Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 03/12/2018 - 07/12/2018

Medical Practitioner's name: Dr Hasan AWAN

GMC reference number: 5174172

Primary medical qualification: MB BS 1987 Islamia University

Type of case
New - Misconduct

Outcome on impairment
Not Impaired

Summary of outcome
No warning
XXX

Tribunal:

Legally Qualified Chair	Ms Melissa Coutino
Medical Tribunal Member:	Dr Meera Ladwa,
Medical Tribunal Member:	Dr Nigel Langford

Tribunal Clerk:	Mr John Poole

Attendance and Representation:

Medical Practitioner:	Present and not represented
GMC Representative:	Mr Christopher Rose, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 06/12/2018

Background

1. Dr Awan qualified in 1987 and started working in the NHS in 2006. At the time of the events that are the subject of this hearing, Dr Awan was practising as a Locum Consultant in Ophthalmology at the University of Southampton NHS Foundation Trust.

2. The allegation that has led to this hearing concerns Dr Awan's management of two patients, Patient A and Patient B, in September 2016.

3. Dr Awan consulted with Patient A on 1 September 2016. It is alleged that he failed to take an adequate history and undertake appropriate examinations and investigations. It also alleged that there were failings in Dr Awan's record-keeping and that he made an inappropriate diagnosis.

4. In addition, it is alleged that, on 9 September 2016, Dr Awan consulted with Patient B and failed to take an adequate history or adequately interpret Patient B's angiogram. It is alleged that Dr Awan's failings in respect of the consultation extended to diagnosis, arranging follow-up and arranging treatment.

5. It is the GMC's case, that in relation to both Patient A and Patient B, Dr Awan did not treat these patients as he should have done. In not recommending macular tests and treatment for each patient there was the potential for patients' eyesight to be affected.

The Allegation and the Doctor's Response

6. The Allegation made against Dr Awan is as follows:

Paragraph 1
On 1 September 2016 you consulted with Patient A and you:

a. failed to:

i. take an adequate history; **To be determined**

ii. examine the anterior segments; **To be determined**

iii. perform a dilated retinal examination;
To be determined

iv. order an urgent Ocular Coherence Tomography scan;
To be determined

v. investigate the likely diagnosis of exudative age related macular degeneration; **To be determined**

vi. respond to the issues raised in the referral letter dated 22 August 2016; **To be determined**

vii. record your reasoning and clinical findings for diagnosing herpes zoster ophthalmicus; **To be determined**

b. in the alternative to paragraph 1ai to 1aiii, failed to record:

i. an adequate history; **To be determined**

ii. your examination of the anterior segments; **To be determined**

iii. performing a dilated retinal examination; **To be determined**

c. inappropriately diagnosed and treated Patient A for herpes zoster ophthalmicus. **To be determined**

Paragraph 2
On 9 September 2016 you consulted with Patient B and you failed to:

a. take an adequate history; **To be determined**

b. adequately interpret Patient B's angiogram; **To be determined**

c. diagnose:

i. rubeosis; **To be determined**

ii. ischaemia; **To be determined**

iii. leakage in the fundus fluorescein; **To be determined**

d. arrange an urgent follow-up within 2 weeks; **To be determined**

e. arrange laser treatment; **To be determined**

f. in the alternative to paragraph 2c, record a diagnosis of:

i. rubeosis; **To be determined**

ii. ischaemia; **To be determined**

iii. leakage in the fundus flourescein. **To be determined**

The Facts to be Determined

7. At the outset of these proceedings, Dr Awan accepted having not undertaken certain actions as outlined in the allegation but did not accept that they amounted to failures. He admitted not having undertaken the tasks set out in paragraphs 1.a.ii, 1.a.iii, 1.a.iv, 1.a.v, 1.a.vi, 1.b.ii, 1.b.iii, but not that he was under a clinical obligation to do them in all the circumstances he was presented with. In going through the allegations at the outset of the hearing, he had provided narrative responses to establish context. As such, the Tribunal is required to determine the entirety of the allegation.

Evidence

8. The Tribunal received expert evidence on behalf of the GMC from Mr C, Consultant Ophthalmic Surgeon and Paediatric Ophthalmologist. Mr C gave oral evidence to the Tribunal in support of his expert report dated 4 September 2018. The Tribunal also heard oral evidence from Dr Awan and had regard to his written response to the allegations. The Tribunal also had regard to the various relevant medical records pertaining to Patients A and B.

9. Mr C explained in his report that Patient A had been seen by Mr M, a Consultant Ophthalmic Surgeon at the Royal Hampshire County Hospital in Winchester on 22 August 2016. After this clinical appointment, Mr M had written a letter of the same date to a macular consultant at Southampton Eye Unit about Patient A. In the letter, Mr M asked for the opinion of a macula consultant about Patient A who presented with a two month history of central blurring in the right eye with reduced visual acuity. Mr M noted Patient A appeared to have a pigment epithelial detachment (PED).

10. In Mr C' expert report, he gave the opinion that the standard of care offered to Patient A fell below the standard to be expected of a reasonably competent Locum Consultant in Opthalmologist due to a failure to take an adequate history; failure to respond to the reason for the referral in the letter from Winchester; failure to examine the anterior segment of either eye; failure to dilate Patient A to allow an adequate retinal examination; failure to describe the retinal findings considering the referral letter.

11. However, Mr C' revised his opinion after a factual error in his report was corrected; namely, that the medical notes do not state the patient was seen 'in Winchester', but rather that the patient was 'seen in isolation'. In light of this, Mr Rose of Counsel put to him, along with additional information, a more specific scenario involving Patient A. Mr C accepted that if Patient A had more than a mild

case of Herpes zoster opthalmicus ('HZO'), was in pain, was unable to open his eyes, had to have two people holding his head, was frail, suffering from COPD that was unstable, and was on oxygen, undertaking macular tests at that time would not have been practical. Nonetheless, he said that he would have expected more detailed notes to have been made. For example, in his report he said:

> 'HA [Dr Awan] has diagnosed right HZO but has not explained why he has made this diagnosis and has not described his clinical findings.'

But once the word 'isolation' was clarified in the patient's notes, he accepted that Dr Awan's conduct in relation to Patient A, while below the standard expected in having notes that were brief, was not seriously below the standard expected. Further, in relation to the HZO, he indicated that while a mild case would have meant that macular testing could go ahead on the day, a very severe case would have necessitated a follow up in a weeks' time to ensure that it was not impacting the patient's vision. However, he accepted that these were two ends of a spectrum and that Dr Awan's treatment of Patient A could have been appropriate as anti-viral medication within 72 hours of the rash appearing was clinically indicated, and that it would be 'unwise' to inject the eye when there was an active viral infection affecting it.

12. By way of brief background with regard to Patient B, Mr C's explains in his report:

> "…Patient B was seen in the medical retina clinic on 22 August 2016 by Mr K, a Speciality Doctor in Ophthalmology. Patient B's vision had not changed significantly from the previous November. There was no anterior chamber rubiosis in either eye but no neovascularisation of the iris in the left eye.
>
> Patient B was thought to have mild right diabetic maculopathy but of note he had new blood vessels on his iris (rubiosis) with normal intraocular pressures. The left eye was healthy… The doctor arranged an urgent fluorescein angiogram to check for ocular ischaemic syndrome (poor overall blood supply to the eye). The plan was to see Patient B back in two weeks with FFA result in a clinic where he could be offered an injection of anti-VEGF (Avastin). Carotid Doppler scanning was arranged to see if there was any blockage of major blood vessels in the neck..
>
> ..
>
> HA saw Patient B on 9 September 2016. The visual acuity of Patient B was 0.32 unaided in the right eye (6/12) and 0.02 in the left eye (6/6) the vision improved in the right eye with a pinhole of 0.12 Logmar (6/9).
>
> HA identified the rubiotic iris on the right and has also noted trans-illumination of both iridis. HA has noted that the carotid Doppler was reported

> as normal and he has written in the letter "no signs of peripheral ischaemia". In the contemporaneous record, HA has written "FFA r/v… no signs of ischaemia in periphery"…
>
> HA's plan was to observe and a follow up arrangement was made for two to three months.
>
> ..
>
> It appears that Mr K who saw Patient B on 22 August 2016 had gone back to check results of the investigations he had organised. This doctor then review the findings of Patient B with consultant Miss R. they looked at the fundus fluorescein angiogram which showed significant areas of ischaemia and leakage consistent with poor blood supply to both eyes."

13. In his report, Mr C stated that:

> 'In my opinion HA did not adequately interpret Patient B's angiogram either from the retina or from the iris in either eye. In my opinion, he did not adequately respond to the evidence of ischaemia and iris new blood vessels. In my opinion, for a Locum Consultant working in a medical retinal clinic, this constitutes a level of care that falls serious below that to be expected of a reasonably competent Consultant Opthalmologist. This is because of the threat to vision suggested by this constellation of findings. HA should have arranged urgent follow-up (within 2 weeks) and laser treatment.'

14. However, in person, Mr C again amended what he said in his report. He had based his report on Dr Awan and subsequent clinicians having sight of the same material. He accepted that if this was not the case, then a different conclusion being reached by Dr Awan was understandable.

The Tribunal's Approach

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

The Tribunal's Analysis of the Evidence and Findings

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

17. Dr Awan gave evidence under oath, he provided a detailed picture of both patients A and B, he provided background material and was able to recall specific

interactions with the patients. Where his memory failed him, he admitted this. He did not shy away from answering any questions from either GMC counsel nor the Tribunal and the Tribunal found him to be credible both in the detail he provided and the manner in which his evidence was provided.

Paragraph 1ai

18. The Tribunal first considered whether, on 1 September 2016, Dr Awan consulted with Patient A and failed to take an adequate history.

19. The Tribunal was satisfied that Dr Awan took an adequate history, given that Dr Awan was able to report what the nurse, Patient A and the person accompanying Patient A had to say about his rash appearing the day before his due appointment and the rationale for not seeking more prompt medical assistance (eg. he was due to see doctors anyway the following day). It accepted that Dr Awan did take an adequate history, as such it found paragraph 1ai of the allegation not proved.

Paragraphs 1aii-iv

20. The Tribunal next considered whether on 1 September 2016, Dr Awan consulted with Patient A and failed to examine the anterior segments, perform a dilated retinal examination, and order an urgent Ocular Coherence Tomography scan.

21. The Tribunal bore in mind that Dr Awan accepted that he did not undertake these actions but denied that they were failures. In response to these sub-paragraphs of the allegation, Dr Awan stated:

> 'ʻ(ii) Not true, as due to patients acute co-morbidity of Herpes zoster ophthalmicus it was almost impossible to examine the anterior segment. Which has occurred on top of his long-standing systemic deteriorating condition of Chronic Obstructive Pulmonary Disease (COPD). This required urgent treatment which I promptly did as evident from the case notes...'
>
> (iii) Not true, as due to the above condition arising acutely, it was impossible to perform dilated fundus examination due to patients difficulty in breathing and acute distress caused by Herpes zoster. Also the patient had very swollen tender eye lids which had completely shut the eye.
>
> (iv) Not true, it was not suitable to do the OCT exam as the patient was on oxygen and still struggling to breathe, it would have been unfair on the patient and would have increased patients distress to wait in the clinic for the OCT exam. Furthermore to force him to keep his chin on the OCT machine would have caused increased distress and pain to try to manually open his eyelids for examination.'

22. Again, the Tribunal found Dr Awan's account to be credible and consistent. It considered that given his account and Mr C' revised position, that these were not failures on his part. As such, the Tribunal found subparagraphs 1aii-avi not proved.

Paragraph 1av

23. The Tribunal then considered whether on 1 September 2016, Dr Awan consulted with Patient A and failed to investigate the likely diagnosis of exudative age related macular degeneration.

24. In his evidence, Dr Awan denied this was a failure for the reasons in response to the allegations above, namely that of Patient A's acute infection, pain, frailty, and co-morbidity. He stated that he could not put Patient A:

> '… through invasive investigation like FFA due to possible risk of causing his breathing difficulty worsening and exposing him to possible risks associated with FFA i.e. allergic reaction, anaphylactic shock or other respiratory or circulatory consequences.'

He said he acted according to the needs of that particular patient on that particular day.

25. In the circumstances, the Tribunal determined that this was not a failure on Dr Awan's part. As such it has found this subparagraph of the allegation not proved.

Paragraph 1avi

26. The Tribunal next considered whether on 1 September 2016, Dr Awan consulted with Patient A and failed to respond to the issues raised in the referral letter dated 22 August 2016.

27. In Dr Awan's evidence he stated that in relation to the issues raised in the referral letter dated 22 August 2016, the patient 'was advised and given an appointment to present in the clinic at a later date for investigations and possible management.' This is supported by his contemporaneous clinic note where he requests OCT/FFA in three weeks.

28. Accordingly, the Tribunal found this subparagraph of the allegation not proved.

Paragraph 1avii

29. The Tribunal then considered whether on 1 September 2016, Dr Awan consulted with Patient A and failed to record his reasoning and clinical findings for diagnosing herpes zoster opthalmicus.

30. In response to this subparagraph of the allegation, Dr Awan stated:

> 'vii) Herpes zoster diagnosis is purely based upon symptoms and obvious clinical signs in the distribution of nerve involvement and typical presentation over half side of forehead as seen on patient A.'

31. The Tribunal considered that while HZO may have obvious and typical signs that are self-evident for a diagnosis to be made. Dr Awan had a duty to make some record of his reasoning and clinical findings in making this diagnosis (eg. to assist colleagues who might later see the patient). As such, the Tribunal found this paragraph of the allegation proved.

Paragraph 1bi-1biii

32. The Tribunal next considered whether Dr Awan failed to record an adequate history, his examination of the anterior segments and performing a dilated retinal examination.

33. In his response to these subparagraphs of the allegation, Dr Awan stated:

> 'b)
>
> (i),(ii),(iii) Not true, for above reasons as I was asked by one of the nurses for help and advice regarding cannulating the patient and injecting the dye which would have caused increased distress to the patient. I took the most suitable action based on the symptoms & signs, in the best interest of the patient. I prescribed a course of oral anti viral tablets and an antibiotic eye ointment.

34. In regard to whether Dr Awan failed to record an adequate history, the Tribunal was of the view that Dr Awan did not record all relevant clinical information that he received and was able to provide to the Tribunal in person. The Tribunal found paragraph 1bi of the allegation proved.

35. In regard to paragraph 1bii and 1biii, the Tribunal noted that these allegations were drafted as alternatives to paragraphs 1ai and 1aii. The Tribunal considered that these allegations fell away given the Tribunal's findings in relation to paragraph 1aii and 1aiii above. Accordingly, the Tribunal found paragraph 1bii and 1biii of the allegation not proved.

Paragraph 1c

36. The Tribunal then considered whether Dr Awan inappropriately diagnosed and treated Patient A for herpes zoster opthalmicus.

37. Dr Awan had stated that he believed he had appropriately diagnosed and treated Patient A given the symptoms present. The Tribunal noted that the person accompanying Patient A had said that Patient A did have visual signs of a rash the day before. Further, the patient's appearance was such that a nurse had deemed him to be highly infectious and placed him in isolation. Dr Awan saw Patient A in isolation and this was recorded on Patient A's notes. Patient A was prescribed anti-viral medication for HZO by Dr Awan with a call back requested for three weeks later. Dr Awan said that he had allowed three weeks for Patient A to get his COPD under control and for the HZO infection to clear up. Anti-viral medication is clinically indicated within 72-hours of an HZO rash appearing. Three weeks later, there was no evidence of HZO recorded by a subsequent Opthalmic clinician. The Tribunal considered on the balance of probabilities, it was not inappropriate for Dr Awan to make such a diagnosis nor treat Patient A in this way. Mr C had indicated patients' responses to prompt treatment could vary but medication would only be effective if provided within 72-hours. Accordingly, the Tribunal found this paragraph of the allegation not proved.

Paragraph 2a

38. The Tribunal next considered whether on 9 September 2016, Dr Awan consulted with Patient B and failed to take an adequate history.

39. The Tribunal noted that Mr C was of the opinion that Dr Awan should have noted that there were no visual changes. In response to this part of the allegation, Dr Awan stated:

> '.. I have taken adequate history with the clinic notes mentioning Patient B as a 'diabetic of 15 years' and there were no other positive symptom or history or note.'

40. The Tribunal also considered Mr C contention that in the circumstances of a diabetic patient who had been subject to a review due to the suspicion of Ocular Ischaemic Syndrome (OIS) and peripheral ischaemia, the negative findings should also be recorded. The Tribunal heard that fuller notes are usually made for new patients with less full notes for patients who are being followed up. The Tribunal in looking through the patient's notes it had been provided with in this case, saw that this was indeed the pattern followed by a number of medics in this clinical environment. It therefore accepted Dr Awan's evidence on this point and it considered that he had not failed to take an adequate history as there were no new symptoms to document. Furthermore, visual acuities had been recorded and demonstrated that there was no change. Accordingly, the Tribunal found this subparagraph of the allegation not proved.

Paragraph 2b

41. The Tribunal next considered whether on 9 September 2016, Dr Awan consulted with Patient B and failed to adequately interpret Patient B's angiogram.

42. Dr Awan denied failing to adequately interpret Patient B's angiogram. In his response to this part of allegation he stated:

> '.. I have interpreted the angiogram correctly on the basis of the available images which were of poor quality. Based on this there was no obvious signs of ischemia correlating with my clinic examination of the peripheral fundus.'

43. In the hearing Mr C suggested that the photographs showed differences between the two eyes having an asymmetrical ischaemic retinopathy. He agreed with Dr Awan that it was 'highly unusual' for this to be present if OIS and carotid blockage had been excluded. In viewing the angiogram looking for evidence of ischaemia, Mr C' oral evidence was that there may be a range of clinical opinions given in its interpretation allowing different doctors to come to different decisions.

44. The Tribunal was of the view that Dr Awan did adequately interpret the angiogram he saw. However it became apparent well into the case that while angiograms of both the retina and iris had been performed, he had only reviewed the results of the retinal angiogram. This was the only angiogram result that had been uploaded onto the system at the time that Dr Awan saw Patient B, he said. The timing of the angiogram of the retina and iris and the time of Patient B's appointment with Dr Awan make this plausible.

45. Dr Awan arrived at his clinical decision that no treatment was required at this time for Patient B on the basis of the result available to him. Dr Awan also took into account Patient B's visual acuity, eye pressures and his carotid doppler results. Having subsequently had his attention drawn to images of the angiogram of the iris of Patient B in this hearing, Dr Awan agreed that had he seen it, he would have treated Patient B with injections in both eyes.

46. The case brought by the GMC was on the basis that Dr Awan did not adequately interpret the angiogram he saw rather than not seeing the angiogram of the iris which by his own admission would have led him to make a different diagnosis. Mr C said that he had based his report on Dr Awan and subsequent clinicians having access to the same material. If this was not the case, and taking into account the different judgements that could properly be made by clinicians it could explain why a different conclusion had been reached.

47. For all the reasons above paragraph 2b is not found proved.

Paragraph 2ci-ciii

48. The Tribunal next considered whether on 9 September 2016, Dr Awan consulted with Patient B and failed to diagnose rubeosis, ischaemia and leakage in the fundus fluorescein.

49. In response to the allegation of failing to diagnose rubeosis, Dr Awan stated in his evidence that:

> '… my clinical notes of 09/09/16 have drawing which shows Rubeosis (marked).'

50. The Tribunal accept Dr Awan's evidence on this point and had regard to the contemporaneous clinical note recorded. It determined that he did not fail to diagnose rubeosis. Given the concessions that Mr C made in his oral evidence, the Tribunal noted that the GMC counsel took a neutral position on this particular of the allegation and did not cross-examine Dr Awan on this point. As such paragraph 2ci of the allegation is found not proved.

51. The Tribunal heard from Mr C and Dr Awan that rubeosis can only occur if ischaemia present. As such, the Tribunal considered that Dr Awan did diagnose ischaemia. Accordingly, it found paragraph 2cii of the allegation not proved.

52. The Tribunal heard that both Dr Awan and Mr C agreed that there was leakage in the fundus fluorescein. However, the extent of the leakage and need to treat was a matter of clinical judgment with doctors making different decisions.

53. The Tribunal accepted Dr Awan's evidence. As such, it found paragraph 2ciii of the allegation not proved.

Paragraph 2d

54. The Tribunal next considered whether on 9 September 2016, Dr Awan failed to arrange an urgent follow-up within 2 weeks.

55. Dr Awan by his own admission acknowledged that had he seen the angiogram of the iris he would have considered that Patient B would benefit from treatment by injection within a 2 week period. However, given that at the time Dr Awan saw Patient B, only the angiogram of the retina was available, Dr Awan contends that he made the best decision he could on the basis of the information that was available at the time. The fact that Patient B was seen two weeks later when the clinician who had requested the angiogram of the retina and iris, saw the results and acted differently is not evidence that Dr Awan failed in his obligations.

56. Given the information that Dr Awan had at the time he saw Patient B, the Tribunal finds paragraph 2d not proved.

Paragraph 2e

57. The Tribunal next considered whether on 9 September 2016, Dr Awan failed to arrange laser treatment.

58. The Tribunal noted Mr C's evidence that different doctors could have different interpretations as to whether laser treatment was required. Given Dr Awan's interpretation, the Tribunal accepted that it was not a failure on his part to arrange laser treatment.

59. In Dr Awan's response to this allegation, he stated that:

> 'I did not arrange laser treatment as it was not warranted any urgent treatment on the basis of no new vascularisation at disc or elsewhere with a good visual acuity and normal intraocular pressure and no symptoms.'

60. The Tribunal accepted Dr Awan's evidence on this point and found that it was not a failure on his part to arrange laser treatment. Accordingly it found this sub-paragraph of the allegation not proved.

Paragraph 2f i-iii

61. The Tribunal next considered whether Dr Awan recorded his diagnoses of rubeosis, ischaemia and leakage in the fundus flourescein. In regard to rubeosis and ischaemia, the Tribunal relies on the decision it reached for paragraph 2ci and ii, that Dr Awan did record his finding for rubeosis and said that this cannot occur without some degree of ischaemia also. He contended that this was common medical knowledge within his specialism which was supported by Mr C. The Tribunal did consider that while Dr Awan did record 'no signs of ischaemia' on the patient's notes, this was intended to reflect his medical view that the ischaemia present was not clinically significant requiring urgent treatment. Accordingly, the Tribunal finds paragraph 2fi and 2fii not proved.

62. In regard to paragraph 2fiii, the Tribunal saw no indication of leakage in the fundus flourescein recorded on the patient's notes and Dr Awan by his own admission indicates he omitted to record this. Therefore the Tribunal found paragraph 2fiii proved.

The Tribunal's Overall Determination on the Facts

63. The Tribunal has determined the facts as follows:

> **Paragraph 1**
> On 1 September 2016 you consulted with Patient A and you:
>
> a. failed to:

i. take an adequate history **Not proved**

ii. examine the anterior segments; **Not proved**

iii. perform a dilated retinal examination; **Not proved**

iv. order an urgent Ocular Coherence Tomography scan; **Not proved**

v. investigate the likely diagnosis of exudative age related macular degeneration; **Not proved**

vi. respond to the issues raised in the referral letter dated 22 August 2016; **Not proved**

vii. record your reasoning and clinical findings for diagnosing herpes zoster ophthalmicus; **Determined and found proved**

b. in the alternative to paragraph 1ai to 1aiii, failed to record:

i. an adequate history; **Determined and found proved**

ii. your examination of the anterior segments; **Not proved**

iii. performing a dilated retinal examination; **Not proved**

c. inappropriately diagnosed and treated Patient A for herpes zoster ophthalmicus. **Not proved**

2. On 9 September 2016 you consulted with Patient B and you failed to:

a. take an adequate history; **Not proved**

b. adequately interpret Patient B's angiogram; **Not proved**

c. diagnose:

i. rubeosis; **Not proved**

ii. ischaemia; **Not proved**

iii. leakage in the fundus fluorescein; **Not proved**

d. arrange an urgent follow-up within 2 weeks; **Not proved**

e. arrange laser treatment; **Not proved**

f. in the alternative to paragraph 2c, record a diagnosis of:

i. rubeosis; **Not proved**

ii. ischaemia; **Not proved**

iii. leakage in the fundus flourescein. **Determined and found proved**

Determination on Impairment - 07/12/2018

1. Following the conclusion of the facts stage, Dr Awan made an application that the hearing should not proceed to the impairment stage. The Tribunal refused this application. The Tribunal's full decision on the application is included at Annex A.

2. 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 Awan's fitness to practise is impaired by reason of misconduct.

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, Dr Awan provided further oral evidence at this stage. He also provided the Tribunal with a bundle of documents which included his Curriculum Vitae and various supportive testimonials.

4. In his oral evidence, Dr Awan spoke of his considerable charity work for a non-governmental organisation, keeping his clinical work in ophthalmology up-to-date. This was supported by testimonials from those who had worked with him in the eye clinics that he had helped to set up. He said that he audited his practice and that the complication rate for his eye surgery was lower than the reported average. He invited the Tribunal to consider the effect any restrictions would have on the faith his patients have in him. He invited the Tribunal to consider his thirty years working in ophthalmology in which there have not been any other concerns raised about his practice.

5. When asked by the Tribunal how he would change his practice going forward, Dr Awan stated that he had learnt his lesson. He indicated that he would continue his good practice of taking a detailed clinical history but that he would be very careful in making notes, ensuring they are clear, legible and detailed.

Submissions

6. Mr Rose submitted that the GMC was neutral in regard to impairment. While he did not make a positive submission on impairment, Mr Rose invited the Tribunal to consider the expert report of Mr C, particularly the findings that Dr Awan's record keeping was below the standard expected.

7. Mr Rose submitted that the following paragraphs of *Good Medical Practice 2013* (GMP) were relevant in this case:

> 19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.
>
> 21. Clinical records should include:
> a) relevant clinical findings
> b) the decisions made and actions agreed, and who is making the decisions and agreeing the actions
> c) the information given to patients
> d) any drugs prescribed or other investigation or treatment
> e) who is making the record and when.

8. Dr Awan submitted that his fitness to practise was not impaired by reason of his misconduct, and his wrongdoing did not meet the threshold of misconduct which was serious.

The Relevant Legal Principles

9. 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.

10. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted in any finding of impairment. First, the Tribunal must consider whether the facts as found proved amounted to misconduct, and such misconduct must be serious. Secondly, if there is finding of misconduct that is serious, the Tribunal must go on to consider in light of all the relevant factors known about the doctors, whether by reason of that misconduct the doctor's fitness to practise is impaired.

11. The Tribunal must determine whether Dr Awan's fitness to practise is impaired today, taking into account Dr Awan's conduct at the time of the events and any relevant

factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

The Tribunal's Determination on Impairment

12. The Tribunal first considered whether the facts as found proved amounted to misconduct.

13. The Tribunal had regard to Mr C' expert opinion that Dr Awan's failures to record an adequate history fell below the standard of care expected rather than seriously below.

14. The Tribunal was satisfied that Dr Awan's note taking was below the standard required by GMP. However, it did not consider that this conduct fell so far short of the standard expected as to amount misconduct that was serious. In reaching this conclusion the Tribunal took account of the evidence before it, including the patient notes of Patients A and B which had entries made by other clinicians and the evidence of Mr C.

15. The Tribunal considered that Patient A must have had physical signs present as it lead to the nurse in the outpatient clinic to have suspected HZO and placed patient A into isolation. Dr Awan confirmed the spot diagnosis. As spot diagnoses can be made by clinicians in circumstances where the symptoms are self-evident the Tribunal found, albeit that additional details are always helpful in circumstances where other clinicians will have to read patient notes, that such behaviours could not be considered to be serious misconduct.

16. Nonetheless, the Tribunal considered that this did not abnegate the need for Dr Awan to explain his clinical findings. While the Tribunal considered that his actions breached paragraphs 19 and 21 of GMP, the Tribunal accepted Dr Awan's evidence at this stage that he generally does make good notes, is 'always praised' in 360 feedback for his note taking, and how in future he will be more scrupulous, making notes legible and placing less reliance on abbreviations, so that these could be relied upon by others without difficulty. Moreover, Dr Awan indicated he is amenable to further training by working in a fellowship or registrar type roles. The Tribunal considered this to be indicative of his positive attitude to improvement and ongoing learning.

17. Having found that the facts found proved do not amount to serious misconduct, the Tribunal has stopped here. The first part of the two-stage test has not been satisfied. The Tribunal has therefore determined that Dr Awan's fitness to practise is not impaired by reason of misconduct.

Determination on Warning - 07/12/2018

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

Submissions

2. On behalf of the GMC, Mr Rose invited the Tribunal to impose a warning in this case. He submitted that both patients were not Dr Awan's regular patients and Dr Awan should have made more substantial records to help subsequent clinicians dealing with these patients' cases. Mr Rose submitted that it is fundamental to ongoing patient care that other clinicians are able to rely on accurate patients' notes. He submitted that Dr Awan's failings could have hampered further care.

3. Dr Awan submitted that a warning was not appropriate in this case. He invited the Tribunal to consider the effect a warning would have on his career ambitions in relation to his overseas charity work in a part of the world where he said there was urgent need for this. He submitted he had learned from his mistakes and would never repeat them.

The Tribunal's Determination on Warning

4. In making its decision, the Tribunal has considered the submissions made by both parties and the GMC's Guidance on Warnings (February 2018 edition) ('the Guidance').

5. The Tribunal had regard to the test for issuing a warning as outlined in the Guidance, which advises that:

> 16. A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:
>
> - there has been a significant departure from Good Medical Practice ('GMP')

6. The Tribunal also had regard to the factors as outlined in the Guidance, particularly the following paragraph:

> 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.

…

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).

7. The Tribunal considered paragraphs 19 and 21 of GMP. It was noted that although there were areas of omission, Dr Awan had also complied with many points listed in paragraphs 19 and 21. It was the view of the Tribunal that Dr Awan's clinical note taking was sufficient to allow safe ongoing clinical care. As such the Tribunal considered that this could not be considered to reach the threshold of significant breaches.

8. The Tribunal also bore in mind Mr C' evidence that Dr Awan's note keeping was below the standard expected rather than seriously below that standard.

9. The Tribunal had regard to the concerns raised and matters found proved against Dr Awan. It paid particular regard to subparagraph (c) as set out in paragraph 20 of the Guidance. In considering the degree to which Dr Awan's omissions affected patient care, public confidence and the reputation of the profession, the Tribunal had especial regard to risk. The omissions that Dr Awan made in his note taking were considered in themselves not to be 'sufficiently serious' as set out in subparagraph (c) to require a formal response.

10. Accordingly, the Tribunal determined that Dr Awan's failures were not so serious to warrant a formal warning on his registration. The Tribunal considered that this would be disproportionate in the circumstances.

XXX

Confirmed
Date 07 December 2018 Ms Melissa Coutino, Chair

ANNEX A – 06/12/2018

Application that the hearing should not proceed to the impairment stage

1. At the conclusion of the facts stage, Dr Awan made an application that the case should not proceed further. He submitted that the facts found proved did not warrant proceeding to the impairment stage.

2. Mr Rose submitted that the GMC was neutral in regard to impairment.

Tribunal decision

3. The Tribunal was mindful that some facts which have been found proved amounted to breaches of GMP. Bearing in the mind the overarching objective, the Tribunal considered that it was appropriate to go on to consider the next stage and consider impairment.