PUBLIC RECORD

Dates: 02/06/2025 - 13/06/2025; 12/01/2026 - 14/01/2026

Doctor:	Dr Firas MAJEED
GMC reference number:	5208152
Primary medical qualification:	MB ChB Al-Mustansirya University

Type of case	Outcome on facts	Outcome on impairment
New - Deficient professional performance	Facts relevant to impairment found proved	Not Impaired

Summary of outcome

Warning

Tribunal:

Legally Qualified Chair	Mr Jonathan Storey
Lay Tribunal Member:	Ms Jo Palmiero
Registrant Tribunal Member:	Dr Pavan Rao

Tribunal Clerk:	Mr Larry Millea

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Scott Ivill, Counsel, instructed by Weightmans
GMC Representative:	Mr Jacob Dyer, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 13/06/2025

1. This determination will be handed down in private. However, as this case concerns Dr Majeed's alleged deficient professional performance a redacted version will be published at the close of the hearing.

Background

2. Dr Majeed qualified in 1993 from Al-Mustansirya University in Iraq and completed his primary medical training in Baghdad in January 2000. Dr Majeed commenced work in the NHS in 2001, initially with provisional registration before obtaining full registration in March 2003 and completing his foundation training in 2014. He has been registered with a licence to practise since 16 November 2009 and has been employed in the UK since that time.

3. At the time of his referral to the GMC, Dr Majeed was employed as an ST3 in Rehabilitation Medicine at the Florence Nightingale Community Hospital in Derby. Since 4 July 2022 he has been employed as a middle grade doctor (ST3 level) in Acute Medicine at the Leicester University Hospitals.

4. The Allegation that has led to Dr Majeed's hearing can be summarised as that, between 29 and 30 January 2024, Dr Majeed underwent a General Medical Council assessment of the standard of his professional performance. It is alleged that Dr Majeed's performance was unacceptable in the following areas: Assessment of Patients' Condition and Clinical Management.

5. It is further alleged that Dr Majeed's performance was a cause for concern in the following areas: Maintaining Professional Performance, Relationship with Patients and Working with Colleagues.

6. The initial concerns were raised with the GMC on 18 March 2022 by Mr A, Responsible Officer at Health Education East Midlands, after concerns were identified in relation to Dr Majeed's professional performance.

The Outcome of Applications Made during the Facts Stage

7. The Tribunal granted an application made by Mr Dyer, on behalf of the GMC, made pursuant to Rule 41 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to admit further witness evidence, namely a written witness Statement of Dr B, who was also called to give oral witness evidence. This application was not opposed by Mr Ivill, on behalf of Dr Majeed.

8. The Tribunal further granted an application, made by Mr Dyer on behalf of the GMC, that any evidence heard in relation to non-disclosable information from OSCE test documentation would be heard in private session, in accordance with Rule 41 of the Rules. This application was not opposed by Mr Ivill, on behalf of Dr Majeed.

The Allegation and the Doctor's Response

9. The Allegation made against Dr Majeed is as follows:

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

1. Between 29-30 January 2024 you underwent a General Medical Council assessment of the standard of your professional performance. Admitted and found proved

2. Your professional performance was unacceptable in the following areas:

    a. Assessment of Patients' Condition; To be determined

    b. Clinical Management. To be determined

3. Your professional performance was a cause for concern in the following areas:

    a. Maintaining Professional Performance; To be determined

b. Relationship with Patients; To be determined

c. Working with Colleagues. To be determined

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

The Admitted Facts

10. At the outset of these proceedings, through his counsel, Mr Ivill, Dr Majeed made admissions to paragraph 1 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 that paragraph of the Allegation as admitted and found proved.

Witness Evidence

11. The Tribunal received evidence on behalf of the GMC from the following witness:

- Dr B, Dr Majeed's Educational Supervisor, who also provided a written witness statement dated 3 October 2022. The Tribunal also received an Educational Supervisor's Report for Dr Majeed produced by Dr B, dated 6 January 2022.

12. Dr Majeed provided his own witness statement, dated 11 April 2025, and also gave oral evidence at the hearing. In addition, the Tribunal received evidence from the following witnesses on Dr Majeed's behalf:

- XXX;
- Dr C, Consultant in Acute and General Medicine, and Dr Majeed's Clinical Supervisor since 2022, who also provided a written witness statement dated 8 April 2025.

Expert Witness Evidence

13. The Tribunal also received evidence from three expert witnesses.

- Professor E, Consultant Physician and GMC Performance Assessor (Team Leader);
- Dr F, Consultant in Acute Medicine and GMC Performance Assessor (Medical);

- Dr G, trained Clinical and Educational Supervisor for foundation, junior and higher speciality training.

14. Professor E and Dr F provided oral evidence to the Tribunal to assist in its understanding of the Performance Assessment undertaken by Dr Majeed. The Tribunal received a Performance Assessment Report dated 28 February 2024 and an addendum report of the GMC Performance Assessors dated 17 March 2025.

15. Dr G produced an expert report on behalf of Dr Majeed, addressing the GMC Performance Assessment Report and its findings, dated 23 May 2025.

Documentary Evidence

16. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to: various clinical guidance documents; Dr Majeed's Rule 7 response letter; a number of testimonials provided on Dr Majeed's behalf; various CPD (Continuous Professional Development) certificates provided by Dr Majeed; and various patient questionnaires.

The Tribunal's Approach

17. 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 Majeed 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.

18. In reaching its determination, the Tribunal took into account all the written and oral submissions from the parties.

19. The Tribunal also took into account the advice provided by the Legally Qualified Chair, which was provided in public session and upon which he invited comment. The Tribunal accepted that advice in full.

20. Dr Majeed has no previous regulatory findings against him and is, therefore, entitled to a good character direction.

The Tribunal's Analysis of the Evidence and Findings

Further Background

21. The Tribunal noted the background to Dr Majeed's case. He was registered with the GMC from March 2003 and completed his foundation training in 2014. Since then he had been released from a number of training programmes. Until February 2022 he was working at the Royal Derby Hospital in Rehabilitative Medicine under his Educational Supervisor Dr B when he was once again released from his training programme, having failed to progress. At the time of the referral to the GMC he was no longer supervised under a training programme.

22. Concerns were raised in an ARCP and a report from Dr B in January 2022. These identified deficits in Dr Majeed's communication, his ability to work in an MDT (Multi-Disciplinary Team), his ability to engage in focussed learning, history taking, clinical examination and identifying and carrying out appropriate investigations. According to Dr B, in the 13 months reviewed Dr Majeed had struggled to show the capabilities expected for the ST3 level. He had failed his PACEs exams after 6 attempts and his clinical skills were insufficient for him to perform some of the procedures required by the curriculum. After much support, including 1:1 sessions, there had been some improvement but there were still concerns about his ability to perform basic medical tasks without close supervision. The GMC took the view that the concerns regarding Dr Majeed's professional performance were long-standing and that there was a lengthy history of failing to progress. There was therefore a need for an objective assessment of his professional performance.

The Performance Assessment Report ('the Report')

23. The Report followed an assessment of Dr Majeed conducted at the GMC Clinical Assessment Centre in Manchester between 29 and 30 January 2024.

24. The assessment team comprised Professor E (Team Leader) and Dr F (Medical Assessor), and was also attended by Mr H, Performance Assessment Officer (PAO) at the GMC.

Assessment tools used

25. Dr Majeed was assessed as a junior doctor working at ST3 level in Acute Medicine and was expected to demonstrate competence for this role. When planning this assessment, the team took into account:

- Dr Majeed's speciality and grade.
- The information about Dr Majeed's practice provided in the portfolio.

First Interview

26. The assessment team conducted a First Interview with Dr Majeed to gain a greater understanding of the context of his practice.

Medical Record Review

27. The assessment team requested 50 sets of medical records of Dr Majeed's most recent work covering his scope of practice, where he has made clinical decisions. The Trust responded on behalf of the Responsible Officer (RO) that activities in the Acute Medical unit are consultant led, where consultants make clinical decisions in the management of patient care. It said that Dr Majeed was supervised, and would not have made any substantive clinical decisions. The Trust also mentioned that as medical records are not electronic, and in the light of its current workload pressures, there would be a delay in collecting medical records manually.

28. The assessment team decided not to review Dr Majeed's medical records as it considered that the records were unlikely to show his clinical decision making.

Third Party Evidence

29. Colleagues of Dr Majeed were asked to participate in the assessment. Two colleagues were interviewed (videocall), and two colleagues asked to complete a Colleague questionnaire (written feedback). The team chose to conduct an interview with those who were likely to have good knowledge of his performance across a broad range of areas.

Observation of Practice

30. It was not possible to conduct an Observation of Practice due to current workload pressure on the Trust.

OSCE

31. An OSCE is an 'objective structured clinical examination'. During the OSCE, a doctor is presented with scenarios that could arise in the course of a normal working day. They are designed to test the doctor's practical skills, clinical methods and interpersonal skills.

32. These were chosen by the assessment team from a list provided by the GMC Assessment Development Team. This selection was chosen to reflect a range of presentations seen in Acute Medicine and to test a range of skills.

33. The role players were briefed by the Team Leader and Medical Assessors to ensure they knew their roles. The scenarios chosen in Dr Majeed's case were:

1 Red flag headache history
2 Management of paracetamol overdose
3 Recognition and management of low potassium
4 Respiratory system examination and management
5 Chest drain consenting
6 Prescribing in DKA
7 Break bad news of sudden unexpected death
8 Moderate asthma attack history taking
9 Management of a patient who has had a TIA
10 Examination and management of Parkinson's disease
11 History and management of shortness of breath in a young man
12 Prescribing in heart failure
13 History and management of seizure from young male
14 SIM – advanced life support defibrillation

Case Based Discussion

34. The team chose eight cases to discuss with Dr Majeed, and several questions were asked about each. All cases were chosen from the OSCE. In advance of the discussion, Dr

Majeed was handed relevant OSCE documentation to refresh his memory, including the task and patient details.

Knowledge Test

35. Dr Majeed undertook a 2.5-hour test of 120 single best answer questions. The questions were chosen by members of the Tests of Competence and Revalidation Assessment Panel and were taken from the GMC item bank or sourced from the appropriate college. The test was invigilated by another PAO.

Simulated patient survey

36. The role players playing patients or carers in the OSCE scenarios were asked these questions:

- How good was the doctor today at each of the following?
  - Being polite and considerate
  - Listening
  - Explaining things in a way the patient/carer would understand
  - Involving the patient in decisions
- Overall, how would you rate this doctor's communication with the patient/carer?
- Please tell us the reasons for your answer

Assessed Interview

37. One assessed interview was conducted.

Overall assessments

38. The overall assessment for each category was made according to the following scale:

Unacceptable indicates that there is evidence of repeated or persistent failure to comply with the professional standards appropriate to the work being done by the doctor, particularly where this places patients or members of the public in jeopardy (i.e. deficient professional performance). This grade should be entered if:

- you have evidence that the criteria for an acceptable level of performance are regularly not being met or
- negative criteria are being met.

Acceptable means that the evidence demonstrates that the doctor's performance is consistently above the standard described above. This grade should only be entered if:

- all, or almost all, of the criteria are satisfied in all, or almost all, of the examples gathered.

Cause for concern means that there is evidence that the doctor's performance may not be acceptable but there is not sufficient evidence to suggest deficient professional performance. The reasons for this grade, rather than 'unacceptable', should be described. This grade should be entered if:

- there is evidence of some instances of unacceptable performance but which, in the view of the assessing team, do not amount overall to unacceptable performance.

39. The Tribunal noted the Team's overall assessment for each category:

Category	Overall assessment
Maintaining Professional Performance	Cause for concern
Assessment of Patients' Condition	Unacceptable
Clinical Management	Unacceptable
Operative/Technical skills	Not assessed
Record Keeping	Not assessed
Safety and Quality	Not assessed
Relationships with Patients	Cause for concern
Working with Colleagues	Cause for concern

40. Accordingly, set against this background, the Tribunal now turns to the evidence in relation to the paragraphs and sub-paragraphs of the Allegation in order to make its findings on the facts.

Paragraph 2

2(a) - Assessment of Patients' Condition

41. In determining whether Dr Majeed's professional performance was unacceptable in assessment of patients' condition, the Tribunal noted the overall findings set out in the Performance Assessment report which states:

> *There is evidence of repeated and persistent failure to comply with the professional standards appropriate to the work at his level in acute medicine. Dr Majeed did not consistently complete a systematic assessment of patients. His approach was judged to be superficial, with important omissions, which resulted in a basic outline only. Dr Majeed's examinations lacked substance and evidence of higher-level thinking. Dr Majeed's diagnostic skills were judged to be that of a junior doctor in acute medicine who would not be able to practice independently at this stage. It was the assessment team's conclusion that Dr Majeed's overall performance was found to be unacceptable.*

42. In his written witness statement, Dr Majeed stated that:

> *In summary, I do not accept that my performance was 'unacceptable' in this area but I do accept that there may be examples which would be considered as 'cause for concern' as identified above in respect of OSCE's 8, 10, 13, 4, 14 and 2.*

43. Dr G's opinion in respect of this category was:

> *I acknowledge that there are some valid areas of concern raised in the Performance Assessment. However, in my view there are valid criticisms of the assessment that would warrant the overall outcome of the assessment in this domain being one of 'cause for concern' rather than 'unacceptable', as it was determined to be.*

44. The Tribunal went on to consider the criticisms relating to the various OSCEs and findings of the Report made on behalf of Dr Majeed, and the evidence and submissions in each regard.

OSCE 1 - Red flag headache history

45. In respect of OSCE 1, the Report states:

Dr Majeed was judged to have not been systematic and fluent in taking history as expected at his level, for examples in OSCE 1; he asked about headache then fleeted to other aspects and returned to ask the onset of headache and then he asked unrelated issues.

46. In his contemporaneous records, appended to the Report, Professor E commented that:

Dr did not take history in systematic way as expected at his level. He asked about headache then smoking, returned to onset of headache and then other unrelated issues.

47. In his contemporaneous records, appended to the Report, Dr F commented that:

The doctor did not obtain the history in a systematic way, expected at his level.

48. In his written statement, Dr Majeed stated that:

My ability to provide comments in respect of each individual OSCE assessment is limited given that there are no recordings or transcripts available for my discussions with the Performance Assessors. This is particularly relevant when being able to comment on OSCE 1 and 11 as the criticisms relate to allegedly not being focused, fluent coherent or systematic.

49. In the absence of any recordings or transcripts of each OSCE assessment, the Tribunal took the view that it had no objective basis on which to consider the assessors' subjective opinion in this regard. For that reason it felt unable to conclude that Dr Majeed's performance in relation to OSCE 1 was unacceptable.

OSCE 2 - Management of paracetamol overdose

50. The Report stated that in respect of OSCE2 that Dr Majeed *"did not check about depression and family issues at home"* and "*did not mention liver damage to be evaluated as set out in King's College Criteria".*

51. In relation to the first of these concerns, Dr Majeed stated in his written witness statement:

> *I accept that it is useful to appreciate whether there are any family difficulties at home, however it should be noted that this Patient was 18 and not a child. I would usually seek to elicit information by adopting a more 'open' questions approach about any concerns that the patient may have which may be impacting on their mental health.*

52. In relation to the second of these concerns, Dr G's opinion – as set out in his written report – was as follows:

> *There was criticism of Dr Majeed in relation to the lack of discussion of the King's College criteria for liver transplantation. In my opinion (as a Consultant seeing multiple patients every week with paracetamol overdoses), this is unfair and unjust criticism. In a patient who has taken an overdose of 20 paracetamol tablets 12 hours prior, from a medical (as opposed to psychiatric) perspective, the main decision is whether treatment with N-acetylcysteine (the antidote) is required.*

53. In his oral evidence Dr G said that the King's College criteria were potentially relevant at a later stage in a patient's treatment.

54. The Tribunal accepted Dr G's evidence regarding the specific use of the King's College criteria and did not therefore consider Dr Majeed's not having referred to them in his Case Based Discussion to be unacceptable in itself.

55. However, it found that Dr Majeed had failed to adequately ask the patient about depression and family issues at home, which he should have done as part of appropriate history-taking, and accepted the Report's findings in this regard.

OSCE 4 - respiratory system examination and management

56. The Report stated that in respect of OSCE 4 *"Dr Majeed was judged to have not examined respiratory system in coherent manner and fluent as expected at his level."*

57. In his written statement, Dr Majeed accepted this criticism, stating that:

I am an experienced clinician and accept that my examination may not have been as systematic as usual due to [XXX] *under exam pressure. When carrying out a respiratory examination, I would usually take a stepwise approach including inspection, palpitation, percussion and then auscultation.*

58. Given that Dr Majeed accepted the criticisms made in the Report, the Tribunal accepted its findings in respect of OSCE 4.

OSCE 8 - Moderate asthma attack history taking

59. The Report stated that in respect of OSCE 8:

Dr Majeed did not ask about [the patient's] medication and check its compliance. He did not explore allergy as the patient had mentioned having a cat at home.

60. In his written statement, Dr Majeed accepted these criticisms, stating that:

I note that the Performance Assessors are critical that I did not check that the patient was compliant with medication or enquire as to allergies given the patient's indication that she had a cat at home. I accept the importance of understanding whether a patient has been compliant with medication and to enquire about any allergies.

61. Dr G's evidence was that he would not necessarily expect a doctor at ST3 level to check compliance in every case, but considered this to be best practice. In the Tribunal's view, however, this was highly relevant and important information in an acute setting which Dr Majeed should have asked about to assist in managing the patient's asthma attack and ongoing management of asthma.

62. Accordingly, it accepted the findings as set out in the Report in respect of OSCE 8.

OSCE 9 - Management of a patient who has had a TIA (transient ischaemic attack)

63. The Report stated in respect of OSCE 9:

Dr Majeed did not assess the patient taking account of ABCD2 score to determine risk level and he was not fluent in taking history in this common condition seen in acute setting.

He did not ask about driving as patient drove daily for her needs, this is an important aspect after TIA.

Dr Majeed did not arrange tests such as blood FBC, glucose, cholesterol and carotid doppler as initial tests in probable TIA.

64. In relation to the first of these concerns, Dr Majeed stated in his written witness statement that:

The Performance Assessors have made criticisms on the basis of not asking questions to the patient in accordance with the ABCDE criteria. As this is not the appropriate guidance to follow, I do not accept any criticisms that are made on this basis.

65. This position was somewhat supported by the evidence of Dr G, who stated in his report that:

It is also worth noting that the use of the ABCD2 or other such scoring systems has actually been specifically advised against in the NICE guidelines (updated in 2019), which state that "do not use scoring systems, such as ABCD2, to assess risk of subsequent stroke or to inform urgency of referral for people who have had a suspected or confirmed TIA". I would, therefore, strongly argue that the failure to refer to such a scoring system is not a valid criticism in this case.

66. This point was addressed in the Performance Assessors' supplemental Report, which stated:

The Team had not suggested that Dr Majeed should have used the ABCD2 as an assessment tool to stratify risk of TIA. The Team had accepted that Dr Majeed made a referral to TIA clinic correctly without using ABCD2 score.

and:

We did not expect Dr Majeed to use ABCD2 for urgent referral, as the Team we had already accepted his referral to TIA clinic was a correct approach in this case. ABCD2 simply points the risk factors for discussion with the patient, this would allow preventive treatment to begin as soon as possible, as mentioned in the guidance.

67. The Tribunal acknowledged and agreed with Dr G's criticism of the reference to the ABCD2 score itself, but accepted the evidence of the Performance Assessors that their primary concern related not to specifically checking the score, but rather to considering the relevant risk factors covered by the ABCD2 methodology such as age, blood pressure, cholesterol, diabetes and duration. The opinion evidence of the Performance Assessors was that Dr Majeed did not address or consider these risk factors adequately, although the Tribunal noted that there was contemporaneous evidence deriving from Dr F that Dr Majeed had in fact asked about diabetes, blood pressure, cholesterol and family history. In the Tribunal's view there was not sufficient evidence before it for it to be persuaded that Dr Majeed's assessment of the patient in this respect was not acceptable.

68. Furthermore, in his contemporaneous notes appended to the Report, Professor E commented that:

> *Dr's history of the current problem was not coherent as expected at his level. He asked about weakness then family history, then alcohol intake and other unrelated issues.*

69. The Tribunal considered that Professor E was an experienced assessor making a record at the time. In the absence of any recordings or transcripts of each OSCE assessment, however, the Tribunal took the view that it had no objective basis on which to consider the assessors' subjective opinion in this regard. For that reason, and noting that Dr F assessed Dr Majeed's history-taking as acceptable, the Tribunal considered that it did not have sufficient evidence to make a positive finding in this regard.

70. Dr Majeed accepted the Performance Assessors' criticism that he did not ask the patient about driving. The Tribunal was satisfied that it had sufficient evidence before it that this was important information in the context of the scenario assessed and that he should have done so given its potential public safety implications. It therefore found Dr Majeed's performance to have been unacceptable in this regard.

71. In respect of the criticism relating to arranging appropriate initial tests, the Tribunal noted the contemporaneous evidence of Professor E, appended to the Report, that *"Dr did not arrange to check FBC, blood glucose, cholesterol, carotid doppler as initial tests".* It accepted the evidence of the Performance Assessors that it is common practice and generally acceptable to arrange for a CT scan, which Dr Majeed did. It also accepted the evidence of Dr G that a carotid doppler test could be carried out at a later time. However, the Tribunal

agreed with the observations of Professor E that Dr Majeed should have arranged further initial tests, and therefore accepted the findings of the Report in this regard.

OSCE 10 - examination and management of Parkinson's

72. The Report stated that in respect of OSCE 10:

> *Dr Majeed did not assess the functional status which was useful in this patient.*

73. Whilst the Tribunal bore in mind that the Performance Assessors stated that Dr Majeed should have obtained a functional history from the patient and asked how it was affecting him in daily living, it also considered the opinion of Dr G, who stated:

> *Dr Majeed was criticised for not performing a functional assessment in this case. XXX. In my opinion, this scenario and description strongly suggests no functional assessment would be required XXX I feel criticism of Dr Majeed in not performing a functional assessment in this case is unreasonable. Overall, in my opinion, I would describe this as acceptable rather than a cause for concern.*

74. The Tribunal was satisfied that, given the instructions provided to Dr Majeed and taking into account the opinion of Dr G, Dr Majeed's assessment of the patient was acceptable in the circumstances.

OSCE 11

75. The Report stated that in respect of OSCE 11:

> *Dr Majeed was not focussed, fluent and coherent in obtaining history of breathlessness and personal sexual history.*

and:

> *Dr Majeed mentioned a number of conditions as a possible differential diagnosis including anaemia, chest infection, malignancy and HIV, without looking at the context of this patient as expected at his level.*

76. Professor E's contemporaneous observations in relation to these matters were:

Dr said anaemia, chest infection, malignancy and HIV. Comment: his differential diagnoses in this patient was not coherent and did not fit in the context.

Dr's history was not focused, fluent and coherent as expected at his level.

77. Dr F commented that:

The doctor did consider anaemia, malignancy, chest infection, In view of multiple partners on sexual history – HIV, did not ask about rash as his differentials. Comment: the doctor did not mention the differentials expected at his level.

The doctor did obtain sexual history, but not focussed and did not explore the sex orientation, that is expected at his level" [the Tribunal noted that Professor E reports *"checked relationship and about protected sex"*]

The doctor history taking is not systematic (mixing symptoms enquiry with other history)

78. The Tribunal considered the opinion of Dr G, who stated:

XXX. There was criticism of Dr Majeed as he "mentioned a number of conditions as a possible differential diagnosis including anaemia, chest infection, malignancy and HIV, without looking at the context of this patient as expected at his level". However, in a young patient with unexplained breathlessness these considerations are reasonable XXX. Whilst it is important to focus the mind of what may be common, I have personally seen far more incidents and patient harm come from being too narrow and focussed in differential diagnosis, as opposed to thinking widely and keeping an open mind. Overall, in my opinion, I would describe this as acceptable.

79. The Tribunal considered the evidence of Dr G that Dr Majeed's performance was acceptable in respect of his differential diagnoses, notwithstanding his opinion (shared by Professor E and Dr F) that malignancy was unlikely in this case. It accepted this evidence and, while agreeing with Professor E, Dr F and Dr G that malignancy appears to have been unlikely, did not consider that Dr Majeed's performance in this regard could reasonably be described as unacceptable.

80. In respect of Dr Majeed's history-taking, the Tribunal did not consider that it had sufficient evidence before it to make an objective assessment of the Performance Assessors' opinions. In the Tribunal's view it could not, therefore, conclude that this aspect of Dr Majeed's performance was below the expected standard.

OSCE 13 - History and management of seizure from young male

81. The Report stated that in respect of OSCE 13:

Dr Majeed asked about faint in a disorganised way and did not check past or family history of seizures.

…

Dr Majeed arranged tests such as ECG, CT scan of head, blood tests including troponin as he did not want to miss out anything rather than a focused approach.

82. Dr G's opinion on the second of these criticisms was that:

XXX

83. In his oral evidence he went on to state that an ECG was a standard test and that it would have been negligent not to undertake one; that a CT scan was important; and that standard blood tests including troponin was reasonable in the circumstances.

84. The Tribunal noted that, in relation to arranging tests and scans, Dr F recorded these contemporaneously as 'acceptable'.

85. In respect of history taking, Professor E commented:

Dr asked about faint, loss of consciousness but not in coherent manner

…

Dr did not check PMH or FH of seizure or collapses.

86. Dr F commented that:

The doctor did not obtain further history regarding collapse and explored the differentials

87. Nevertheless he also recorded some aspects of Dr Majeed's performance as acceptable, commenting:

The doctor did establish this is the first episode of collapse

…

The doctor did obtain past history, family history, drug history.

88. In his written statement, Dr Majeed stated:

I accept that it would have been helpful to check family history in respect of seizures.

89. The Tribunal considered that Professor E took a more critical position than Dr F in regard to the tests arranged by Dr Majeed. The Tribunal accepted the evidence of Dr G and the opinion of Dr F in this regard and found that Dr Majeed's performance was therefore acceptable.

90. In regard to the history-taking, the Tribunal felt unable in the absence of a verbatim transcript, recording or other similar detailed contemporaneous evidence to conclude that Dr Majeed had, as Professor E noted, asked about faint *"but not in a coherent manner"*. As to the issue of whether he "did not check past or family history of seizures" the Tribunal noted that the Performance Assessors appeared to provide conflicting evidence, with Professor E stating that Dr Majeed did not do so, but Dr F's contemporaneous observations indicating that he did. In the circumstances, the Tribunal determined that, on balance, Dr Majeed's performance was acceptable in this aspect also.

OSCE 14 - SIM – advanced life support defibrillation

91. The Report stated that in respect of OSCE 14:

Dr Majeed did not assess the patient using an established ABCDE approach at any stage, he asked to sedate the patient who was in peri-arrest, his overall approach did not show the expected emergency in this case.

92. The Tribunal noted that Dr G was also of the opinion that this was unacceptable and that Dr Majeed did not dispute the findings as set out in the Report, stating in his written statement that:

I accept the concerns raised by the Performance Assessors in respect of this patient.

Paragraph 2(a) summary

93. In summary, the Tribunal found that Dr Majeed had performed at an unacceptable level in respect of OSCEs 2, 4, 8, 9 and 14 for the reasons set out above. It also found that there was insufficient evidence to demonstrate unacceptable performance in relation to OSCEs 1, 10, 11 and 13.

94. The Tribunal considered the submissions made on behalf of Dr Majeed that the third-party evidence and the evidence of his current Clinical Supervisor contradict the findings set out in the Report and demonstrate that his performance is acceptable, particularly in relation to his history-taking and fluency with patients. However, the Tribunal noted that Dr Majeed is working with supervision under conditions on his registration, and so this evidence reflects his performance in a somewhat protected environment where his decision-making is referred to and checked with Consultants.

95. The Tribunal considered that despite the positive evidence that Dr Majeed is working well with these protective factors in place and his performance has been deemed adequate by his current Medical Supervisor, there was clear evidence, which it accepted, that Dr Majeed's performance in the context of the GMC Performance Assessment was, in several regards, unacceptable.

96. The Tribunal also considered the evidence and submissions in relation to XXX and how this may have detrimentally affected his performance at the time of the Performance Assessment. It accepted that he may have been affected by XXX which could have contributed to the discrepancy between his real-life performance and his performance during the Performance Assessment. However, it was not satisfied that it had been provided strong evidence as to how this undermined the findings in the Report.

97. The Tribunal accepted the submissions made on behalf of the GMC in this regard, namely that:

> *There was no documented history of* [XXX] *prior to* [XXX] *prepared following the referral to the GMC; The issue of* [XXX] *was never previously raised by doctor Majeed in the context of assessments and examinations; The issue of* [XXX] *was never previously raised (or since) with any of his supervisors; The issue of* [XXX] *was not mentioned by him in his portfolio prior to the assessment process and he did not indicate* [XXX]*; In the second interview at assessment doctor Majeed described the Team as "sensible" and "supportive" that they and "made the process easy, he enjoyed the process and he had no issues with the process";* [XXX] *and there is no evidence that any were apparent to the Assessment Team at the time of assessment; The assessment process itself was non-confrontational and without pressure of time; Professor E went out of his way to ensure well-being and ensured that Dr Majeed was aware he could ask for breaks whenever he felt the need.*

98. Therefore, while accepting that Dr Majeed's self-reported XXX may have been present and a factor in his overall performance, it did not consider that it undermined the findings it had made above.

99. Having reminded itself of the relevant criteria, the Tribunal was satisfied that there was evidence that the criteria for an acceptable level of performance were regularly not being met and that Dr Majeed's professional performance was unacceptable in the area of Assessment of Patients' Condition.

100. Accordingly, it found paragraph 2(a) of the Allegation proved.

2(b) Clinical Management

101. In determining whether Dr Majeed's professional performance was unacceptable in clinical management, the Tribunal considered the overall findings as set out in the Report which states:

> *There is evidence of repeated and persistent failure to comply with the professional standards appropriate to the work of a junior doctor in medicine and general practice. Dr Majeed's performance places patients at risk. During the OSCE stations, Dr Majeed*

made some acceptable treatment suggestions, but the treatment options given to patients were often limited in their range and lacked overall clarity in common medical conditions seen by junior doctor at his level. Evidence from the CBD showed Dr Majeed's rationale for management was often found lacking. It was the assessment team's conclusion that Dr Majeed's overall performance was found to be unacceptable.

102. In his written witness statement, Dr Majeed stated that:

I do not accept that my professional performance in respect of 'Clinical Management' was unacceptable in this area although I accept that there are examples that may indicate a 'cause for concern' as indicated below in respect of OSCE's 2, 6, 12 and 13.

103. Dr G's opinion in respect of this domain was:

Overall, I acknowledge that there are some valid areas of concern raised in the Performance Assessment in relation to Clinical Management. However, in my view, there are valid criticisms of the assessment that would warrant the overall outcome of the assessment of this domain being one of 'cause for concern' rather than 'unacceptable', as it was determined to be.

104. The Tribunal went on to consider the criticisms relating to the various OSCEs and the evidence and submissions in each regard.

OSCE 1 - Red flag headache history

105. The Report stated in respect of OSCE1:

In discussion of OSCE 1; Dr Majeed did not refer the patient to a neurosurgeon for probable intracranial bleed or give antibiotic as he also suspected meningitis

106. In his written statement, Dr Majeed stated:

I understand the importance of prescribing antibiotics in a timely way if meningitis is suspected. This was a differential diagnosis but I considered SAH to be much more likely. I note that there are conflicting statements made by the Assessors in respect of the contact with the neurosurgeons. At page 66 of the report it states that I did

consider neurological referral but at page 76 it is commented under unacceptable that I didn't include neurological referral in my management plan. Finally, at page 76 it is commented under 'acceptable', that I did discuss the need for urgent surgical opinion regarding a bleed on the brain. In terms of my usual practice in this type of situation I would refer to the Neurosurgeons once the scan results had been received.

…

As there was no evidence of intracranial bleeding at this stage, I would not be able to justify a neurological referral. In terms of my usual practice, I would only refer to the Neurosurgeons once the scan results had been received

As there was no evidence of intracranial bleeding at this stage, I would not be able to justify a neurological referral. In terms of my usual practice, I would only refer to the Neurosurgeons once the scan results had been received.

107. Dr G's opinion was:

Criticism for not involving a neurosurgeon prior to diagnosis of subarachnoid haemorrhage is not valid. I would agree with Dr Majeed's assertion that he would refer to a neurosurgeon only once the scan results had been received. Overall, I would describe this as a cause for concern (in relation to failure to provide antibiotics), rather than unacceptable.

108. In his contemporaneous observations appended to the Report, Dr F noted as an example of acceptable practice that, during the practical OSCE, *"The doctor did consider neurosurgical referral"* and Professor E also noted as acceptable that *"Dr explained to the patient that we need to get an urgent surgical opinion for bleed on the brain"*.

109. In his oral evidence, however, Professor E stated, in relation to the Case Based Discussion, that:

One can explain to the patient a certain management plan which may be correct. But we need to know the reasoning – in the reasoning we would be looking for him to say, I am expecting the most likely reason to be a bleed in brain or an infection; if the scan shows a bleed I will be contacting my seniors or neurosurgery.

110. The Tribunal noted, however, that the question posed of Dr Majeed in the Case Based Discussion was *"What was your management plan, considering your differential diagnosis?"*. In the Tribunal's view, and for the reasons set out by Dr G (with which Dr F agreed in oral evidence) it was not unreasonable in the circumstances for Dr Majeed not to make a referral to a neurosurgeon, and it was not unreasonable in the context of the Case Based Discussion for him simply to set out his management plan and not to provide any reasoning along the lines suggested in oral evidence by Professor E.

111. The Tribunal was, however, satisfied that it was necessary in the circumstances of OSCE 1 – in which he suspected the patient had meningitis – for Dr Majeed to give antibiotics to the patient and that he did not do so. In the Tribunal's view this amounted to unacceptable performance that could have put the patient at risk.

OSCE 2 - Management of paracetamol overdose

112. The Report stated that in respect of OSCE 2:

> *In OSCE 2, a patient who had taken overdose; Dr Majeed started on treatment with n-acetyl cysteine without checking the need for this. In discussion of the case, he did not mention how he decided the treatment without taking account of paracetamol level and time scale of overdose.*

113. In respect of the case-based discussion, Professor E stated:

> *Dr said that paracetamol might cause toxicity to liver hence given n-acetylcysteine. Comment: Dr did not mention how did he decide the treatment taking account of paracetamol level and time scale"*

114. Dr F stated:

> *The doctor did consider hepatic necrosis due to paracetamol and risk of liver failure. (Comment: did not mention how he decided to give N acetyl cysteine)*

115. The Tribunal noted that the question put to Dr Majeed only asked for his reasoning as to why he gave n-acetyl cysteine, not how he decided on the dose.

116. In his written statement, Dr Majeed stated:

I note that the Performance Assessors are critical of the fact that I started on treatment without checking the need for it and I did not mention how I decided the treatment without taking into account paracetamol levels and the time scale of the overdose. I apologise for not providing a clear rationale of the prescription of N-Acetyl Cysteine. I am familiar with this and follow the policy which is in place at my current Trust when treating patients with paracetamol overdoses. I was not asked during the discussion to evaluate liver damage in accordance with the king college criteria or the factors which determine when to commence the patient on N acetyl cysteine treatment.

117. Dr G's opinion was that:

XXX. I would have considered it best practice for Dr Majeed to have discussed these nuances relating to weight. However, there is a fair argument that he was 'being on the safe side' by advocating for the use of N-acetylcysteine in this case (and in practice you would almost always do more good than harm in doing so). Overall, in my opinion, I would describe this as a cause for concern rather than unacceptable.

118. The Tribunal considered the differing opinions of the Performance Assessors and Dr G on this matter, and also the evidence set out within the Report that Dr Majeed's rationale for management was often lacking.

119. The Tribunal accepted that the weight of the patient was not provided or considered as part of the examination but took the view that it would have been appropriate for Dr Majeed to have discussed those matters in the Case Based Discussion.

120. The Tribunal accepted the evidence of Dr G that Dr Majeed was *'being on the safe side'* by advocating for the use of N-acetylcysteine and *'in practice you would almost always do more good than harm in doing so'.* However, it also noted the evidence of Dr F that there are known side effects from the use of N-acetylcysteine, and that the drug had run out at times due to its overuse.

121. On balance, the Tribunal accepted the evidence of the Performance Assessors that Dr Majeed should have been able to demonstrate in the Case-Based Discussion the process behind his decision-making and how he arrived at the appropriate dosage. It acknowledged, however, that the question posed to Dr Majeed was somewhat ambiguous and so concluded

that his literal, limited answer to it, while raising concerns about his ability to apply his knowledge, could not in isolation be considered unacceptable.

OSCE 5 - Chest drain consenting

122. The Report stated that in respect of OSCE 5:

> *In discussion of OSCE 5; Dr Majeed did not provide reason for the treatment by chest drain but focused on obtaining consent*

123. The evidence of both Performance Assessors, Dr Majeed and Dr G was that Dr Majeed had explained the reason for the chest drain to the patient during the OSCE assessment. The Performance Assessors' criticism related to his not having explained the reason separately to them in the later Case Based Discussion.

124. The GMC's submissions in respect of this were:

> *In relation to OSCE5 (chest drain consenting), given that Dr Majeed did give reasons to the patient for the chest drain in the OSCE itself and that the focus of the OSCE was on consent, it is accepted that there was scope for confusion in the question asked in case-based discussion and the Tribunal should ignore this criticism.*

125. The Tribunal concluded that on the basis of all the evidence before it, Dr Majeed had provided a reasonable explanation as to the reason for the treatment by chest drain to the patient. It concluded that as the scenario focused on consent issues, given that the reasoning for the treatment had been appropriately addressed with the patient, and given that there could be no doubt that Dr Majeed understood that reasoning, the fact that Dr Majeed did not reiterate it in the case-based discussion did not amount to a legitimate criticism and could not properly be characterised as unacceptable.

OSCE 6 - Prescribing in DKA

126. The Report stated that in respect of OSCE 6:

> *In OSCE 6, a patient who had diabetic ketoacidosis; Dr Majeed did not prescribe fluids, thromboprophylaxis in correct section of prescription sheet, this may delay in providing treatment by nursing staff and putting patient safety at risk.*

127. In his written statement, Dr Majeed stated:

> *I accept that I included the required information in the incorrect section of the prescription chart, I apologise for this error. This was not a chart that I was familiar with using.*

128. Dr G's opinion was that:

> *The sample drug chart provided to Dr Majeed in this scenario was not fully realistic (for instance, XXX. This may partially account for his error in the stressful exam situation with an unfamiliar chart (whereas in practice he would have time become accustomed to local charts) beforehand.*

129. The Tribunal accepted the evidence of Dr G. Noting that the information provided by Dr Majeed was not incorrect, and bearing in mind the format of the sample drug chart he was required to use – which Dr G considered "not fully realistic" – the Tribunal did not consider that, in itself, Dr Majeed's failure to include the information in the correct section amounted to unacceptable performance.

OSCE 8 - Moderate asthma attack history taking

130. The Report stated that in respect of OSCE 8:

> *In discussion of OSCE 8; Dr Majeed provided a wrong reason for giving nebuliser and hydrocortisone of preventing future episodes rather than immediate relief from bronchospasm*

131. In his contemporaneous observations appended to the Report, Professor E commented that:

> *Dr said that the patient was wheezing and had bronchospasm and to prevent future episodes. Comment: whilst treatment might help bronchospasm, stat dose does not prevent future episodes.*

132. In his contemporaneous observations appended to the Report, Dr F commented:

The doctor did – wheezy and sob, reason for considering IV hydrocortisone states to prevent the future attacks of asthma comment: IN hydrocortisone half life of six hours can not be used to prevent future attacks…

133. In his written statement, Dr Majeed stated:

I believe that the Performance Assessors have misunderstood my explanation in respect of this patient. I understand that a nebuliser and hydrocortisone treatment are focused predominately on immediate treatment and relief. I also did not say that nebulisers were given to prevent future episodes, I mentioned that hydrocortisone may help to prevent future episodes.

134. The Tribunal accepted the evidence of Dr G that a nebuliser and hydrocortisone would prevent another asthma attack in the short term. It took the view that, while the Performance Assessors considered Dr Majeed to have been referring to future, unrelated, asthma attack episodes, Dr Majeed's reference to the "future" was potentially ambiguous and could have meant the immediate future, i.e. another asthma attack later that day, which Dr G agreed nebuliser and hydrocortisone might potentially prevent.

135. The Tribunal was not satisfied that there was sufficient evidence to find that Dr Majeed had incorrectly understood the use of the nebuliser and hydrocortisone and so did not consider his performance in this regard, and in itself, to be unacceptable.

OSCE 9 - Management of a patient who has had a TIA (transient ischaemic attack)

136. The Report stated that in respect of OSCE 9:

In discussion of OSCE 9; Dr Majeed did not mention initial plan to manage TIA, but instead mentioned doing assessment and giving urgent thrombolysis. The proposed treatment was not indicated in this patient

In OSCE 9; Dr Majeed failed to provide any advice about driving or mention sources for that advice, as the patient drove daily. This may potentially put patient and public safety at risk

137. In his contemporaneous observations relating to the Case Based Discussion, Professor E commented that:

Dr said he will do ABCDE assessment and arrange for urgent thrombolysis. Comment: this patient had TIA and did not require thrombolysis urgently

and:

Dr said his plan included CT scan, but did not mention any other initial management plan

138. In his contemporaneous observations relating to the Case Based Discussion, Dr F commented that:

arranged CT head, stroke referral, he wanted to rule out SOL comment: the doctor did not answer the question of what was his initial management plan after diagnosis of TIA in the patient

and:

assess just like any patient with ABCDE. His top priority is to assess risk factors and obtain a time scale to see eligibility for thrombolysis. (Comment: patient was diagnosed with TIA, and is symptom-free, there is no need for thrombolysis assessment)

139. In his written statement, Dr Majeed stated :

I have no specific recollection of mentioning the need for urgent thrombolysis which would not have been appropriate, it would have also been completely contradictory to my clearly stated plan to prescribe aspirin and refer this patient to the TIA clinic. Had I mentioned this I would have expected the performance assessors to have requested clarification on this given that it would be completely inappropriate and I can definitely say that they did not ask for any further clarification around this point. I can only assume that there has been a misunderstanding in my communication with the Performance Assessors in respect of this point.

140. In his submissions on behalf of Dr Majeed, Mr Ivill stated:

Dr Majeed has no recollection of having said to give the patient urgent thrombolysis and he knew it would not be appropriate. It is also contradicted by the symptoms having resolved and his management plan of prescribing aspirin and referring the patient to the TIA clinic. He contends there has been a misunderstanding. Professor E said he didn't ask clarification as he, wrongly in my submission, stated that clarification is not allowed. I say wrongly because the guidance to the assessors specifically states that questions of clarification may be asked ("you may ask the doctor to clarify their response"). It does not say that clarification cannot be sought. Dr G agreed the error would be so stark it would prompt clarification. The rigid structure of the assessment and lack of opportunities for clarification contributed to misunderstandings, which do not reflect his actual clinical abilities.

141. Dr G's opinion was that:

In my view, this would be so significant an error that mentioning thrombolysis in a discussion where it was clear that the symptoms had resolved would have most likely prompted clarification to be sought. This is Dr Majeed's view from his witness statement, and I agree with him.

142. The evidence of Professor E and Dr G was that mentioning thrombolysis was a serious error. The Tribunal did not accept the criticism made of the Performance Assessors on behalf of Dr Majeed as the guidance they were provided with states:

You may ask the doctor to clarify their response or draw them back to the question but you should avoid asking additional or follow-on questions as these cannot be accurately recorded during the discussion.

143. In the Tribunal's view, Dr Majeed had given a clear, albeit incorrect response, and that therefore there was no clarification needed as to his response.

144. Notwithstanding Dr Majeed's appropriate handling of the practical OSCE exercise, his reference to thrombolysis in the Case Based Discussion was plainly wrong and, in itself, unacceptable.

145. In his written statement Dr Majeed accepted the criticism in respect of failing to discuss driving with the patient, stating:

I understand the importance of advising a patient with a suspected TIA that they shouldn't drive and apologise for omitting this as part of my discussion with the patient.

146. The Tribunal agreed with Dr Majeed in this regard and accepted the criticisms and assessment of Dr Majeed's performance as set out in the Report in relation to OSCE 9.

OSCE 10 - Examination and management of Parkinson's disease

147. The Report stated in respect of OSCE 10:

In discussion of OSCE 10; Dr Majeed identified probable Parkinson disease with symptoms but decided to refer to neurologist rather than starting on initial treatment, which will delay in treating the patient

148. In his contemporaneous observations, Professor E wrote:

Dr said that he would refer him to neurologist to start treatment and did not mention his reason or indication for prescribing medication despite Dr mentioned that the patient has symptoms

149. In his contemporaneous observations, Dr F wrote:

Has to be seen by neurology before prescribing meds. He did not prescribe any medications.

and:

The doctor acknowledged patient is symptomatic. He did rule out Parkinson + syndromes, drug induced Parkinson's. But did not consider stating the treatment

150. In his written statement, Dr Majeed stated that:

The Performance Assessors are critical of the fact that I did not initiate the prescribing of Parkinson medication despite suspecting this as a diagnosis. I would not initiate as this would usually be done by a specialist following referral or discussion. This criticism is not accepted as it would not be considered appropriate for a doctor working at ST3

level to initiate such specialist medication in this setting without guidance from a specialist, such as a geriatrician with specialist interest in Parkinson's disease or a neurologist.

151. Dr G's opinion was that:

I completely agree with Dr Majeed that it would not be within the remit of an Acute/General medicine physician (even a Consultant) to start medications for suspected Parkinson's disease without the input of a physician with expertise in this area.

152. On behalf of Dr Majeed, Mr Ivill submitted that:

When it was put to Dr F what Dr G had said, Dr F said that he completely agrees with Dr G when it comes to the medication as part of the treatment and that he wouldn't expect him to start the medication and he wasn't talking about medication. The Tribunal may, however, feel that on p96 it is clear the criticism was that Dr Majeed decided to refer to the neurologist "rather than prescribing medication".

153. On behalf of the GMC, Mr Dyer submitted that:

In relation to OSCE10 there was a difference of expert opinion. Given that Dr G was of the firm view that no treatment should be started before the referral to neurology, the Tribunal could not criticise Dr Majeed were he to take the same view. However, this was once again a question in case-based discussion (taking account of answers he had already given the simulation). It is clear from the notes that in fact Dr Majeed had made the decision to prescribe the patient medication. He then failed to articulate an answer to the question "How did you arrive at the decision to prescribe for this patient?

154. The Tribunal determined that the criticism contained in the Report in relation to Dr Majeed's performance in relation to OSCE 10 was not reasonable. Both Dr G and Dr F agreed that it was not inappropriate for Dr Majeed, as a middle grade acute physician, not to commence treatment for Parkinson's disease, even in circumstances in which a probable diagnosis had been made by him. Indeed, Dr G was clear that the relevant guidelines require patients to be referred untreated (in order to avoid complicating the diagnostic picture),

rendering Dr Majeed's actions during the Performance Assessment entirely appropriate in the circumstances. The Tribunal agreed.

OSCE 12

155. The Report stated in respect of OSCE 12:

In OSCE 12; Dr Majeed did not prescribe oxygen and GTN infusion in correct section of the prescription sheet and prescribed wrong dose of furosemide, this may delay in providing treatment by nursing staff and putting patient safety at risk.

156. In his contemporaneous observations, Professor E commented that:

Dr did not prescribe furosemide in correct dose, putting patient safety at risk as it is unlikely to help the patient.

157. In his contemporaneous observations, Dr F commented that:

The doctor did not prescribe correct furosemide dosage

158. In his written statement, Dr Majeed stated that:

I accept that I included the required information in the incorrect section of the prescription chart, I apologise for this error. This was not a chart that I was familiar with using.

159. For the same reasons as it gave in relation to OSCE 6 above, the Tribunal determined that filling out the incorrect section of the form was not in itself unacceptable.

160. The Tribunal did however accept the evidence of the Performance Assessors that Dr Majeed's prescribing the wrong dose of furosemide was unacceptable (given its potential to cause patient harm), albeit the only failure of that nature in the course of his Performance Assessment.

OSCE 13 - History and management of seizure from young male

161. The Report stated in respect of OSCE 13:

In OSCE 13; Dr Majeed did not refer the patient to a specialist clinic (First seizure clinic) for evaluation. Comment it is essential for a young patient with suspected first seizure should be seen by a specialist

In discussion of OSCE 13; Dr Majeed did not mention management options but repeated how he will assess and keep the patient in hospital for 24 hours, which was not needed in a stable patient

162. Professor E commented in his contemporaneous observations that:

Dr did not refer the patient to a specialist clinic (First seizure clinic). Comment: this young patient requires a full evaluation by a specialist.

163. Dr Majeed accepted in his written statement that:

I should have indicated that this patient should be referred to the first seizure clinic in the first instance.

164. In respect of not mentioning management options and keeping the patient in hospital for 24 hours, Professor E commented in his contemporaneous observations:

Dr said he would check ABCDE, blood test, toxicology but did not mention any management options.

and:

Dr said as he had a fit, he would keep the patient in hospital for 24 hours for his recreational drug overdose. Comment: admission to hospital was not required in this stable patient.

165. Dr F commented that:

ABCDE, bp and temp send bloods, urine, keep in under obs and monitor GCS. The doctor did not mention any management option in particular.

and:

Overdose needs observation. He would check toxbase and make sure it is not fit, needs 24 hour observation. Probably due to ecstasy. (Comment: This was not needed in a stable patient with first seizure)

166. The Tribunal noted that Dr F records *"kept under the observation"* as *"acceptable"* and *"The doctor decided to admit the patient with first seizure"* as also acceptable.

167. Dr G's opinion was that the patient should have been admitted, and that it would be normal practice to do so in the circumstances of OSCE 13 for 24 hours until the patient was seizure-free.

168. On the basis of the evidence before it, the Tribunal concluded that Dr Majeed's decision to admit the patient for observation was acceptable in the circumstances for the reasons given by Dr G. It noted the Performance Assessors' criticism that Dr Majeed did not in the Case Based Discussion mention other or future management options, but did not consider this in itself to amount to unacceptable performance given that the question Dr Majeed was asked was somewhat ambiguous. The Tribunal was however in no doubt that Dr Majeed should have referred the patient to a first seizure clinic, which Dr Majeed admitted. In the Tribunal's view this was unacceptable as it could have caused both a delay in the patient's treatment and potential associated harm.

Paragraph 2(b) summary

169. In summary, the Tribunal found that Dr Majeed had performed at an unacceptable level in respect of multiple OSCEs (specifically OSCEs 1, 9, 12 and 13).

170. The Tribunal considered the submissions made on behalf of Dr Majeed that the third-party evidence and the evidence of his current Clinical Supervisor contradict the findings set out in the Report. However, the Tribunal noted that Dr Majeed is working with supervision under conditions on his registration, and so this evidence reflects his performance in a somewhat protected environment where his decision-making is referred to and checked with Consultants.

171. The Tribunal considered that, despite the positive evidence that Dr Majeed is working well with these protective factors in place and that his performance has been deemed adequate by his current Medical Supervisor, there was clear evidence, which it accepted, that

Dr Majeed's performance in the context of the GMC Performance Assessment was, in several regards, unacceptable.

172. The Tribunal also considered the evidence and submissions in relation to XXX and how this may have detrimentally affected his performance at the time of the Performance Assessment. It accepted that he may have been affected by XXX which could have contributed to the discrepancy between his real-life performance and his performance during the Performance Assessment. However, it was not satisfied that it had been provided strong evidence as to how this undermined the findings in the Report.

173. Having reminded itself of the relevant criteria, the Tribunal was satisfied that there was evidence before it that the criteria for an acceptable level of performance were regularly not being met and that Dr Majeed's professional performance was therefore unacceptable in the area of Clinical Management.

174. Accordingly, it found paragraph 2(b) of the Allegation proved.

Paragraph 3

3(a) Maintaining Professional Performance

175. In determining whether Dr Majeed's professional performance was a cause for concern in maintaining professional performance, the Tribunal considered the overall findings as set out in the Performance Assessment report which states:

> *Dr Majeed achieved a score of 78.33% in his knowledge test, which is above the standard set mark of 65.73%. However, there were consistent concerns from the performance assessment team that Dr Majeed was performing at a lower standard than that of his peers. This was also the case when Dr Majeed was asked about guidelines, he was not aware of guidance for common conditions. Dr Majeed had listed a range of educational activities attended, but he did not provide example where he had changed his clinical practice following these activities. There was evidence that Dr Majeed did not consistently complete a systematic Assessment of patients. His approach was judged to be superficial, with important omissions, and resulted in basic outline only. Dr Majeed's examinations lacked substance and evidence of higher-level thinking. His diagnostic skills were considered to be limited to a junior doctor who would not be able to practice independently at this stage*.

176. Dr Majeed's response, as set out in his written statement was that:

I do not accept the Performance Assessors grading of cause for concern for this area. I was extremely pleased to achieve 78.33% in the knowledge test. I am aware that the standard set mark is 65.73% and it is accepted by the Performance Assessors that my score is above the standard set mark.

177. The Tribunal went on to consider the criticisms relating to the various components of the Performance Assessment and the evidence and submissions in this regard.

178. The Tribunal noted that Dr Majeed scored 78.37% in the knowledge test, above the standard set mark. His Clinical Supervisor confirmed that his knowledge and skill levels were above those of his peers and up to date.

OSCE 9

179. The Report sets out that:

In discussion of OSCE 9; Dr Majeed did not expand on application of guidelines in managing suspected Transient Ischaemic Atack (TIA) comment, doctor did not mention any established guidelines in management of TIA.

180. Professor E stated in his contemporaneous observations appended to the Report:

Dr said that this would include ABCD2 score, but did not expand on application of guidelines or risk factor criteria.

181. Dr F stated that:

the doctor considered ABCDE approach and to be seen in 24 hours at TIA clinic comment: no guidelines were mentioned.

182. In his oral evidence, Professor E said that his criticism was for not applying guidelines in the management process to address the ABCD2 risk factors, namely age, blood pressure, clinical features, duration and diabetes.

183. In his written statement, Dr Majeed stated:

I note that the Performance Assessors are critical of not mentioning established guidelines for the management of a suspected TIAs. The Performance Assessors have stated that I failed to use the ABCD criteria when assessing this patient. This is despite current guidance advising that scoring systems, such as ABCD2 should not be used when assessing risk of subsequent strokes or to inform urgency for referral for people who have had a suspected or confirmed TIA. The current recognised practice is that patients should be referred urgently to the TIA clinic (within 24 hours) and prescribe aspirin to the patient. I also do not agree that it necessary to discuss thrombolysis with this patient as I did not consider this to be indicated for this patient. I am aware that the TIA clinic carry out their own specific investigations when they see the patient to decide on appropriate treatment and follow up.

184. The Tribunal accepted the evidence that the ABCD2 score should not be used for assessing future risk, but as a template or methodology for looking at risk factors more broadly. Although it noted the contemporaneous evidence of Dr F that Dr Majeed had asked the patient about various relevant risk factors, including blood pressure, cholesterol and diabetes, it accepted the evidence of the Performance Assessors that Dr Majeed had failed to demonstrate that he had considered these during the case-based discussion and that this amounted to unacceptable performance.

Continuing professional development and educational activity

185. The Report summarises that:

Dr Majeed mentioned a case of high blood pressure but did not provide any example of how his learning had changed his clinical practice.

186. In his contemporaneous observations, Professor E stated that:

Dr mentioned a case of high blood pressure, where he reduced the BP gradually. He checks ECG, Blood tests for LFT, any encephalopathy, when do you give amlodipine. Comment: Dr was not coherent and gave no example of a change in practice.

187. In his contemporaneous observations, Dr F commented that:

The doctor did attend weekly medical meetings and discusses various medical topics eg: patient with high BP at GPAU, he learned how to bring BP down gradually to avoid end organ damage… Comment: the doctor did not answer the question asked and did not mention of any changes in his practice due to educational events.

188. In his written statement, Dr Majeed sets out that:

I also note that the Performance Assessors have commented that I did not mention or apply guidance in a common condition and give specific reference to a high blood pressure which I mentioned. I do recall mentioning this learning and accept I may not have given more information about how this has changed my clinical practice but I cannot recall about being asked to do this. I can confirm that since this learning I have ensured that I ask patients to keep a blood pressure diary to monitor blood pressure following a change in blood pressure and to liaise with their GP regarding optimisation of blood pressure control.

189. The Tribunal was entirely satisfied on the basis of the contemporaneous evidence before it that Dr Majeed was asked by the Performance Assessors to give an example of how his learning had changed his clinical practice but did not do so except in very general terms. It agreed with the Performance Assessors that Dr Majeed's failure to provide any such example was unacceptable.

190. In the light of the Performance Assessors' observations the Tribunal considered carefully whether Dr Majeed's performance in the category of Maintaining Professional Performance could be properly characterised as a cause for concern. In the Tribunal's view there was evidence of some instances of unacceptable performance in this area, notwithstanding the many positive observations also within the Report. Accordingly, it accepted the findings of the Report and the Performance Assessors in relation to Maintaining Professional Performance and concluded that Dr Majeed's professional performance was a cause for concern in this area.

191. Accordingly, it found paragraph 3(a) of the Allegation proved.

<u>3(b) Relationship (Communication) with Patients</u>

192. The Report summarises that:

Overall assessment: Dr Majeed's performance in the category of Relationships with Patients is found to be cause for concern.
There is evidence of some instances of unacceptable performance but these, in the view of the team, do not amount overall to unacceptable performance.
The assessing team's view was that Dr Majeed was polite and used a patient-focused approach when communicating with patients. However, aspects of Dr Majeed's communication skills were not acceptable, and he did not check patients' understanding of information and used jargon without clarifying meaning. Dr Majeed demonstrated how he took steps to engage patients in their care, but this was not often the case with complex patients, thus demonstrating a superficial and limited approach.

193. Dr Majeed's response, as set out in his written statement was:

I do not accept the Performance Assessors grading of cause for concern in this area. I note that in respect of the 52 occasions that I could be scored by the patient in the OSCEs, I only scored 'poor' on 2 occasions. I also note that I received numerous positive comments about my relationship with patients from my colleagues who provided comments as part of the third-party interviews which are included below.

OSCEs

194. The Report sets out that:

In OSCEs 1, 2, 3, 4, 5 and 7; in most applicable stations, Dr Majeed was polite, said his name but did not check patient's identity or mentioned the purpose of the consultation

In OSCE 7; when breaking bad news, Dr Majeed did not show any sympathy or offer bereavement counselling.

In OSCEs 4, 5, 9 and 11; Dr Majeed used unexplained medical jargon such as PCP, COPD, TIA, immune-compromised which patents did not understand.

In OSCE 4; Dr Majeed asked the patient to check peak flow rate without any explanation how to do it.

195. With regard to not checking the patient's identity, Dr Majeed said that he would always do so in a normal clinical setting, and Professor E accepted that the assessment was an artificial environment and did not doubt that Dr Majeed would ordinarily do so. Nevertheless the Tribunal considered that checking a patient's identity is important, even in a simulated assessment, and that Dr Majeed's repeated failure to do so in the Performance Assessment was unacceptable, even if it was not typical of his practice and performance generally.

196. In respect of the use of jargon, Dr F commented in his contemporaneous observations that:

The doctor used medical jargon, the patient couldn't understand.

197. Professor E commented in his contemporaneous observations that:

Dr used medical jargon without explaining to the patient such as obstructive airways, COPD, which patient did not understand

198. In his written witness statement, Dr Majeed stated that:

The Performance Assessors have stated that I used unexplained medical jargon in respect of OSCEs 4,5,9 and 11 which patients did not understand. I accept that when using medical jargon this should be explained to patients and I would always do this if I felt that a patient did not understand the terminology that I was using. I apologise for not explaining all relevant medical terminology during these OSCE assessments.

199. Given the multiple instances identified in the Report and the evidence of the Performance Assessors, the Tribunal accepted that Dr Majeed had used medical jargon which the patients did not understand, and that this was also unacceptable.

200. In respect of Dr Majeed asking a patient to check peak flow rate without any explanation how to do it Professor E commented in his contemporaneous observations that:

Dr did not explain how to check peak flow rate, just asked the patient to blow without any instructions.

201. In his written statement, Dr Majeed stated that:

The Performance Assessors are also critical that I did not know how to check a peak flow rate. I am aware of how to check a peak flow rate. My experience, in clinical practice, is that patients who have previous breathing difficulties are often familiar with how to take a peak flow measurement but I would always offer guidance if they were not familiar or they were not doing this correctly and would ask a patient to carry out the PEFR in front of me to ensure that they are doing it correctly.

202. The Tribunal accepted the evidence of the Performance Assessors, and whilst acknowledging that Dr Majeed may discuss this more thoroughly in his usual practice, he did fail to do so at the Performance Assessment and that this was unacceptable.

203. In respect of not showing any sympathy or offering bereavement counselling in respect of OSCE 7, Dr Majeed stated that:

The Performance Assessors have stated that I did not show any sympathy or offer bereavement counselling to this patient. I do not accept that I didn't show any sympathy to the patient. I note that the patient made the following comments about the consultation: Hesitant and a little afraid of my distress when he entered. He then tried to regain control a little sharply but he did improve in confidence and warmth as the role play continues. Too quietly spoken.

204. Professor E's contemporaneous observations record the following:

Dr did not explain what happened in sympathetic way. He said that the patient collapsed and had cardiac arrest "that's bottom line" in non sympathetic way.

…

Dr did not offer any bereavement counselling.

…

Dr acknowledged the relative's distress and showed some sympathy.

205. Dr F commented that:

The doctor did not offer the Bereavement support and after death information …

The doctor did not show sensitivity and empathy to the person expected in the situation.

206. Given the contradictory evidence before it, which included observations from Professor E that Dr Majeed had *"[shown] some sympathy"* but also made some comments other than *"in sympathetic way"*, and given the difficulties without a transcript or recording of objectively assessing the opinions of both Performance Assessors, the Tribunal declined to make any positive finding that Dr Majeed failed to show sympathy to the patient in OSCE 7. It was, however, satisfied on the basis of the evidence before it that he did not offer bereavement counselling, although the Tribunal did not consider this individual oversight to be so significant as to amount to unacceptable performance.

207. On behalf of the GMC, Mr Dyer submitted that Dr Majeed demonstrated how he took steps to engage patients in their care, but this was not often the case with complex patients, demonstrating a superficial and limited approach. He submitted that although Dr Majeed disputes that he failed to show sympathy in OSCE7 (breaking bad news of sudden unexpected death), the contemporaneous notes suggest otherwise and it is clear that he did not offer bereavement counselling. He submitted that whilst it is fair to say that Dr Majeed was able to point to many favourable reports of his relationship with patients, the objective evidence from the assessment process nevertheless indicates a cause for concern.

208. On behalf of Dr Majeed, Mr Ivill submitted that:

11 individuals each separately assessed Dr Majeed in respect of four separate questions. Of the 44 answers, on only two occasions was there a categorisation of poor. The same 11 individuals were further asked how they would rate Dr Majeed's communication; not one said poor. In short, two 'poor' categorisations in answer to 55 questions (as a percentage, approximately 3.5%).

The Assessment team also spoke to Dr I *who said that Dr Majeed has a kind nice demeanour and has good communication skills with family. Mr J said that Dr Majeed listens to patients, understands their viewpoint (p138).*

Professor E agreed that it was a positive picture and that Dr Majeed's communication skills are good.

Paragraph 3(b) summary

209. Whilst the Tribunal took into account both the evidence that Dr Majeed may have been affected by XXX, and the positive evidence in respect of his "real world" communication with patients, it concluded that these did not undermine its findings in relation to the areas where, during the Performance Assessment, his professional performance fell short of the standards expected. Having regard to the relevant criteria, set out above, it determined that Dr Majeed's professional performance was reasonably assessed as a cause for concern in this area.

210. Accordingly, it found paragraph 3(b) of the Allegation proved.

3(c) Working with Colleagues

211. The Report summarises that:

Dr Majeed's colleagues reported that he was polite, pleasant, a good communicator, and accessible. However, there was evidence from the assessing team's observation that Dr Majeed did not give consideration to using the multi-disciplinary team when assessing patients or making management plans in managing complex unwell patients.

212. Dr Majeed's response, as set out in his written statement is that:

I do not accept the Performance Assessors grading of cause for concern for this area. The examples provided by the Performance Assessors were in respect of OSCE 10 and 11. The Performance Assessment does not allow for any interaction with colleagues as it is an artificial environment. They also relate to an alleged failure to refer rather than how I work with colleagues. It is accepted by the Performance Assessors that the feedback I received from colleagues indicated that I was polite, pleasant, a good communicator and accessible.

As part of the Performance Assessment comments were sought from Dr C, my Clinical Supervisor since July 2022, Dr I, Acute Medicine Consultant who I have worked with

since 2022 and Dr K, Trust Grade ST3 Acute Medicine Registrar who I had worked with for approximately 15 months at the time of the Performance Assessment and Mr J, Charge Nurse who I had worked with for approximately 17 months. All of these individuals attested to my ability to work well with my colleagues and no concerns were raised with the Performance Assessors. I have also received positive direct feedback whilst I have been employed at the Trust in respect of my performance. In addition, one of the requirements of my interim conditions is that I provide a report from my Supervisor at every review hearing. All of these reports have been positive and no concerns have been raised.

213. The Tribunal went on to consider the criticisms relating to the various OSCEs and the evidence and submissions in each regard.

OSCE 10

214. As to OSCE 10, the Report summarises the Performance Assessors' concerns as follows:

Dr Majeed did not involve other colleagues in managing this patient who has probable Parkinson disease such as specialist nurses, physio, and occupational therapists.

215. In his contemporaneous observations appended to the Report, Professor E stated:

Dr said that he would involve neurologist or care of the elderly specialist, but did not mention MDT including physio, OT, specialist nurse.

and also commented that:

Dr did not include referring to other therapist in MDT such as physio. Occupational therapist or specialist nurses.

216. Dr F noted that:

Neurology and COE team, either way. Comment: did not mention Physio, OT, HDT and SALT therapy.

217. Dr Majeed sets out in his written statement that:

The Performance Assessors are critical that I did not involve colleagues in managing this patient with probable Parkinson's disease (such as specialist nurses, physio and occupational therapists). The hospital guidelines where I am currently employed state that if there is a suspicion that a patient may have Parkinson's disease then they need to be referred to a Neurologist or a Care of the Elderly Consultant, to confirm this diagnosis and also, before referring the patient to specialist nurses, occupational therapy and physiotherapy. It would not be appropriate to complete these referrals before a diagnosis has been made and these referrals would usually be completed by the team that make the diagnosis.

218. Dr G stated:

"It would not be appropriate for a patient to be referred to a Parkinsons disease specialist nurse if the diagnosis had not already been established."

219. The Tribunal accepted the evidence of Dr Majeed and, given the potential for local variation in practice and guidelines, was not satisfied that Dr Majeed's failure to involve other professionals in the care of this patient was unacceptable.

OSCE 11

220. The Report summarises in relation to OSCE 11 that:

Dr Majeed did not involve sexual health team in managing this patient who has probable HIV.

221. Professor E noted contemporaneously, in relation to the Case Based Discussion, that:

D[r] said he would involve infectious disease specialist. Comment: Dr did not mention sexual health specialist or specialist nurse.

222. Dr F commented similarly that:

Infectious disease team, respiratory team, needs regular follow up. The doctor did not mention sexual health team referral which is more appropriate.

223. In his written statement, Dr Majeed stated that:

> *The Performance Assessors are critical that I did not involve the sexual health team in managing this patient with probable HIV. At my current trust, a diagnosis needs to be confirmed in the first instance before a patient is referred to the sexual health team*
>
> Dr G said:
>
> *A key criticism of Dr Majeed here was failure to refer to the sexual health team prior to diagnosis of HIV. As described above, in the inpatient setting, one would wait for the diagnosis to be confirmed before making such a referral.*

224. In the Tribunal's view, however, given the evidence before it that the patient's probable diagnosis was HIV, and given his associated sexual history, it was not acceptable for Dr Majeed, in the Case Based Discussion, to make no mention at all of a referral to the sexual health team.

225. Notwithstanding the positive evidence from Dr Majeed's colleagues, the Tribunal agreed with the Performance Assessors that, while there was not sufficient evidence from which it could be concluded that Dr Majeed's performance in this area was unacceptable overall, there was nevertheless some evidence of unacceptable performance such that it was reasonable to find his performance in the area of Working with Colleagues to be a cause for concern.

226. Accordingly, it found paragraph 3(c) of the Allegation proved.

The Tribunal's Overall Determination on the Facts

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

1. Between 29-30 January 2024 you underwent a General Medical Council assessment of the standard of your professional performance. **Admitted and found proved**

2. Your professional performance was unacceptable in the following areas:
   a. Assessment of Patients' Condition; **Determined and found proved**
   b. Clinical Management. **Determined and found proved**

3. Your professional performance was a cause for concern in the following areas:
   a. Maintaining Professional Performance; **Determined and found proved**
   b. Relationship with Patients; **Determined and found proved**
   c. Working with Colleagues. **Determined and found proved**

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

Determination on Impairment - 14/01/2026

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

The Outcome of Applications Made during the Impairment Stage

2. The Tribunal refused the GMC's application, made pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to admit further evidence. The Tribunal's full decision on the application is included at Annex A.

The Evidence

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

4. The Tribunal received in support of Dr Majeed nine testimonials from colleagues.

5. The Tribunal also received:

- Dr Majeed's written reflections on the Performance Assessment and factual findings of the Tribunal, dated August to December 2025;
- 35 Continuous Professional Development (CPD) certificates, dated May 2024 to December 2025;
- Patient questionnaires provided for Dr Majeed between September 2023 and May 2025;

- Dr Majeed's Case-Based Discussion (CBD) Portfolio, dated May 2024 to December 2025, including teaching feedback dated June 2025;
- Clinical Supervisor Report dated 28 December 2025.

Submissions

On behalf of the GMC

6. On behalf of the GMC, Mr Dyer submitted that Dr Majeed's fitness to practise was impaired by reason of deficient professional performance.

7. Mr Dyer submitted that, while the Tribunal had found some aspects and findings of the Performance Assessment to be incorrect or insufficient, it had broadly agreed with the overall assessment and conclusions made, including that Dr Majeed's performance was unacceptable in the areas of *Assessment of Patients' Condition* and *Clinical Management*.

8. Mr Dyer submitted that these findings did not relate to isolated incidents, but rather reflected repeated deficiencies in several areas, that Dr Majeed's skills were judged to be that of a junior doctor in acute medicine who would not be able to practise independently, and that his performance placed patients at risk. Mr Dyer submitted that the treatment options provided by Dr Majeed were often limited in range and demonstrated a lack of clarity in the management of patients.

9. Mr Dyer submitted that it was self-evident that, at the time of the Performance Assessment, Dr Majeed's fitness to practise was impaired. He submitted that, while there was a very large amount of positive evidence provided to the Tribunal by Dr Majeed, this was not sufficient to demonstrate that the concerns had been fully remediated and that his fitness to practise was not currently impaired.

10. Mr Dyer submitted that the Tribunal should consider the nature of the different types and categories of evidence and what weight to attribute to these. He submitted that there was a very clear conflict between what was presented in testimonials and feedback and the objective evidence of the Performance Assessment. He submitted that the Performance Assessment was a robust and transparent process, was independent, was designed by experts, and was, to a certain degree, tailored to Dr Majeed's level and experience.

11. Mr Dyer submitted that testimonials, patient feedback and CBD records fall into a different category and were not robust and independent in the same way as the Performance Assessment. He submitted that, while the testimonials provided by Dr Majeed were positive, there was not really any recognition of the issues identified by the Performance Assessment and that without such recognition it was difficult to establish what change there had been and what improvements had been made.

12. Mr Dyer submitted that the Tribunal may think that there was a need for substantial objective evidence to show a significant change in professional performance since that formal assessment took place, and that the evidence provided was not sufficient to replace or contradict the rigorous assessment undertaken by the Performance Assessment team.

On behalf of Dr Majeed

13. On behalf of Dr Majeed, Mr Ivill submitted that Dr Majeed's fitness to practise was not currently impaired.

14. Mr Ivill submitted that Dr Majeed's performance in January 2024 was deemed unacceptable in the areas of *Assessment of Patients' Condition* and *Clinical Management*, and that, while his performance was deemed a cause for concern in the areas of *Maintaining Professional Performance, Relationship with Patients* and *Working with Colleagues*, the latter were not sufficient to suggest deficient professional performance.

15. Mr Ivill submitted that the Tribunal's findings at the facts stage did not support all the conclusions of the Performance Assessment as to the extent to which Dr Majeed's performance was unacceptable. He submitted that, while there were findings of unacceptable professional performance in relation to *Assessment of Patients' Condition* and *Clinical Management*, the areas deemed to be unacceptable within those categories were significantly less following the Tribunal's findings of fact than those identified by the assessment team.

16. Mr Ivill submitted that the Tribunal had acknowledged at the facts stage that there may well be instances where Dr Majeed's performance, in the context of the Performance Assessment, may not reflect his performance in the real world and his day-to-day practice.

17. Mr Ivill submitted that Dr Majeed had provided significant and comprehensive evidence to demonstrate that he had remediated the concerns identified, including CPD,

written reflections, testimonials from colleagues, patient feedback and CBDs. He submitted that all this evidence demonstrated that Dr Majeed had satisfactorily developed and embedded this insight and remediation.

18. Mr Ivill submitted that the patient feedback provided was universally positive and that all the patients who had provided feedback had stated that they were confident about Dr Majeed's ability to provide care and that they would be completely happy to see him again.

19. Mr Ivill submitted that 16 different doctors had assessed Dr Majeed in the almost two-year period since the Performance Assessment, including three doctors and 13 consultant doctors. He submitted that all the evidence provided demonstrated that Dr Majeed is safe and reliable and that his knowledge and skills align with the expectations of a middle grade doctor. He submitted that the feedback and testimonials provided demonstrate that those assessing him were not aware of any concerns regarding patient safety in Dr Majeed's current role.

20. Mr Ivill submitted that there was no evidence to support any meaningful suggestion that the concerns identified by the Performance Assessment were evident in Dr Majeed's current practice and that the evidence of his current performance was very much to the contrary, demonstrating that any shortcomings had been remediated and embedded, with no aspects of his performance said to be unacceptable.

21. Mr Ivill submitted that, in summary, there was an insufficiency of evidence to support the contention of a current and ongoing risk to patient safety, or that Dr Majeed's fitness to practise is currently impaired.

The Relevant Legal Principles

22. 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.

23. 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 deficient professional performance; and then whether any such deficient professional performance should lead to a finding of impairment.

24. The Tribunal must determine whether Dr Majeed's fitness to practise is impaired today, taking into account Dr Majeed's performance 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.

25. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the test set out in *Grant*. The Tribunal noted that any of the following features are likely to be present when a doctor's fitness to practise is found to be impaired:

> *a. 'Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. Has in the past and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The Tribunal's Determination on Impairment

Deficient Professional Performance

26. The Tribunal considered its findings at the facts stage that Dr Majeed's performance was unacceptable in the areas of *Assessment of Patients' Condition* and *Clinical Management*. It also found that his performance was a cause for concern in the areas of *Maintaining Professional Performance, Relationship with Patients and Working with Colleagues*.

27. The Tribunal was satisfied that the Performance Assessment, carried out in January 2024, represented a fair sample of Dr Majeed's performance, covering a range of techniques and situations, and was robust, balanced and transparent in its process and findings.

28. While the Tribunal accepted some of the criticisms made of specific aspects of the Performance Assessment on behalf of Dr Majeed at the facts stage, it nonetheless accepted the overall findings of the Performance Assessment.

29. The Tribunal considered that even taking account of the fact that the Performance Assessment was an artificial environment, and making allowances for the fact that Dr Majeed found the process stressful, this did not explain the deficiencies identified.

30. The Tribunal concluded that its finding that Dr Majeed's practice was unacceptable in such key areas of medical practice must give rise to a risk of harm to patients.

31. The Tribunal went on to consider Good Medical Practice (2013) ('GMP') (which was in force during the period leading up to Dr Majeed's Performance Assessment and on its first day), in particular *Domain 1: Knowledge, skills and performance.* It considered the following paragraphs to be applicable:

> *7 You must be competent in all aspects of your work, including management, research and teaching.*
>
> *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*
>
> *c refer a patient to another practitioner when this serves the patient's needs.*
>
> *16 In providing clinical care you must:*
>
> *a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*
>
> *b provide effective treatments based on the best available evidence*
>
> *.....*

18 *You must make good use of the resources available to you.*

32. In concluding that these paragraphs of GMP were applicable, the Tribunal noted that Dr Majeed was told that his performance was deficient prior to the Performance Assessment and had not taken timely steps to address this.

33. The Tribunal determined that the Performance Assessment had identified significant deficiencies in Dr Majeed's performance and that his performance had fallen significantly below the standards expected in relation to *Assessment of Patients' Condition* and *Clinical Management*.

34. The Tribunal therefore concluded that Dr Majeed's performance fell so far short of the standards of performance reasonably to be expected of a doctor as to amount to deficient professional performance.

Impairment

35. The Tribunal, having found that the facts found proved amounted to deficient professional performance, went on to consider whether, as a result of that deficient professional performance, Dr Majeed's fitness to practise is currently impaired.

36. The Tribunal was of the opinion that the shortcomings found in Dr Majeed's performance, which related to specific areas of his practice, were remediable departures from the standards expected.

37. In reaching its decision on impairment, the Tribunal considered the evidence before it which could demonstrate that Dr Majeed had developed insight and remediated the deficiencies identified by the Performance Assessment and accepted by the Tribunal at the facts stage.

38. The Tribunal noted that there had been, since January 2024, no further Performance Assessment carried out in relation to Dr Majeed, and that the evidence provided by him as to his performance was in the form of patient feedback, testimonials, records of case-based discussions, and CPD. It considered that, while such forms of evidence may not be as robust or objective as a Performance Assessment, the quality and quantity of the evidence provided by Dr Majeed in this case was nonetheless significant.

39. The testimonials provided on Dr Majeed's behalf were from colleagues who were familiar with his practice, some of whom worked with him in senior or supervisory roles. These testimonials spoke positively of his practice and approach to patient care, and did not identify any serious concerns which might indicate that Dr Majeed's performance was below the required standards.

40. The Tribunal was mindful that Dr Majeed has been practising under conditions, providing a level of oversight and supervision, since 26 May 2022. However, none of the testimonials were caveated such that they indicated that Dr Majeed was practising satisfactorily only by virtue of the conditions. Rather, they indicated that the standard of his work and performance met expectations for a doctor at his grade generally. This provided some reassurance to the Tribunal that the evidence and testimonials provided could be taken at face value and were not dependent on the conditions on Dr Majeed's practice being in effect.

41. The professional feedback provided on Dr Majeed's behalf included patient surveys, case-based discussions and a Clinical Supervisor's Report. The Tribunal was told by Mr Ivill that this evidence amounted to the totality of the feedback received by Dr Majeed for the relevant period, and also demonstrated that his professional performance was to the standard expected, including in the areas of *Assessment of Patients' Condition* and *Clinical Management*.

42. Dr Majeed also provided a significant amount of evidence of CPD relating to the areas of concern identified by the Performance Assessment and the Tribunal's findings at the facts stage.

43. In addition, Dr Majeed provided written reflections in respect of the areas of concern. The Tribunal considered that these reflections could have contained more detail of Dr Majeed's reflection regarding his own personal performance and how he had already changed, and would in the future change, his practice and approach going forwards. However, the reflection provided related to the specific areas of practice identified in his Performance Assessment and supported the CPD, testimonial and feedback evidence provided by Dr Majeed which demonstrated that he had remediated the applicable areas.

44. While Dr Majeed's Performance Assessment was, in the Tribunal's view, more robust evidence in principle, it took into account that it had taken place two years ago. The evidence provided by Dr Majeed at this stage of proceedings, which was multi-faceted and from

numerous sources, was comprehensive and up-to-date. The Tribunal therefore attributed more weight to the current evidence in its assessment of whether Dr Majeed had satisfactorily remediated his deficient professional performance and whether he was currently impaired.

45. In particular, the Tribunal attributed significant weight to the report of Dr Majeed's Clinical Supervisor, Dr C, which states:

> *"Dr. Majeed is a safe and competent doctor.*
>
> *…*
>
> *He demonstrates strong patient assessment skills, including thorough history-taking and clinical examination. His management plans are appropriate and well-structured. Importantly, he recognizes his limitations and seeks senior input whenever necessary.*
>
> *…*
>
> *I am aware of concerns previously raised regarding Dr. Majeed's clinical management. Based on my observations, his management of acute medical conditions has been appropriate. He consistently seeks help when required and engages in case-based discussions with consultants, receiving positive feedback.*
>
> *…*
>
> *He has reflected on topics highlighted in Performance Assessment as unacceptable or cause of concern and also done Case Based Discussion on these topics with different consultants. He actively updates his knowledge through weekly departmental teaching and e-learning modules.*
>
> *…*
>
> *Dr. Majeed maintains excellent relationships with colleagues and treats patients with respect. He recently collected patient feedback during his placement, which was overwhelmingly positive.*
>
> *…*

Overall, Dr. Majeed is a safe, competent, and reliable doctor. His knowledge and skills align with the expectations of a middle-grade doctor. I am not aware of any concerns regarding his honesty or patient safety in his current role."

46. The Tribunal also attributed significant weight to the testimonial of Dr L, Consultant Physician at Leicester Royal Infirmary, which stated:

"Dr Firas Majeed has worked with me on a number of occasions over the last 2 years. I am aware that he is the subject of a Fitness to Practise Investigation, and had an assessment at the GMC in January 2024

Dr Majeed's clinical performance has improved considerably over the last 2 years He has been a registrar in my team mainly in the Same Day Medical Clinic, but i have also worked with him on the Acute Frailty Unit

His knowledge and skills, i believe, are now at a good standard . He competently assesses patients' problems, reaches sensible differential diagnoses and makes sound and reasonable management plans

He has also started to work at a quicker pace

He regularly leads the cardiac arrest team, and i have not been made aware of any problems or issues At no point have i been concerned about his clinical performance"

47. The Tribunal also found persuasive the following testimonial of Dr M, Clinical Director for Emergency and Specialist Medicine at the University Hospitals of Leicester and Acute Medical Consultant:

"I first met Dr Majeed when he began working in the Acute Medicine department at Leicester Royal Infirmary in the capacity of a registrar. I often worked clinical shifts with him.

During the time I have worked with him, including at present, I feel he is a safe and conscientious doctor. He takes time to assess his patients and then makes an appropriate list of differential diagnosis with sensible management plans. He is capable of independent decision making and has worked across several areas in Acute

medicine including the admission units, same day emergency care and the medical high dependency unit.

From my personal observations he has a kind and compassionate bedside manner and is supportive of his junior colleagues. I have not personally witnessed any issues in his interactions with colleagues and have found him to be friendly and approachable."

48. In light of all the available evidence, the Tribunal was not satisfied that the GMC had demonstrated a current or ongoing risk to patient safety, or any other reason, that would justify a finding of current impairment.

49. The Tribunal therefore determined that Dr Majeed's fitness to practise is not impaired.

Determination on Warning - 14/01/2026

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

Submissions

On behalf of the GMC

2. On behalf of the GMC, Mr Dyer submitted that the GMC was not seeking the issuing of a warning in this case. He submitted that in light of the GMC Guidance on Warnings ('the Guidance') this would not be proportionate in the circumstances of the case.

On behalf of Dr Majeed

3. On behalf of Dr Majeed, Mr Ivill submitted that a warning would not be appropriate and would be disproportionate.

4. Mr Ivill submitted that Dr Majeed has insight into his shortcomings, that there has been no repetition, that there are relevant and appropriate references, and that the Tribunal was satisfied that he had remediated the applicable areas of his practice. He submitted that these factors demonstrate that the Tribunal could have confidence that standards would be upheld without the imposition of a warning.

The Tribunal's Determination on Warning

5. The Tribunal had regard to the Guidance, its previous determinations and all of the evidence previously adduced in these proceedings.

6. In reaching its determination, the Tribunal bore in mind the relevant paragraphs of the Guidance.

7. The Tribunal considered paragraph 20 of the Guidance, as set out below, to be applicable in this case:

> *20. The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.*
>
> *a. There has been a clear and specific breach of Good medical practice or our supplementary guidance.*
> *b. The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor's fitness to practise has not been found to be impaired.*
> *c. A warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely relating to a doctor's health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.*
> *d. There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).*

8. The Tribunal found at the impairment stage that Dr Majeed's deficient professional performance breached multiple paragraphs of Good Medical Practice (2013) ('GMP'). It

concluded that these were significant departures from GMP in central areas of medical practice which had clear and obvious implications for patient safety.

9. The Tribunal considered that its impairment decision was finely balanced and that Dr Majeed's deficient professional performance, in all the circumstances, had approached the threshold for a finding of impairment. It concluded that if there was a repetition then this would likely result in a finding of impaired fitness to practise.

10. The Tribunal was also satisfied that there was a need to record formally the particular concerns because additional action may be required in the event of any repetition.

11. The Tribunal considered that paragraph 32(a) of the Guidance, as set out below, was also applicable in this case:

> **32.** *If the decision makers are satisfied that the doctor's fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of factors to determine whether a warning is appropriate. These might include:*
>
> *a. the level of insight into the failings*
>
> *…*

12. Although the Tribunal had seen sufficient evidence of remediation and consistently acceptable practice since the assessment in January 2024, at his current level and in his current role, to justify a finding that Dr Majeed is not currently impaired. However, the Tribunal reminded itself of its finding at the impairment stage that *"The Tribunal considered that these reflections could have contained more detail of Dr Majeed's reflection regarding his own personal performance and how he had already changed, and would in the future change, his practice and approach going forwards."* Although the Tribunal considered that Dr Majeed had remediated the specific concerns identified in his Performance Assessment, it did not find his insight at this stage to be complete.

13. The Tribunal therefore determined to issue the following warning in accordance with Section 35D(3) of the Medical Act 1983 and Rule 17(2)(m) of the Rules:

Between 29-30 January 2024 Dr Majeed underwent a General Medical Council assessment of the standard of his professional performance. His professional performance was unacceptable in the following areas: Assessment of Patients' Condition and Clinical Management.

This performance does not meet with the standards required of a doctor. It puts patient safety at risk, and must not be repeated. The required standards are set out in *Good medical practice* and associated guidance.

In this case, paragraphs 7, 15, 16(a) &(b) and 18 of GMP are particularly relevant, namely:

7 *You must be competent in all aspects of your work, including management, research and teaching.*

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*

c *refer a patient to another practitioner when this serves the patient's needs.*

16 *In providing clinical care you must:*

a *prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*

b *provide effective treatments based on the best available evidence*

.....

18 *You must make good use of the resources available to you.*

Whilst this failing in itself is not so serious as to require any restriction on Dr Majeed's registration, it is necessary in response to issue this formal warning.

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

14. The interim order of conditions in place is revoked with immediate effect.

15. That concludes this case.

ANNEX A – 14/01/2026

Application to admit further evidence

1. On 12 January 2026, having reconvened at the impairment stage, Mr Dyer, counsel on behalf of the GMC, made an application under Rule 34(1) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules') to admit further evidence.

2. The application related to the recommendations of the Performance Assessors, which was redacted from the Performance Assessment Report provided to the Tribunal at the facts stage of the hearing.

Submissions

On behalf of the GMC

3. Mr Dyer submitted that the evidence he sought to submit was part of the Performance Assessment Report which dealt with the recommendations of the Performance Assessors. He submitted that the evidence was relevant to Dr Majeed's level of professional performance and the steps required to improve his performance and ensure safety.

4. Mr Dyer submitted that it would be fair to admit the evidence and that the Tribunal could consider the appropriate weight to attach to it and how it impacts upon what has occurred in the intervening period.

On behalf of Dr Majeed

5. Mr Ivill, counsel, submitted that he opposed the admission of the evidence. He submitted that the hearing had reached the impairment stage and that the Tribunal should assess whether there was current impairment, with any decision flowing from the Tribunal's earlier findings and based on its professional judgement.

6. Mr Ivill submitted that the evidence that the GMC sought to adduce was neither relevant to the Tribunal's decision, nor fair to admit. He submitted that it would be undesirable to have the opinion of another influencing the Tribunal's independent judgement in relation to the matter of impairment.

The Tribunal's Decision

7. Rule 34(1) states:

> *"The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law."*

8. As to the issue of relevance, the Tribunal noted that the opinions and recommendations of the Performance Assessors were based on the entirety of their findings, some of which the Tribunal had not accepted at the facts stage.

9. On balance, the Tribunal accepted the submission made on behalf of Dr Majeed that the question of impairment was for it to make as of today. The Tribunal was not, therefore, satisfied that the recommendations of the Performance Assessors at an earlier stage (nearly two years before), which were based in part on certain findings which the Tribunal had not accepted at the facts stage, were relevant to its decision making at this stage of the hearing.

10. The Tribunal also considered that there may be a perceived risk of prejudice to Dr Majeed if the Tribunal were made aware of opinions beyond the information already provided to it and upon which its determination on the facts was based.

11. Accordingly, the Tribunal determined to refuse the GMC's application.