PUBLIC RECORD

Dates: 12/02/2024 - 01/03/2024

Medical Practitioner's name:	Dr Fakher GENDY
GMC reference number:	3642991
Primary medical qualification:	MB BCh 1974 University of Asyut

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

Summary of outcome

Suspension, 9 months

Tribunal:

Legally Qualified Chair	Mr Sean Ell
Lay Tribunal Member:	Mrs Lorna Taylor
Medical Tribunal Member:	Dr Jane Mamelok

Tribunal Clerk:	Mx Nate Caruso-Kelly

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Andrew Colman, Counsel, instructed by the MDDUS
GMC Representative:	Mr Nicholas Walker, 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 - 23/02/2024

Background

1. Dr Gendy qualified in 1974 at Assuit University in Egypt. Dr Gendy worked as an SHO Obstetrician in Ireland, the United Kingdom, and Saudi Arabia until 1995. Between 1995 and 2014, Dr Gendy worked as a Consultant Obstetrician in the United Kingdom and Egypt. From July 2014 to April 2021, he held locum contracts in obstetrics and gynaecology at a number of NHS hospitals as well as providing care in the private sector. He worked at the Northern Devon Healthcare Trust ('the Trust') on three separate occasions. Firstly, in 2017 for approximately two weeks; in 2018 for approximately six months; and then on a long-term locum contract between November 2019 and March 2021.

2. The allegation that has led to Dr Gendy's hearing can be summarised as; Dr Gendy completed theatre booking forms for Patients A and B, and falsely recorded in both forms that the procedure was 'repair of a small labial tear', which was dishonest and designed to conceal the fact that he intended to carry out hymenoplasty procedures on Patients A and B.

3. Further, it is alleged that on 12 November 2020 Dr Gendy treated Patient C and failed to adequately communicate with attending staff, in that he did not explain his rationale for proceeding with instrumental delivery and he told midwifery colleagues that fetal monitoring was unnecessary. Further, that he failed to explain his rationale to Patient C. It is also alleged that he failed to diagnose, in a timely manner, that shoulder dystocia had occurred, that he failed to manage it adequately by performing internal manoeuvres and that he applied inappropriate traction. Finally, that he recorded in Patient C's medical records that he had performed internal manoeuvres when he had not, and this was dishonest.

4. It is also alleged that on 26 February 2021 Dr Gendy treated Patient D and failed to recognise, in a timely manner, that Patient D had suffered a maternal collapse. He then failed to respond to that, in that he did not; play an active role in resuscitating Patient D, consider the emergency delivery of Patient D's baby in light of the collapse, provide adequate

guidance to the MDT, or communicate the urgency of the clinical picture to the attending anaesthetist. It is also alleged that Dr Gendy failed to recognise the significance of Patient D's blood loss and failed to give consideration to; the tone of the uterus, any tissue remaining in the uterus, any trauma to the genital tract and/or uterus, or thrombin. Further that Dr Gendy failed to request in a timely manner the administration of the required medication, attempt to limit ongoing bleeding by performing bimanual compression to Patient D's uterus, and he failed to remain in theatre while Patient D was bleeding and instead leaving to contact Mr E ([Mr E]). Finally, it is alleged that Dr Gendy failed to recognise Patient D's massive obstetric haemorrhage, adequately perform bimanual compression of her uterus when asked to do so, and appropriately lead the MDT during the emergency.

5. The initial concerns about Patient D and Patient C were raised with the GMC by the Trust on 17 May 2021, following an internal investigation. The concerns about Patients A and B were raised during the GMC investigation into Dr Gendy's practice.

The Outcome of Applications Made during the Facts Stage

6. The Tribunal granted the GMC's application, made pursuant to Rule 17(2)(c) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that paragraph 8 (c) (v) of the Allegation be amended. The GMC submitted that the amendment would correct a grammatical error and ensure that the paragraph of the allegation made sense. There was no objection from Dr Gendy to the amendment. The Tribunal was satisfied that the amendment could be made without any injustice.

The Allegation and the Doctor's Response

7. The Allegation made against Dr Gendy is as follows:

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

Theatre booking form(s)

1. On or around 4 February 2020 you completed a theatre booking form for:

   a. Patient A;

   b. Patient B;

   and you falsely recorded 'repair of a small labial tear' in the procedure name section.
   Admitted and found proved.

2. You knew that the information you included in the theatre booking form(s) as set out in paragraph 1 was:

   a. untrue;

b. not accurate;

in that you had intended to perform a hymenoplasty on Patient A and/or Patient B and not the repair of a small labial tear.
Admitted and found proved.

3. Your actions as described at paragraph(s):

a. 1a were:

i. dishonest by reason of paragraph 2a;
To be determined.

ii. designed to conceal the fact that you had intended to perform a hymenoplasty on Patient A and not the repair of a small labial tear;
To be determined.

b. 1b were:

i. dishonest by reason of paragraph 2a;
To be determined.

ii. designed to conceal the fact that you had intended to perform a hymenoplasty on Patient B and not the repair of a small labial tear.
To be determined.

Patient C

4. On or around 12 November 2020 you treated Patient C and you failed to:

a. adequately communicate with:

i. the attending midwifery and/or anaesthetic staff, in that you:

1. did not explain your rationale for proceeding with instrumental delivery;
To be determined.

2. told one or more midwifery colleagues that fetal monitoring was unnecessary, or words to that effect;
To be determined.

ii. Patient C, in that you did not explain the rationale for proceeding

with instrumental delivery;
To be determined.

b. diagnose in a timely manner that shoulder dystocia had occurred;
To be determined.

c. adequately manage the shoulder dystocia, in that you:

i. did not proceed to internal manoeuvres;
To be determined.

ii. continued to apply inappropriate axial traction.
To be determined.

5. You recorded in Patient C's medical records that you had performed internal manoeuvres ('the Entry'), which was untrue.
To be determined.

6. You knew that the Entry in Patient C's medical records was untrue.
To be determined.

7. Your actions as described at paragraph 5 were:

a. designed to cover up the fact that you had not performed internal manoeuvres;
To be determined.

b. dishonest by reason of paragraph(s) 6 and 7a.
To be determined.

Patient D

8. On or around 26 February 2021 you treated Patient D and you failed to:

a. recognise, in a timely manner, that Patient D had suffered maternal collapse;
To be determined.

b. adequately respond to the fact that Patient D had suffered maternal collapse, in that you did not:

i. play an active role in the initial resuscitation of Patient D;
To be determined.

ii. consider the emergency delivery of Patient D's baby in

light of the maternal collapse;
To be determined.

iii. provide adequate guidance to the multi-disciplinary team ('MDT') as to how to manage and/or respond to the maternal collapse;
To be determined.

iv. communicate the urgency of the clinical picture to the attending anaesthetist, in that you did not explain the need for a general anaesthetic;
To be determined.

c. adequately manage Patient D's postpartum haemorrhage, in that you did not:

i. recognise the significance of Patient D's blood loss and/or transfusion;
To be determined.

ii. give consideration, in a timely manner, to:

1. the tone of the uterus;
To be determined.

2. any tissue remaining in the uterus;
To be determined.

3. any trauma to the genital tract and/or uterus;
To be determined.

4. thrombin;
To be determined.

iii. request, in a timely manner, the administration of one or more of the medications listed in Schedule 1 to improve uterine tone;
To be determined.

iv. attempt, in a timely manner, to limit the ongoing vaginal bleeding by bimanual compression of Patient D's uterus;
To be determined.

v. ~~left~~ remain in the theatre whilst Patient D was ~~still~~ bleeding and instead left to ~~so that you could~~ contact Mr E, rather than delegating this to an appropriate colleague;
To be determined.

d. recognise, in a timely manner, Patient D's massive obstetric haemorrhage;
To be determined.

e. adequately perform bimanual compression of Patient D's uterus when Ms F asked you to do so;
To be determined.

f. appropriately lead the MDT during the emergency.
To be determined.

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

The Admitted Facts

8. At the outset of these proceedings, through his counsel, Mr Colman, Dr Gendy made admissions to paragraphs 1 and 2 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 of the Allegation as admitted and found proved.

The Facts to be Determined

9. In light of Dr Gendy's response to the Allegation made against him the Tribunal is required to determine whether Dr Gendy's actions at paragraphs 1 and 2 were dishonest or designed to conceal the fact that he had intended to perform hymenoplasties on Patients A and B. The allegations relating to Patient C and Patient D were denied in their entirety.

Witness Evidence

10. The Tribunal received evidence on behalf of the GMC from the following witnesses, who also gave oral evidence at the hearing:

- Dr H, speciality doctor in anaesthetics, dated 20 April 2023;
- Ms F, Labour Ward Co-ordinator, dated 11 January 2022;
- Mr E, Consultant Obstetrician and Gynaecologist, dated 9 December 2021;
- Ms I, maternity care assistant, dated 20 April 2023;
- Ms J, Senior Midwife, dated 19 May 2022;
- Ms K, Midwife, dated 19 April 2023;
- Dr L, Paediatrician (specialty trainee in Paediatrics), dated 11 May 2022 and 19 May 2023;
- Dr N, speciality doctor in anaesthetics, dated 14 April 2023;
- Patient C, dated 24 April 2023; and

- Patient C's partner, Mr G, dated 15 May 2023.

11. Dr Gendy provided his own witness statement dated 30 August 2023 and gave oral evidence at the hearing.

Expert Witness Evidence

12. The Tribunal also received evidence from 2 expert witnesses. Dr O is a Consultant in Obstetrics and Gynaecology, having joined the Specialist Register in 2009, and being appointed consultant the same year. Dr O was lead for Obstetric Governance in Craigavon Hospital until 2020 and was then appointed Chair of Serious Adverse Incident Reviews. Dr O provided three reports dated 2 April 2022, 19 September 2022, and 15 May 2023, concerning Patients C and D, and gave oral evidence at the hearing.

13. Dr P was appointed Consultant Obstetrician and Gynaecologist in 1990 and retired from clinical practice in 2022. Dr P held various posts including Labour Ward Lead and Patient Safety Lead for the East Midlands Strategic Health Authority. Dr P provided a report dated 13 April 2023, concerning Patients A and B, and gave oral evidence at the hearing.

Documentary Evidence

14. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to theatre booking forms for Patients A and B, emails between Dr Gendy and Mr Q dated 4-5 February 2020, various testimonials on Dr Gendy's behalf, referral from the Trust dated 17 May 2021, Datix completed by Ms J dated 12 November 2020, Patient C's available medical notes, Patient D's available medical notes, Ms F's statement to the Trust, undated, and Mr E's statement to the Trust, undated, and Dr Gendy's Rule 7 responses dated 22 November 2022 and 12 June 2023.

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 Gendy 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

16. 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.

<u>Paragraphs 3 (a) i and 3 (b) i</u>

17. The Tribunal first considered whether Dr Gendy's action when he recorded *'repair of a small labial tear'* on the theatre booking forms for Patients A and B, when he knew that the information on the form was untrue and not accurate, was dishonest.

18. The Tribunal first ascertained Dr Gendy's knowledge and belief at the time. In his witness statement he explained:

> *'Both patients informed me that they wanted a hymen repair due to cultural reasons. They were both very worried about the potential reprisals if their family or their community found out that they had undertaken a hymenoplasty.*
> *Both patients therefore asked if there was a way of undertaking the procedure where their family would not find out. As the patients' medical records are private, their family would not see those, but there was the possibility that a family member could see the theatre list or the procedures in the Ward Sister's station, which would follow the theatre booking form. … Having booked the procedures under the names of 'repair of a small labial tear',*
>
> *I received an email from Mr Q (Managing Director at Pall Mall Medical), in which he asked me whether the procedures were hymenoplasty procedures. I was completely open and honest about the fact that they were hymenoplasty Procedures.'*

19. The Tribunal further considered the contents of the email which Dr Gendy sent to Mr Taylor on 5 February 2020, the day after the booking forms were completed, in which he stated:

> *'These are my own private patients and they are for hymenoplasty but they preferred to have the operation under the name of repair of a labial tear to protect themselves. It was their own choice which I have to respect. Person R told me about another case which I asked him to contact you about directly.*
> *I did not know we do not do them at PMM as I did one last year and was PMM patient and I had to contact Person S for a price and she was done in theatre but I can not remember the fee.*
>
> *I do respect your opinion and will not do these patients at PMM in the future.'*

20. The Tribunal was mindful that hymenoplasty was, at the time, a highly contentious procedure, and became illegal shortly after these events. The Tribunal also bore in mind the extreme cultural sensitivities around the procedure, and that the patients had expressed a fear about the potential risk to their safety and wellbeing if their families were to become aware they had undergone the procedure.

21. The Tribunal noted that when challenged by Mr Q the following day, Dr Gendy was immediately open about the real procedure he was to undertake. The Tribunal considered this supportive of Dr Gendy's evidence that he intended to inform PMM and his colleagues that the procedure would be a hymenoplasty before carrying it out.

22. The Tribunal also noted that his explanation to Mr Q about why he had put a different procedure on the booking form was to protect the patients. Given the proximity to his decision to put a different procedure on the booking form, the Tribunal considered this significant evidence as to his thinking at the time. The Tribunal was of the view that his email to Mr Q also supported Dr Gendy's explanation that he was concerned there was a risk of the name of the procedure being seen by the patients' families on the theatre list, either on the theatre room door or else in the Ward Sister's office and he was trying to protect the patients. The Tribunal considered that although the risk of any family member seeing the theatre list was remote, the consequences of the procedure being discovered by their families could have been extremely serious for the patients.

23. The Tribunal accepted that at the time Dr Gendy had agreed to do the hymenoplasty for the patients he had been unaware of PMM's decision not to undertake the procedures anymore. Once notified by PMM of the decision he informed the patients that he would be unable to carry out the procedure for them. There was no other discernible motivation for Dr Gendy to complete the booking forms in the way that he did, save for the reason given to Mr Q, to protect the patients.

24. The Tribunal accepted Dr Gendy's evidence that he believed it was permissible to disguise the name of the procedure to protect a patient, provided the medical records were accurate and the patient and his colleagues were aware of the true procedure. Further, Dr Gendy intended the inaccuracy to be limited to the booking form / theatre list, documents which he believed would not be retained as a part of the patients' medical record. The Tribunal therefore concluded that at the time Dr Gendy's genuine held belief was that completing the booking form inaccurately, in the way he did, was required to protect the patients from potential serious harm from their families.

25. Having ascertained (subjectively) the actual state of Dr Gendy's belief as to the facts, the Tribunal proceeded to consider whether his conduct was honest or dishonest by applying the (objective) standards of ordinary decent people. The Tribunal concluded that given all the circumstance ordinary decent people would not view Dr Gendy's conduct as dishonest, his action designed as it was, to protect the patients from potential serious harm.

26. The Tribunal therefore found paragraphs 3 (a)i and 3(b)i not proved.

Paragraphs 3 (a) ii and 3 (b) ii

27. The Tribunal then considered whether Dr Gendy's actions were designed to conceal the fact that he had intended to perform a hymenoplasty on Patients A and B and not the repair of a small labial tear.

28. The Tribunal bore in mind that the GMC's case in relation to this allegation was that Dr Gendy had intended to conceal the procedure from both patients' families and from PMM

itself. The Tribunal therefore first considered whether Dr Gendy had attempted to conceal the procedure from the patients' families.

29. The Tribunal took into account Dr Gendy's evidence, set out above, and his oral evidence, that he filled out the booking form incorrectly in order to prevent the hymenoplasties being listed on the theatre list, and therefore conceal the procedure from any family member who may accompany the patient and see the list. He did so to protect the patients. The Tribunal concluded that in respect of the patients' families Dr Gendy, as he accepted, had intended to conceal the true procedure from them at the patients' request.

30. The Tribunal next considered whether Dr Gendy had intended to conceal the procedure from PMM. The Tribunal took into account Dr Gendy's email to Mr Q, set out above, in which he immediately informed Mr Q that he was intending to perform hymenoplasties, and he made no attempt to convince Mr Q otherwise. The Tribunal accepted Dr Gendy's evidence that he always intended to fully inform PMM of the true procedure to be performed and therefore concluded that it was more likely than not that Dr Gendy had not intended to conceal from PMM he was to undertake hymenoplasty procedures.

31. The Tribunal therefore found paragraphs 3 (a) ii and 3 (b) ii proved, on the basis that Dr Gendy had intended to conceal the procedures from the families of Patients A and B, but not from PMM.

Paragraph 4 (a) i 1

32. The Tribunal first considered what Dr Gendy's rationale was for proceeding with an instrumental delivery. Dr Gendy recorded in Patient C's notes:

> *'12/11/2020*
> *0710*
> *Had fetal heart decel again to 90 recovered with change in the base line from 130 to 120. V/E Cx is fully dilated head is +1 ROT ↓ on pushing. For trial of instrumental delivery in theatre +- c/s. Pt informed of all the risks. Agreed. Signed the consent form. Dr T informed.'*

33. The Tribunal also took into account Dr Gendy's witness statement, in which he stated, '*In the delivery room the fetal heart rate showed decelerations and the cervix was fully dilated with a low head, so it was in the interests of the baby to expedite delivery by instrumental delivery or caesarean section.*'. Dr Gendy added to this in his oral evidence by setting out that Patient C was suffering from maternal fatigue and her baby was quite large.

34. The Tribunal therefore accepted that Dr Gendy had a clear rationale as to why he decided to proceed with an instrumental delivery at the time. The Tribunal then considered whether Dr Gendy had explained this rationale to the midwifery and anaesthetic team.

35. Dr Gendy's evidence was that he had fully explained his rationale to the midwifery staff, but they disagreed with his approach. Dr Gendy considered it necessary to take a different approach to the midwives' view to ensure patient safety. The difference in view is supported to some extent by the entry made in Patient C's medical notes by Ms J, the senior midwife attending Patient C:

> *'staff grade shown CTG + aware is Normal. Wants to carry on with instrumental delivery. Consultant called for 2nd opinion Dr T.'*

36. In her witness statement Ms J expanded on her note stating:

> *'In the delivery room the fetal heart rate showed decelerations and the cervix was fully dilated with a low head, so it was in the interests of the baby to expedite delivery by instrumental delivery or caesarean section … I asked Mr Gendy if he had discussed his decision to do an instrumental with the consultant on call, Dr T, and he said he had. I was surprised when he told me this. I didn't agree with the situation, so I called Dr T myself at around 07:40. She said that Mr Gendy had described the situation quite differently.'*

37. The Tribunal further took into account the retrospective entry made in Patient C's medical records shortly after the birth by Ms K, a midwife attending Patient C:

> *'discussed ? need for forceps without any trial of pushing with Dr Gendy in view of normal CTG … He wishes to continue.'*

38. The Tribunal further took into account Ms K's witness statement, in which she stated:

> *'I recall that we had a briefing before going to theatre and I asked Dr Gendy if he felt we needed to continue with an instrumental delivery at this stage because the CTG had been normal for around 25 minutes, and he said 'yes'. Dr Gendy did not explain the reason behind the plan for forceps delivery to me. I would presume it was because of the patients prolonged deceleration or bradycardia episode, but he never explained.'*

39. The Tribunal found that Ms K's entry in the patients notes, although retrospective, was made within hours of Patient C's delivery. This is supported by her witness statement, in which she recollects questioning Dr Gendy on why they were proceeding with an instrumental delivery and that she did not receive a clear explanation from him.

40. The Tribunal considered both Ms J and Ms K's notes in the record to be supportive of one another as to their lack of understanding as to why Dr Gendy was proceeding to an instrumental delivery; to the extent that it necessitated Ms J contacting the Consultant. The Tribunal considered the different description to Ms J and the Consultant to be supported by the difference in Dr Gendy's note of his rationale and the midwifery notes as to their understanding of the position. The Tribunal considered this significant evidence that Dr

Gendy had not fully explained his rationale for the instrumental delivery to either Ms J or Ms K.

41. The Tribunal further took into account the evidence of Dr N, the anaesthetist who was called to assist in theatre with Patient C's epidural. In her witness statement, Dr N stated:

> *'I don't recall Dr Gendy giving any explanation as to why an instrumental delivery was being attempted, however in my experience we do not usually get that kind-of information communicated to us on the anaesthetic team.'*

42. The Tribunal considered there were three corroborating accounts which stated that Dr Gendy did not fully explain his rationale for proceeding with an instrumental delivery, which was supported in the notes recorded in the patient's records. The Tribunal therefore preferred the evidence of Dr N, Ms K and Ms J to Dr Gendy's on this matter.

43. The Tribunal was mindful, however that Dr N stated she would not ordinarily expect an explanation as to why the procedure was happening, but only what the procedure was. Given Dr N's evidence, the Tribunal considered it was not a failure for Dr Gendy to have not explained the rationale behind his decision to proceed with an instrumental delivery to the anaesthetist.

44. The Tribunal therefore found that Dr Gendy had only failed to inform the midwifery staff of his rational for proceeding with an instrumental delivery.

45. The Tribunal therefore found paragraph 4 (a) i 1 proved on that basis.

Paragraph 4 (a) i 2

46. The Tribunal accepted the opinion of Dr O that Dr Gendy was under a duty to communicate with midwifery colleagues that fetal monitoring should continue:

> *'The fetal scalp electrode (FSE) needs to be removed before forceps blades are applied. However, in the context of an instrumental delivery, monitoring of the fetal heart during the delivery is essential and should be completed using an abdominal transducer.*
>
> *If Midwife J's comments in her statement are accepted, it was not appropriate for Dr Gendy to tell Midwife K to not bother with fetal monitoring. If this is accepted, Dr Gendy's practice at this point fell seriously below the expected standard.'*

47. The Tribunal first considered the retrospective entry made in Patient C's notes by Ms K shortly after Patient C's delivery:

> *'FSE removed. Told by Dr Gendy not to use external monitoring but commenced as essential to monitor fetal wellbeing: FH 120bpm'*

48. The Tribunal further took into account Ms K's witness statement, in which she stated:

'When forceps are going to be applied, we have to remove the FSE monitoring from the baby's head in case it results in a caesarean birth. I went to put the abdominal monitoring back on, which I recall that Dr Gendy said not to and that it was unnecessary because we were about to deliver the baby. I cannot remember if I said anything to him in response, although I imagine that either myself or Ms J would have said that we were going to continue monitoring. The standard practise and care would be to continue to monitor the baby's heartrate and therefore we recommenced the abdominal monitoring.'

49. The Tribunal also took into account Ms J's entry in Patient C's medical records:

'0750 FSE was removed – Ms K asked to take off completely, advised should monitor externally.'

50. The Tribunal also took into account Ms J's witness statement in which she stated:

'Mr Gendy then decided to remove the fetal scalp electrode and told Ms K not to monitor at all. His words were 'not to bother'. I disagreed with that decision as the fetus needed to be monitored until delivery.'

51. The Tribunal was mindful of Dr O's evidence that it would be extremely unusual to completely discontinue fetal monitoring; however, it was necessary to remove the FSE to facilitate the forceps delivery. Given Dr Gendy's lengthy experience in the management of instrumental deliveries the Tribunal considered it unlikely that he would have explicitly requested there be no fetal monitoring at all.

52. The Tribunal accepted the accounts of Ms J and Ms K, supported by their contemporaneous notes, that they had understood Dr Gendy had instructed that they should remove the FSE and not recommence monitoring in a different way. Although the Tribunal accepted Dr Gendy would not have intended to convey the total removal of monitoring, that is certainly how his comments were perceived and understood. Dr Gendy's words had the effect of instructing the midwives that any fetal monitoring, rather than the FSE, was unnecessary.

53. The Tribunal, taking into account its previous finding regarding Dr Gendy's inadequate communication with the midwifery staff about his rationale, considered that it was more likely that this was down to poor communication by Dr Gendy. The Tribunal therefore concluded that Dr Gendy failed to adequately communicate with his midwifery colleagues by using words that had the effect of implying, incorrectly, that fetal monitoring was unnecessary.

54. The Tribunal therefore found paragraph 4 (a) i 2 proved.

Paragraph 4 (a) ii

55. The Tribunal accepted the evidence of Dr O that Dr Gendy was under a duty to explain to Patient C his rationale for proceeding with instrumental delivery:

> *'If the risk of further problems because of infection was indeed a concern on his part in and around 07:10, it was reasonable to proceed with instrumental delivery, to expedite delivery of the fetus, albeit that he should have communicated this to and the attending midwifery and anaesthetic staff.*
>
> *IF this situation is demonstrated, Dr Gendy's communication fell seriously below the expected standard, rather than his decision to proceed with an instrumental delivery.'*

56. In her evidence Patient C explained that:

> *'I recall that Dr Gendy said something like 'We're going to get you down to delivery and get this baby out. This might be hopefully with forceps, or it might be a C-section'. … I remember that Dr Gendy checked on my baby and told me that he had turned back-to-back. I remember that I vividly said that I did not want a caesarean section ('C-section') unless it was an absolute emergency.'*

57. Patient C did not recall signing a consent form but accepted one must have been done. At the time Patient C was in an extremely stressful situation and was concerned about the possibility of having to undergo a caesarean section.

58. The Tribunal noted the consent form which was signed by Patient C and Dr Gendy on 12 November 2020. The form specifies an '*Operative Vaginal Delivery: forceps and/or vacuum assisted delivery (ventouse)*'. Further Dr Gendy has made a handwritten addition to the form under '*Other procedure*', which reads '*caesarean section'.* The Tribunal considered it more likely than not that as part of the consent process Dr Gendy would have explained the reasons why he was proceeding to an instrumental delivery.

59. Dr Gendy now accepts that, with hindsight, he would have spent more time with Patient C to allow for her and her partner to ask any questions they may have had. The Tribunal was satisfied that it was more likely than not he did adequately explain the rationale for proceeding to an instrumental delivery to Patient C.

60. The Tribunal therefore found paragraph 4 (a) ii not proved.

Paragraph 4 (b)

61. The Tribunal accepted Dr O's opinion that given Dr Gendy's experience he should have been able to identify the shoulder dystocia and it would be extraordinary if he could not:

> *'I would expect any doctor working on a middle grade rota to be able to diagnose shoulder dystocia. Instrumental delivery is a recognised risk factor for shoulder dystocia, as are a maternal BMI of more than 30 kg/m2 (Patient C BMI at booking was 33 kg/m2)26.*
>
> *If the head delivers onto the maternal perineum and then appears to retract, or 'turtle-neck', I would expect the delivering doctor to note this and indicate clearly to the multidisciplinary team that shoulder dystocia has been diagnosed. The accounts of the methods used to relieve the shoulder dystocia and deliver the baby differ. Dr Gendy appears to have noted difficulty with delivery of the shoulders in his summary note in the operative record.*
> *…*
> *If it is accepted that Dr Gendy did not identify the shoulder dystocia clearly, despite being advised by Midwife J, his practice will be shown to have fallen seriously below the expected standard.'*

62. The Tribunal took into account that in his medical note completed shortly after delivery of Patient C's baby Dr Gendy recorded '*Alive male baby delivered with some difficulties in delivering the shoulders.*' Dr O accepted that description was synonymous with shoulder dystocia. The Tribunal was satisfied that Dr Gendy had recorded immediately after the delivery a diagnosis of shoulder dystocia.

63. The Tribunal also took into account Patient C's recollection that Dr Gendy stated to her during the delivery, '*He's stuck on your pelvis'*. The Tribunal found that although this is a non-medical explanation, it does reflect shoulder dystocia, as the baby's shoulder becomes stuck on the pelvis and cannot be delivered.

64. In contrast to Dr Gendy's claim that he had diagnosed shoulder dystocia is the entry in Patient C's medical records made by Ms J, which stated:

> *'0755 Episiotomy + pull x 2 Head delivered facing ROL position maternal left.*
> *0756 No delivery of anterior shoulder, Mr Gendy applying traction with pushing Nil coming. I moved to maternal right side + commenced suprapubic pressure and could feel anterior shoulder aspect of back communicated clearly 'shoulder dystocia' - to put legs into McRoberts'*

65. The Tribunal also took into account the retrospective entry in Patient C's records made shortly after by Ms K:

> *'0755 2nd pull, episiotomy and delivery of head, resituated to face maternal left*

0756 Baby not delivering despite maternal pushing and axial traction. Dr Gendy initially said not SD however shoulder dystocia clearly communicated by Ms J – she is applying suprapubic pressure to R side. I have told Patient C to stop pushing'

66. Both accounts are corroborative of each other that Dr Gendy did not communicate shoulder dystocia to them. However, neither is able to comment on Dr Gendy's state of knowledge at the time. The Tribunal took into account its previous findings that there had been poor communication from Dr Gendy to his colleagues and there were concerns from both Ms K and Ms J about Dr Gendy's decision to proceed with an instrumental delivery.

67. The Tribunal was mindful that Dr Gendy was performing the delivery himself and would have been fully appraised of the position of the baby throughout the delivery. The Tribunal preferred Dr Gendy's evidence particularly given his extensive experience in obstetrics and Dr O's evidence that it would be extraordinary for a senior obstetrician not to be able to identify shoulder dystocia. The Tribunal considered his diagnosis was supported by Patient C's evidence and his notes at the time. The Tribunal considered it highly unlikely he would have recorded in his notes an indication of shoulder dystocia if he had not diagnosed it and it was more likely than not that he had.

68. The Tribunal therefore found paragraph 4 (b) not proved.

Paragraph 4 (c) i

69. The Tribunal accepted Dr O's evidence that the correct management of shoulder dystocia is to proceed to internal manoeuvres:

'All of these training packages use the same algorithm included in the guideline from the RCOG entitled 'Shoulder Dystocia'27, included as a separate document to this report as Appendix 2. I would expect any doctor working on the middle grade rota in Obstetrics to know how to manage shoulder dystocia as a basic skill.

If it is accepted that Dr Gendy did not know when or how to proceed to internal manoeuvres, despite being prompted to do so by Midwife J and continued to use axial traction without success, as is the comment by Midwife J, his practice in this area of management of shoulder dystocia fell seriously below that expected.'

70. The Tribunal took into account the retrospective entry made in patient C's notes by Ms K shortly after the delivery, which states, '*Ms J has suggested he [Dr Gendy] does internal manoeuvres'*. The Tribunal also considered the note made by Ms J, which states, '*Mr Gendy still applying traction to fetal head – asked him to 'stop' + to start internal manoeuvre … Mr Gendy asked a 2nd time to stop traction to fetal head + to start internal manoeuvres. Informed that shoulder is coming'.*

71. The Tribunal further took into account the witness statement provided by Dr L, the paediatrician in attendance, which stated:

> *'During the delivery of baby I do not recall any member of staff performing internal manoeuvres. I remember the baby's head being delivered. I remember a lot of flexion and pressure being applied to deliver the anterior shoulder. I don't recall seeing Dr Gendy insert his hand or attempt to perform internal manoeuvres.'*

72. The Tribunal then considered Dr Gendy's contemporaneous note, in which he stated, '*int. manoeuvres used*'.

73. The Tribunal further took into account Patient C's witness statement, in which she stated:

> *'I remember watching them perform 'internal manoeuvres' and I think it was Dr Gendy. I remember feeling like the doctor's entire arm was inside me. I have grown up in the countryside and watched many calves being born; in that moment I felt like a cow.'*

74. Given the Tribunal's finding that Dr Gendy had diagnosed shoulder dystocia, the correct treatment of that would be to proceed to internal manoeuvres. The Tribunal was mindful that none of the contemporaneous notes, state specifically that Dr Gendy did not perform internal manoeuvres, nor do others claim to have performed internal manoeuvres themselves. Dr Gendy's surgical note confirms that he did perform internal manoeuvres and his evidence is supported by Patient C who remembers Dr Gendy performing internal manoeuvres. As such the Tribunal was satisfied that it was more likely than not that Dr Gendy had performed internal manoeuvres.

75. The Tribunal therefore found paragraph 4 (c) i not proved.

<u>Paragraph 4 (c) ii</u>

76. The Tribunal accepted Dr O's opinion that the use of excessive axial traction would be inappropriate:

> *'It is difficult to be clear if Dr Gendy applied 'too much' pressure. It has been my experience that babies born after management of shoulder dystocia can be bruised, even when traction and force has been used judiciously.'*

77. The Tribunal first considered the entry in the medical notes by Ms J, '*Mr Gendy still applying traction to fetal head – asked him to 'stop' + to start internal manoeuvre … Mr Gendy asked a 2nd time to stop traction to fetal head + to start internal manoeuvres. Informed that shoulder is coming'*. The Tribunal noted that although Ms J had asked Dr Gendy to stop applying traction to the fetal head on two occasions it has found that Dr Gendy had himself identified the shoulder dystocia.

78. The Tribunal also took into account the witness statement provided by Dr L, in which he stated:

> *'I do remember when Mr Gendy was delivering the head that he was applying some pressure. I chatted with the midwives afterwards and we agreed that we felt that it was far too much pressure. I would have chatted to Ms J as she was present at the delivery with me.*
>
> *I think that during the delivery, me and some of the general theatre staff were making eye contact to make the inference that Mr Gendy was applying too much pressure. I can't recall who it was that I was looking at, but I think Ms J would have been present as well.'*

79. The Tribunal further took into account the statement provided by the anaesthetist Dr N, in which she stated:

> *'I saw the paediatrician, Dr L, when he came to bring the baby to Patient C. He looked distressed and so I took him into the adjoining anaesthetic room and I asked him if he was okay. I remember that he was shaking whilst speaking and seemed distressed. I felt like he needed a debriefing and some reassurance. Dr L said 'that was the roughest delivery I have ever witnessed'. I asked him what had happened and all I recall him saying was 'It was a shoulder dystocia'. I asked him if they were taking the baby upstairs to paediatrics and he said 'yes, definitely'. I asked Dr L 'Will you make a statement and take it further?' and I remember that he said yes.'*

80. The Tribunal also took into account the witness statement provided by Ms K, who stated:

> *'My distinct recollection was that the force being applied to the baby's head by Dr Gendy was excessive and was not routine or appropriate. It seemed to me that Dr Gendy was pulling at the baby's head and neck because he did not know what else to do. It was as if he did not know the appropriate management for shoulder dystocia. It felt like Dr Gendy used excessive force because he did not know what to do next.'*

81. The Tribunal further took into account the shoulder dystocia form completed by Ms K shortly after the delivery, which noted '*appeared to be excessive traction (please ese photos of bruise to baby's neck)'.* The Tribunal considered this to be significant evidence of the traction used by Dr Gendy.

82. The Tribunal noted that Dr L had been standing directly behind Dr Gendy and was disturbed by the force applied, so much so that he discussed it after the delivery with Dr N. The Tribunal also considered this evidence to be significant. The Tribunal bore in mind that, at the time, Dr L was an ST3 paediatrician who would have seen a significant number of deliveries and been able to identify excessive traction.

83. Dr Gendy's evidence was that he did not apply excessive axial traction. Dr Gendy's note in Patient C's records makes no mention of traction, how much, when, or for how long.

84. The Tribunal noted that following the delivery a Datix report was lodged by the midwife. The Tribunal considered this supportive that there were concerns about the delivery at the time. Although the Tribunal concluded Dr Gendy had diagnosed shoulder dystocia and performed internal manoeuvres, it considered the evidence was supportive of him having applied excessive traction and therefore he used inappropriate axial traction during the delivery.

85. The Tribunal therefore found paragraph 4 (c) ii proved.

Paragraph 5, 6 and 7

86. The Tribunal, having determined that it was more likely than not that Dr Gendy did perform internal manoeuvres, found paragraph 5 not proved.

87. The Tribunal, having found that Dr Gendy did not make an untrue entry in Patient C's medical records, found paragraph 6 not proved.

88. The Tribunal, having found paragraphs 5 and 6 not proved, therefore found paragraph 7 not proved in its entirety.

Paragraph 8 (a)

89. The Tribunal accepted Dr O's evidence that Dr Gendy was under a duty to recognise that Patient D had suffered a maternal collapse:

> *'Collapse of a mother at any time in pregnancy, but especially in the third trimester, is the subject of standard training in management of obstetric emergencies.*
>
> *I would have expected Dr Gendy to have been aware of the change in physiological condition of Patient A as he was present in the room at the time. It is highly likely that use of the buzzer by the attending midwives resulted in a number of additional staff attending, including Ms F.*
>
> *This alone should have alerted Dr Gendy to a major concern, even if he was facing the other way when Patient A's condition deteriorated so suddenly.'*

90. The Tribunal first considered Dr Gendy's entry in Patient D's medical notes made at the time of Patient D's collapse:

> *'0045 Pt felt faint BP 90/60 Pulse 90 bpm*
> *↑fluid stop oxytocin*

Feeling better now

0046 Fetal bradycardia to 90 not recovering, for Cat CS
Mr E informed'

91. The Tribunal noted there is no explicit mention of a maternal collapse in the note. Mr E's evidence was that he was unaware of the maternal collapse until a midwife informed him in the latter stages of the event and that Dr Gendy had made no mention of it to him in the initial telephone call explaining the reason for the caesarean section.

92. The Tribunal also considered the note made by an attending midwife:

'0037 Patient D noticed to be unresponsive
Mr Gendy remains in the room
Patient D lied down flatter
Oxygen therapy commenced
Emergency bell pulled
BP 70/46 IV fluids increased
0038 RM U, Ms I, RM V into room in response to this
Patient D slightly responsive
FHR remains ↓
0040 Position changed to L lateral
Mr Gendy did not repeat V/E or apply FSE
In view of CTG considering C/section
0041 Patient D slightly responsive
Emergency bleep call put out
0044 Patient D in R lateral, Mr Gendy attempted to go through consent form, epidural stopped
Patient D taken around to theatre.'

93. The Tribunal noted that there was a distinct difference between Dr Gendy's contemporaneous note and that of the attending midwife. The Tribunal further noted that it appeared that Dr Gendy had been making his note of '*felt faint*' at a time when Patient D was said to be unresponsive and was being resuscitated with oxygen and intravenous fluids.

94. Dr Gendy's retrospective note, written several hours later, described Patient D's condition at 00.54 as '*felt faint*' and that she '*felt better*' following the interventions of the midwives.

95. The Tribunal further took into account Ms D's witness statement to the Trust prepared shortly after the incident, in which she described responding to the emergency buzzer which was pulled:

'At 00:40 I responded to the emergency buzzer in her room Patient D was pale and unresponsive, her blood pressure was 70/40, she had already been laid flat we turned

her onto left lateral. We removed the flow valve and octopus from the cannula and started squeezing through IV Plasmalyte, the fetal heart was 60bpm. Mr Gendy was in the room with his back to us writing in his notes despite the emergency buzzer going and all the midwives on the shift being in the room. I shouted to him that the fetal heart was 60bpm and not recovering could he assist. At 00.41 Her blood pressure was 74/40, I asked if we should give Ephedrine he did not reply. At 00.42 the fetal heart had still no recovered, there was no variability within the bradycardia we therefore put out and obstetric emergency call Patient D remained pale and uncommunicative. Her blood pressure had improved by 00.43 to 115/62 but the fetal heart was still not improving, Mr Gendy did not seem to be able to make a decision when I asked him whether we should be going for a grade one section. We called this at 00.44 and left the room at 00.45.'

96. The Tribunal found that her account supports the contemporaneous notes in demonstrating that Dr Gendy was not aware of or was responding to Patient D's sudden collapse. The Tribunal consider Dr Gendy's contemporaneous and retrospective notes do not show an awareness of the maternal collapse, which was markedly distinct from the patient feeling faint that he described. Dr Gendy makes no mention of the emergency buzzer being pulled, or the numerous members of staff, including Ms F, who rushed into the room and the steps they took.

97. The Tribunal took into account the likelihood of a doctor of Dr Gendy's experience not recognising a maternal collapse but determined that Dr Gendy's own notes, and the account of Ms F and medical notes from other staff, establish that it is more likely than not that he failed to recognise, in a timely manner, that Patient D had suffered a maternal collapse.

98. The Tribunal therefore found paragraph 8 (a) proved.

Paragraph 8 (b)

99. The Tribunal accepted Dr O's opinion that Dr Gendy was under a duty to respond to the fact that Patient D had suffered maternal collapse:

'Dr Gendy's failure to join the multidisciplinary team in immediate resuscitation, his failure to consider emergency delivery without instruction from Ms F and his failure to communicate the urgency of the situation with colleagues in anaesthetics may all be considered as failures to respond to Patient A's deterioration in condition in a timely manner. For the reasons discussed at 4.02, Dr Gendy's practice in this area fell seriously below the standard expected of a reasonably competent obstetric middle grade doctor.'

Paragraph 8 (b) i

100. The Tribunal took into account its finding at paragraph 8 (a), that Dr Gendy did not recognise Patient D's maternal collapse in a timely manner. The Tribunal further considered

the evidence of Ms F prepared shortly after the event, set out above, that Dr Gendy was stood in the room with his back to the team and not assisting, which the Tribunal accepted. The Tribunal further noted that Dr Gendy's contemporaneous and retrospective notes do not detail actions taken by him to resuscitate Patient D. The Tribunal also consider it unlikely that if Dr Gendy had been playing an active role in the resuscitation of Patient D he would have been making contemporaneous notes.

101. The Tribunal therefore found paragraph 8 (b) I proved.

Paragraph 8 (b) ii

102. The Tribunal considered Dr Gendy's contemporaneous and retrospective notes, set out above, which state that the reason for emergency caesarean section was fetal bradycardia. There was no mention in Dr Gendy's notes of maternal collapse being the reason for proceeding to an emergency delivery.

103. The Tribunal also took into account the witness statement provided by Mr E to the Trust shortly after the incident, in which he stated:

> *'00:46: I received a phone call from the locum middle tier doctor that was on duty, Mr Gendy. He rang to inform me that he wanted to take Patient D to theatre for a category 1 caesarean section due to a fetal bradycardia. I agreed with his decision. He did not ask me to attend and I asked him to proceed as quickly as possible.'*

104. The Tribunal noted Mr E's evidence that he had been unaware of Patient D's collapse until much later, and he recalled the reason for the emergency delivery being communicated to him as fetal bradycardia rather than maternal collapse.

105. The Tribunal determined that, taking into account Dr Gendy's own note of his reasoning for the emergency delivery, his failure to recognise that Patient D had suffered a maternal collapse in a timely manner and the information which he communicated to Mr E, it was more likely than not that he did not consider the emergency delivery of Patient D's baby in light of the maternal collapse.

106. The Tribunal therefore found paragraph 8 (b) ii proved.

Paragraph 8 (b) iii

107. The Tribunal, having found above that Dr Gendy had not recognised the maternal collapse in a timely manner, then considered whether he had provided adequate guidance to the MDT as to how to respond.

108. The Tribunal accepted the evidence of Ms F, that the midwifery team 'automatically' went through the procedure to resuscitate Patient D and did not receive instruction to do so

from Dr Gendy. The Tribunal also considered the midwifery notes, set out above, which detail the actions taken to resuscitate Patient D.

109. The Tribunal therefore determined that Dr Gendy did not provide instruction to the MDT in managing Patient D's collapse.

110. Accordingly, the Tribunal found paragraph 8 (b) iii proved.

Paragraph 8 (b) iv

111. The Tribunal considered the witness statement provided by Dr H, the anaesthetist, in which he stated:

> *'When I got to theatre, I could see that the woman was confused but awake. To the best of my recollection, Dr Gendy did not brief me on the situation or make any communication with me. I do not recall Dr Gendy making any attempt to communicate the urgency of the clinical picture to me. In my experience, the lack of communication was unusual. I would typically expect to have a briefing from the obstetrician, but Dr Gendy did not do this.'*

112. In Dr Gendy's oral evidence, he stated that he did not recognise Dr H when he gave evidence, and that he must have been mistaken about who he spoke to before the procedure. The Tribunal was therefore satisfied that it was more likely than not that Dr Gendy had not communicated with the anaesthetist the urgency of the clinical picture and the need for a general anaesthetic.

113. The Tribunal therefore found paragraph 8 (b) iv proved.

Paragraph 8 (c) i

114. The Tribunal first took into account Dr Gendy's witness statement, in which he stated:

> *'It is also accepted as a matter of fact that I was not initially aware of the extent of Patient D's blood loss, which was due to my position at the theatre table and not being told by theatre staff about the blood on the floor. … I was entirely focused on ensuring the safe delivery of the baby and then on closing Patient D's uterus. Notwithstanding this, I twice asked about Patient D's blood loss during the operation. … I recollect that just as I was suturing Patient D's skin, Ms F informed me that on the opposite side of the patient there was blood on the operating theatre floor. This was not visible from where I was standing, and it was said to be in excess of 2000ml. No member of theatre staff had previously informed me about this.'*

115. The Tribunal accepted Dr Gendy's statement that he did not notice the blood loss until the drapes were removed. The Tribunal also took into account the statement of Ms I, who stated that after Dr Gendy finished suturing Patient D:

'Mr Gendy moved legs when a gush of blood came out. At this point I was able to see a lot of blood loss on the floor. Both I and the scrub nurse communicated to Mr Gendy that there was a lot of blood loss on the floor, however he took no notice of us. … At 01:30 Ms F was in theatre. Again, Mr Gendy reassured Ms F that the blood loss was fine. At 01:40 mayor obstetric haemorrhage protocol was called. At 01:43, four units on the way to labour ward. I then tried to get all the blood loss that was on the floor with incos. At 01:53 I measured five incos. The blood loss was 1852ml. At 01:56 measured another five incos which made the blood loss 2808ml.'

116. Ms F in her statement to the Trust stated:

'I again asked Mr Gendy if everything was ok, he stated that there were no problems I pointed out that there was quite a lot of blood on the floor, he advised that it was mostly liquor…
I was called back into theatre at 1.30 by MCA (Maternity Care Assistant/theatre runner) Ms I as she was worried about the blood on the floor and Mr Gendy continued to say there was no bleeding. I asked him to review the blood loss PV (per vaginum) he pulled the drapes off as he had completed the suturing and applied the abdominal dressing. He seemed very surprised by the amount of blood on the sheets beneath her, I asked him whether she had any active bleeding, he examined her PV and assured me there was no active bleeding. At 01.40 Someone from theatre came to ask me to cross match 2 units of blood, the anaesthetist will use the O Negative emergency blood now, as the measured blood was over 2 litres we initiated the Major Haemorrhage Protocol, the Haematologist advised that she would send the 4 units straight over. Mr Gendy again asked if blood loss is under control which he confirmed it was and 40iu Oxytocin in 500mls NaCl was running at 125mls per hour.'

117. The Tribunal further noted that, as set out in Mr E's witness statement, the Massive Obstetric Haemorrhage protocol was called by Dr H, not Dr Gendy, at around the time Dr Gendy finished suturing.

118. The Tribunal found that while Dr Gendy stated he was aware of the blood loss, Dr H was the person present who called the MOH protocol, and Ms I stated that Dr Gendy did not react to the information about large amounts of blood being discovered. Further, Dr Gendy assured Mr E he could leave at 01.20 as he felt the urgency of the situation had passed and repeatedly told Ms F that there was no active bleeding, and that the blood loss was under control. The Tribunal found that this suggested that Dr Gendy did not appreciate the seriousness of the blood loss at this point.

119. The Tribunal therefore determined that Dr Gendy did not recognise the significance of Patient D's blood loss.

120. Accordingly, the Tribunal found paragraph 8 (c) i proved.

Paragraph 8 (c) ii

121. The Tribunal accepted Dr O's opinion:

> *'If a woman has already lost 1000mls at CS and there is sufficient concern from the anaesthetists to commence red cell transfusion, I would expect the registrar to have considered the 4 T's of PPH (see above) and to have requested administration of various medicine which aim to improve uterine tone. … Causes of PPH in Obstetrics are often grouped into conditions referred to as 'the 4 Ts', namely Tone of the uterus, Tissue remaining in the uterus (placental), Trauma to the genital tract and uterus and Thrombin (referring to reduced ability for the blood to clot).'*

122. The Tribunal considered Dr Gendy's retrospective note, in which he stated:

> *'I went back to see the patient who had GA from the operation and when I massaged the uterus there was a gush of about 400ml of blood with no clotting. I was worried about DIC and informed Mr E and asked him to come to theatre.'*

123. The Tribunal noted that Dr Gendy's retrospective note does not show a consideration of the 4 T's, and escalates directly to a consideration of DIC, which is a rare clotting disorder. Dr Gendy does not record checking the tone of the uterus, checking for placental tissue, clots, or injuries to the genital tract although he stated he had these in mind. In oral evidence, Dr Gendy stated that he informed Mr E of his suspicion of DIC on two occasions, however in his retrospective note Dr Gendy recorded he only considered DIC after he had spoken to Mr E the first-time following delivery. It is unclear why Dr Gendy would have suspected DIC in his first call to Mr E following the procedure, given his evidence that he believed there was no active bleeding at that time. Therefore, the Tribunal did not consider his recollection of his processes during his treatment of Patient D to be as reliable. The Tribunal was not satisfied that Dr Gendy had given consideration to the factors set out at paragraph 8 (c) ii.

124. Accordingly, the Tribunal found paragraph 8 (c) ii proved in its entirety.

Paragraph 8 (c) iii

125. The Tribunal accepted Dr O's opinion that Dr Gendy was under a duty to request, in a timely manner, the drugs required to improve uterine tone:

> *'I would expect a reasonably Obstetric middle grade doctor, regardless of seniority, to be aware of the medicines, the doses involved and to communicate with anaesthetic colleagues about administration and assessment of response. I would have expected that Patient A should have had an intravenous infusion of Syntocinon commenced, at the time when the vaginal loss and loss on the floor was noted, if not earlier.*

I would have expected the Registrar to have considered the use of Ergometrine. This is usually given by injection by the anaesthetist, while the obstetrician remains scrubbed. I would have expected that consideration was given to the use of Misoprostol at the conclusion of the CS. The 5 tablets mentioned are the standard dose and these are given together into the patient's rectum; it is most common to administer these when the vaginal loss is being swabbed. Haemabate is also given to try to manage PPH, usually after all the other medicines described above.'

126. The Tribunal noted the anaesthetic chart which details the drugs administered to Patient D:

'Syntometrine (no time given)
Ergometrine 02.33 and 03.15
Syntocinon infusion (no time given)
Haemabate 02.30, 02.50, 03.05, 03.2[?], 03.37
Misoprostol 02.25
Tranexamic acid (no time given for first dose), 03.35 2nd given in theatre
Oxytocin IV 02.53
Cryo 2 unit 03.54
HB 127 03.58'

127. The Tribunal noted that this chart is supported by the notes made contemporaneously in theatre by the theatre scribe.

128. In his witness statement to the Trust shortly after the incident, Mr E stated:

'02:22: I received a further phone call and was asked to attend as the patient was still in theatre with an estimated blood loss now charted at 2.8 litres and there was evidence of ongoing vaginal bleeding. Having revisited what medical management the patient had received to this point for her massive obstetric haemorrhage, I asked Mr Gendy to give tranexamic acid and additional uterotonics stat, in addition to the oxytocin infusion that was already in progress, and stated that I was on my way.'

129. The Tribunal further took into account Mr E's witness statement, in which he also stated:

'Following Mr Gendy's reassessment of I received a further call from him at 02:22 during which he advised that was still in theatre, the blood loss was now estimated at 2.8 litres and there was evidence of ongoing bleeding. I explained to him I was not reassured given that had suffered such an amount of blood loss, the bleeding was continuing and that standard measures to treat the blood loss had not yet been commenced. I would have expected that some actions would have already been taken, for example, certain medications to contract the uterus and to stop bleeding should, generally, have already been administered. … I made recommendations of medications

for Mr Gendy to give stat and then made my way back to the hospital as quickly as I could.'

130. The Tribunal noted that the anaesthetist chart reflects that the drugs began being administered at 02.25, immediately after Dr Gendy's phone call with Mr E in which Mr E directed him to begin the MOH drugs protocol. The Tribunal further took into account the witness statement of Ms F, who stated:

'I asked the anaesthetist to give 250mcg of Haemabate, which is a drug used to contract the uterus, as Dr Gendy was giving no instruction. Patient D was still bleeding, and her uterus was not contracting - we're trained on what protocol to follow for PPH and were by then doing so, but as the doctor, Dr Gendy should have been leading the situation.'

131. The Tribunal bore in mind that the MOH had been called at 01.40, and that this was the time at which the drugs protocol should have been started to try and control Patient D's bleeding. The Tribunal was mindful that most of these drugs are in fact administered by the anaesthetist, however the senior obstetrician should give directions for their administration. The Tribunal noted a gap of more than 40 minutes between the MOH being called and the drugs being administered, many of which were started at Mr E's request.

132. The Tribunal therefore found paragraph 8 (c) iii proved.

Paragraph 8 (c) iv

133. The Tribunal accepted Dr O's opinion that bimanual compression should have been started in a timely manner:

'Finally, if the uterus has poor tone or is still bleeding as evidenced by vaginal loss, it is common to massage the uterus to try to encourage it to 'tighten' or to compress it ('bimanual compression') with one hand pressing on the maternal lower abdomen and the other pressing from below, within the vagina.'

134. The Tribunal took into account the note made by the theatre scribe at the time that Dr Gendy began uterine massage at 02.58, following Ms F having begun 'rubbing uterus' at 02.32. The Tribunal considered this to be significant evidence as to the point at which Dr Gendy commenced bimanual compression.

135. The Tribunal further considered the evidence of Mr E in his statement to the Trust, that Dr Gendy did not appear able to adequately perform bimanual compression and that when he arrived Ms F was conducting uterine massage:

'02:37: I arrived into theatre to find Ms F conducting uterine massage. A concise briefing was performed which included an update of the measured blood loss
...

02:58 I asked Mr Gendy to take over performing the bimanual compression from me. However, I did not feel that his technique was sufficient enough to keep the uterus contracted and so I resumed the uterine massage including bimanual compression myself, whilst considering other health care staff that could fulfil the role effectively.'

136. The Tribunal also considered the evidence of Ms F, that Dr Gendy did not seem to know how to perform bimanual compression:

'At 02:32, whilst I was massaging the uterus, I asked Dr Gendy to perform bi-manual compression. He did not respond to my request or start compression and did not seem to know how to do so. Bi-manual compression is a way of contracting the uterus physically.'

137. The Tribunal accepted Mr Walker's submission that Dr Gendy's evidence to the Tribunal about bimanual compression / massage was at times confusing. The Tribunal bore in mind that during his oral evidence, Dr Gendy seemed to struggle to demonstrate bimanual compression as described by Dr O in her report. The Tribunal was of the view that Dr Gendy's hand gestures suggested a rubbing movement rather than forceful compression of the uterus. The Tribunal found that Dr Gendy's seeming inability to demonstrate bimanual compression as explained by the expert was consistent with Mr E's account that he was unable to perform it adequately on Patient D. The Tribunal had regard to the positive testimonial evidence about Dr Gendy's abilities as a doctor and his experience but preferred the evidence of Mr E.

138. The Tribunal concluded that Dr Gendy had failed to, in a timely manner, undertake bimanual compressions.

139. The Tribunal therefore found paragraph 8 (c) iv proved.

Paragraph 8 (c) v

140. The Tribunal accepted Dr O's opinion that it would have been inappropriate for Dr Gendy to leave the theatre when Patient D was actively bleeding:

'It was not necessary for Dr Gendy to leave the theatre when there was ongoing blood loss, in order to ring the on-call consultant. I would have expected Dr Gendy to have asked one of the senior midwives in attendance to ask Ms F to call Mr E and for Dr Gendy to have stayed in theatre. Dr Gendy should have considered the causes of PPH and worked through treatment of these in line with standard emergencies management.

I cannot find any reason why he was required to leave Patient D at this time to make a phone call. This practice demonstrates an apparent lack of understanding of the critical nature of Patient D's condition at that time and a lack of taking responsibility as the most senior obstetric doctor on site, to care for Patient D as best he could until

Mr E arrived. I have never experienced this sort of behaviour in the context of PPH, let alone MOH. Dr Gendy's practice in leaving theatre while Patient D was still bleeding fell seriously below the expected standard.'

141. Dr Gendy accepts that he left theatre to call Mr E. The Tribunal noted Dr Gendy's witness statement, in which he stated, *'I concede that I should have delegated this task to a more junior member of the team.'* Dr Gendy explained that at the time he was of the opinion that there was no active bleeding and it was safe for him to leave. The Tribunal accepted Dr O's evidence that if there was no active bleeding there was no urgency for Dr Gendy to leave to call the Consultant and he could have waited for the telephone to become available in theatre.

142. The Tribunal noted Mr E's evidence to the Trust shortly after the incident that during the telephone call:

'it appeared that he was not fully reassured with the patient's current condition and so I asked him to go back to theatre urgently to perform a thorough reassessment and to update me promptly.'

143. The Tribunal took into account Ms F's statement to the Trust that following Dr Gendy's call to Mr E, she too rang the Consultant and on her return to theatre, '*Patient D was uncovered and I could see there was ongoing bleeding*'.

144. At the time Dr Gendy made the call the patient's blood loss was over 2 litres. The Tribunal was satisfied that Dr Gendy should not have left theatre to call Mr E when he did, especially given Mr E's observation that Dr Gendy did not appear reassured with the patient's condition. As Dr Gendy himself now accepts, he should have delegated the call to an appropriate colleague. The Tribunal, accepting Dr O's evidence, concluded that the decision to leave theatre to make the call was a failure.

145. The Tribunal therefore found paragraph 8 (c) v proved.

Paragraph 8 (d)

146. As set out above, the Tribunal accepted Dr O's opinion that Dr Gendy was under a duty to recognise, in a timely manner, Patient D's massive obstetric haemorrhage.

147. The Tribunal has found that it was Dr H who initiated the MOH protocol at 1.40, and Mr E who directed the appropriate drugs to be administered in response. Further, the Tribunal has found that Dr Gendy failed to undertake bimanual compression in a timely manner. The Tribunal determined that, having failed to recognise the significance of Patient D's ongoing bleeding and react appropriately, Dr Gendy had failed to recognise Patient D's massive obstetric haemorrhage in a timely manner.

148. The Tribunal therefore found paragraph 8 (d) proved.

Paragraph 8 (e)

149. The Tribunal, as set out above, has found that Dr Gendy failed, in a timely manner, to carry out bimanual compression of Patient D's uterus. The Tribunal noted that the earliest record of Dr Gendy carrying out bimanual compression is at 2.58, noted by the scribe in theatre, after Mr E arrived. The Tribunal found that this supported Ms F's assertion that Dr Gendy had failed to perform bimanual compression when requested to do so at an earlier stage.

150. The Tribunal further found, as set out above, that Dr Gendy was quickly stopped from performing bimanual compression due to his poor technique, which is support by the scribes note, stating that the 'Bakari balloon' was sent for at 2.59.

151. The Tribunal considered Dr Gendy's account that he and Mr E were doing bimanual compression alternately for some time, however it found no evidence, whether in Mr E's statement or the contemporaneous notes, to support Dr Gendy having attempted bimanual compression more than once.

152. The Tribunal therefore concluded that Ms F had requested that Dr Gendy undertake bimanual compression and he had not done so until Mr E arrived and directed him to do so, however he was stopped from continuing shortly after due to poor technique.

153. The Tribunal therefore found paragraph 8 (e) proved.

Paragraph 8 (f)

154. The Tribunal accepted the opinion of Dr O that Dr Gendy was under a duty to lead the MDT during the emergency:

> *'If Ms F's comments above are accepted, Dr Gendy did not lead the emergency; she expected him to and directed the team when he did not. If Mr E's comments above are accepted, Dr Gendy did not ensure that the appropriate medication and treatment of bimanual compression was completed as would have been expected; this demonstrated that Dr Gendy had not led the emergency treatment adequately until Mr E took over. For these reasons, Dr Gendy did not lead the emergency to the standard expected of a reasonably competent obstetric middle grade doctor and his practice at these points fell seriously below the expected standard.*
>
> *Also as discussed above, it is possible that Dr Gendy panicked and 'froze', particularly given Ms F's description of him as like a rabbit in headlights.*
>
> *There may be information from Dr Gendy which could be considered as mitigation in relation to his leadership although it is difficult to understand how such mitigation could be accepted as lasting from the time when Patient A collapsed (00:40) until Mr*

E returned to theatre and assumed the role of leader in Patient A's treatment (02:37).'

155. The Tribunal noted Dr H's account, that he has '*no real recall of him [Dr Gendy] leading anything*'. The Tribunal also took into account Ms F's account that Dr Gendy '*was not speaking and so I was having to lead. Dr Gendy was like a rabbit in headlights – he kept saying 'I didn't expect this'.*

156. The Tribunal found that Dr Gendy's failure to administer the required drugs, give directions to the MDT, respond to Patient D's maternal collapse, or initiate the MOH protocol, all show a failure to lead the MDT. The Tribunal accepted that many of the directions were given by Ms F and Mr E, by phone or following his arrival preferring their evidence to Dr Gendy's.

157. The Tribunal was mindful that a doctor of Dr Gendy's experience would be expected to deal with the emergency appropriately and that there are a number of testimonials from former colleagues speaking positively to Dr Gendy's abilities and experience. However, the Tribunal considered that the evidence, including the contemporaneous notes and statements prepared for the Trust investigation, establish that there was a failure on Dr Gendy's part to adequately lead the MDT on this occasion. This started at the point he failed to recognise Patient D's maternal collapse in a timely manner, and continued through to his failure to deal with Patient D's excessive blood loss, to initiate the MOH protocol, administer the correct drugs in a timely manner, and appropriately manage the situation.

158. The Tribunal therefore found paragraph 8 (f) proved.

The Tribunal's Overall Determination on the Facts

159. The Tribunal has determined the facts as follows:

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

Theatre booking form(s)

1. On or around 4 February 2020 you completed a theatre booking form for:

   a. Patient A;

   b. Patient B;

   and you falsely recorded 'repair of a small labial tear' in the procedure name section.
   Admitted and found proved.

2. You knew that the information you included in the theatre booking form(s) as set out in paragraph 1 was:

a. untrue;

b. not accurate;

in that you had intended to perform a hymenoplasty on Patient A and/or Patient B and not the repair of a small labial tear.
Admitted and found proved.

3. Your actions as described at paragraph(s):

a. 1a were:

i. dishonest by reason of paragraph 2a;
Determined and found not proved.

ii. designed to conceal the fact that you had intended to perform a hymenoplasty on Patient A and not the repair of a small labial tear;
Determined and found proved.

b. 1b were:

i. dishonest by reason of paragraph 2a;
Determined and found not proved.

ii. designed to conceal the fact that you had intended to perform a hymenoplasty on Patient B and not the repair of a small labial tear.
Determined and found proved.

Patient C

4. On or around 12 November 2020 you treated Patient C and you failed to:
a. adequately communicate with:

i. the attending midwifery and/or anaesthetic staff, in that you:

1. did not explain your rationale for proceeding with instrumental delivery;
Determined and found proved.

2. told one or more midwifery colleagues that fetal monitoring was unnecessary, or words to that effect;
Determined and found proved.

ii. Patient C, in that you did not explain the rationale for proceeding with instrumental delivery;
Determined and found not proved.

b. diagnose in a timely manner that shoulder dystocia had occurred;
Determined and found not proved.

c. adequately manage the shoulder dystocia, in that you:

i. did not proceed to internal manoeuvres;
Determined and found not proved.

ii. continued to apply inappropriate axial traction.
Determined and found proved.

5. You recorded in Patient C's medical records that you had performed internal manoeuvres ('the Entry'), which was untrue.
Determined and found not proved.

6. You knew that the Entry in Patient C's medical records was untrue.
Determined and found not proved.

7. Your actions as described at paragraph 5 were:

a. designed to cover up the fact that you had not performed internal manoeuvres;
Determined and found not proved.

b. dishonest by reason of paragraph(s) 6 and 7a.
Determined and found not proved.

Patient D

8. On or around 26 February 2021 you treated Patient D and you failed to:

a. recognise, in a timely manner, that Patient D had suffered maternal collapse;
Determined and found proved.

b. adequately respond to the fact that Patient D had suffered maternal collapse, in that you did not:

i. play an active role in the initial resuscitation of Patient D;
Determined and found proved.

ii. consider the emergency delivery of Patient D's baby in light of the maternal collapse;
Determined and found proved.

iii. provide adequate guidance to the multi-disciplinary team ('MDT') as to how to manage and/or respond to the maternal collapse;
Determined and found proved.

iv. communicate the urgency of the clinical picture to the attending anaesthetist, in that you did not explain the need for a general anaesthetic;
Determined and found proved.

c. adequately manage Patient D's postpartum haemorrhage, in that you did not:

i. recognise the significance of Patient D's blood loss and/or transfusion;
Determined and found proved.

ii. give consideration, in a timely manner, to:

1. the tone of the uterus;
Determined and found proved.

2. any tissue remaining in the uterus;
Determined and found proved.

3. any trauma to the genital tract and/or uterus;
Determined and found proved.

4. thrombin;
Determined and found proved.

iii. request, in a timely manner, the administration of one or more of the medications listed in Schedule 1 to improve uterine tone;
Determined and found proved.

iv. attempt, in a timely manner, to limit the ongoing vaginal bleeding by bimanual compression of Patient D's uterus;
Determined and found proved.

v. ~~left~~ remain in the theatre whilst Patient D was ~~still~~ bleeding and instead left to ~~so that you could~~ contact Mr E, rather than

delegating this to an appropriate colleague;
Determined and found proved.

d. recognise, in a timely manner, Patient D's massive obstetric haemorrhage;
Determined and found proved.

e. adequately perform bimanual compression of Patient D's uterus when Ms F asked you to do so;
Determined and found proved.

f. appropriately lead the MDT during the emergency.
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 - 27/02/2024

160. 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 Gendy's fitness to practise is impaired by reason of misconduct.

The Evidence

161. 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 a list of literature reviewed by Dr Gendy between 5 October 2021 and 2 December 2023, a certificate for PROMPT dated 9 March 2022, a certificate for 'Avoiding risk in consent: a masterclass for doctors' dated 22 March 2022, and 'Managing human factors for safe practice' dated 23 March 2022.

Submissions

162. On behalf of the GMC, Mr Walker submitted that all of the facts found proved in this case amount to misconduct which is serious and justifies a finding of impaired fitness to practise. Mr Walker submitted that the facts found proved in relation to Patient D are very serious, possibly more so than those for Patients A, B, and C, but the Tribunal should take into account that there are findings in respect of four patients in a period of just over a year. Further, Mr Walker submitted that the Tribunal must take into account the broad scope of the allegations found proved, which relate to falsification of records, failures to communicate with colleagues, failure to notice and respond to medical events, failure to manage the medical events, administer what should have been routine, and a failure to lead.

163. Mr Walker submitted that Patient D's PPH was undoubtedly an extremely serious situation and Dr Gendy's failures put her at risk of harm. Mr Walker submitted that if the Tribunal were to find that these failings were negligent, this would be particularly serious and would amount to misconduct. Mr Walker further submitted that the facts found proved in relation to Patient A and B are serious, and while he acknowledged that Dr Gendy did not believe the form would be retained as part of the medical record, he noted that the Tribunal had not explicitly rejected Dr P's evidence that the booking forms would form part of the medical record. Mr Walker submitted that while the Tribunal did not necessarily need to consider this issue at the facts stage, it may be a factor to consider at the impairment stage, in view of the seriousness of the conduct.

164. Mr Walker submitted that the following paragraphs of Good Medical Practice (2013, as amended) ('GMP') are relevant in this case: 1, 4, 7, 15, 16 (b) and (d), 24, and 35-37.

165. In relation to impairment, Mr Walker submitted that, on the evidence found proved, Dr Gendy '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'. Mr Walker submitted that Dr Gendy does not believe he did anything wrong, has shown little insight into or appreciation of the situation, sought to blame others, displayed confusion as to the appropriate treatment and how it was to be administered, and ignored those around him. The consequences of which led to Patient D being put at unwarranted risk of harm. Mr Walker submitted that the Tribunal cannot be satisfied that this would not happen again.

166. Mr Walker further submitted that Dr Gendy has brought the profession into disrepute by falsification of patient records in relation to Patients A and B, although he accepted that on the basis that the Tribunal found those facts proved, they may carry less weight. Mr Walker submitted that Dr Gendy has in the past breached a fundamental tenet of the medical profession, namely the spirit of paragraph 1 of GMP.

167. In summary, Mr Walker submitted that there is both misconduct and impairment, that the misconduct is serious, involving four patients across much of Dr Gendy's discipline, and taken together, his fitness to practise is impaired. Mr Walker submitted that such a finding is necessary when considering the regulatory role of the Tribunal and applying the facts found proved to the overarching objective.

168. On behalf of Dr Gendy, Mr Colman submitted that in regard to Patients A and B, neither the admissions nor the limited findings of the Tribunal are serious enough to amount to professional misconduct. Mr Colman submitted that given the express findings that Dr Gendy's actions were designed to protect patients from potential serious harm, it may follow that a fellow member of the profession would not find his conduct to be deplorable, any more than ordinary decent people would find it dishonest.

169. In regard to Patient C, Mr Colman submitted that Dr Gendy's failures to communicate with the midwifery team occurred under pressure of circumstances and time, and reminded the Tribunal that it had found that the failure to communicate in respect of the fetal

monitoring was a misunderstanding. Mr Colman further submitted that the Datix report, which had images of the baby's head and neck bruising attached, did not report any harm, loss or damage to the baby and was closed without further action being taken, and that the Tribunal should take this into account when assessing the gravity of those failings.

170. In regard to Patient D, Mr Colman stated that Dr Gendy accepts that these findings represent multiple acts of omission, some of which are serious. Mr Colman submitted that Dr Gendy has sought to remedy the deficiency in his practise in the last three years by remedial activity, particularly the PROMPT course, recommended by Dr O, and he has kept up to date with the CPD required by the Royal College of Obstetrics and Gynaecology. Mr Colman acknowledged that the Tribunal has a duty which extends beyond patient safety, and accepted that the Tribunal need to address not just Dr Gendy's safety as an individual surgeon but the impact of misconduct on broader aspects of the public interest.

The Relevant Legal Principles

171. 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.

172. In approaching the 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 could lead to a finding of impairment.

173. The Tribunal must determine whether Dr Gendy's fitness to practise is impaired today, taking into account Dr Gendy'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.

The Tribunal's Determination on Impairment

Misconduct

Paragraphs 1 and 2

174. At the outset of the hearing Dr Gendy made admissions to paragraphs 1 and 2 of the Allegation. In his evidence to the Tribunal, he accepted that with hindsight that he should not have done what he did and would not do so again in the future, but he had completed the forms in the way that he did to protect the patients.

175. The Tribunal, in its findings on fact, found that Dr Gendy had not acted dishonestly when he completed the booking forms with inaccurate information, but had been seeking to protect the patients from the potential risk of serious harm, were their families to see the

theatre list on the day of the procedures. The Tribunal therefore considered whether these paragraphs amounted to misconduct in light of that finding.

176. The Tribunal considered whether a fellow member of Dr Gendy's profession would find his conduct deplorable. The Tribunal determined that practitioners would be of the view that recording false information in patient records is clearly wrong and is a departure from paragraph 19 of GMP:

> *'19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.'*

177. The Tribunal, however, took into account Dr Gendy's intention behind the false record on the booking form was to protect the patients from potential serious harm. The Tribunal accepted the submission made to it by Mr Colman, that in the same way that ordinary decent people would not find Dr Gendy's actions to be dishonest, a fellow practitioner would not view this conduct as deplorable.

178. In conclusion, the Tribunal determined that while Dr Gendy's actions were a breach of GMP which amounted to misconduct, his reason for doing so means that the misconduct falls short of amounting to serious misconduct.

179. The Tribunal therefore found that paragraphs 1 and 2 did not amount to serious misconduct.

Paragraphs 3 (a) ii and 3 (b) ii

180. The Tribunal found that Dr Gendy's actions in entering false information on the booking forms amounted to misconduct but not serious misconduct on the basis that Dr Gendy's intention was to protect the patients from potential serious harm. The Tribunal therefore concluded that Dr Gendy's actions in attempting to conceal the nature of the procedure from the patients' families was misconduct, in that it involved falsifying patient documents contrary to GMP, however it does not amount to serious misconduct, taking into account his reason for doing so.

181. The Tribunal therefore found that paragraphs 3 (a) ii and 3 (b) ii did not amount to serious misconduct.

Paragraph 4 (a) i 1

182. The Tribunal considered that Dr Gendy's conduct was a departure from paragraph 35 of GMP:

> *'35 You must work collaboratively with colleagues, respecting their skills*

and contributions.'

183. The Tribunal, in its determination on facts, set out that Dr Gendy's lack of communication about why he was proceeding to an instrumental delivery caused confusion among the midwifery team, and resulted in the midwives feeling they had to take action on their own initiative. The Tribunal determined that a middle grade doctor of Dr Gendy's considerable experience would be expected to be able to explain his rationale to others present and manage the situation accordingly. Although Patient C's baby was delivered successfully, the Tribunal noted that the confusion caused by Dr Gendy could have posed a risk to Patient C and her baby.

184. The Tribunal then considered whether Dr Gendy's poor communication with the midwifery team would be viewed as deplorable by other members of the profession, in the circumstances. The Tribunal determined that while Dr Gendy's actions were unprofessional and showed a lack of communication and teamwork, they fell short of amounting to serious professional misconduct.

185. The Tribunal therefore found that paragraph 4 (a) i 1 did not amount to serious misconduct.

Paragraph 4 (a) i 2

186. The Tribunal, in its findings of fact, determined that it was unlikely that Dr Gendy had intended to tell the midwives to stop all fetal monitoring, however his poor communication had led them to believe that was what he wanted. The Tribunal noted that this finding was one of several findings in respect of Dr Gendy's lack of communication, however, taken on its own, it did not result in harm to Patient C or her baby as the midwives recommenced monitoring of their own accord. The Tribunal considered that this further showed Dr Gendy's poor communication and lack of collaborative teamwork.

187. The Tribunal then considered whether Dr Gendy's conduct would be viewed as deplorable by other members of the profession. The Tribunal determined that while Dr Gendy's actions were unprofessional and again showed a lack of communication and teamwork, they did not amount to serious misconduct.

188. The Tribunal therefore found paragraph 4 (a) i 2 did not amount to serious misconduct.

Paragraph 4 (c) ii

189. The Tribunal, in its findings of fact, determined that Dr Gendy had inappropriately managed the shoulder dystocia by continuing to apply inappropriate axial traction to the baby's neck by using excessive force. The Tribunal noted Dr O described this as seriously below the standard to be expected of a doctor of Dr Gendy's experience.

190. The Tribunal set out the impact of Dr Gendy's inappropriate application of traction in its findings of fact – that it was extremely distressing for the staff in the room, in particular Dr L, the attending paediatrician, and the midwives. The Tribunal noted that Ms J was so concerned by Dr Gendy's actions that she submitted a Datix, and the baby's bruises were photographed. The Tribunal bore this in mind as to the extent of the force that was perceived to be used by Dr Gendy.

191. The Tribunal further considered that there was a potential risk of harm to Patient C's baby from the inappropriate force being applied by Dr Gendy. Although the Datix report, did not report any harm, loss or damage to the baby and was closed without further action being taken, the Tribunal did not consider that minimised the gravity of Dr Gendy's failing, given the potential risk to Patient C's baby.

192. The Tribunal concluded that Dr Gendy's actions were seriously below the standard to be expected, resulted in distress to his colleagues, and put Patient C's baby at risk of harm. The Tribunal considered Dr Gendy's conduct would be viewed as deplorable by other members of the profession and therefore amounted to serious misconduct.

193. The Tribunal therefore found paragraph 4 (c) ii did amount to serious misconduct.

Paragraph 8

194. The Tribunal considered paragraph 8 in its entirety, as it relates to a course of conduct involving Patient D.

195. The Tribunal first considered the evidence of Dr O as to the seriousness of Dr Gendy's failings:

> *'Dr Gendy's failure to respond to Patient D's collapse and his failure to provide guidance or comment to the multidisciplinary team in any useful way is practice which falls seriously below the standard I would expect of any obstetric middle grade doctor, regardless of their seniority. …*
>
> *Dr Gendy's behaviours and practice in the management of Patient D are remarkably unusual as compared to reasonably competent obstetric middle grade doctors with whom I've worked, as are the number of concerns about practice which fell seriously below the expected standard.*
>
> *Based on these two factors, my overall opinion of Dr Gendy's practice in relation to Patient D was that it fell seriously below the standard expected of a reasonably competent obstetric middle grade doctor.'*

196. The Tribunal found that in his treatment of Patient D, Dr Gendy had shown a clear departure from paragraphs 15 (a) and (b), and 16 (b):

'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 …'

197. The Tribunal further found that in his communication with Mr E, Dr Gendy had shown a clear departure from paragraph 35 of GMP, as set out above. The Tribunal in particular noted Dr Gendy's failure to inform Mr E of Patient D's maternal collapse.

198. The Tribunal found that the management of Patient D's collapse was taken over by others in the room, and the description of Dr Gendy during the PPH as being '*like a rabbit in the headlights*' was accurate. The Tribunal bore in mind the notes written by Dr Gendy which fail to reflect in any way the seriousness of Patient D's condition at the outset.

199. The Tribunal concluded that Dr Gendy's failure to recognise Patient D's serious blood loss, to take the lead in the management of that situation, administer the appropriate drugs and inform Mr E what was happening, were further examples of Dr Gendy's poor communication with others and his poor leadership of the MDT during the incident.

200. The Tribunal found that the overall management of Patient D's condition by Dr Gendy fell seriously below the standard to be expected and would be regarded as deplorable by fellow members of the profession.

201. The Tribunal therefore found that paragraph 8, in its entirety, amounted to serious misconduct.

Impairment

202. The Tribunal having found that the facts found proved in relation to paragraphs 4 (c) ii and 8, in its entirety, amounted to misconduct went on to consider whether, as a result of that misconduct, Dr Gendy's fitness to practise is currently impaired.

203. The Tribunal first considered Dr Gendy's insight into his misconduct. The Tribunal accepted that Dr Gendy recognises the seriousness of the findings, however it was concerned that Dr Gendy, in his oral evidence, had sought to blame others for mistakes made in the care of Patients C and D. Dr Gendy stated that the tranexamic acid was not administered to Patient D in a timely manner because he expected the anaesthetist, Dr H, to have done it

already, but he was delayed as he was unable to find a vein. Dr Gendy further stated that he was not told by Ms F or Ms I about the volume of blood Patient D had lost, and he expected them to tell him without being asked. The Tribunal also noted Dr Gendy's assertion that Ms F should have rung Mr E when Patient D's blood loss reached 2000ml, rather than himself, but she had not done so. The Tribunal therefore concluded that whilst Dr Gendy had shown some insight into his misconduct, it was limited.

204. The Tribunal next considered the remediation undertaken by Dr Gendy. The Tribunal noted the certificates provided by Dr Gendy, and the list of literature which he has reviewed. The Tribunal noted that this evidence was not accompanied by any reflection from Dr Gendy on how the training had informed his practice going forward, or how he had learnt from the courses. The Tribunal further noted that the courses were not targeted towards all of the issues raised in the Allegation.

205. The Tribunal noted that in respect of his poor communication, while Dr Gendy had undertaken a course titled 'Managing human factors for safe practice', he had not provided a reflection on this learning and how he might improve his situational awareness, communication, teamworking, or leadership skills. Taking into account the lack of evidence of reflection, the Tribunal concluded that Dr Gendy has shown limited evidence of remediation.

206. The Tribunal took into account the positive testimonials provided by Dr Gendy and noted that they spoke highly of his skills as a clinician and raised no concerns about his ability to practise. The Tribunal also noted that Dr Gendy has previously worked at consultant level and has worked in obstetrics and gynaecology for a significant period of time, without concern. The Tribunal was mindful, however, that it had found proved serious allegations relating specifically to Dr Gendy's identification of Patient D's maternal collapse as well as management of her PPH/ massive obstetric haemorrhage. In addition, the Tribunal found Dr Gendy's clinical skills – in not performing the bimanual compressions effectively and applying excessive axial traction were seriously below the standard expected of a clinician of Dr Gendy's experience. The Tribunal therefore attached limited weight to the testimonials.

207. The Tribunal determined that while this may be a one-off incident in a long career, there are a number of serious departures from GMP, including the failure to recognise a maternal collapse, and then adequately manage the resulting PPH/ massive obstetric haemorrhage. The Tribunal did not consider that the failings identified are evidenced as being remediated by the CPD provided, and although some insight has been demonstrated, Dr Gendy has on occasion sought to attribute blame to others. The Tribunal was therefore satisfied that there remains a risk of repetition, given the limited insight and remediation.

208. The Tribunal determined that a finding of impairment is necessary in this case to protect, promote and maintain the health safety and well being of the public, and given the seriousness of its findings in respect of the care of Patient D 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.

209. The Tribunal has therefore determined that Dr Gendy's fitness to practise is currently impaired by reason of misconduct.

Determination on Sanction - 01/03/2024

210. Having determined that Dr Gendy'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

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

Submissions

212. On behalf of the GMC, Mr Walker submitted that the appropriate sanction in this case is suspension. Mr Walker submitted that the facts found proved represent serious misconduct which show an obvious and real risk to the patients involved, notably Patient D, as well as serious and multiple breaches of GMP. Mr Walker submitted that the misconduct was not a one-off as there were findings in relation to more than one patient. Mr Walker submitted that to allow Dr Gendy to return to unrestricted practice would fail to satisfy all three limbs of the overarching objective.

213. Mr Walker submitted that while the Tribunal should take into account the mitigating factors in this case, they may afford them less weight due to the patient safety concerns. Mr Walker submitted that there were no mitigating factors present, save for the fact that Dr Gendy has no previous findings of impaired fitness to practise.

214. In regard to aggravating factors, Mr Walker submitted that there is no real evidence of insight or substantial remediation, no fulsome expression of regret or apology, and although Dr Gendy should not be penalised for challenging the Allegation, he has stated that he fails to see where he might have made errors.

215. Mr Walker submitted that anything less than suspension would fail to meet the seriousness of the case. Mr Walker submitted that conditions would not be appropriate as they would not satisfy the identifiable risk to patient safety, in that Dr Gendy showed confusion in relation to treatment that should have been routine. Mr Walker accepted, however, that this is conduct which is not fundamentally incompatible with continued registration.

216. Mr Walker submitted that if the Tribunal were to order a period of suspension, it ought to be a lengthy one. Mr Walker submitted that the Tribunal may consider some of the

factors in paragraph 109 of The Sanctions Guidance (2024) ('SG') are not present in this case, in that the Tribunal has found that Dr Gendy has not shown a deliberate or reckless disregard for the principles in GMP, nor has he done serious harm to others deliberately, but perhaps through incompetence. Mr Walker further submitted that the GMC does not seek to persuade the Tribunal that Dr Gendy has shown persistent lack of insight. Mr Walker submitted that insufficient time has passed since the Tribunal's findings of fact for it to make an accurate determination as to whether there is a lack of timely development of insight.

217. In summary Mr Walker submitted that the most appropriate and proportionate sanction would be a lengthy period of suspension, the misconduct in this case falling short of a need for erasure.

218. On behalf of Dr Gendy, Mr Colman submitted that the Tribunal must put out of its mind the evidence it has heard in relation to the application for VE. Mr Colman submitted that Dr Gendy's wish to retire does not extend to wishing for his long career to end in disciplinary erasure, and that the Tribunal must act proportionately.

219. Mr Colman submitted that erasure is not the appropriate sanction in this case. Mr Colman submitted that none of the factors which might indicate erasure is appropriate are present. Mr Colman submitted that the misconduct is not so serious as to be fundamentally incompatible with being a doctor. Mr Colman accepted that the Tribunal has found a clear and serious departure from GMP which risked patient safety, but it has not expressly found that behaviour to be reckless or deliberate. Mr Colman further submitted that it caused no actual harm, isn't a case of abuse of trust or violation of patient's right, doesn't involve offences of a sexual nature or violence, there is no longer any question of dishonesty, and while Dr Gendy has limited insight, he does not have a persistent lack of insight into the seriousness of his actions or the consequences.

220. Mr Colman submitted that there are a number of the more serious features of the case – serious departures from GMP, failure to take prompt action when patient safety was compromised, lack of responsibility, risk to patient safety and public confidence, impact on vulnerable people and risk of harm, reluctance to take remedial action – which are not indicative of erasure, but are examples of aggravating features which can be taken into account when deciding on the length of a suspension. They are, he submitted, factors consistent with a period of suspension rather than erasure.

221. Mr Colman accepted that Dr Gendy has shown limited evidence of remediation, and explained why that might be so, but submitted that does not mean that Dr Gendy is incapable of remediation in a way that would be incompatible with continued registration.

222. Mr Colman submitted that conditions would provide for complete patient safety in respect of the clinical failings in this case, in that the Tribunal could impose conditions which prohibit Dr Gendy from undertaking any obstetrics and require him to undertake a performance assessment before resuming any practice in obstetrics. Mr Colman submitted that while this would be a drastic restriction on Dr Gendy's registration, it would protect

public safety and maintain public confidence in the profession as it would protect obstetric patients and uphold professional standards. Mr Colman submitted that conditions would address the concerns in this case.

223. Mr Colman submitted that the testimonials and other evidence about Dr Gendy's career speak of the many years of valued service that he has given to the NHS and that the findings in this case are not so dire to drive the Tribunal to ruin that long history of public service with the disgrace of disciplinary erasure. Mr Colman submitted that the public interest and public safety can be protected by conditional registration.

The Tribunal's Determination on Sanction

224. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken the SG into account and borne in mind the over-arching objective.

225. 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 or discipline doctors, even though they may have a punitive effect. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Gendy's interests with the public interest.

226. Before considering what action, if any, to take in respect of Dr Gendy's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

Aggravating Factors

227. The Tribunal found the following aggravating factors; Dr Gendy has shown limited insight into his misconduct, Dr Gendy has shown a failure to work collaboratively with colleagues, and his misconduct had the potential to cause serious harm to patients.

Mitigating Factors

228. The Tribunal found the following mitigating factors; Dr Gendy has made a partial attempt at remediation with some relevant training, and Dr Gendy has provided positive testimonials from colleagues.

229. The Tribunal bore in mind the aggravating and mitigating factors throughout its deliberations on the appropriate and proportionate sanction to impose, if any. The Tribunal considered each sanction in ascending order of severity, starting with the least restrictive.

No action

230. The Tribunal first considered whether to conclude the case by taking no action.

231. The Tribunal determined that, in view of the serious nature of its findings on the facts and impairment, it would be neither sufficient, proportionate nor in the public interest to conclude this case by taking no action. The Tribunal determined that there were no exceptional circumstances and therefore there could be no justification for taking no action.

Conditions

232.The Tribunal first considered whether the misconduct in this case is remediable. The Tribunal determined that the misconduct relates to clinical matters which can be remediated through training, education, and support.

233. The Tribunal had regard to paragraph 81 of the SG, and considered that conditions may be appropriate in cases where the misconduct relates to clinical practice:

> *'81 Conditions might be most appropriate in cases:*
> *b involving issues around the doctor's performance*
> *c where there is evidence of shortcomings in a specific area or areas of the doctor's practice'*

234. The Tribunal, in its determination on impairment, found that the misconduct in this case relates only to clinical failings, and therefore the imposition of conditions could be appropriate. The Tribunal was, however, concerned by the serious failings in respect of the care and treatment of Patient D and the significant departures from GMP. Although the Tribunal has not concluded that Dr Gendy's misconduct was reckless or grossly negligent, it was mindful of the potential risk of serious harm to Patient D and that the misconduct involved failures in a number of areas of basic treatment; including a failure to recognise maternal collapse and excessive blood loss. The Tribunal also bore in mind the opinion of Dr O that Dr Gendy's conduct was seriously below the standard to be expected of an experienced doctor and a number of his failings were inexplicable.

235. The Tribunal considered the following matters would be of particular concern to members of the public and the profession:

- The impact that Dr Gendy's delivery of Patient C's baby had on Dr L and the midwives present due to the excessive use of force;
- The completion of his notes whilst Patient D was being resuscitated in the same room, having not recognised the maternal collapse; and
- How he became like a 'rabbit caught in headlights' during the treatment of Patient D, resulting in the midwifery staff having to make decisions.

236. The Tribunal therefore concluded that conditions would not be proportionate in this case to mark the seriousness of Dr Gendy's misconduct and would be insufficient to maintain public confidence in the medical profession and promote and maintain proper professional standards and conduct for members of that profession.

Suspension

237. The Tribunal took into account the following paragraphs of the SG when considering whether suspension may be appropriate:

> *'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. …*
>
> *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).'*

238. The Tribunal also considered the further factors set out in paragraph 97 of the SG which indicate that suspension is appropriate in this case:

> *'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.'*

239. The Tribunal, having determined that Dr Gendy's misconduct consists of remediable clinical failings, then considered whether it is fundamentally incompatible with continued registration. The Tribunal concluded that while Dr Gendy's remediation is currently inadequate, there is no evidence to suggest that remediation may be unsuccessful in the future. The Tribunal determined that Dr Gendy's misconduct is not fundamentally incompatible with continued registration, however it is so serious that a suspension would be appropriate to maintain public confidence in the profession and to uphold and maintain proper professional standards and conduct for the profession.

<u>Erasure</u>

240. Before concluding that suspension is the appropriate and proportionate sanction in this case, the Tribunal considered the sanction of erasure. The Tribunal did not find that Dr Gendy's misconduct is fundamentally incompatible with continued registration and therefore did not consider erasure to be appropriate and it would in the circumstances be a disproportionate outcome.

241. The Tribunal therefore determined that a period of suspension was the appropriate and proportionate sanction in this case.

Length of Suspension

242. When considering the length of the suspension to impose, the Tribunal determined that a period of 9 months would allow Dr Gendy a realistic opportunity to further develop his insight and to remediate the numerous failings identified in his practice. The Tribunal was mindful that this is a significant period of suspension, however it took into account that Dr Gendy's failings relate to two patients, and in Patient D's case the Tribunal had identified a wide range of serious failings.

243. Tribunal therefore determined that a suspension of 9 months was proportionate in all the circumstances.

Review

244. The Tribunal determined to direct a review of Dr Gendy's case. A review hearing will convene shortly before the end of the period of suspension, unless an early review is sought by either Dr Gendy or the GMC. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Gendy to provide evidence demonstrating how he has developed his insight, remediated his misconduct and maintained his clinical knowledge and skills. It therefore may assist the reviewing Tribunal if Dr Gendy provides:

- Evidence that he has kept his clinical knowledge and skills up to date, including ongoing CPD;
- Evidence of learning and reflection in the following areas: effective communication and working collaboratively with colleagues, human factors and the importance of situational awareness in emergency situations, and diagnosis and identification of early warning signs on the management of obstetric emergencies such as shoulder dystocia, PPH, and Massive Obstetric Haemorrhage; and
- Any other material which Dr Gendy considers will assist the reviewing Tribunal.

Determination on Immediate Order - 01/03/2024

245. Having determined that Dr Gendy's registration be suspended for 9 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Gendy's registration should be subject to an immediate order.

Submissions

246. On behalf of the GMC, Mr Walker submitted an immediate order is necessary to protect members of the public, taking into account the Tribunal's findings on patient safety. Mr Walker further submitted that as the Tribunal has previously been informed, there are interim orders in place in respect of other pending matters, and were the Tribunal to impose an immediate order, the GMC invites the Tribunal to revoke the interim orders currently in place.

247. On behalf of Dr Gendy, Mr Colman submitted that he is neutral on the matter, taking into account Dr Gendy's ongoing interim order of suspension.

The Tribunal's Determination

248. The Tribunal has taken into account the relevant paragraphs of the SG which state:

> *'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…'*

249. The Tribunal carefully considered the above paragraphs of the SG before concluding, in light of the earlier findings by the Tribunal, particularly in relation to the risk to public safety, it is necessary in order to protect the public, to uphold the public interest, and to maintain and promote proper professional standards, to direct an immediate order of suspension.

250. This means that Dr Gendy's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, 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.

251. Having imposed an immediate order, the Tribunal considered the GMC's submissions that all interim orders should be revoked as they are no longer necessary. The Tribunal determined to revoke the interim orders.

252. The interim orders are hereby revoked.

253. That concludes the case.

ANNEX A – 29/02/2024

Application for Voluntary Erasure

254. Dr Gendy made an application to the General Medical Council (GMC) for Voluntary Erasure ('VE') on 27 February 2024 under the GMC (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations Order of Council 2004/2609 (VE Regulations).

255. The GMC referred the VE application to this Tribunal for it to decide whether to allow him to be voluntarily erased.

Evidence

256. The Tribunal considered documentary evidence which included the following:

- Dr Gendy's online application form for VE, dated 27 February 2024;
- Letter from MDDUS in support of Dr Gendy's application for VE, dated 26 February 2024;
- Email from GMC confirming referral of Dr Gendy's application for VE to this Tribunal, dated 27 February 2024;
- Medical Services Statement, dated 11 July 2023;
- GMC Decision to discontinue case, dated 29 December 2020; and
- Agreed Case Summaries.

Submissions

<u>On behalf of Dr Gendy</u>

257. On behalf of Dr Gendy, Mr Colman submitted that Dr Gendy wishes to make an application for voluntary erasure from the medical register. Mr Colman informed the Tribunal that Dr Gendy is now 74 years old and wishes to retire. Mr Colman accepted that there are other pending fitness to practise investigations in relation to Dr Gendy.

258. Mr Colman set out that Dr Gendy faces further allegations in a case relating to a stillbirth in March 2019, in respect of which Dr Gendy was criticised by the Coroner in July 2020 and then self-referred to the GMC, and an allegation relating to the defective performance of a labiaplasty in breach of interim conditions in June 2023. Mr Colman stated that the stillbirth case was initially closed by the GMC in December 2020, but reopened under Rule 12 in 2023 and referred to Case Examiners in July 2023. Mr Colman noted that a decision on whether to refer the case to an MPT was yet to be made. Mr Colman stated that although expert evidence had previously been sought which described discrepancies between the medical records and Dr Gendy's recollection as 'minor and understandable', he understood that these allegations may now be revived.

259. Mr Colman submitted that Dr Gendy maintains that any breach of interim conditions was unintentional. Mr Colman reminded the Tribunal that this matter is still at the Rule 4 investigatory stage and resulted in Dr Gendy's registration being suspended in July 2023. Mr Colman further stated that Dr Gendy faced an investigation and possible prosecution by the CQC, and he had been informed this morning by the GMC that Cheshire Police are investigating an offence contrary to s. 18 of the Offences Against the Person Act 1861. Mr Colman submitted that the suggestion that a surgeon who performs an operation negligently or poorly has an intent to cause grievous bodily harm would be a novel and dangerous extension of the law, and he therefore submitted that such a charge has little chance of proceeding beyond the initial enquiries.

260. Mr Colman submitted that Dr Gendy had intended to continue practising medicine when the matters before this Tribunal arose, however he has found the proceedings chastening and emotionally distressing, and as such feels he is now wishes to retire, having given his account to this Tribunal. Mr Colman submitted that Dr Gendy would be unable to participate in any proceedings in the future and is concerned for the effect they have on his health and wellbeing. Mr Colman further submitted that Dr Gendy is struggling financially and sees little point in maintaining his registration when he does not intend to practise in the future. Mr Colman submitted that Dr Gendy has no intention to work anywhere in the world as a doctor and simply wants to retire.

261. Mr Colman referred the Tribunal to paragraph 9 (b) of the GMC 'Guidance on making decisions on voluntary erasure applications and advising on administrative erasure' (March 2021) ('the VE Guidance') which sets out the circumstances in which caution should be exercised when considering a VE application:

> *'i The allegations are unclear and further evidence is needed to clarify their precise nature and seriousness.*
> *ii We have not obtained the evidence needed to assess the seriousness of the allegations and whether it would harm the public interest to grant VE or proceed with AE. This may include medical records, an expert report, relevant witness statements and information from local investigations, including audit data. Without key evidence, it will be difficult to make an informed judgement about whether VE or AE can appropriately proceed.*
> *iii VE and AE are not necessarily permanent and a doctor can apply for restoration at any time. As part of their overall assessment of the public interest, case examiners must assess the risk posed by a future restoration application. This can be done by considering the likelihood of the doctor seeking restoration and whether we will be able to revive the unresolved allegation(s) should they do so.'*

262. Mr Colman submitted that factors i and ii are not applicable to the outstanding cases, and in the instant case, the evidence has been heard and determined upon. Mr Colman reminded the Tribunal that the stillbirth case has been subject to a Coroner's inquest and Rule 12 process, and the breach of interim conditions case is clear, in that the facts are not in dispute, and the only matter to be decided is whether the breach was deliberate or a

misunderstanding. Mr Colman submitted that factor iii can be assessed by the Tribunal, taking into account Dr Gendy's desire to retire, and that, in the improbable event of a restoration application, the unresolved allegations could be revived.

263. Mr Colman submitted that the allegations in this case have been fully investigated and heard in public, and while Dr Gendy has not received a sanction, no sanction imposed could exceed erasure. Mr Gendy submitted that the finding of impaired fitness to practise is in itself a mark of regulatory reproach to the effect that professional standards and public confidence can be upheld.

264. Mr Colman submitted that the allegations in this case were framed as misconduct rather than deficient professional performance, however they plainly relate to clinical failings on Dr Gendy's part, and he accepted that the stillbirth case also relates to similar clinical concerns about performance. Mr Colman submitted that those concerns have already been heard in public at the inquest. Mr Colman further submitted that the alleged breach of interim conditions also involves clinical concerns and submitted that these may be dealt with by the pending CQC proceedings.

265. Mr Colman submitted that of the factors in paragraph 23 which indicate that voluntary erasure is not appropriate, perhaps only two could be said to apply. In regard to the ongoing criminal investigations, Mr Colman submitted that the maximum penalty for carrying on a regulated activity without being CQC registered is 12 months imprisonment, which the Tribunal may not consider constitutes a 'serious offence', to which the guidance gives no definition. In regard to allegations of gross negligence or recklessness about a risk of serious harm to patients, Mr Colman submitted that it is arguable whether Dr Gendy's failings amount to gross negligence or recklessness. Mr Colman submitted that a presumption of impaired fitness to practise is not relevant in this case where the Tribunal has already found Dr Gendy's fitness to practise to be impaired.

266. Mr Colman further submitted that paragraph 24 (b) – that exceptional circumstances where VE may still be granted include an allegation that does not involve violence or dishonesty which is at the lower end of spectrum of seriousness of conduct that attracts a presumption of impairment – is relevant in this case. Mr Colman submitted that the allegations do not involve violence or dishonesty and are at the lower end of the spectrum of seriousness of conduct which attracts a presumption of impairment. Mr Colman further submitted that the likelihood of Dr Gendy ever returning to practice is extremely remote due to the stage of his career, and the length of time he has been out of practice.

267. In summary, Mr Colman submitted that the combination of this public hearing and the Coroner's inquest have sufficiently addressed the public interest in ventilation of those matters. Mr Colman submitted that the need to further ventilate the stillbirth case in public was not considered crucially important when it was closed in 2020, and further proceedings would achieve little more but to prejudice the doctor's health and wellbeing potentially. Mr Colman submitted that erasure would eliminate any risk of repetition of Dr Gendy's failings,

and it is right and proportionate in all the circumstances to grant the application for voluntary erasure.

On behalf of the GMC

268. Mr Walker, on behalf of the GMC, submitted that the application is strongly resisted and there is a strong public interest in this case proceeding to sanction. Mr Walker submitted that each element of the overarching objective is triggered in this case, and it would not be in the public interest to allow a doctor to VE where there are outstanding concerns about their fitness to practise. Mr Walker submitted that while the public will be protected by a decision to allow VE, the overarching objective has to be considered and it is not in the public interest for registrants facing disciplinary proceedings to avoid the consequences by ceasing to be registered.

269. Mr Walker submitted that the two outstanding cases are serious matters. Mr Walker submitted that in relation to the stillbirth incident, all matters are being considered, including the probity matters raised by the Coroner. Mr Walker submitted that there will be a focus on what was said and done and not just on what is a matter of record, and therefore witness' may need to be called many years after the events. He reminded the Tribunal of the expert witness' opinion that Dr Gendy's conduct was seriously below the standard to be expected.

270. In regard to the labiaplasty case, Mr Walker submitted that this is a serious allegation, and breaches of orders should always be ventilated fully. Mr Walker submitted that to allow VE in these circumstances would be contrary to the public interest and not in the interests of the profession, who need to understand that they will be called to account for such failures and cannot seek VE and retire to avoid scrutiny.

271. Mr Walker accepted that Dr Gendy is 74 and any application to restore his registration would be made beyond that point, however he submitted that fact cannot be determinative and is simply a factor to take into account. Mr Walker submitted that a restoration hearing would have to consider recollections to those involved in the stillbirth at least 5 or 6 years after the event, and delay would prejudice that process. Mr Walker submitted that the matter having been ventilated at an inquest does not mean that the public interest has been satisfied in regard to fitness to practise proceedings which have a different function.

272. Mr Walker submitted that to allow Dr Gendy to be removed from the register voluntarily while two criminal investigations are underway would result in public confidence being undermined. Mr Walker submitted that the Tribunal should not considered whether there are reasonable prospects of a conviction but consider the fact that there is an investigation ongoing into one of the most serious criminal offences available.

273. In regard to gross negligence or recklessness, Mr Walker submitted that given the Tribunal's findings in relation to Patient D, it is at least arguable that the current matter falls

within that category. Mr Walker therefore submitted that the Tribunal must consider carefully whether there are any exceptional circumstances which may allow VE to be granted.

274. Mr Walker submitted that when considering if any exceptional circumstances are present in this case, the Tribunal should not conclude that the findings it has made, nor the outstanding matters, are at the lower end of spectrum in terms of serious allegations which may lead to a finding of impaired fitness to practise.

The Tribunal's Approach

275. The Tribunal had regard to the *Guidance on making decisions on voluntary erasure applications and advising on administrative erasure* ('the VE Guidance').

276. The Tribunal conducted a balancing exercise, taking into account the interests of Dr Gendy and the public interest in considering his application for VE.

277. Throughout its deliberations, the Tribunal bore in the mind the need to uphold the overarching objective 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.

The Tribunal's Decision

278. The Tribunal first considered whether any of the factors set out at paragraph 23 of the VE Guidance may be relevant in this case. The Tribunal considered the following may be relevant:

> *'23 The following are examples of cases where (except in exceptional circumstances) it will not be in the public interest to allow voluntary erasure or proceed with administrative erasure before the conclusion of fitness to practise proceedings, including a MPT hearing in some cases. This is because they involve a conviction for a serious criminal offence or the allegation carries a presumption of impaired fitness to practise.*
>
> > *a Ongoing police investigations or convictions for serious offences*
> > *Although it is not possible to provide an exhaustive list, the key issue is whether public confidence would be undermined if the GMC did not fully investigate the matter.*
> > *…*
> >
> > *h Allegations of gross negligence or recklessness about a risk of serious harm to patients.'*

279. The Tribunal considered the submission by Mr Walker that the conduct in this case has involved gross negligence or reckless disregard for the safety of patients. The Tribunal has made no findings in these proceedings that Dr Gendy has acted either in a reckless manner, nor that his conduct amounted to gross negligence. In regard to the stillbirth, the Tribunal noted that the previous review of the case by the GMC did not consider the matter serious enough to proceed to an MPT, and although the Tribunal was mindful that the case is being reevaluated, it considered that the decision to discontinue would suggest failings amounting to gross negligence were not previously identified. The Tribunal therefore determined that this factor was not applicable in this case.

280. The Tribunal then considered whether the other outstanding matter, relating to the breach of the interim order, is relevant under paragraph 23 (a). The Tribunal noted that Dr Gendy currently faces two ongoing criminal investigations, the first instigated by the CQC for undertaking a procedure at a Practice which was not registered with the CQC, and the second by Cheshire Police for the offence of s.18 grievous bodily harm. The Tribunal determined that these are both very serious offences, grievous bodily harm being a clearly serious offence, and the other carrying a potential sentence of 12 months imprisonment. Given the CQC matter involves Dr Gendy practising at an unlicensed premises, the Tribunal was not persuaded by Mr Colman's submission that the CQC matter was not a serious offence. The Tribunal therefore determined that either offence, if Dr Gendy was convicted, would carry a presumption of impaired fitness to practise, and therefore paragraph 23 (a) is applicable.

281. Having determined that circumstances are present which indicate the VE would not be appropriate, the Tribunal then considered whether there are exceptional circumstances where it may be appropriate to allow VE, under paragraph 24 of the VE Guidance:

> *'24 There may sometimes be exceptional circumstances when it is appropriate to allow voluntary or administrative erasure prior to the conclusion of the fitness to practise process, even if a case falls into one of the categories above. These may include cases:*
>
> > *a involving violence and dishonesty where a careful balancing of the relevant factors leads to the conclusion that the presumption of impairment is rebutted because the doctor's behaviour is at the lower end of the spectrum and does not pose a risk to public protection and therefore it would be appropriate for erasure to proceed. For example, the doctor has assaulted someone in a pub or engaged in an act of minor dishonesty such as stealing a low value item. It would be disproportionate to not allow erasure to proceed in these circumstances.*
> >
> > *b where the allegation does not involve violence or dishonesty but is at the lower end of the spectrum of seriousness of conduct that attracts a presumption of impairment and the fact that the likelihood of the doctor ever returning to practice is extremely remote due to the stage of their career, their retirement status and/or the length of time they have been out of practice*

amounts to an exceptional circumstance that would make it appropriate for erasure to proceed. For example, an isolated incident of a doctor prescribing without a licence.

c where the doctor does not have capacity to understand the allegations or to seek/act on legal advice [see paragraphs 53 to 57 below]

d where the doctor is suffering from a terminal or very serious illness and there is no prospect they will recover sufficiently to practise medicine again.'

282. The Tribunal found that none of the circumstances in paragraph 24 are applicable in this case. The Tribunal was mindful that Dr Gendy has found the proceedings stressful, however it has not been provided with any medical evidence to show that this is beyond the stress to be expected with protracted legal and regulatory proceedings. The Tribunal took into account Dr Gendy's age and indicated desire to retire but bore in mind that until very recently he intended to continue in practice. The Tribunal therefore considered the likelihood of him seeking to return to practise is not necessarily an 'extremely remote' one.

283. The Tribunal determined that the outstanding police and CQC investigations and the potential probity matters in relation to the stillbirth case were not at the lower end of the spectrum, and a risk to public protection was evident. Although there has been an inquest in respect of the stillbirth case and there may be criminal proceedings in respect of the labiaplasty, the Tribunal considered the public interest would not be satisfied solely by those given the different role fitness to practise proceedings play in maintaining public confidence and upholding proper professional standards. The Tribunal therefore did not identify any matters which would amount to exceptional circumstances so as to outweigh the public interest in allowing the GMC investigations and this case to continue at this time.

284. The Tribunal considered paragraph 16 and 21 of the VE Guidance to be relevant in this case:

'16 Case examiners should assess the seriousness of the allegations and whether it would undermine public confidence in the medical profession if they were not fully investigated. This may involve the allegations being heard in public at a tribunal hearing and the doctor receiving a sanction. This in itself strengthens public confidence that proper standards of conduct and performance are being upheld.

21 Where it is alleged that a doctor has significantly and/or persistently breached the professional standards we set for doctors, this gives rise to a public interest in the alleged breaches being properly investigated (with a public hearing held in some cases) and not evaded.'

285. The Tribunal considered the seriousness of the outstanding allegations that Dr Gendy faces and determined that it would undermine public confidence that proper standards of conduct and performance were being upheld were they not fully investigated and heard in

public. In respect of its own findings, and considering the outstanding matters, the Tribunal determined that Dr Gendy had potentially consistently breached professional standards and as such there is a public interest in allegations being properly investigated and not evaded at this stage.

286. The Tribunal was mindful that in granting an application for VE, it would satisfy the overarching objective in that it would, given the Tribunal's previous finding, protect patients from unwarranted risk of harm from Dr Gendy; however, it determined that granting the application would undermine public confidence in the profession and undermine proper professional standards and conduct for members of the profession given the seriousness of the outstanding matters and the Tribunal's own findings in respect of Patient D.

287. The Tribunal therefore refused Dr Gendy's application for Voluntary Erasure.

Schedule 1

Intravenous infusion of Syntocinon
Ergometrine
Misoprostol
Haemabate