud's conduct was dishonest.

85. It determined that paragraph 5(a) of the Allegation was found proved.

Paragraph 4(b)

86. The Tribunal considered paragraph 4(b) of the Allegation, whether Dr Farboud on 21 September 2017 knew that when he had texted Dr C and told him that Patient B '*hasn't got a dead ear, Webers lateralised to the operate ear*', that was untrue.

87. The Tribunal had found proved that Dr Farboud had failed to carry out an adequate and appropriate assessment of Patient B's facial nerve, nystagmus and hearing function, as set out above. The Tribunal had also found that Dr Farboud had not performed the Weber test and Dr Farboud had admitted reporting the results of the Weber test to Dr C. The Tribunal was of the view that as Dr Farboud had not performed the Weber test, but accepted reporting to Dr C the results of that test, it must be untrue. The results cannot be reported if the test had not been performed and therefore, Dr Farboud must have known that the information provided to Dr C was untrue.

88. The Tribunal therefore found paragraph 4(b) of the Allegation proved.

Paragraph 5(b)

89. The Tribunal considered whether Dr Farboud 's conduct was dishonest. The Tribunal had found that Dr Farboud knew that the information Dr Farboud had texted to Dr C was untrue because he had not carried out a Weber test. The Tribunal considered whether ordinary decent people would consider Dr Farboud's conduct was dishonest.

90. The Tribunal was of the view that ordinary decent people would consider Dr Farboud's conduct as dishonest, Dr Farboud had said in a text to his supervisor that he had completed the Weber test when he had not.

91. Therefore, it found that paragraph 5(b) of the Allegation was found proved.

Paragraph 4(c)

92. The Tribunal considered paragraph 4(c) of the Allegation, whether Dr Farboud knew that the information he had texted Dr C, '*she [Patient B] has no nystagmus or vertigo, just unsteady*' was untrue because of his omission in failing to carry out an adequate and appropriate assessment of Patient B's facial nerve, nystagmus and hearing function.

93. The Tribunal had found proved that Dr Farboud had failed to carry out an adequate and appropriate assessment of Patient B's facial nerve, nystagmus and hearing function, as set out above. Dr Farboud had admitted that he had texted Dr C the information. The Tribunal concluded that Dr Farboud knew the information he had texted Dr C was untrue.

94. The Tribunal therefore found paragraph 4(c) of the Allegation proved.

Paragraph 5(c)

95. The Tribunal considered whether Dr Farboud's conduct was dishonest. The Tribunal had found that Dr Farboud knew that the information he had texted to Dr C was untrue because he had not carried out an adequate and appropriate assessment of Patient B's facial nerve, nystagmus and hearing function. The Tribunal considered whether ordinary decent people would consider Dr Farboud's conduct was dishonest.

96. The Tribunal was of the view that ordinary decent people would consider Dr Farboud's conduct as dishonest. Dr Farboud had said in a text to his supervisor that there was no nystagmus or vertigo and that Patient B was just unsteady, when he had not carried out the tests to determine this.

97. Therefore, the Tribunal found that paragraph 5(b) of the Allegation was found proved.

The Tribunal's Overall Determination on the Facts

98. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

Patient A

1. On 28 April 2017 you carried out Septoplasty and Bilateral Antral Washout ('BAWO') on Patient A and you:

    a. failed to:

        i. obtain consent from Patient A for the change in the procedure from Functional Endoscopic Sinus Surgery ('FESS') to BAWO; Admitted and found proved

        ii. inform Patient A of the complications associated with BAWO; Admitted and found proved

        iii. make an adequate record in Patient A's medical records of:

            4. the change in procedure from FESS to BAWO; Admitted and found proved

            5. the reasons for altering the procedure from FESS to BAWO; Admitted and found proved

            6. your discussion with Patient A regarding the complications associated with BAWO. Admitted and found proved

Patient B

2. On 18 September 2017 you carried out a cortical mastoidectomy ('the surgery') on Patient B and:

    a. you continued drilling:

        i. when it was not clinically indicated; Admitted and found proved

        ii. after Dr C told you 'to finish the procedure and close up,' or words to that effect; Determined and found not proved.

    b. your surgery was inadequate in that you:

        i. failed to:

1. ~~use a facial nerve monitor during the surgery~~; Withdrawn

2. recognise the:

   a. short process of incus; **Admitted and found proved**

   b. facial nerve; **Admitted and found proved**

   c. labyrinth; **Admitted and found proved**

3. recognise that you had caused injury to:

   a. short process of incus; **Admitted and found proved**

   b. facial nerve; **Admitted and found proved**

   c. labyrinth; **Admitted and found proved**

ii. caused injury to the:

1. short process of incus; **Admitted and found proved**

2. facial nerve; **Admitted and found proved**

3. labyrinth; **Admitted and found proved**

iii. upon becoming unsure where you were drilling in the ear you failed to:

1. stop drilling; **Determined and found proved**

2. seek assistance from a more senior colleague; **Determined and found proved**

c. following the surgery you failed to:

i. carry out an adequate and appropriate post-operative assessment of Patient B's:

1. facial nerve; **Admitted and found proved**

2. nystagmus; **Admitted and found proved**

3. hearing function; **Admitted and found proved**

ii. recognise that the head bandage would not have caused Patient B's:

1. vertigo; **Determined and found not proved**

2. facial nerve weakness; **Admitted and found proved**

iii. recognise the possibility that you had caused an iatrogenic injury to the facial nerve and labyrinth; **Admitted and found proved**

iv. discuss the serious complication as described in paragraph 2bii with Dr C or another senior colleague; **Admitted and found proved**

v. put in to place an adequate and appropriate management plan as you did not organise:

1. urgent high resolution CT scan of the temporal bones; **Admitted and found proved**

2. bone conduction audiogram; **Admitted and found proved**

3. the commencement of steroids to reduce oedema of the facial nerve; **Admitted and found proved**

4. the commencement of a vestibular sedative; **Admitted and found proved**

5. for Patient B's eye to be protected with lubricants; **Admitted and found proved**

d. you advised Patient B that the head bandage was the cause of her facial weakness and that it would improve. **Admitted and found proved**

3. On 21 September 2017 you:

a. reviewed Patient B and you failed to:

i. carry out an adequate and appropriate assessment of Patient B's:

1. facial nerve; **Determined and found proved**

2. nystagmus; **Determined and found proved**

3. hearing function; **Determined and found proved**

ii. perform a tuning fork Weber test; **Determined and found proved**

iii. in the alternative to paragraph 3aii, to correctly interpret the result of the tuning fork Weber test; **Determined and could not be found proved**

iv. make appropriate and adequate records in Patient B's medical records; **Admitted and found proved**

b. texted Dr C and told him that 'she [Patient B]:

i. hasn't got a dead ear, Webers lateralised to the operate ear'; **Admitted and found proved**

ii. has no nystagmus or vertigo, just unsteady'. **Admitted and found proved**

4. You knew the statement you made at paragraph:

a. 2d was untrue because you knew that a head bandage would not cause facial weakness; **Determined and found proved**

b. 3bi was untrue because of your omissions as described at paragraph 3aii; **Determined and found proved**

c. 3bii was untrue because of your omissions as described at paragraph 3ai. **Determined and found proved**

5. Your actions at paragraph:

a. 2d were dishonest by reason of paragraph 4a; **Determined and found proved**

b. 3bi were dishonest by reason of paragraph 4b; **Determined and found proved**

c. 3bii were dishonest by reason of paragraph 4c. **Determined and found proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. **To be determined**

Determination on Impairment - 20/06/2022

99. 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 Farboud's fitness to practise is impaired by reason of misconduct.

The Evidence

100. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence as follows:

- Continued professional development documentation ('CPD') documentation including but not limited to: Acute Facial Palsy; Communicating in Organisations; Good Practice in Consent for Hospital Doctors; Effective Leadership; Medical Record Keeping. Various dates.

101. The Tribunal also received in support of Dr Farboud number testimonials, all of which it has read.

Submissions

On behalf of GMC

102. On behalf of the GMC, Ms Kathryn Johnson, Counsel submitted that Dr Farboud's fitness to practise is impaired by reason of his misconduct. She submitted that Dr Farboud's misconduct had breached several fundamental tenets of the profession including: making the care of their patients their first concern; be competent; take prompt action if they think the patient safety was compromised; and maintain trust in doctors and the profession by being open, honest and acting with integrity.

103. She submitted that the failures in relation to Patient A relate to a failure to take proper consent and to make adequate records. She referred to Mr G's expert report, which referred to the separate consent guidance which sets out the requirement for a doctor to inform a patient that treatment may result in serious adverse outcomes, and that this was a requirement even if the likelihood was very small. Mr G's opinion was that written consent should have been obtained for the amended procedure and set out that record keeping was inadequate. Mr G's opinion in relation to the failures in relation to Patient A

was that the failings were below, but not seriously below the standard reasonably expected of a doctor at Dr Farboud's stage of training.

104. Ms Johnson submitted that there had been very serious failings in relation to Patient B and in respect of dishonesty. She submitted that Dr Farboud's oral evidence that *'he was not as good as surgeon as he thought he was'*, was to his credit, but that he failed to realise that and appreciate that at the relevant time was of concern.

105. Ms Johnson submitted that in relation to the clinical aspect of the case, there had been a number of failings which related to clinical care. She submitted that Dr Farboud's poor standard of care in relation to Patient B had resulted in life changing consequences for her. Patient B's appearance had been significantly affected, she was unable to work or walk far unaided. In addition, Patient B was unable to do things that she previously did.

106. Ms Johnson submitted that Dr Farboud accepted that he continued drilling when it was not clinically indicated to do so, but this failure was aggravated by his failure to stop and to seek assistance. She submitted that had he done so the injury may have been avoided. His failures on the day of the operation and during the procedure itself, were compounded by his failures postoperatively, firstly on 18 September 2017 and then on 21 September 2017. As a result of Dr Farboud's failure to appreciate the extent of the injury, Patient B had not been properly assessed for a significant period of time. It was only when she was seen by Dr C nine days later that the catastrophic nature of the damage was appreciated. By that time, an earlier opportunity for an earlier management plan and surgery had been at lost.

107. Ms Johnson submitted that when assessing the seriousness of the clinical aspects of the case, it is relevant that Dr Farboud's failings covered the period of several days following the procedure itself. There were a number of opportunities that Mr Farboud had to appreciate the damage that had been caused, but he failed to take them. She submitted that those aspects alone are sufficient to amount to serious misconduct.

108. Ms Johnson submitted that the dishonesty was serious. She submitted that from the evidence the Tribunal can conclude that Dr Farboud knew there was a serious problem. Dr Farboud came in specifically on the morning of 21 September 2017, such was his concern. She submitted that he sought to minimise the symptoms of Patient B and to go further and to cover up what he had done. She submitted that Dr Farboud was dishonest to Patient B and Dr C, his supervisor. She submitted that the facts in relation to Patient B amounted to serious misconduct. She submitted Dr Farboud's actions fell significantly

below the appropriate standard and his actions had brought the profession into disrepute.

109. Ms Johnson submitted that Dr Farboud at the outset of the proceedings admitted a number of paragraphs of the Allegation. However, he had denied the very serious paragraphs of the Allegation in relation to dishonesty. She submitted that it could not be said that Dr Farboud had insight. She submitted that the CPD provided showed that some steps had been made by Dr Farboud in terms of remediation into the clinical aspect. However, there had been no remediation in relation to the dishonesty given that those matters had been denied.

110. She submitted that there was a risk of repetition of such dishonest conduct. She also submitted that the testimonials are of limited weight because they were of considerable age and further it is clear that the authors did not know at the time they wrote their testimonials the full extent of the Allegation. She submitted that a finding of impairment should be made and it was necessary to protect the public, to maintain public confidence and to uphold proper standards of conduct for the profession.

On behalf of Dr Farboud

111. Mr Buchanan, Counsel on behalf of Dr Farboud did not make any submissions on impairment and stated that the GMC's submissions are well founded.

The Relevant Legal Principles

112. 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.

113. In approaching its decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious and then whether the finding of that misconduct which was serious could lead to a finding of impairment.

114. It also bore in mind the case of *General Medical Council v Meadow [2006] EWCA Civ 1390* in which it was held:

'…the purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past.'

115. The Tribunal must determine whether Dr Farboud's fitness to practise is impaired today, taking into account Dr Farboud's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

116. When considering whether fitness to practice is currently impaired, *CHRE v NMC and Paula Grant [2011] EWHC 927 (paragraph 76)* endorsed the following test, formulated by Dame Janet Smith in the Fifth Shipman Report:

'*Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future."*

The Tribunal's Determination on Impairment

Misconduct

117. The Tribunal first considered whether the facts found proved against Dr Farboud amount to misconduct. Misconduct can be found in circumstances where there have been serious departures from expected standards of conduct and behaviour, which can be identified by reference to Good Medical Practice dated April 2019 ('GMP').

Patient A

118. The Tribunal bore in mind that the Allegation in relation to Patient A related to Dr Farboud's failure to take proper consent and his failure to make adequate records.

119. The Tribunal identified that the following paragraphs of GMP are relevant:

> *'17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research*
> *…*
> *21 Clinical records should include:*
> *…*
> *b the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
> *c the information given to patients'*

120. The Tribunal considered whether Dr Farboud's failure to take proper consent amounted to misconduct which was serious. It considered Mr G's medical report dated 8 July 2019:

> *'In Consent: patients and doctors making decisions together GMC 2008: para 32 states "You must tell patients if an investigation or treatment might result in a serious adverse outcome, even if the likelihood is very small."*
>
> *In considering expressions of consent para 44 states "Before accepting a patient's consent, you must consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed."*

121. The Tribunal accepted GMC submissions and Mr G's opinion that Dr Farboud's failure to take proper consent '*fell below the standard expected of a reasonably competent Speciality Registrar in Otolaryngology*'. The Tribunal determined that Dr Farboud's conduct, failure to take proper consent from Patient A, did not fall so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

Record keeping Patient A and Patient B

122. The Tribunal took into consideration the Allegation in relation to record keeping for both Patient A and Patient B. The Tribunal considered whether Dr Farboud's failure to make adequate records amounted to misconduct which was serious.

123. The Tribunal considered Mr G's opinion in relation to Patient A, '*Record keeping in my opinion fell below the standard expected of a reasonably competent Speciality Registrar in Otolaryngology*'.

124. The Tribunal bore in mind Mr H's opinion in relation to Patient B, he was of the opinion that Dr Farboud's failure to make adequate records was seriously below the standards expected.

125. The Tribunal bore in mind that Mr G when he had written his expert report was not privy to information in respect of the paragraphs in the Allegation in relation to Patient B. The Tribunal accepted GMC's submissions and Mr H's expert opinion that inadequate recording keeping fell seriously below the standards. The Tribunal has concluded that Dr Farboud's conduct in relation to recording keeping, taking Patient A and Patient B together, amount to serious misconduct.

Patient B

126. The Tribunal identified that the following paragraphs of GMP are relevant:

> *'7 You must be competent in all aspects of your work, including management, research and teaching.*
> *…*
> *14 You must recognise and work within the limits of your competence.*
> *…*
> *15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
> *a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> *b promptly provide or arrange suitable advice, investigations or treatment where necessary*

16 In providing clinical care you must:
…
b provide effective treatments based on the best available evidence
…
d consult colleagues where appropriate
…
55 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:
a put matters right (if that is possible)
b offer an apology
c explain fully and promptly what has happened and the likely short-term and long-term effects.
…
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. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.'

127. The Tribunal considered Mr H's opinion in his expert report dated 12 October 2021, *'Overall, I think the standard of care was seriously below that expected of a reasonably competent ST8 ENT trainee'*. In addition, it bore in mind his comments in his email dated 8 June 2022:

'If the Tribunal find that Mr Farboud misinterpreted the instruction given to him by Mr C and believed some more drilling was required. Does this affect your opinion as set out in paragraphs 4.02 and 4.03

In response to your question, I would say that if there was misinterpretation of the instructions of Mr C to Mr Farboud and that he believed there was more drilling to be done to complete the operation, it would affect my opinion in that he didn't ignore the instruction of Mr C to stop operating.
He didn't recognise the inner ear and facial nerve whilst operating and did cause injuries to these structures, but these are potential complications that we consent for pre-operatively.
However, I would maintain that his post-operative assessment of the patient was seriously below standard.'

128. The Tribunal reflected on the opinion of Mr H about whether the surgery performed by Dr Farboud was performed adequately and appropriately. He stated:

> *'Firstly, I would expect a reasonably competent ST8 ENT trainee to recognise these structures and not injure them. If these structures were inadvertently damaged, I would expect the trainee to stop and notify the supervising consultant or another senior colleague. This standard of care was seriously below that expected of a reasonably competent ST8 ENT trainee.'*

129. The Tribunal bore in mind the paragraphs of GMP as set out above and accepted Mr H's opinion. Dr Farboud had failed to recognise where he was when he was drilling, failed to stop drilling and failed to seek assistance from a senior colleague and following these failings a catastrophic injury occurred. Following surgery, he had failed to carry out an adequate and appropriate post operative assessment of Patient B. The Tribunal found the care of Patient B to be misconduct which was serious.

130. The Tribunal bore in mind that honesty was a fundamental tenet of the medical profession. It determined to find dishonesty to be misconduct which was serious.

131. The Tribunal has concluded that Dr Farboud's conduct amounted to misconduct which was serious.

Impairment

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

133. The Tribunal accepted that Dr Farboud's denial of some paragraphs of the Allegation did not amount to lack of insight. It also found that Dr Farboud had not given dishonest evidence or deliberately sought to mislead the Tribunal.

Clinical failings

134. The Tribunal bore in mind that Dr Farboud had admitted a lot of the paragraphs of the Allegation at the outset of the hearing in relation to the clinical failings including recording keeping of Patient A and Patient B. The Tribunal was of the view that Dr Farboud had done extensive remediation by way of CPD courses and had shown genuine

remorse for his conduct in his oral evidence. The Tribunal noted that Dr Farboud had offered an unreserved apology to Patient B in his text message to Dr C on 29 September 2017, *'When the patient comes back to Uhw do let me know so I can come and apologise in person to her again.'* The Tribunal took into consideration that this was early on when the injury to Patient B had been discovered.

135. The Tribunal bore in mind that Dr Farboud had produced limited reflection into the clinical failings and what he had learnt.

Dishonesty

136. The Tribunal was of the view that the Dr Farboud had not provided the Tribunal with any evidence of insight into the dishonesty. The CPD documentation had related to one aspect of probity which had been covered in a leadership course Dr Farboud had completed. Dr Farboud had not produced a reflective statement as to what had led him to behave dishonestly.

Conclusion

137. The Tribunal bore in mind that there had been limited reflection produced by Dr Farboud on the clinical failings and recording keeping and what he had learnt, and dishonesty. The Tribunal concluded that remediation was insufficient and that Dr Farboud had partial insight into the conduct and there was a risk of repetition. Dr Farboud's conduct had caused harm to patients. Accordingly, the Tribunal found that Dr Farboud had acted to bring the profession into disrepute; breached a fundamental tenet of the profession and acted dishonestly. Furthermore there was a risk he could do so in the future.

138. The Tribunal also found that a finding of impairment was necessary to protect and promote the health, safety and wellbeing of the public, promote and maintain public confidence in the medical profession and to promote and maintain proper professional standards and conduct for members of the profession. The Tribunal found that public confidence in the medical profession would be undermined if there were no finding of impairment in this case, where Dr Farboud had been dishonest with a patient and to his supervisor and whose clinical failings had caused harm to Patient B.

139. The Tribunal has therefore determined that Dr Farboud's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 21/06/2022

140.Having determined that Dr Farboud's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

141.The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions

142.On behalf of the GMC, Ms Johnson submitted that the appropriate sanction was suspension. She submitted that Dr Farboud had made admissions to the clinical aspects but not to the serious aspects in relation to dishonesty. Dr Farboud had shown genuine remorse for clinical failings and had demonstrated insight into this and provided some remediation, however reflection had been limited. Dr Farboud had no previous disciplinary findings recorded against him.

143.Ms Johnson submitted there were also aggravating factors to consider. Dr Farboud had shown a lack of insight into probity. There had been a number of opportunities to identify injury to Patient B however they had not been taken. There had been three instances of dishonesty which had been found proved. He was dishonest to Patient B and to his supervisor, Dr C. Patient B was left with life changing effects arising from the procedure and a catastrophic impact on her life.

144.Ms Johnson submitted that it was inappropriate to take no action and this was not a case where undertakings had been agreed. She also submitted that it was inappropriate to impose conditions, because the conditions would not be workable, although there was no evidence that Dr Farboud would not comply with them. She submitted that in any event due to the seriousness of the case, in particular probity, meant that conditions would not be appropriate.

145.Ms Johnson submitted that suspension was the appropriate sanction because the misconduct was serious but fell short of being fundamentally incompatible with continued registration. She submitted that there had been no evidence of repetition

since the incident, which had occurred some five years ago. She submitted that it should be recognised and acknowledged that Dr Farboud had not been working in a clinical career.

146. Ms Johnson submitted that the period of suspension was a matter for the Tribunal's discretion, the Tribunal would consider the extent of departure from GMP and the extent of Dr Farboud's acts of dishonesty. She submitted that the dishonesty was significant and sustained dishonesty which meant a substantial period of suspension was required.

147. Ms Johnson submitted in relation to erasure, that it should only follow if that was the only way to protect the public. She submitted that it was the GMC's position that the dishonesty, although serious, was not of such an extent for Dr Farboud to be erased.

On behalf of Dr Farboud

148. On behalf of Dr Farboud, Mr Buchanan submitted that he agreed with the principals that had been set out by Ms Johnson. He submitted that suspension was not disputed and it was not a case that called for erasure. He submitted that notwithstanding the undoubted gravity of this case, both in terms of the consequences for Patient A and the dishonesty found, was not of such a degree that required the ultimate sanction.

149. He submitted that in relation to the post operative conduct most particularly the dishonesty found, that Dr Farboud, having discerned that there had been injury to Patient B, had panicked. Dr Farboud had acted in a way that was wholly out of character. He submitted that was not to trivialise the conduct, but to invite the Tribunal to bear in mind its own experience of human nature. He submitted that the evidence from the testimonial witnesses gave a very positive assessment of Dr Farboud's personal and professional character. He submitted that the misconduct was reprehensible, however invited the Tribunal to put it into proper context.

150. Mr Buchanan submitted that in Dr Farboud's oral evidence, he said that at the time of the relevant incident when the operation was performed on Patient B, he was a very confident surgeon, but having reflected upon that matter, he stated very clearly and humbly in front of the Tribunal that he had now realised that he was not as good as he thought he was. He submitted that there was a high degree of insight and some hope for the future. Dr Farboud understood that the training pathway that may have led to him becoming a consultant ENT surgeon was not one that was sensibly available to him and had no fixed view on his professional future.

151. Mr Buchanan submitted that Dr Farboud had certainly recognised that if he was to continue in this speciality, it could only be as an associate specialist or as a staff grade employee, that was to say, at a level and in a role which reflected the actuality of his abilities as opposed to the abilities he had thought he had. The other route he was considering was general practice training with a specialist interest in ENT. He submitted that Dr Farboud had very clearly demonstrated that he had a degree of insight. Dr Farboud had a career break from late 2018 and prior to that for eight months he was subject to conditions.

152. Mr Buchanan submitted that the Tribunal had recognised that Dr Farboud had done extensive remediation but there had been a lack of remediation in respect of dishonesty. He submitted that a considerable amount had been done in respect of core skills and there was a genuine remorse for his conduct. He submitted that with appropriate intensive work that Dr Farboud could in the future return to practice. He submitted that there are steps that could be taken to remediate his dishonesty, such as a professional ethics course in combination with a significant period of reflection. He submitted that it would be just and proportionate in this case to suspend Mr Farboud's registration. He submitted that erasure was not necessary.

The Tribunal's Determination on Sanction

153. The decision as to the appropriate sanction, if any, to impose in this case is a matter for the Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken the Sanctions Guidance dated November 2020 ('SG') into account and borne in mind the overarching objective.

154. The Tribunal reminded itself that the main reason for imposing any sanction is to protect the public and that sanctions are not imposed to punish doctors, even though they may have a punitive effect. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Farboud's interests with the public interest.

Aggravating and Mitigating Factors

155. The Tribunal has already set out its decision on the Facts and Impairment which it took into account during its deliberations on sanction. Before considering what action, if any, to take in respect of Dr Farboud's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

156.The Tribunal identified the following aggravating factors:

- The catastrophic injury caused to Patient B, which had a serious impact on her life.
- Patient B's injury could have been identified at an earlier stage if it was not for Dr Farboud's failings/dishonesty.
- Dr Farboud's lack of insight into the clinical failings, in the absence of reflection.
- Dr Farboud had shown no insight into the dishonesty, whilst the Tribunal accepted that Dr Farboud's denial of dishonesty did not amount to lack of insight.
- Whilst the dishonest misconduct was not sustained, the Tribunal was of the view that Dr Farboud had maintained the dishonesty. It was of the view that the dishonesty which had related to the head bandage was not the most serious and it had only been maintained over a short period of time. It had, however, found that there had been two incidents of dishonesty: Dr Farboud's bedside discussion with Patient B about the head bandage; and the one text which Dr Farboud had sent to Dr C dated 21 September 2017, which had been split by the GMC into two incidents of dishonesty. The Tribunal considered the text message to be one incident and to be the more serious of the two incidents of dishonest misconduct.

157.Having identified aggravating factors in this case, the Tribunal identified the mitigating factors to be:

- Dr Farboud was a man of previous good character, against whom there had been no previous adverse GMC findings.
- Dr Farboud had made extensive admissions to the clinical failings at the outset of the proceedings.
- Dr Farboud had expressed willingness to apologise to Patient B at an early stage, however had been unable to apologise to Patient B because the Trust had asked him not to. He had also apologised again through the course of these proceedings.
- He had shown remorse which was genuine.
- Extensive remediation had been completed for the clinical failings.

- Whilst the Tribunal had not given this a lot of weight, it bore in mind that, at the time of the incidents Dr Farboud was a year 8, trainee surgeon and had been acting under the supervision of a consultant, Dr C.

- Lapse of time since the incident, it had been nearly five years.

- There had been no evidence that the misconduct had been repeated.

158. The Tribunal balanced the aggravating factors and the mitigating factors. It was of the view that the mitigation was significant for the clinical failings but not for the dishonesty. Overall it concluded that the aggravating factors outweighed the mitigating factors.

159. The Tribunal considered each sanction in ascending order of severity, starting with the least restrictive.

No action

160. The Tribunal first considered whether to conclude the case by taking no action. The Tribunal was of the view that, having regard to the nature of the case, taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances. The Tribunal determined that there are no exceptional circumstances in this case and that, given the seriousness of its findings, it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

161. The Tribunal next considered whether to impose conditions on Dr Farboud's registration. It noted that dishonesty does not fall into the categories of misconduct usually identified in SG where conditions are likely to be appropriate. In light of Dr Farboud's dishonesty, the Tribunal determined that conditions would not be sufficient to promote or maintain public confidence in the medical profession, or proper professional standards and conduct for members of the medical profession or to safeguard the health, safety and wellbeing of the public.

Suspension

162. The Tribunal then went on to consider whether imposing a period of suspension on Dr Farboud's registration would be proportionate and sufficient to satisfy the overarching objective.

163. The Tribunal considered paragraph 91, 92, 97 (a), (e), (f) and (g) of SG to be particularly relevant to its consideration of suspension:

> '91 *Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> 92 *Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*
> …
> *97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> *a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
> …
> *e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> *f No evidence of repetition of similar behaviour since incident.*
>
> *g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

164. The Tribunal considered the aggravating and mitigating factors it had identified. It recognised that the purpose of suspension was to have a deterrent effect, but it also had a punitive effect on a doctor as it prevented the doctor from earning a living.

165. The Tribunal bore in mind that whilst there had been a serious breach of GMP the misconduct was not fundamentally incompatible with Dr Farboud's continued registration. Dr Farboud had acknowledged in his evidence in respect of the clinical failings that he would do his utmost to ensure it would not happen again. The Tribunal considered that there was no evidence before it to show that remediation was unlikely to be successful, there had been no evidence of repetition since 2017 and Dr Farboud had partial insight into the clinical failings.

166. The Tribunal bore in mind that there had been a lapse of time of nearly five years since the incident.

167. The Tribunal considered the SG on erasure but was of the view that, while it had found that Dr Farboud's actions did amount to a number of breaches of GMP, these individual breaches, taking account of the mitigation in this case, were not so serious as to constitute a fundamental incompatibility with continued registration. It was of the view that Dr Farboud had not shown a blatant disregard for GMP. The Tribunal was of the view that the serious clinical failings and dishonesty were in relation to one patient. The failure in relation to inadequate recording keeping was in relation to two patients. The dishonesty, although it had been maintained by Dr Farboud following the surgery, had not been considered by the Tribunal to be persistent.

168. Taking all of the evidence, submissions and its own deliberations into account, the Tribunal was satisfied that a period of suspension would mark the seriousness of Dr Farboud's misconduct. It found that a period of suspension would send out a signal to the profession and the public about what was regarded as behaviour unbefitting a registered doctor.

169. Having considered the sanctions in ascending order of restrictiveness and having determined to suspend Dr Farboud's registration, the Tribunal went on to consider the length of the period of suspension.

170. In deciding on the period of suspension, it took into account the seriousness of Dr Farboud's actions including the dishonesty and catastrophic injury that had been caused to Patient B due to the clinical failings. It also bore in mind the need to demonstrate clearly to Dr Farboud, the profession and the public that his actions were unacceptable. In the Tribunal's consideration of the length of suspension, it particularly took into account the seriousness of how Dr Farboud's misconduct and dishonesty had put patient safety at risk.

171. The Tribunal determined to suspend Dr Farboud's registration from the medical register for a period of eight months. It was satisfied that such a period marked the seriousness of Dr Farboud's misconduct and upheld the overarching objective to protect and promote the health, safety and wellbeing of the public, promote and maintain public confidence in the medical profession and promote and maintain proper professional standards and conduct for the members of the profession and maintain public confidence in the profession.

Review

172. The Tribunal determined to direct a review of Dr Farboud's case. A review hearing will convene shortly before the end of the period of suspension, unless an early review is sought.

173. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Farboud to demonstrate how he has further developed insight and remediated his misconduct which included dishonesty. Any future Tribunal may be assisted if Dr Farboud provides:

i. Evidence that he has reflected on the Tribunal's findings;
ii. Evidence of reflections on what had led him to behave dishonestly and further reflection on the clinical failings;
iii. Evidence of remediation in particular any training with respect to probity;
iv. Evidence that he has kept his medical knowledge and skills up to date including relevant Continued Professional Development; and
v. Any other relevant evidence that Dr Farboud considers will assist the reviewing tribunal.

Determination on Immediate Order - 21/06/2022

174. Having determined to suspend Dr Farboud's registration from the Medical Register the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Farboud's registration should be subject to an immediate order.

Submissions

On behalf of the GMC

175. On behalf of the GMC, Ms Johnson submitted that it was appropriate for an immediate order of suspension. She submitted that it was in the public interest to make such an order, given the serious nature of the concerns that had been proved in this case and the fact that they involved dishonesty. She submitted that the public would expect, in the circumstances of this case, for there to be an immediate order.

176. Ms Johnson requested the Tribunal to revoke the interim order currently in place with immediate effect.

On behalf of Dr Farboud

177. On behalf of Dr Farboud, Mr Buchanan made no submissions.

The Tribunal's Determination

178. The Tribunal had careful regard to the submissions made by the parties and to the guidance contained within the SG at paragraphs 172, 173 and 178 which states that:

> *'172. The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173. An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> *178. Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The*

tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'

179. The Tribunal bore in mind that Dr Farboud, at present, is not practising clinically as a doctor. It considered the submissions and in light of all the circumstances of the case and in particular having regard to the seriousness of the misconduct, the Tribunal determined that it was necessary to impose an immediate order of suspension on Dr Farboud's registration, to protect members of the public and it was in the public interest.

180. This means that Dr Farboud's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from today unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

181. The interim order currently imposed on Dr Farboud's registration will be revoked when the immediate order takes effect.

182. This concludes the case.

Confirmed

Date 21 June 2022 Mrs Julia Oakford, Chair