PUBLIC RECORD

Date: 28/02/2024

Medical Practitioner's name:	Dr Francisco MENA MOLINA *Also known as Dr MENA*
GMC reference number:	3421718
Primary medical qualification:	LMS 1988 Universidad de Granada

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

Summary of outcome

Conditions revoked

Tribunal:

Legally Qualified Chair	Miss Gillian Temple-Bone
Lay Tribunal Member:	Mrs Sue Wadham
Medical Tribunal Member:	Dr Janet Nicholls

Tribunal Clerk:	Ms Angela Carney

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Christopher Marsh-Finch, Counsel, instructed by Verrals Solicitors
GMC Representative:	Ms Emma Gilsenan, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Impairment - 28/02/2024

1. At this review hearing the Tribunal now has to decide in accordance with Rule 22(1)(f) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules') whether Dr Mena's fitness to practise is impaired by reason of misconduct.

Background

2. Dr Mena qualified in 1988 from the Universidad de Granada, Spain. He moved to England after graduation and worked in Cardiology for three years before returning to Spain. He subsequently worked in a private practice in Gibraltar before joining the Gibraltar Health Authority (GHA) in 2001 as a GP.

3. The facts the Tribunal found proved at Dr Mena's hearing which took place in May, July and August 2023 (the 2023 Tribunal), were in summary, that Dr Mena failed to provide good clinical care to three patients A, B and C at various times between 2014 and 2018..

Patient A

4. Dr Mena was involved in the care and treatment of Patient A between May 2014 and May 2019 during which time he had requested Prostate-Specific Antigen (PSA) blood tests. The 2023 Tribunal found proved that Dr Mena failed to review and act on the PSA test results and arrange a referral to urology. The 2023 Tribunal also found proved that Dr Mena failed to obtain informed consent for PSA testing, did not record the reason for requesting the testing and did not discuss with Patient A the risks of a false positive result leading to potentially unnecessary investigations or a negative result causing cancer to be missed.

Patient B

5. Patient B had a history of congestive heart failure, had undergone a MitraClip procedure, had a defibrillator implant, was on anticoagulant medication and required regular check-ups. On 7 October 2016 Patient B consulted with Dr Mena.

6. The 2023 Tribunal found proved that Dr Mena failed to assess Patient B's vital observations, including temperature and oxygen saturation, for signs of a chest infection by performing chest auscultation and the level of breathlessness. That Tribunal also found proved that Dr Mena failed to adequately review Patient B's clinical record to see whether or not there was any history of relevance and to refer him for same-day review in Accident and Emergency and/or by a Cardiologist.

7. The 2023 Tribunal found proved that Dr Mena inappropriately prescribed flecainide to Patient B as he did not discuss this case with a Cardiologist prior to prescribing, did not have advanced skills in the diagnosis and management of cardiological symptoms and illnesses nor did he have extensive experience of prescribing and managing a range of antiarrhythmic medication, including flecainide. Further it found proved that Dr Mena failed to arrange review within one to four weeks and did not obtain informed consent in that he did not discuss the risks, benefits and side effects.

8. Following the consultation, Patient B continued to feel unwell and was taken to A&E on 11 October 2016.

Patient C

9. Patient C had a previous history of heart valve problems for which she was prescribed warfarin, an anticoagulant used to reduce the risk of blood clot formation. She had undergone heart valve surgery and was also suffering from peripheral vascular disease.

10. The 2023 Tribunal found proved that on 23 April 2018, Dr Mena consulted with Patient C and failed to obtain an adequate history, including whether she was unwell at the time of the consultation, there were signs of a gastrointestinal pathology such as bleeding or cancer, including vomiting, weight loss, change in bowel habit, upper abdominal pain, vomiting blood, and her previous medical history.

11. The 2023 Tribunal also found proved that Dr Mena failed to perform an abdominal examination, and assess basic observations, including blood pressure, and pulse. Further, that Tribunal found proved that Dr Mena failed to refer Patient C for a specialist outpatient assessment within two weeks and record any reference with respect to lower back pain of history taking, examination and explanation of red flags.

12. On 11 May 2018, Patient C was admitted to hospital with shortness of breath, fatigue, dizziness, dark stools, and dyspepsia. According to the discharge letter, she was diagnosed with an upper gastrointestinal bleed, causing loss of blood in her gut, leading to anaemia. Concerns were raised by a consultant in relation to Dr Mena, noting that Patient C was taking warfarin and that a history of black stools had been noted.

13. The 2023 Tribunal found proved that between 2017 and 2019, on one or more occasion, Dr Mena did not review laboratory results in a timely manner or at all and deleted pathology results emails without reviewing the contents.

14. The 2023 Tribunal found that Dr Mena's treatment of Patients A, B and C fell seriously below the standard expected and amounted to serious misconduct.

15. In relation to the laboratory results the 2023 Tribunal noted that whilst there was no evidence of any adverse outcome as a result of Dr Mena's failure to review them. there could have been grave consequences and compromised patient safety. As such, the 2023 Tribunal determined that Dr Mena's actions would be considered deplorable by other members of the medical profession. The 2023 Tribunal considered that Dr Mena had put patients at risk by not reviewing their results in a timely manner or at all. It found that Dr Mena's conduct fell seriously below the standard expected and to amount to serious misconduct.

16. The 2023 Tribunal determined that Dr Mena's actions failed to adequately protect Patients A, B and C. It also determined that public confidence in the profession would be undermined by these failures and a member of the public would be shocked if a finding of impairment was not made. The 2023 Tribunal determined that a finding of impairment was therefore required in order to protect and promote the health, safety and wellbeing of the public; promote and maintain public confidence in the medical profession; and promote and maintain proper professional standards and conduct for the members of the profession. The 2023 Tribunal therefore determined that Dr Mena's fitness to practise was impaired by reason of misconduct.

17. The 2023 Tribunal considered that Dr Mena's insight was deficient and required further development. It considered the impact on public confidence and the need to maintain and promote professional standards and determined that conditions to practice safely under supervision, whilst Dr Mena's insight developed further, would be the proportionate sanction.

18. The 2023 Tribunal considered that an order of conditions was the most appropriate way to address Dr Mena's misconduct and would satisfy the overarching objective. It considered that patient safety, public confidence in the profession and the upholding of proper professional standards would be sufficiently protected by an order of conditions. The 2023 Tribunal determined that the overarching objective would be satisfied by imposing an order of conditions on Dr Mena's registration for a sufficient period to allow Dr Mena to develop adequate insight into his failings. It determined to impose an order of conditions for a period of 6 months and directed a review.

19. The 2023 Tribunal considered that a future Tribunal may be assisted by:

- a reflective statement addressing Dr Mena's understanding of the impact of his misconduct on patients, public confidence and professional standards.

- Dr Mena will also be able to provide any other information that he considers will assist including any reports from his clinical supervisor/ responsible officer.

The Evidence

20. The Tribunal has taken into account all the evidence received, both oral and documentary.

21. In his oral evidence Dr Mena told the Tribunal that in his statements of reflection he tried to explain his insight into his misconduct. He explained his modified working practise and the work he has undertaken to remediate his misconduct with Dr D. He said that he sent the second statement of reflection to ensure that he had properly explained himself as English is not his first language. He wished the Tribunal to be aware of his thoughts and insight as in the past it was deemed to be insufficient. Dr Mena confirmed that two of the patients remain under his care and he has apologised to them for his misconduct.

22. Dr Mena confirmed that the GHA have acted on the concerns he raised regarding the appointment system. He said that the appointment times have now been doubled from 5 to 10 minutes per patient to allow for documentation to be completed. Dr Mena said that he sees 36 patients a day, and works five days a week. He explained that the GHA have allowed him one morning a week to deal with administration including the receipt of test results and said that this was introduced a couple of years ago. Dr Mena confirmed that there have been no concerns raised about his clinical practice.

23. Ms Gilsenan referred Dr Mena to paragraph 149 of the 2023 Tribunal's determination on impairment:

> *'149. The Tribunal had regard to Dr Mena's reflective statement and considered that he is still not taking full responsibility for his failings and continues to blame the system. It considered that whilst there is some insight, he continues to blame his high pressure working environment. The Tribunal is not satisfied that Dr Mena has taken adequate responsibility for his failings in an imperfect system.'*

24. Dr Mena confirmed that he no longer blamed the system for his failings. He said that he has reflected on his failings. He said he has ensured that he will not repeat these failings. He said the practice now allows time for doctors to action reports and results. He said that this has improved the system. He also said that unscheduled appointments have now been stopped to allow him to concentrate on the patient he is seeing. He said that following the 2023 hearing he reflected and he recognised that the failings were his as he is responsible for his patients.

25. Ms Gilsenan referred Dr Mena to the following sentence in his statement of reflection dated 14 February 2024:

> *'I now feel I have reached a level which allows me to deliver a high standard and safe level of care to my patients within the limitations of a 10- minute appointment. This is supported by my supervisor who feels confident in my work.'*

26. Dr Mena explained that some appointments take less than 10 minutes, and some take longer. He said feedback from patients was positive even if their appointment was delayed. He said that if a patient requires extra time, he extends the appointment as necessary. He said that he often works through his lunch to enable him to do his job properly. He said that he believes he remains a popular doctor and many patients book appointments in advance. He said that his patients are happy with his practice.

27. Ms Gilsenan referred Dr Mena to paragraph 150 of the 2023 Tribunal's determination on impairment:

> *'150. The Tribunal went on to consider Dr Mena's insight and considered that his insight is incomplete. It considered that the misconduct is capable of remediation, however, some failings are attitudinal. It considered Dr Mena's insight into his conduct regarding Patient A to be very limited and his insight into his particular failings is lacking. The Tribunal considered that there remains a risk of repetition due to Dr Mena's incomplete insight. It considered that Dr Mena had not reflected on the impact of his failings on public confidence and on the reputation of the medical profession.*

28. Dr Mena said that he fully accepted that the failings were entirely his. He said that his patients are his responsibility. He said he does not want to make the same mistakes again. He said it is important to recognise mistakes in order to remediate them. He said that he had reflected on his failings many times, at work and in time after work and he has tried not to commit those failings again. The half day a week has helped him and also he has not allowed interruptions in his clinic. In the past some people would come to see him but he thinks that his patient management is better.

29. Dr Mena said that in relation to Patient A he should have acted more promptly regardless of whether or not he was busy, by referring him for further assessment. In relation to the risk of repetition he said that he has reflected many times for his practice and for his patients to try and not make any mistakes. He said that he has changed and he apologises for his past mistakes.

30. Dr Mena said that he has reflected on public confidence and tries not to repeat his mistakes in order to provide good medical care to his patients and to the community.

31. Dr Mena provided two statements of reflection dated 14 and 26 February 2024, as follows:

> *'As we approach the end of my supervised period of work, I would like to take this forward to my thoughts on how I feel I have adapted and improved my overall practice as a response to previous failings.*

With the support of my supervisor and colleagues I have had the opportunity to continue to review and reflect on my own practice over the last six months. I have found this to be a very valuable exercise in improving every aspect of my work. In comparing my practice to my peers and to the standards set by GMC guidelines I have established insight into pas failings and areas which were requiring strengthening. I now feel I have reached a level which allows me to deliver a high standard and safe level of care to my patients within the limitations of a 10- minute appointment. This is supported by my supervisor who feels confident in my work.
I have particularly focused on good recording of important aspects of consultation. In particular, documenting and advising I have offered to patients, excluding red flags and safety netting. I have also reflected and modified prescribing habits to ensure safe prescribing. It was also clear to me that investigation results and letters arriving to me require to be checked and vetted asap. These often contain important information which could significantly impact on patients' health and cannot be left unchecked for too long. I now always aim to have all results checked within 7 days – ideally within 48 hours. This often involves me leaving late or coming into work in my own spare time or making alternative arrangements when I am on prolonged leave. I am happy to do this and I think I am coping well with the demands.
I will miss my fortnightly encounters with Dr D, but he assures me he is always available for advice as most colleagues are. I have once again regained my confidence and passion for my profession, but at the same time I am conscious of the risk of developing complacency. I will, therefore, review all areas of previous concerns at regular intervals as part of my CPD. I have a better understanding on how to reflect on my own work and make changes when needed.
In summary, I must say that the past 3-4 years have been difficult at a personal and professional level. However, now that I reflect back, I feel I must appreciate that I have come out of this a better doctor and can deliver a higher level of safe health care to my patient. I hope and trust that the hearing committee is able to concur with this and allow me to exercise my practice and continue to look after patients.'

'In addition to the above, my reflection has included considering the impact of my previous shortcoming on patients and how this may have impacted on their well-being. Not only this, but the impact this can have on public confidence particularly in a small community. I am fully aware of the expected professional standards and have taken all measures to ensure that these are upheld going forwards.'

32. The Tribunal received the following documentary evidence which included but was not limited to:

- Correspondence between the GMC and Dr Mena
- Workplace Reports from Dr D, GP Lead and Workplace Reporter/Clinical Supervisor, dated 24 August 2023, 15 December 2023 and 17 February 2024
- Dr Mena's case reviews with Dr D dated 20 September 2023, 18 October 2023, 23 November 2023, 15 December 2023, 18 January 2024, and 14 February 2024
- Dr Mena's letter containing his statement of reflection dated 14 February 2024

- Dr Mena's email containing further reflections dated 26 February 2024

Submissions

33. On behalf of the GMC, Ms Emma Gilsenan, Counsel, submitted that in light of Dr Mena's additional oral evidence regarding his reflections on his misconduct, the GMC is neutral on the matter of impairment. She stated that impairment is a matter for the Tribunal. Ms Gilsenan referred the Tribunal to the guidance on impairment. Ms Gilsenan confirmed that Dr Mena has complied with the conditions on his registration. She also confirmed that the GMC is neutral on the risk of repetition.

34. On behalf of Dr Mena, Mr Christopher Marsh-Finch, Counsel, said that Dr Mena is a popular doctor. He said that Dr Mena has been under investigation for a number of years. He said that not only has Dr Mena affirmed that he has 'learnt his lesson'. Mr Marsh-Finch referred the Tribunal to the objective evidence from the doctors supervising Dr Mena. He said the reports were of a high calibre. He submitted that Dr Mena has fully addressed his misconduct and has fully reflected upon it. Mr Marsh-Finch said that Dr Mena continues as a valued member of the GHA and the patient list he has is enormous and during his supervision there have been nothing but positive reports. He submitted that Dr Mena's practice no longer poses a risk of repetition. He said that Dr Mena has accepted the gravity of his mistakes in the past and has addressed his difficulties by staying late and giving patients sufficient time to address their concern. He said that Dr Mena is trying to accommodate the patients within the system. Mr Marsh-Finch submitted that Dr Mena is now safe to practise unrestricted. He stated that Dr Mena now has a completely different outlook to what he had in the past. Mr Marsh- Finch reminded the Tribunal of Dr Mena's written and oral reflections and the Tribunal can be certain that he can be allowed to practise without conditions and is safe to do so. He said that Dr Mena is not a doctor who is trying to evade facing up to his responsibilities. He submitted that it is clear that the public has confidence in Dr Mena and the system.

The Relevant Legal Principles

35. The Tribunal reminded itself that the decision of impairment is a matter for the Tribunal's judgement alone. As noted above, the previous Tribunal set out the matters that a future Tribunal may be assisted by. This Tribunal is aware that it is for the doctor to satisfy it that he would be safe to return to unrestricted practise.

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

The Tribunal's Determination on Impairment

Misconduct

37. The Tribunal noted the 2023 Tribunal found Dr Mena's conduct was a serious departure from the standards expected, his misconduct was serious, and potentially placed patients at risk of harm. The Tribunal noted that at the impairment stage the 2023 Tribunal considered that Dr Mena's insight was incomplete. The 2023 Tribunal imposed conditions on Dr Mena's registration which included supervision.

38. The Tribunal heard that Dr Mena has complied with the conditions on his registration.

39. The Tribunal noted the reports from Dr Mena's clinical supervisor, Dr D. In Dr D's last report dated 14 February 2024, he stated:

> *'The cases discussed this month continue to show a very good level of medical practise. History taking, examination, consultation techniques as well as good prescribing habits and appropriate management, continue at a high standard with no concerns. Dr Mena is also up to date with all his letters and results. There have been no concerns or issues raised about his practice.*
> *This being likely our last encounter Dr Mena and myself had a deep discussion and reflection about progress made in the areas he needed to strengthen, which he has done successfully.*
> *Good and appropriate documentation is now an established characteristic of Dr Mena's work. Compared to many of his peers I would say that Dr Mena excels in this area.*
> *His history taking & examination techniques are also at a very good level with the constraint of a 10 min appointment.*
> *Dr Mena has always been good at involving patient in their care but is now more conscientious of refusing a patient request when it is not in their best interest or may risk his own practise. He sticks within guidelines. This is especially evident in prescribing NSAIDs, benzodiazepines or considering potential drug interactions.*
> *Finally, I am very satisfied in the overall improvement in Dr Mena's practise. This was already obvious before we started the last 6-month period of supervised practise. I am happy to say that these high standards have been maintained consistently for the last 6 months.'*

40. Dr Mena provided this Tribunal with reflections on his misconduct and how he remediated and had modified his practise. Dr Mena apologised to the Tribunal and to his patients for his misconduct.

41. The Tribunal found that there is clear evidence of Dr Mena's reflection, insight and remediation. The Tribunal considered that Dr Mena has fully acknowledged and reflected on his past mistakes. It noted that Dr Mena previously, in part, blamed the 'system' for his own failings. He stated in oral evidence that previously he should have stayed late, seen the results and acted upon them. He stated he has no-one else to blame but himself. Following his prioritising his patient's needs regardless of the time the 'system' allows for them, the GHA accepting the time allowed for each patient at 5 minutes needed extending to 10

minutes, providing additional time to complete the related administration following patient appointments, his past mistakes have now been accepted in full and addressed. The Tribunal is of the opinion that Dr Mena has taken full responsibility for his actions and were encouraged when he acknowledged that the failings were his, the patients his responsibility alone and that he needs to work around any failings in the 'system.'

42. The Tribunal noted that Dr Mena's clinical practice has undergone monthly assessments which he appears to have appreciated and enjoyed. Dr Mena said he would miss this supervision in the future but was aware that he can seek advice and support from Dr D and other colleagues.

43. Given Dr Mena's insight and remediation, the Tribunal was satisfied that the risk of repetition is low. Having remediated his misconduct, the Tribunal determined that all three limbs of the overarching objective, including to promote and maintain proper professional standards and conduct for members of that profession have been satisfied.

44. The Tribunal has therefore determined that Dr Mena's fitness to practise is no longer impaired by reason of misconduct.

45. The Tribunal noted that Dr Mena's conditions are due to expire on 12 March 2024. This Tribunal noted that the 2023 Tribunal considered the impact of Dr Mena's misconduct on public confidence and the need to maintain and promote professional standards and determined that conditions to practice safely under supervision, whilst Dr Mena's insight developed further, would be the proportionate sanction.

46. This Tribunal has determined that Dr Mena has fully remediated his misconduct, the risk of repetition is low and his fitness to practise is no longer impaired. It was also mindful that the public should not be deprived, for longer than is necessary, of a good doctor who has fully remediated his misconduct.

47. Accordingly, the Tribunal determined that the conditions on Dr Mena's registration are hereby revoked with immediate effect.

48. That concludes this case.