PUBLIC RECORD

Dates: 01/07/2024 - 19/07/2024

Medical Practitioner's name:	Dr Hassan EL TERAIFI
GMC reference number:	3234200
Primary medical qualification:	MB ChB 1977 University of Baghdad

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Consideration of impairment not reached

Summary of outcome

Voluntary erasure

Tribunal:

Legally Qualified Chair	Mr Robin Ince
Lay Tribunal Member:	Ms Catherine Pease
Medical Tribunal Member:	Dr Janet Nicholls

Tribunal Clerk:	Miss Hinna Safdar - 01/07/2024 to 03/07/2024 Ms Fiona Johnston - 04/07/2024 Miss Jemine Pemu - 04/07/2024 to 12/07/2024, 19/07/2024 Mrs Anne Bhatti – 15/07/2024 Ms Angela Carney – 18/07/2024

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Stephen Brassington, Counsel, instructed by Weightmans
GMC Representative:	Ms Faye Rolfe, 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 - 17/07/2024

1. Dr El Teraifi qualified in 1977 with a MBChB from Baghdad University Medical School, Iraq. Dr El Teraifi came to the UK in 1981 where he worked as a Senior House Officer/ Registrar at the Royal London and St Andrews Hospital, London until 1986. He then took up a Registrar position at the Queen Elizabeth II Hospital between August 1986 and September 1987. After he qualified, he spent a number of years working as a pathologist in both the UK and the Middle East and has over 40 years of post-qualification experience.

2. At the time of the events which gave rise to the Allegation, Dr El Teraifi was practising first as a locum histopathologist from March 2016 to June 2019 at NHS Ayrshire and Arran ("Arran") after which he worked as a consultant locum histopathologist at Salisbury NHS Foundation Trust from 10 June 2019.

3. The allegation that has led to Dr El Teraifi's hearing can be summarised as that on 10 June 2019, whilst working as a locum doctor at Salisbury NHS Foundation Trust ("Salisbury") Dr El Teraifi sought to conceal information relating to restrictions placed on his practice by Arran, on or around 31 May 2018.

4. It is additionally alleged that on 28 August 2019, whilst employed at the Royal Devon and Exeter NHS Foundation Trust ("Royal Devon") Dr El Teraifi sought to conceal information relating to the early termination of his contract by Salisbury due to concerns about his clinical capabilities. It is alleged that Dr El Teraifi's actions in concealing the information were dishonest.

5. It is further alleged that Dr El Teriafi provided poor clinical care to seven patients between 5 May 2018 and July 2019, including failures in respect of clinical diagnoses made.

6. The initial concerns were raised with the GMC on 25 September 2019 by Dr L, Medical Director/Deputy Chief Executive of Salisbury. The Trust then carried out a local investigation.

The Outcome of Applications Made during the Facts Stage

7. On 2 July 2024, the Tribunal granted the GMC's application made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the

Rules'), to amend the Allegation and withdraw paragraphs 7 and 8. Mr Stephen Brassington, Counsel, on behalf of Dr El Teraifi did not oppose the application.

8. On 4 July 2024, the Tribunal granted the GMC's application made pursuant to Rule 17(6) the Rules, to amend the Allegation and withdraw paragraph 6b. Mr Brassington, Counsel, on behalf of Dr El Teraifi did not oppose the application.

9. On 10 July 2024, the Tribunal granted the GMC's application made pursuant to Rule 17(6) the Rules, to amend the Allegation and withdraw paragraph 10. Mr Brassington, Counsel, on behalf of Dr El Teraifi did not oppose the application.

10. On 12 July 2024 the Tribunal granted Mr Brassington's application on behalf of Dr El Teraifi to Rule 17(2)(g), that there was no case to answer in relation to paragraphs 1, 2, 3, 4, 12, 13, 14, 16 and 17 of the Allegation. The Tribunal refused the application in relation to paragraph 5 of the Allegation. The Tribunal's full decision can be found at Annex A.

11. On 15 July 2024 the Tribunal granted the GMC's application made pursuant to Rule 17(6) the Rules, to amend the allegation and withdraw paragraph 15. Mr Brassington, Counsel, on behalf of Dr El Teraifi did not oppose the application.

The Allegation and the Doctor's Response

12. The Allegation made against Dr El Teraifi is as follows:

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

NHS Ayrshire and Arran restrictions

~~1. Between around July 2016 and March 2019, you worked as a locum doctor at University Hospital Crosshouse for NHS Ayrshire and Arran, and on or around 31 May 2018 your practice there was made subject to the restrictions set out in Schedule 1 ('the Restrictions').~~ Deleted under Rule 17(2)(g)

~~2. On 10 June 2019, you began working as a locum doctor at Salisbury NHS Foundation Trust ('Salisbury') and you failed to ensure that:~~

~~a. a responsible person at Salisbury;~~ Deleted under Rule 17(2)(g)

~~b. an appropriate person at RM Medics who placed you at Salisbury,~~ Deleted under Rule 17(2)(g)

~~was made aware of the Restrictions.~~

~~3. You knew you should have ensured that:~~

~~a. a responsible person at Salisbury;~~ Deleted under Rule 17(2)(g)

~~b. an appropriate person at RM Medics,~~ Deleted under Rule 17(2)(g)

~~was made aware of the Restrictions.~~

~~4. Your failure as described at:~~

~~a. paragraph 2a was:~~

~~i. designed to conceal the Restrictions from Salisbury;~~ Deleted under Rule 17(2)(g)

~~ii. dishonest by reason of paragraphs 3a and 4ai;~~ Deleted under Rule 17(2)(g)

~~b. paragraph 2b was:~~

~~i. designed to conceal the Restrictions from RM Medics;~~ Deleted under Rule 17(2)(g)

~~ii. dishonest by reason of paragraphs 3b and 4bi.~~ Deleted under Rule 17(2)(g)

Clinical concerns

5. On or around 5 May 2018, you prepared a histopathology report on Patient A and you failed to diagnose ductal carcinoma in situ. To be determined

6. On or around 17 June 2019, you prepared a histopathology report on Patient B and you failed to:

a. establish a diagnosis of lentigo maligna; Admitted and found proved

~~b. mention the possibility of a blue nevus.~~ Withdrawn under Rule 17(6)

~~7. On or around 19 June 2019, you prepared a histopathology report on Patient C and you failed to identify a focus of carcinoma.~~ Withdrawn under Rule 17(6)

~~8. On or around 20 June 2019, you prepared a histopathology report on Patient D and you made an unequivocal diagnosis of dermatofibroma when other possibilities should have been considered, and were suggested by the clinical details.~~ Withdrawn under Rule 17(6)

9. On or around 21 June 2019, you prepared a histopathology report on Patient E and you failed to identify a pathological process and, as a result, you did not

provide any explanation of their symptoms or consider potential treatable causes for them. Admitted and found proved

10. ~~On or around 27 June 2019, you prepared a histopathology report on Patient F and you failed to identify the presence of dysplasia.~~ Withdrawn under Rule 17(6)

11. On or around 2 July 2019, you prepared a histopathology report on Patient G and you failed to make a diagnosis of idiopathic inflammatory bowel disease consistent with Crohn's disease. Admitted and found proved

Royal Devon and Exeter NHS Foundation Trust ('the Trust')

~~12. On or around 28 August 2019, you started a locum contract at the Trust, and you failed to notify:~~

~~a. a responsible person at the Trust, such as the clinical lead;~~ Deleted under Rule 17(2)(g)

~~b. an appropriate person at Independent Clinical Services ('ICS'), the agency who had placed you at the Trust,~~ Deleted under Rule 17(2)(g) ~~in a timely manner that your previous contract at Salisbury had been terminated early due to concerns about your clinical capabilities and/or that Salisbury were investigating your clinical practice.~~

~~13. You knew you should have told:~~

~~a. a responsible person at the Trust, such as the clinical lead;~~ Deleted under Rule 17(2)(g)

~~b. an appropriate person at ICS,~~ Deleted under Rule 17(2)(g) ~~of the matters referred to at paragraph 12.~~

~~14. Your actions as described at paragraph 12 were:~~

~~a. designed to conceal from the Trust that concerns had been raised at Salisbury about your clinical performance and/or that as a consequence, your contract had been terminated early;~~ Deleted under Rule 17(2)(g)

b. ~~dishonest by reason of paragraphs 13a and/or 13b and 14a~~. Deleted under Rule 17(2)(g)

15. ~~On a date around 2 October 2019, you made the statements set out in Schedule 2 to Dr H, or words to that effect, after he asked you "what was the story at Salisbury?", or words to that effect.~~ Withdrawn under Rule 17(6)

~~16. You knew that the information as set out in Schedule 2 would give a false impression of what had happened at Salisbury in that you:~~

~~a. did not work 60 hours a week;~~ Deleted under Rule 17(2)(g)

~~b. knew that Salisbury were investigating your work after your initial two weeks, and that concerns had been raised.~~ Deleted under Rule 17(2)(g)

~~17. Your actions as described at paragraph 15 were dishonest by reason of paragraphs 16a and 16b.~~ Deleted under Rule 17(2)(g)

The Admitted Facts

13. At the outset of these proceedings, through his counsel, Mr Brassington, Dr El Teraifi made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

14. In light of Dr El Teraifi's response to the Allegation made against him, the Tribunal is required to determine the outstanding paragraph 5 of the Allegation.

Factual Witness Evidence

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

- Dr I, Associate Medical Director for Women's, Children's and Diagnostic Services at Area Laboratories, formerly the Clinical Director from 2017 until 2022, by video link;
- Dr J, consultant histopathologist at Salisbury District Hospital ('Salisbury'), by video link.
- Ms K, Group Clinical Director of the Acacium Group (formally Independent Clinical Services ('ICS'));
- Dr H, Consultant Histopathologist at Royal Devon & Exeter NHS Foundation Trust ('RDE');

16. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Ms M, former Interim Head of Medical Staffing and Employee Relations at Royal Devon and Exeter NHS Foundation Trust ('the RDE');
- Dr N, Responsible Officer and Chief Medical Officer of Salisbury NHS Foundation Trust ('the Trust').

17. Dr El Teraifi provided his own witness statement, dated 10 June 2024. Dr El Teraifi did not give oral evidence at the hearing. Prior to the closing of Dr El Teraifi's case on facts, Mr Brassington asked the Tribunal to disregard Dr El Teraifi's witness statement.

Expert Witness Evidence

18. The Tribunal also received written expert reports and heard oral evidence from three expert witnesses called by the GMC. This evidence was directed at assisting the Tribunal in understanding whether Dr El Teraifi's reporting for each of the 7 patients was adequate and appropriate and if not, why not.

19. Professor O gave evidence by video link and provided an expert report dated 5 May 2023 in respect of paragraph 5 of the Allegation. He is a Consultant Histopathologist working in the NHS and independent private practice and visiting Professor at the University of Kent.

20. Professor P provided an expert report dated 13 October 2021. He is a Consultant Histopathologist and former director of examinations for the Royal College of Pathologists. Professor P was due to give evidence to the Tribunal in relation to paragraphs 6, 7, 8, 9 and 11 of the Allegation. However, as paragraphs 6a, 9 and 11 were admitted by Dr El Teraifi and paragraphs 6b, 7 and 8 of the Allegations had been withdrawn by the GMC, Professor P did not give any oral evidence to the Tribunal.

21. Professor Q gave evidence by video link and provided an expert report dated 13 February 2023 in relation to pargaraph 11 of the Allegation. She is a professor of Practice in Histopathology and Consultant Histopathologist at Imperial College London and Imperial College Healthcare NHS Trust. Following her oral evidence, the GMC withdrew pargaraph 11 of the Allegation.

22. The Tribunal also received a written expert report and heard oral evidence from one expert witness called on behalf of Dr El Teraifi. Professor R gave evidence by video link and provided an expert report dated 28 March 2024. He is an Emeritus Professor of Histopathology at Barts Cancer Institute, Barts and the London School of Medicine and Dentistry, Queen Mary University of London. Professor R gave evidence in relation to paragraphs 6a, 6b, 7, 8, 9 of the Allegation.

23. A joint expert report was prepared by Professor O and Professor R dated 28 June 2024. In addition, a joint expert report was prepared by Professor P and Professor R, also dated 28 June 2024.

24. A further joint expert report was prepared by Professor Q and Professor R dated 1 July 2024.

Documentary Evidence

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

- Exhibits to Ms K witness statement, various dates;
- Exhibits to Dr N witness statement, various dates;
- Exhibits to Dr J witness statement, various dates;
- Exhibits to Dr H witness statement, various dates;
- Exhibits to Ms M witness statement, various dates;
- Exhibits to Dr I witness statement, various dates;
- Original histology reports for Patients A, B, C, D, E, F and G, various dates.

Submissions

26. The Tribunal decided to include detailed submissions made by the parties on the facts due to the technical nature of the evidence relating to paragraph 5 of the Allegation.

On behalf of the GMC

27. Ms Rolfe submitted that the key points to consider in relation to paragraph 5 of the Allegation are essentially (i) the Tribunal's decision as to whose expert opinion it prefers and (ii) whether this was a B2 error or a B1 error.

28. Professor O in his expert report originally stated that this was a case where some people may well conclude that this was B2 error, but his opinion was that it was a B1 error. Professor O concluded that, despite there being a lack of consensus at the multidisciplinary team meeting and despite a number of points (gleaned from the report of Professor R) which had been put to Professor O in cross-examination, this was still, in his view a serious error because it was so easily recognisable as ductal carcinoma in situ ("DCIS").

29. Ms Rolfe submitted that Professor O said that the description of the error as a B2 error, (because one small clump that had been missed) did not fit the reality of the matter since this was a sample that had two clear areas of DCIS. This was very clear in the slide A1, and that being missed, along with all of the other indicators, meant that this could be correctly categorised as serious enough to form a B1 error.

30. Ms Rolfe submitted that Professor R's view was that this was essentially one example of DCIS, notwithstanding that there were two ducts present. All the other criticisms of Dr El Teraifi flowed from that one failure to notice essentially that. All of the other suggestions on

the three slides and in the clinical report were not conclusive of it being DCIS, but just factors that could well be commensurate with another diagnosis.

31. Ms Rolfe submitted that Professor O's evidence was that all of those facts, taken together, were matters that would have, to an experienced consultant histopathologist, been easily recognisable, albeit they may not have been determinative.

32. Ms Rolfe submitted that Professor O's downgrading of some of the paragraphs of the Allegation had resulted in some of the paragraphs of the Allegation being withdrawn, which was testimony to his balanced approach.

33. Ms Rolfe referred the Tribunal to Professor R's evidence where none of his opinions had changed from his report, he had not made any concessions and he stood by all of the gradings that he gave in the first instance. She submitted that could be because Professor R thinks he was right and he probably believes himself to be right, but it could be that he simply was not prepared to move on any of his opinions because he is so eminent in his field.

34. However, she submitted that all the professors from whom the Tribunal had heard are experienced in their field, including Professor O. She submitted that the Tribunal should therefore take into account his views as equally as it would Professor R's and weigh in them in balance.

35. Ms Rolfe submitted that the experts' evidence was that if it was a B2 error then it was not seriously below the standards expected of a consultant histopathologist and if it was a B1 error then that was seriously below the standards expected of a consultant histopathologist. Accordingly, if the Tribunal agreed with Professor O that this was a B1 error, then it was to find the charge proved; if it agreed with Professor R that it was a B2 error, then it was to find the charge not proved.

<u>On behalf of Dr El Teraifi</u>

36. Mr Brassington reminded the Tribunal that the burden of proof was on the GMC. He submitted that the question to be asked was, in essence, "was this a B1 or a B2 error"?

37. Mr Brassington referred the Tribunal to Professor O's expert report which stated that, even with the slides that he had, Professor O indicated that further levels would still be helpful in the analysis of this very poor sample. He submitted that there was no disagreement that it was a poor sample, it was a poor sample of scant material, much of which was blood clot, and there were only tiny fragments of breast tissue from which to conduct the exercise.

38. Mr Brassington submitted that in comparing the two experts' respective expertise, it was to note that Professor R was the 'Histopathologist's pathologist'. He was as eminent as it gets, and his work, which was extraordinary over decades, was recognised as such, and for that reason Mr Brassington invited the Tribunal to have regard to the experts' respective experience. Professor R made no concessions because he was right and it was not as if

Professor R had simply, as a blanket statement, said, that everything that happened here was 'okay'. Mr Brassington submitted that Professor R had been very critical of Dr El Teraifi in three cases, and he had offered criticism where it was merited in his judgement and he has, of course, understood his duty as an independent expert. In this case he was fair and even handed.

39. Mr Brassington invited that Tribunal to contrast that approach with Professor O who had offered the Tribunal a range of opinion in respect of whether this was a B1 or B2 error. Professor O had said in his original report that there would be a range of opinion amongst experts as to whether or not this was a B1 or a B2 error, he said the distinction between the two in this particular case was "difficult". Professor O went on to talk about the fragmentation of the small biopsy and the fact that much of the tissue was benign and he would "tend" to classify the discrepancy as B1. Professor O went on to say that it was "borderline" on a B2 discrepancy and there would be a range of opinions in this regard in his summary.

40. Mr Brassington referred the Tribunal to the joint expert report whereby Professor O reiterated the fact that he would say that this could be either a B1 or a B2 error. Mr Brassington submitted that Professor O '*flip-flopped on this*'. He had gone from B1 or B2 to a hardening of his position on B1 when he agreed with Mr Brassington in cross examination. He submitted that this contrasted with Professor R, who has been steadfast in his judgement that it was a B2 error.

41. Mr Brassington further submitted that Professor R was also reasonable when engaging with the suggestion of confirmation bias in his oral evidence. He submitted that this was in contrast to the approach taken by Professor O, who could not contemplate that such would impact upon his judgement. Professor R had mentioned the lack of consensus in the multidisciplinary meeting and the departmental discussions in his report. It was right that the Tribunal had no evidence as to who it was that was engaged in the multidisciplinary meeting and the departmental discussions. Mr Brassington did not invite the Tribunal to speculate about that as Dr El Teraifi had not given evidence on this. However, the Tribunal knew as a fact that the sample was sent out to a specialist breast histopathologist at Glasgow for her to make a judgement about it and therefore further work was done. This was a fact that could be taken into account, namely that the lack of consensus fitted into a B2 definition.

42. Mr Brassington submitted that Professor R was plainly eminent, he was critical when he needed to be, was fair and even handed. He submitted that the GMC had failed to establish why the Tribunal should ignore the opinion of Professor R following testing of his evidence. He submitted that it was a question for experts because there was a failure to diagnose DCIS and that was a failure that one could expect a number of consultant histopathologists to make. It was a B2 error, and it was not something which could amount to falling far below the appropriate standard.

43. Mr Brassington agreed with the Tribunal that the word 'failure' in the charge meant that a B1 error would have had to be made, not a B2 error.

The Tribunal's Approach

44. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and the standard of proof is the balance of probabilities, which is often expressed as 'more likely than not', or 'more probable than not', no more and no less, there is no sliding scale commensurate with the seriousness of any allegation. The GMC has to prove its case by at least 50.1%; this conversely means that there is room for 49.9% of doubt and also means that if the Tribunal found matters finely balanced at 50/50, the GMC has failed to prove its case. Further, as the burden of proof is on the GMC, the doctor does not have to prove anything.

45. The Tribunal is required to decide just one outstanding charge. Both parties have agreed that the case turns upon the Tribunal's view of the opinions of the respective experts, Professor O for the GMC and Professor R for Dr El Teraifi. In relation to the expert evidence, the Tribunal reminded itself that, when considering expert evidence and deciding what weight to give to it, it was entitled to take account of: the expert's expertise and experience in their chosen field of medicine; whether they have based their findings on evidence or mere supposition; whether they have been objective; whether they have been consistent in their views and if not, the reasons for any change in such; and whether, in the Tribunal's opinion, their reasoning was sound and based upon the evidence before them.

The Tribunal's Analysis of the Evidence and Findings

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

Paragraph 5

47. The Tribunal considered whether Dr El Teraifi, on 5 May 2018, prepared a histopathology report on Patient A and failed to diagnose ductal carcinoma in situ.

48. As to the meaning of paragraph 5 of the Allegation, it is accepted by all that a misdiagnosis took place. The issue was whether this amounted to a 'failure'. For the purposes of this case, both parties agree that the GMC puts its case on the basis that the failure had to be serious enough to amount to a B1 error and not to a B2 error. If the Tribunal found that it was a B2 error, the paragraph of the Allegation fails; if the Tribunal found that it was a B1 error, it is proved. Further, the parties agreed that, if the Tribunal found the charge proved, this does not mean that the Tribunal has prejudged any decision it has to make at the Impairment stage when it comes to deciding whether the facts proved amount to Misconduct, which requires Dr El Teraifi's failures to amount to a falling far below the standards expected.

49. Once again, due to the techincal nature of the issues before the Tribunal, it has included direct quotations from the respective reports of Professor O and Professor R.

50. The Tribunal bore in mind the following part of Professor O's expert report dated 5 May 2023:

> *'3. OPINION*
>
> *3.01 These are scanty breast biopsies and much of the material presented is blood clot and tiny fragments of benign breast parenchyma. However, in slides labelled A1, there are two fragments which contain small areas of DCIS of high nuclear grade. One of these areas has an irregular outer border and whilst definite microinvasion is not seen, further levels could be helpful.*
>
> *3.02 The initial report issued by Dr H El Teraifi on 5 May 2018 is as follows "Microscopy shows apocrine metaplasia, duct ectasia, fibrosis, chronic inflammatory cell infiltration, epitheliosis and benign microcalcification. There is no evidence of malignancy. Conclusion: Benign (B2)".*
>
> *3.03 I do not agree with this report. Whilst the amount of DCIS present in these scanty biopsies is small, failure to recognise the atypical epithelial changes and incorrectly classifying the intraductal epithelial proliferation as epitheliosis and apocrine change falls below the standard expected of a reasonably competent Consultant Histopathlogist. Failure to recognise and report the presence of necrosis or to highlight the significance of the large foci of coarse microcalcification dismissing these as benign also suggests lack of diagnostic skill or failure to undertake careful and thorough morphological examination of the slides.*
>
> *3.04 Using the Royal College of Pathologists' system of categorisation for discrepancies, this could be classified as either a B1 discrepancy (A diagnosis that one is surprised to see from any pathologist e.g. an obvious cancer reported as benign) or a B2 discrepancy (A diagnosis that is fairly clearly incorrect, but which one is not surprised to see a small percentage of pathologists suggesting e.g. a moderately difficult diagnosis, or missing a small clump of malignant cells in an otherwise benign biopsy).*
>
> *3.05 Distinction between an RCPath B1 and B2 discrepancy is difficult in this case. The biopsies are small and fragmented, and much of the tissue submitted is benign. However, the standard expected for a pathologist reporting breast cancer screening biopsies is high, and the clinical information provided suggested a malignant diagnosis, specifically high grade DCIS (M4 with microcalcification). On this basis, I would tend to classify the discrepancy as a B1 discrepancy, but there could be a range of opinion in this regard*
>
> *…*
>
> *4.01 The reporting of breast biopsies on patient [A] reference 18P07036 by Dr H El Teraifi on 5 May 2018 was incorrect and represents a breach of duty of care in*

medicolegal terms, and a discrepancy classified by RCPath as B1 or B2. I favour a B1 discrepancy (A diagnosis that one is surprised to see from any pathologist e.g. an obvious cancer reported as benign), but it is borderline on a B2 discrepancy (A diagnosis that is fairly clearly incorrect, but which one is not surprised to see a small percentage of pathologists suggesting e.g. a moderately difficult diagnosis, or missing a small clump of malignant cells in an otherwise benign biopsy). There could be a range of opinions in this regard.

4.02 I am specifically asked to give my opinion of the overall standard of care provided by Dr El-Teraifi compared to that of a reasonably competent Consultant in Histopathology, in particular whether it was below the standard expected/below but not seriously below the standard expected/seriously below the standard expected. Where my opinion is that the standard of care was either below, or seriously below the expected standard, I am asked to provide reasons why.

4.03 In my opinion, as stated above, the report of Dr El-Teraifi is clearly below the standard expected. I have tried to lay out in the report above that there is likely to be a range of expert opinion as to whether this is below but not seriously below the standard expected, or is seriously below the standard expected.

4.04 In my opinion, failure to diagnose DCIS in this case, when there are a number of microscopic features which indicate its presence, namely comedo-type necrosis, cytological atypia, mitotic activity and coarse stromal microcalcification, falls seriously below the standard expected for a competent Consultant Histopathologist. In addition, the biopsy-taker indicated a high level of suspicion of malignancy by using the M4 mammographic imaging classification (this is classification is similar to the biopsy classification listed above). This M4 classification should have increased the vigilance of the reporting pathologist.

51. The Tribunal bore in mind Professor R's expert report dated 13 May 2024:

'(a) My review: Lab No 18P/70365 This is the biopsy of the left breast taken on 3rd May 2019 and reported by Dr El Teraifi on 5th May 2019. I note that the clinical details given on the form state: 'Screen detected M4 calc'.

The specimen was described as: '14G stereo biopsy calcs breast (L)': multiple fibro-fatty cores and fragments received in three cell safe cassettes ranging from 1 to 8 mm.

Histological examination shows that there are three series of slides: A1 shows fragments of breast tissue and two of these show clear solid type DCIS, one with comedonecrosis. There is also a focus of coarse microcalcification. There is no evidence of invasive carcinoma. A2 shows blood clot and fragments of adipose tissue, with foci of coarse microcalcification and bland ductal epithelium. A3 shows fragments

of adipose tissue and atrophic breast parenchyma with no evidence of DCIS or malignancy.

The appearances are those of ductal carcinoma in situ (DCIS) of the breast. There is no evidence of invasive carcinoma.

(b) Dr El Teraifi's report: he advised that this showed apocrine metaplasia, duct ectasia, fibrosis, chronic inflammatory cell infiltration, epitheliosis and benign microcalcification. There is no evidence of malignancy. Conclusion: Benign (B2)".

At a MDT review of this case, concerns were noted and there was no consensus within the department. It was referred for external review and a Dr X from the Queen Elizabeth Hospital in Birmingham made a diagnosis of DCIS of high nuclear grade. There was no invasive carcinoma.

(c) Professor O's report: he advises that there are fragments which contain small areas of DCIS of high nuclear grade with large foci of coarse microcalcification should raise suspicion of nearby DCIS.

He disagrees with Dr El Teraifi's initial report says failure to recognise the atypical epithelial changes or to highlight the significance of the large foci and more falls below the standard of a reasonably competent consultant histopathologist and suggests a lack of diagnostic skill. Dr El Teraifi not only failed to recognise the presence of DCIS, but failed to indicate any suspicion of atypia or possible malignancy.

There is likely to be a range of expert opinion as to whether this is a B1 or a B2 error, but Dr El Teraifi classified the case as B2 (benign) when in fact it was B5a (non-invasive. He should also have noted the high degree of clinical suspicion (M4).

(d) My analysis: Dr El Teraifi advised that this case showed no evidence of malignancy and graded it a benign B2 when in fact there were two foci of DCIS. I note that in this case there was a departmental review, and that no consensus was reached. As Professor O remarks, these are scanty breast biopsies and much of the material presented is blood clot and tiny fragments of benign breast parenchyma, and I would advise that this is a B2 error - (a diagnosis that is fairly clearly incorrect, but which one is not surprised to see a small percentage of pathologists suggesting e.g. a moderately difficult diagnosis or missing a small clump of malignant cells in an otherwise benign biopsy) - here the latter.

(e) Conclusion: I would therefore advise that this case is one where a similar report would have issued by a number of consultant histopathologists, and it is therefore not below the standard expected of a consultant histopathologist. However, the duty of care score is high since the patient could have been discharged only to return with invasive carcinoma and metastases and would be 5 (major harm).

52. The Tribunal noted that, in his oral evidence, Professor O agreed that calcification (which occurred when cells died) could be seen but that the fragments did not look malignant. However, in his view, this should have made Dr El Teraifi look harder. The diagnostic material was small compared to the material present, but it was enough to demonstrate DCIS. He "would expect" it to have been noticed. In cross-examination, Professor O agreed that he had used descriptions such as: it was a "difficult" exercise; he would "favour" B1 but could not exclude B2; and that the categorisation was "borderline". When asked about the departmental review, he stated that he had not mentioned it in his report because it was "immaterial" to the actual assessment of the case but conceded that it "obviously had some relevance" although he did not consider it relevant at the time he prepared his report. He agreed that he could see that it might have had some importance. Further, when asked if he should have sought more information from the GMC about the departmental review, he agreed that he did not think about it as deeply as Mr Brassington said he should have done and that this "maybe…was a weakness". In addition, Professor O clarified that his conclusion in the joint report that Dr El Teraifi's report fell "below" the standard expected, should have read "seriously below".

53. The Tribunal accepted that Professor O had considerable expertise and experience as a Consultant Histopathologist and that he based his findings on the evidence before him. The Tribunal noted that Professor O maintained his view that this was a B1 error, but accepted that it was borderline, that other Histopathologists would classify it as a B2 error, and that it was not straightforward to diagnose DCIS. However, there was some uncertainty and qualification in his evidence as outlined above.

54. The Tribunal noted that Professor R had essentially concentrated on the classification falling squarely as a B2 classification. Professor R had stated that this case was one where a similar report would have been issued by a number of consultant histopathologists, and it was therefore not below the standard expected of a consultant histopathologist. Furthermore, Professor R had indicated that there was a lack of consensus at the hospital, whereby they had to refer to an outside specialist histopathologist and therefore it was not unreasonable for Dr El Teraifi to have made the diagnosis that he did. The Tribunal noted that Professor R maintained his opinion under cross-examination and confirmed that only one of the three slides considered by Dr El Teraifi exhibited any trace of DCIS. Further, the Tribunal noted that he conceded that, despite his emminence, he himself made mistakes, which the Tribunal considered was an indication of his ability to contemplate the possibility of him being wrong, which in turn emphasised his even-handed approach. Finally, like Professor O, Professor R agreed that the potential seriousness of the error (applying the duty of care score) "should not affect the classification" of the error (namely whether it was B1 or B2).

55. In conclusion, therefore, the Tribunal found that Professor R's evidence was more reliable and consistent in his categorisation of Dr El Teraifi's error.

56. The Tribunal accordingly concluded that it preferred the evidence of Professor R over Professor O, namely that it was a B2 error classification, and agreed with the experts that if it was a B2 error then it was would not fall seriously below the standard expected of a

consultant histopathologist. Accordingly, taking account of the agreement between the parties, namely that if it found that the classification of the error to be B2, then the GMC had failed to prove it case, the Tribunal determined that paragraph 5 of the Allegation was found not proved.

The Tribunal's Overall Determination on the Facts

57. The Tribunal has determined the facts as follows:

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

NHS Ayrshire and Arran restrictions

~~1. Between around July 2016 and March 2019, you worked as a locum doctor at University Hospital Crosshouse for NHS Ayrshire and Arran, and on or around 31 May 2018 your practice there was made subject to the restrictions set out in Schedule 1 ('the Restrictions').~~ Deleted under Rule 17(2)(g)

~~2. On 10 June 2019, you began working as a locum doctor at Salisbury NHS Foundation Trust ('Salisbury') and you failed to ensure that:~~

~~a. a responsible person at Salisbury;~~ Deleted under Rule 17(2)(g)

~~b. an appropriate person at RM Medics who placed you at Salisbury,~~ Deleted under Rule 17(2)(g)

~~was made aware of the Restrictions.~~

~~3. You knew you should have ensured that:~~

~~a. a responsible person at Salisbury;~~ Deleted under Rule 17(2)(g)

~~b. an appropriate person at RM Medics,~~ Deleted under Rule 17(2)(g)

~~was made aware of the Restrictions.~~

~~4. Your failure as described at:~~

~~a. paragraph 2a was:~~

~~i. designed to conceal the Restrictions from Salisbury;~~ Deleted under Rule 17(2)(g)

~~ii. dishonest by reason of paragraphs 3a and 4ai;~~ Deleted under Rule 17(2)(g)

~~b. paragraph 2b was:~~

~~i. designed to conceal the Restrictions from RM Medics;~~ Deleted under Rule 17(2)(g)

~~ii. dishonest by reason of paragraphs 3b and 4bi.~~ Deleted under Rule 17(2)(g)

Clinical concerns

5. On or around 5 May 2018, you prepared a histopathology report on Patient A and you failed to diagnose ductal carcinoma in situ. Determined and found not proved

6.

7. On or around 17 June 2019, you prepared a histopathology report on Patient B and you failed to:

a. establish a diagnosis of lentigo maligna; Admitted and found proved

~~b. mention the possibility of a blue nevus.~~ Withdrawn under Rule 17(6)

~~8. On or around 19 June 2019, you prepared a histopathology report on Patient C and you failed to identify a focus of carcinoma.~~ Withdrawn under Rule 17(6)

~~9. On or around 20 June 2019, you prepared a histopathology report on Patient D and you made an unequivocal diagnosis of dermatofibroma when other possibilities should have been considered, and were suggested by the clinical details.~~ Withdrawn under Rule 17(6)

10. On or around 21 June 2019, you prepared a histopathology report on Patient E and you failed to identify a pathological process and, as a result, you did not provide any explanation of their symptoms or consider potential treatable causes for them. Admitted and found proved

11. ~~On or around 27 June 2019, you prepared a histopathology report on Patient F and you failed to identify the presence of dysplasia.~~ Withdrawn under Rule 17(6)

12. On or around 2 July 2019, you prepared a histopathology report on Patient G and you failed to make a diagnosis of idiopathic inflammatory bowel disease consistent with Crohn's disease. Admitted and found proved

Royal Devon and Exeter NHS Foundation Trust ('the Trust')

~~13. On or around 28 August 2019, you started a locum contract at the Trust, and you failed to notify:~~

~~a. a responsible person at the Trust, such as the clinical lead;~~ Deleted under Rule 17(2)(g)

~~b. an appropriate person at Independent Clinical Services ('ICS'), the agency who had placed you at the Trust,~~ Deleted under Rule 17(2)(g)

~~in a timely manner that your previous contract at Salisbury had been terminated early due to concerns about your clinical capabilities and/or that Salisbury were investigating your clinical practice.~~

~~14. You knew you should have told:~~

~~a. a responsible person at the Trust, such as the clinical lead;~~ Deleted under Rule 17(2)(g)

~~b. an appropriate person at ICS,~~ Deleted under Rule 17(2)(g)

~~of the matters referred to at paragraph 12.~~

~~15. Your actions as described at paragraph 12 were:~~

~~a. designed to conceal from the Trust that concerns had been raised at Salisbury about your clinical performance and/or that as a consequence, your contract had been terminated early;~~ Deleted under Rule 17(2)(g)

b. ~~dishonest by reason of paragraphs 13a and/or 13b and 14a~~. Deleted under Rule 17(2)(g)

16. ~~On a date around 2 October 2019, you made the statements set out in Schedule 2 to Dr H, or words to that effect, after he asked you "what was the story at Salisbury?", or words to that effect.~~ Withdrawn under Rule 17(6)

~~17. You knew that the information as set out in Schedule 2 would give a false impression of what had happened at Salisbury in that you:~~

~~a. did not work 60 hours a week;~~ Deleted under Rule 17(2)(g)

~~b. knew that Salisbury were investigating your work after your initial two weeks, and that concerns had been raised.~~ Deleted under Rule 17(2)(g)

~~18. Your actions as described at paragraph 15 were dishonest by reason of paragraphs 16a and 16b.~~ Deleted under Rule 17(2)(g)

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

ANNEX A – 12/07/2024

Application pursuant to Rule 17(2)(g)

58. At the close of the GMC's case Mr Brassington, Counsel, on behalf of Dr El Teraifi, made an application under Rule 17(2)(g) of the Rules that there was no case to answer in respect of a number of paragraphs of the Allegation.

59. Mr Brassington's application concerned the following paragraphs of the Allegation:

NHS Ayrshire and Arran restrictions

1. Between around July 2016 and March 2019, you worked as a locum doctor at University Hospital Crosshouse for NHS Ayrshire and Arran, and on or around 31 May 2018 your practice there was made subject to the restrictions set out in Schedule 1 ('the Restrictions').

2. On 10 June 2019, you began working as a locum doctor at Salisbury NHS Foundation Trust ('Salisbury') and you failed to ensure that:
   a. a responsible person at Salisbury;
   b. an appropriate person at RM Medics who placed you at Salisbury,
   was made aware of the Restrictions.

3. You knew you should have ensured that:
   a. a responsible person at Salisbury;
   b. an appropriate person at RM Medics,
   was made aware of the Restrictions.

4. Your failure as described at:
   a. paragraph 2a was:
      i. designed to conceal the Restrictions from Salisbury;
      ii. dishonest by reason of paragraphs 3a and 4ai;
   b. paragraph 2b was:
      i. designed to conceal the Restrictions from RM Medics;
      ii. dishonest by reason of paragraphs 3b and 4bi.

Clinical concerns

5. On or around 5 May 2018, you prepared a histopathology report on Patient A and you failed to diagnose ductal carcinoma in situ.

Royal Devon and Exeter NHS Foundation Trust ('the Trust')

12. On or around 28 August 2019, you started a locum contract at the Trust, and you failed to notify:
    a. a responsible person at the Trust, such as the clinical lead;
    b. an appropriate person at Independent Clinical Services ('ICS'), the agency who had placed you at the Trust,
    in a timely manner that your previous contract at Salisbury had been terminated early due to concerns about your clinical capabilities and/or that Salisbury were investigating your clinical practice.

13. You knew you should have told:
    a. a responsible person at the Trust, such as the clinical lead;
    b. an appropriate person at ICS,
    of the matters referred to at paragraph 12.

14. Your actions as described at paragraph 12 were:
    a. designed to conceal from the Trust that concerns had been raised at Salisbury about your clinical performance and/or that as a consequence, your contract had been terminated early;
    b. dishonest by reason of paragraphs 13a and/or 13b and 14a.

16. You knew that the information as set out in Schedule 2 would give a false impression of what had happened at Salisbury in that you:
    a. did not work 60 hours a week;
    b. knew that Salisbury were investigating your work after your initial two weeks, and that concerns had been raised.

17. Your actions as described at paragraph 15 were dishonest by reason of paragraphs 16a and 16b.

Submissions

Submissions on behalf of Dr El Teraifi

60. Mr Brassington submitted, in relation to paragraph 1, that the GMC had failed to produce any evidence to establish that, on or around 31 May 2018, Dr El Teraifi's practice was made subject to "restrictions". He submitted that the GMC has produced a letter written to Dr El Teraifi which is to "clarify" and "expand" upon a discussion held on 21 May 2018 yet there

is no evidence to show that this letter was ever given to the doctor. Furthermore, he submitted that the Tribunal is unable to establish what in that letter represents either an expansion of or clarification of what may have been said during any meeting.

61. Mr Brassington further submitted, in relation to paragraph 1, that the letter appears to limit Dr El Teraifi to the same hours that were standard for all histopathologists in the department and the same 48 points. He submitted that there are no notes of the discussion held on 21 May 2018, nor was there any witness evidence from anyone who attended the meeting. Mr Brassington submitted that there is no formal material indicating that any restriction was placed upon the doctor by way of hours or types of reporting, nor is there any evidence of the duration of any notional restriction even if any were imposed or evidence of why any restriction was imposed. He submitted that the only evidence provided shows that Dr El Teraifi left Ayrshire for financial reasons and not clinical incompetence.

62. Mr Brassington submitted, in relation to paragraphs 2 and 3, that no one could be notified of any "restrictions", because none had been imposed. He submitted that Dr El Teraifi must first have knowledge of any "restriction" in order for his conduct to amount to a "failure". Mr Brassington submitted that the GMC has not produced any evidence that Dr El Teraifi was aware of any "restriction." He submitted that the duty on Dr El Teraifi to ensure a responsible person at Salisbury was informed of restrictions has not been established on any of the evidence provided by the GMC.

63. In relation to paragraph 2b of the Allegation, Mr Brassington submitted that it has not been established on any of the evidence provided that Dr El Teraifi had a duty to ensure that an appropriate person at RM Medics was made aware of the Restrictions. He submitted that paragraph 2 of the Allegation refers to "restrictions", not to an "incident" or "complaint", to which the RM Medics Handbook refers. He further stated that there is no clarity of when an incident needs to be reported and there is no evidence of a duty to ensure such reporting, even if a clinician were aware of a restriction and were there evidence of a restriction. Mr Brassington therefore submitted that there is no evidence of any knowledge of a duty to ensure reporting at paragraphs 3a and 3b. In respect of 3b, there is no dispute that Dr El Teraifi was provided with the staff handbook, but the handbook does not establish any "duty to ensure" and so fails.

64. Mr Brassington submitted, in relation to paragraph 4, that the GMC has failed to produce any evidence upon which to properly and safely establish a designed plan to conceal restrictions from either Salisbury or RM Medics. He submitted that not a single witness who was party to the conversations said to have occurred at Ayrshire was called and that no accurate note of what was said during any such conversation has been provided. He stated that no evidence has been called to suggest Dr El Teraifi received the letter dated 31 May 2018, in fact the contrary from Dr I. He submitted that there was no evidence produced of the letter being even sent or received and there is a complete absence of further evidence on the issue. Mr Brassington further stated that Ms K conceded that the CV was sent to Salisbury before Dr El Teraifi was even asked about his thoughts on the job, and that no attempt was

ever made to verify the contents of his CV with him, either pre, intra or post the offer of employment.

65. Mr Brassington submitted, in relation to paragraph 5, that the GMC has led evidence that indicates that a B2 error cannot amount to a below standard reporting. Professor O accepted in the Joint Expert Report that a B2 error was not below standard, and he was unable to rule out that a body of Consultant Histopathologists would grade this as a B2 error. Mr Brassington submitted that Professor O omitted from his report reference to the fact that an MDT and departmental discussion was inconclusive, and there was a lack of consensus amongst the clinicians which required the sample to be sent to a specialist breast tissue histopathologist at Glasgow to review. This, he submitted, is the very definition of a B2 error. Mr Brassington submitted that Professor O acknowledged that the samples were further cut to produce more and deeper sections and was unable to say that the slides he based his opinion upon were the same slides that were viewed by Dr El Teraifi. He submitted that the GMC is bound by their own expert opinion, and thus cannot safely exclude that this was a B2 error; accordingly, he maintained that the charge cannot survive. It would be unsafe to continue.

66. Mr Brassington submitted, in relation to paragraphs 12,13 and 14, that the GMC must present evidence of early termination of contract due to concerns regarding clinical ability and / or an ongoing investigation into his clinical practice. He submitted that no such evidence was provided. He also submitted that the GMC must present evidence that Dr El Teraifi would have a duty to inform either a responsible individual at Royal Devon and Exeter NHS Foundation Trust ("RDE") or ICS but no such duty has been evidenced. Mr Brassington also submitted that the GMC must present evidence of dishonest concealment which requires knowledge of both the fact and reasons of termination and of a duty to broadcast such reasons, but no such evidence has been provided.

67. Mr Brassington reminded the Tribunal of the unchallenged evidence of Dr J:
"*Q. During the meeting on 8.8.19 Dr El Teraifi was not dismissed, an agreement was reached that he would no longer work for the hospital, and that is what happened? A. Yes. I think that is a fair comment.*"

68. Mr Brassington submitted that there was no evidence that Dr El Teraifi was told of any ongoing investigation, any ongoing audit or any GMC referral. He submitted that Dr J gave evidence that there was no system in place at the time to make Dr El Teraifi aware of any audit/ investigation, and that he could not say that Dr El Teraifi had been made aware of either. Mr Brassington stated that Dr J accepted that there was no formal documentation either by letter or email evidencing a termination of contract for the pleaded reasons. He submitted that it is important to recall that Dr El Teraifi had already been offered the job prior to any interaction with Salisbury, nor was he asked about it by either ICS or RDE.

69. Mr Brassington submitted, in relation to paragraphs 16 and 17 that paragraph 17 of the Allegation is predicated firstly on the number of hours that Dr El Teraifi worked at Salisbury. He submitted that Dr El Teraifi was contracted to work 50 hours a week at Salisbury

(25% more than most Consultant Histopathologists). He submitted that it is not possible to extrapolate the difference between 50 and 60 hours in a casual conversation into an act of dishonesty, particularly against the backdrop of the evidence regarding the lack of knowledge of an ongoing investigation. Mr Brassington submitted that Dr J was clear that Dr El Teraifi would not have believed himself dismissed from Salisbury, nor was he told of any ongoing investigation. He stated that Dr El Teraifi's rehearsal of hours and a lack of engagement is not capable of amounting to a dishonest attempt to give a false impression.

70. Mr Brassington submitted that as far as Dr El Teraifi was concerned he had been given a clean bill of health after the initial 2-week audit which was standard. Thereafter there had been a disagreement regarding a gynae case following which there had been mutual agreement that he would leave. He submitted that there was no dismissal and no ongoing investigation.

Submissions on behalf of the GMC

71. Ms Rolfe submitted in relation to paragraph 1 of the Allegation that the GMC rely on the letter of 31 May 2018 which states that there was a meeting attended by Dr El Teraifi, Dr T and Dr S on 21 May 2018, the purpose of which was to discuss diagnostic errors in several cases which he reported. She submitted that this letter 'expands on and clarifies' issues raised in that meeting and expresses concern that long hours could contribute to errors so, to avoid this, they were reducing his hours worked and the 'points' he could consider per day. She also submitted that Dr El Teraifi was restricted from reporting breast *screening* core biopsies.

72. Ms Rolfe submitted that Dr I confirmed she was not in the meeting of 21 May 2018 and had no knowledge or notes of what was said to Dr El Teraifi in it, so she cannot help with what it was that was 'expanded upon' or 'clarified' between the meeting and the letter. She submitted that it is correct to state that the GMC have not produced a covering email, read receipt or any other proof of the letter being received by Dr El Teraifi. Dr I says she received it mostly likely by email but cannot remember and cannot say how it was sent to Dr El Teraifi. She stated that there is no other evidence about these restrictions beyond the letter such as their duration or them having been formalized into a contract.

73. Ms Rolfe submitted that in evidence Dr I stated that all histopathologists in the department were limited to 40 hours per week and 48 points *as standard*. She submitted that the 'restrictions' therefore amounted to Dr El Teraifi being brought into line with the employed histopathologists. She stated that Dr I could not recall what hours he was working beforehand. Ms Rolfe submitted that Dr I did not agree with the suggestion that all pathologists were at one point limited to 40 hours per week for financial reasons. However, Ms Rolfe submitted that Ms V in XXX the email chain says: "*We decided not to renew Dr El Teraifi's booking after March for financial reasons…. During his time here we did restrict the amount of hours he worked and also the type of cases he received. His work was audited as part of our clinical audit and for those cases undergoing MDT review. We found no issues that gave us any patient safety concerns*." She submitted that another person in the chain Ms W stated, "*we did not renew his contract at 31 March 2019, but I don't believe it was for patient*

safety reasons, moreover he was slow." Ms Rolfe submitted that Dr I clarified that there is a difference between 'breast core biopsies' and 'breast *screening* core biopsies'.

74. Ms Rolfe submitted that the Tribunal has seen a letter addressed to Dr El Teraifi, recounting a dated meeting. She stated that it would be bizarre if the meeting had simply never occurred. She submitted that, whilst the restrictions on hours and points had the effect of bringing him into line with other colleagues, that is not conclusive of the reason *why* the restrictions were imposed. She further stated that whilst financial considerations may have been a factor, or relevant to others who worked under the same restrictions, the letter makes clear that as far as Dr El Teraifi was concerned, the restrictions flowed from concerns about clinical competency. Ms Rolfe submitted that Dr I's evidence was that breast *screening* core biopsies are distinct from other breast core biopsies. Therefore, Dr El Teraifi may well have continued reporting on a category of such cases, whilst still being subject to these restrictions.

75. Ms Rolfe submitted in relation to paragraphs 2 and 3, that Dr El Teraifi has signed a document exhibited by Ms K requiring him to inform the agency if 'under investigation' or 'suspended' by the GMC or his employer, and to abide by the contents of their handbook. She stated that Ms K stated that pages 25-28 of their handbook sets out the relevant matters to be complied with, which broadly covers 'complaints' and 'incidents', and uses the language 'if you are required to report an incident that has occurred' without setting out the circumstances when you would. Ms Rolfe submitted that Ms K within her statement sets out the requirement to inform the agency of any complaint (even if it has been resolved locally). She stated that whilst the language of the handbook is more readily applicable to those in patient-facing roles who may receive a complaint in the traditional sense, the GMC would argue it must apply equally to Dr El Teraifi's colleagues' concerns about his diagnostic error rate arising in the internal departmental context that he operated within.

76. Ms Rolfe reminded the Tribunal of a doctor's general duty of candour to declare any workplace restrictions to his employer or agency placing him in employment. She referred the Tribunal to paragraph 100 of Good Medical Practice (2013) (GMP) which states that if you have restrictions placed on your practice you must without delay inform any other organisations you carry out medical work for.

77. Ms Rolfe submitted in relation to paragraph 4 that the finding of this charge must flow from the Tribunal's decision on the previous 3 charges. She stated that the GMC would argue that if it is considered there is sufficient evidence that Dr El Teraifi knew of the restrictions, he had a duty to declare them and knew as much, by not doing so, he was acting dishonestly. She submitted that the duty of candour is not limited to waiting to be asked to check a CV, or relying on the fact other colleagues were restricted in a similar way, but imposes on doctors a duty of full and frank disclosure. Ms Rolfe submitted that Ms K gave evidence of a pre-screening call before Dr El Teraifi's next placement in which he would have had the opportunity to declare these matters and he declined to.

78. Ms Rolfe submitted in relation to paragraph 5 that Professor O has given evidence on a missed diagnosis of DCIS. He concludes that to do so is a B1 error ie an error one is surprised to see from any pathologist, and amounts to a serious falling below the standards of a reasonably competent histopathologist. Ms Rolfe submitted that by 'showing his workings' so to speak and by working through the possibility of B2 and onto B1, Professor O has opened himself up to the criticism he faces on behalf of Dr El Teraifi. Ms Rolfe stated that what distinguished Professor O from Professor Q, or other experts who conceded that the errors were not seriously below the standard expected, is the clear reasoning he gave to come down in favour of B1: that is, the fact that there were multiple examples in the slide of abnormal cells; the report which came with the slides contained 'heavy hints' about what the histopathologist should find by way of calcifications; and when Dr El Teraifi graded on the cancer scale he was 4 levels away from what the independent Dr X concluded (B2 vs B5a).

79. Ms Rolfe submitted that it is Professor O's expert opinion that has been sought, not his opinion on what other experts would think. He is within his rights to say that whilst other experts might say B2, I say B1, without it being the case that in doing so he makes B1 an untenable conclusion. Ms Rolfe further submitted that it is also not right to point to the lack of consensus on the slide at MDT review and say that there existed a range of opinion there so it must be a B2 as this involves too much speculation. She submitted that the report reads "*At MDT review of this case, focal changes raising concern were noted. This case was discussed within the department but didn't lead to a consensus regarding the nature of the changes. Therefore this case has been referred for specialist review*."

80. Ms Rolfe submitted that we do not know what the lack of consensus concerned. She stated that it is unclear if there was agreement over there being DCIS but lack of agreement over what grade to give the error, or if it was all histopathologists involved in the decision. She submitted that Professor O defended his actions in ignoring this passage when coming to his decision on B1 by saying that he *assumed* one of the histopathologists in the MDT was Dr El Teraifi himself, which would account for the lack of consensus. Dr El Teraifi denies having been that outlier, says is he was never in the MDT for these types of cases, but there is no evidence but his word on this either way, so it remains speculation.

81. Ms Rolfe submitted in relation to paragraphs 12,13 and 14c that Dr El Teraifi denies knowing there was an investigation taking place into his work, or that his contract was terminated early because of clinical concerns. He knew of an isolated gynae concern, and he had agreed to end his placement there if that was what Salisbury wanted- but not that there was an audit, investigation into a significant error rate or a GMC referral. He denies he was dismissed early for clinical concerns. She submitted that Dr J in his evidence conceded a number of points:

- He agreed with the proposition that *"during the meeting on 8.8.19 (with Dr J and his Clinical Director Ms Y) Dr El-Teraifi was not dismissed, rather an agreement was reached that he would no longer work for the hospital*."

- He could not recall what was said in that meeting beyond that Dr El Teraifi was being let go. There is no letter or email or contemporaneous note setting out why Dr El Teraifi's contract was terminated/ or not continued in post.
- He said there was no formalised process for what happened when there is a large-scale investigation into or audit of someone's work- including whether they are told or not. He could not say that Dr El Teraifi had been made so aware. He thought it highly unlikely he would have been told of any GMC referral.

82. Ms Rolfe submitted that Dr J's written statement states that Dr El Teraifi was suspended pending a full audit. Dr El Teraifi accepts he was spoken to about concerns around his reporting of a gynaecological specimen. She submitted that the GMC argue that regardless of the semantics used in the dismissal meeting, and Dr El Teraifi's agreement to leave, he must have known that there were clinical concerns beyond one report, that prompted the suspension and discussion. Ms Rolfe submitted that the GMC rely on the same points as above, in relation to paragraph 4, about a doctor's duty of candour to his employer, and by extension employment agency, in relation to his duty to declare these concerns.

83. Ms Rolfe submitted in relation to paragraphs 16 and 17 that Dr El Teraifi maintains his position regarding knowledge of the investigation and says that he was working 50 hours, which was still 25% more than the 40 hours we know from Dr I was normal for most Consultant Histopathologists. Dr El Teraifi stated that it is not possible to extrapolate the difference between 50 and 60 hours in a casual conversation to an act of dishonesty, particularly against the backdrop of the evidence regarding the lack of knowledge of an ongoing investigation.

84. Ms Rolfe submitted that this charge is contingent on the Tribunal's finding that Dr El Teraifi had the knowledge, duty and knowledge of the duty to declare the clinical concerns and early termination. She stated that the GMC argue, that by knowing he was suspended, and being let go because of clinical concerns, his exaggeration of hours worked, and reference only to the early, positive days of his employment is a dishonest attempt to conceal poor performance at Salisbury.

The Tribunal's Approach

85. The Tribunal carefully considered the written and oral submissions of both counsel. In reaching its decision, it had full regard to all the evidence presented to date by the GMC, both oral and documentary.

86. The Tribunal had regard to Rule 17(2)(g) of the Rules:

> *"the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld".*

87. The Tribunal accepted the advice of the Legally Qualified Chair (LQC) and had particular regard to the case of *R v Galbraith* [1981] 1 WLR 1039, which sets out that:

> *(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.*
> *(2) The difficulty arises where there is some evidence but it is of a tenuous character; for example, because of inherent weakness or vagueness, or because it is inconsistent with other evidence.*
>
> > *(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.*
> > *(b) Where, however, the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury. [...] There will always [...] be borderline cases. They can safely be left to the discretion of the judge.'*

88. The Tribunal noted that this authority has been applied by the courts to disciplinary proceedings, recently in the case of Solicitors Regulation Authority v Sheikh [2020] EWHC 3062 (Admin) where Davis LJ held that the key question at the half-time stage is whether, on one possible view of the evidence, there is evidence upon which a reasonable tribunal (not all reasonable tribunals) could find the matter proved when making the final adjudication. If the answer is yes, then there is a case to answer.

89. In respect of the allegations that Dr El Teraifi acted dishonestly, the Tribunal bore in mind that it would be required to apply the test laid down by the Supreme Court in *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67 *('Ivey')*, namely that the Tribunal should first ascertain subjectively the actual state of Dr El Teraifi's knowledge or belief as to the facts. Whether the belief is reasonable may be a matter of evidence, but reasonableness is not an additional requirement when considering whether the belief was genuinely held. The Tribunal will then ascertain whether his conduct was dishonest applying the objective standards of ordinary decent people.

90. The Tribunal also had regard to the LQC's advice that the proper test to be applied remains that enunciated in *Galbraith* and the requirement that the court should consider the evidence as a whole, including both its weaknesses and strengths. It is necessary to make an assessment of the evidence as a whole.

The Tribunal's Determination

91. The Tribunal kept foremost in its mind that, at this stage, it was required to determine the sufficiency of the evidence presented by the GMC. It went on to consider each paragraph of the Allegation separately and the evidence it has been provided with so far.

92. In making its decision, the Tribunal considered whether the evidence presented, when taken at its highest, supported the GMC's case as set out in the Allegation.

Paragraph 1,2,3 and 4

93. The Tribunal considered paragraphs 1,2,3 and 4 of the Allegations in tandem as they are so closely linked.

94. The Tribunal had regard to the letter dated 31 May 2018, which was written by Dr T, and which stated:

> *"I am writing to expand upon and clarify some of the issues raised at our meeting on the 21/5/18, which was also attended by Dr S. The purpose of this meeting was to discuss diagnostic errors in several cases which you have reported.*
>
> *As a department we fully appreciate that all pathologists make mistakes, and we are very aware that pathologists work under an immense amount of pressure, which can been exacerbated by long hours of intense work . We are concerned that this could contribute to error being made. We wish to provide a supportive and safe environment for all the pathologists working here and as part of that we believe it is essential to limit the amount of hours you are working to 40 hours per week, with a workload allocation of 48 points per day. We feel that this will provide a less pressurised working environment and facilitate ease of reporting. You will also no longer be reporting breast screening core biopsies.*
>
> *We appreciate the hard work you have put into the department and hope you continue to work with us."*

95. The Tribunal also bore in mind that Charge 1 alleges that the restrictions were imposed on or around 31 May 2018, the date of the letter, and does not allege that they were imposed at the meeting which took place 10 days earlier, on 21 May 2018. Further, the Tribunal notes that the letter does not purport to say that any restrictions were discussed and imposed at the meeting.

96. The Tribunal accepts the GMC's argument that there is sufficient evidence to show that, on 21 May 2018, there was a meeting between Dr El Teraifi, Dr T and Dr S. However, it notes that neither Dr T nor Dr S have given evidence to the Tribunal and that no notes/minutes of the meeting have been produced.

97. The Tribunal considers that, at most, the letter dated 31 May 2018 confirms that, following the meeting on 21 May 2018, Dr S and Dr T made a decision that Dr El Teraifi should be limited to working 40 hours per week, with a maximum allocation of 48 points per day and that he should no longer prepare reports on breast screening core biopsies. However, it also notes that there is a complete lack of formalisation of that decision, such as

reference in the letter to the duration of the restrictions and the absence of a request to the doctor for acknowledgement that he understood and accepted such a variation. Further, no other documents had been provided, such as work schedules, internal memoranda or wage slips demonstrating that the restrictions were ever formally implemented.

98. The Tribunal also considered the email of 15 August 2019, sent by Ms V in which she stated, "*We decided not to renew Dr El Teraifi's booking after March for financial reasons. He was employed as a locum histopathologist through an agency, Global Medics… During his time here we did restrict the amount of hours he worked and also the type of cases he received. His work was audited as part of our clinical audit and for those cases undergoing MDT review. We found no issues that gave us any patient safety concerns*." The Tribunal therefore noted that Ms V, who was listed as a proposed recipient of the letter dated 31 May 2018, nonetheless stated that there were no patient safety concerns in relation to Dr El Teraifi.

99. The Tribunal recognised that, although there is some evidence within Ms V's email about restricting Dr El Teraifi's working hours and the type of cases he received, her email does not give any reason for these restrictions and goes on to state that there were no patient safety concerns. The Tribunal considered that there was accordingly a contradiction in the evidence in that the letter dated 31 May 2018 referred to clinical concerns as the purported reason for the restrictions yet Ms V stated that there were no patient safety concerns. The Tribunal also noted that he was asked to work exactly the same number of hours as other employed consultants and that his contract was not renewed purely for financial reasons. Taking all these factors together, the Tribunal was led to the conclusion that there was insufficiently clear evidence produced by the GMC to show that Dr El Teraifi's practice was formally made subject to restrictions. As such, it considers that his case falls within the situation envisaged by Lord Lane CJ in the case of *R v Galbraith,* namely: *"where there is some evidence but it is of a tenuous character; for example, because of inherent weakness or vagueness, or because it is inconsistent with other evidence"*.

100. Accordingly, the Tribunal concludes that the evidence produced by the GMC, taken overall, is so unsatisfactory that the Tribunal could not find Charge 1 proved.

101. Having found that Charge 1 was incapable of being proved, it follows that there is no necessity to go on to consider the other associated charges, 2, 3 and 4. However, on the basis that it may be wrong in finding that Dr El Teraifi's practice was not made subject to restrictions, the Tribunal has nonetheless gone on to consider the other principal argument put forward by Mr Brassington in relation to Charges 2, 3 and 4, namely that Dr El Teraifi was not made aware of the decision to restrict his practice.

102. The Tribunal noted that no evidence had been produced by the GMC to demonstrate that Dr El Teraifi had either been sent the letter dated 31 May 2018 or was otherwise made aware of the decision to restrict his practice. There was no evidence from Dr T or from Dr S; the letter contains no postal address, nor does it refer to any email address for Dr El Teraifi; similarly, there was no evidence confirming that Dr El Teraifi received the letter.

Furthermore, the Tribunal reminded itself of the evidence of Dr I who stated that she did not know how she received the letter but expected that it would have been by email. Furthermore, the Tribunal considered that it does not necessarily follow that because one person received the letter, all the intended recipients also received it.

103. The Tribunal therefore concluded that there was insufficient evidence provided by the GMC to prove that Dr El Teraifi ever received this letter or that he was made aware of it or of the restrictions. Noting the concession by Ms Rolfe that, if the Tribunal found that insufficient evidence had been adduced by the GMC to show that Dr El Teraifi was aware of the restrictions, Charges 2, 3 and 4 would automatically fall away, it therefore concluded that the evidence produced by the GMC, taken overall, is so unsatisfactory that the Tribunal could not find Charges 2, 3 and 4 proved.

104. The Tribunal therefore granted Mr Brassington's applications under Rule 17(2)(g) of the Rules in respect of paragraphs 1,2,3 and 4 of the Allegation.

Paragraphs 5

105. The Tribunal considered the evidence of Professor O who stated that the diagnosis of Dr El Teraifi was a B1 category error. The Tribunal noted that Professor O acknowledges that some pathologists would disagree and say this is a B2 error. Despite being challenged on this, Professor O maintained his position and although, taken overall, his evidence did variously suggest that this could be classified as simply falling below and at times falling seriously below or far below the standards expected, Professor O still maintained that his classification of a B1 error was appropriate. Further, he clarified that he considered that the error fell seriously below the standards expected. Consequently, the Tribunal did not consider his evidence to be so unreliable or discredited that the allegation is not capable of being proved.

106. The Tribunal noted that Mr Brassington's suggestion that the slides that Professor O saw were not exactly the same as those which Dr El Teraifi saw and that it may be possible that Professor O saw a number of different slides. However, the Tribunal did not consider that this discredited Professor O who merely analysed what was sent to him. Furthermore, the Tribunal noted that this was not raised as an issue in the joint report of Professor O and Professor R, so the Tribunal did not view this as significant. Accordingly, the Tribunal concluded that the evidence of Professor O is not adversely affected by this issue.

107. The Tribunal therefore determined that there is some evidence to indicate that there is a case to answer in relation to paragraph 5 of the Allegation.

108. The Tribunal therefore refused Mr Brassington's application under Rule 17(2)(g) of the Rules in respect of paragraph 5 of the Allegation.

Paragraphs 12, 13 and 14

109. The Tribunal accepted that there were significant concerns about Dr El Teraifi's clinical errors during the period of time that he was working at Salisbury (as exemplified by paragraphs 6a, 9 and 11 of the Allegation). However, the Tribunal noted that there is no documentary evidence to show that he knew that his previous contract at Salisbury had been terminated early due to concerns about his clinical capabilities and/or that Salisbury were investigating his clinical practice.

110. The Tribunal noted the oral evidence of Dr J given during cross examination in which he accepted that a meeting took place on 8 August 2019 about the "index case" which was a gynaecological matter that Dr El Teraifi had misreported. Dr J confirmed that during that meeting there was a discussion about the index case and that Dr El Teraifi was asked what his intentions were. Dr J stated that he had no recollection of what was said other than Dr El Teraifi being told that he was no longer going to be employed. Dr J stated that he believed that there were no notes of the meeting, nor did he believe that any letter was written to Dr El Teraifi about any dismissal. Dr J agreed that there were no emails to which he could refer informing him or Dr El Teraifi about the outcome of the meeting and he could also not recall whether, during that meeting, Dr El Teraifi was told about any ongoing investigation. Further, Dr J stated that he could not recall whether Dr El Teraifi was told about an ongoing audit. Dr J stated that he was '*pretty certain he would not have been told about the audit.*' Dr J was also *'pretty sure*' that Dr El Teraifi would not have been told that he was being reported to the GMC at that meeting. Dr J said it would be a fair comment that Dr El Teraifi was not told at the meeting that he had been suspended or dismissed; he merely agreed that he would no longer be working for Salisbury.

111. The Tribunal therefore did not consider that there was sufficient evidence to demonstrate that Dr El Teraifi was aware that his previous contract at Salisbury had been terminated early due to concerns about his clinical capabilities and/or that Salisbury were investigating his clinical practice. The Tribunal was satisfied that Dr El Teraifi did not know that his contract had been terminated for the reasons stated in Charge 12.

112. The Tribunal therefore granted Mr Brassington's applications under Rule 17(2)(g) of the Rules in respect of paragraphs 12, 13 and 14 of the Allegation.

Paragraphs 16 and 17

113. The Tribunal noted that Charge 16 a alleged that Dr El Teraifi "*knew*" that what he said during his conversation with Dr H "*would give a false impression*" about what happened at Salisbury because he did not work 60 hours a week.

114. The Tribunal noted that Dr El Teraifi accepted that he was not contracted to work 60 hours a week. However, the context in which he made the statement was that Salisbury had asked him "*to do a lot of work*". Furthermore, the Tribunal is aware that Dr El Teraifi was contracted to work 50 hours a week which is more than the standard 40 hours a week that

Consultant Histopathologists worked as part of their normal contracted hours. The Tribunal considered the context and concluded that Dr El Teraifi saying he worked 60 hours when he was already working more than consultants usually worked was, at worst, an exaggeration. The Tribunal further considered that, by itself, such an exaggeration, taken in context, would not be capable of proving that Dr El Teraifi "*knew*" that what he said during his conversation with Dr H "*would give a false impression*" about what happened at Salisbury. Moreover, no evidence has been produced by the GMC to show that Dr El Teraifi never worked more than 50 hours a week.

115. The Tribunal noted that Charge 16 b alleged that Dr El Teraifi "*knew*" that what he said during his conversation with Dr H "*would give a false impression*" about what happened at Salisbury because he knew that Salisbury were investigating his work and that concerns had been raised.

116. The Tribunal has already found that there is insufficient evidence to show that Dr El Teraifi knew that Salisbury was investigating him or that he had any knowledge that he was suspended or was being released due to clinical concerns. The Tribunal notes Ms Rolfe's concession in paragraph 37 of her written submissions that Charges 16 and 17 are predicated upon the Tribunal finding otherwise. Accordingly, on that basis, the Tribunal considers that there is insufficient evidence available to find Charge 16 b proved.

117. In relation to Charge 17, notwithstanding Ms Rolfe's concession, the Tribunal has nonetheless gone on to consider whether its finding that Dr El Teraifi's action, in stating that he worked 60 hours rather than 50 hours, was an exaggeration, could amount to dishonesty. The Tribunal was of the view that, given full knowledge as to the context in which he made the statement, ordinary decent people would not consider Dr El Teraifi's conduct to be dishonest, as working 50 hours was already more than the standard 40 hours worked by other Consultant Histopathologists and therefore consistent with the point that he was making, namely that he was asked "*to do a lot of work*" at Salisbury.

118. The Tribunal therefore considered that there was insufficient evidence to demonstrate that Dr El Teraifi knew that saying that he worked 60 hours a week would give a false impression of what had happened at Salisbury. The Tribunal also concluded that Dr El Teraifi did not know that Salisbury were investigating his work after his initial two weeks, and that concerns had been raised. Accordingly, there was insufficient evidence to show that his actions were dishonest.

119. The Tribunal therefore granted Mr Brassington's applications under Rule 17(2)(g).

ANNEX B – 19/07/2024

Application for Voluntary Erasure

120. On 17 July 2024, following the Tribunal's determination on facts and prior to submissions on the matter of impairment of fitness to practise, Mr Brassington made an application on Dr El Teraifi's behalf for Voluntary Erasure ('VE') under the GMC (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations Order of Council 2004/2609 (VE Regulations).

121. In accordance with paragraph 3(8) of the VE Regulations, the Registrar referred Dr El Teraifi's VE application to this Tribunal to determine because the hearing had commenced.

122. Rule 3(8) states:

> *'(8) Where, on the date the Registrar receives an erasure application, an allegation against the practitioner has been referred to the MPTS for them to arrange for it to be considered by a Medical Practitioners Tribunal under the Fitness to Practise Rules and the hearing before the Medical Practitioners Tribunal has commenced, the Registrar shall refer the application to the MPTS for them to arrange for it to be determined by the Medical Practitioners Tribunal, and the application shall be determined by the Medical Practitioners Tribunal accordingly.'*

123. The Tribunal was satisfied that it had jurisdiction to hear Dr El Teraifi's application for voluntary erasure.

Submissions

124. Mr Brassington submitted that Dr El Teraifi wishes to make an application for voluntary erasure from the medical register pursuant to Rule 3(8) of the Rules.

125. Mr Brassington told the Tribunal that Dr El Teraifi was now aged 70 (XXX) and he has retired. He has not worked since October 2019 due to an interim order of conditions which was so restrictive that it was "*virtually impossible for him to obtain employment*". He had had 38 years of unblemished service as a doctor so this outcome is a tragedy for him and possibly for others. Mr Brassington stated that the end of Dr El Teraifi's career had been "*destroyed*" due to the allegations against him which have taken nearly five years to come to a hearing. He said that Dr El Teraifi "*feels strongly about that and is disappointed, to say the least*". Further, the investigation that was conducted by the GMC was "*perfunctory*" and had elongated the case considerably, bringing his career to an end "*prematurely and frankly, unnecessarily*".

126. Mr Brassington went on to say that the allegations had been investigated and fully litigated with the involvement of expert evidence. If any application for restoration were made, any FTP investigation could be restarted, especially since the facts had been admitted

and there would be no problems with witness recollection. Mr Brassington submitted that the public interest would be guarded by the granting of the voluntary erasure as there would be complete protection for patients. He confirmed that Dr El Teraifi will no longer be working as he has not been for the last five years, he is not registered to work overseas nor does he have any plans to do so.

127. Mr Brassington referred to the GMC's guidance entitled '*Guidance on making voluntary erasure applications and advising on administrative erasure'* (March 2021), ('the Guidance'). He said that nothing in this case in terms of the facts has been left unresolved and there has been litigation of these issues to conclusion at the factual stage and no more. Further, Mr Brassington submitted that these allegations relate only to three clinical issues against Dr El Teraifi. In particular, he referred the Tribunal to paragraphs 23 and 24 ("*Cases where VE…should not proceed unless there are exceptional circumstances*") and maintained that Dr El Teraifi's case did not fall into such serious categories. Consequently, the public interest would be protected if a VE was granted.

128. Mr Brassington finally referred to paragraphs 43 and 44 of the Guidance and submitted that Dr El Teraifi's case fell squarely into them, especially since there was no evidence before the Tribunal that Dr El Teraifi's errors had resulted in serious harm to any patient or significant public concern. Further, it was to Dr El Teraifi's credit that he had engaged in the proceedings in order to "*clear his good name*".

129. Ms Rolfe concurred with Mr Brassington's submissions. She submitted that Voluntary erasure would be the sensible and appropriate course. She reminded the Tribunal of Dr El Teraifi's age and the stage of his career, his future intentions and (were those future intentions to change) the fact that safeguards existed by virtue of the stage reached in these proceedings. Essentially, all the remaining allegations against Dr El Teraifi are ones that were admitted at the beginning of these proceedings. Consequently, if needed, the proceedings could simply be revived quite easily if Dr El Teraifi's fitness to practise needed to be investigated at a restoration phase.

130. Ms Rolfe submitted that this is a case that only involves clinical concerns, rather than there being anything more serious, and referred to the examples in the Guidance concerning presumption of impairment but agreed that this is not that kind of a case.

131. Ms Rolfe stated that, in terms of protection of the public and with the clinical concerns that have been admitted, voluntary erasure is the best outcome for the public as well as the doctor on this occasion. Ms Rolfe confirmed that she did not oppose the application for voluntary erasure but fully supports it.

The Tribunal's Approach

132. The Tribunal has borne in mind that the decision as to whether or not to grant Dr El Teraifi's application for voluntary erasure is a matter for it alone to determine, exercising its own judgment. In doing so it had regard to the Guidance and noted that, although principally

directed at Case Examiners, it was applicable to the Tribunal's deliberations and any departure from it must be carefully reasoned and recorded.

133. The Tribunal had regard to the submissions made by Mr Brassington and those of Ms Rolfe. In addition, it had regard to the documentary evidence provided to it which included Dr El Teraifi's 'UD8' form and his application form for Voluntary Erasure.

134. The Tribunal considered the provisions in paragraphs 23 and 24 of the Guidance and it is right to say that the allegations admitted and found proved do not fall into any of these categories.

135. The Tribunal noted that Dr El Teraifi has retired from clinical practice, has not worked for five years and has no intention to return to clinical practice either in the UK or overseas.

136. The Tribunal considered paragraphs 41, 43 and 44 of the Guidance, which state:

> *'41. With some exceptions, erasure can usually proceed in cases involving health, language or performance as they do not generally raise significant public interest concerns. The future risk to patients arising from a restoration application is low because the doctor will have to demonstrate their fitness to practise by undergoing an objective assessment should they wish to return to practice.*
>
> *43. In most cases where the concerns solely relate to a doctor's performance or clinical competence, it is likely to be appropriate to grant VE or authorise AE even where a performance assessment has found the doctor is not fit to practise or is only fit to practise on a limited basis. Patients will be protected by the doctor's erasure as they will be unable to work. The risk arising from any restoration application will be small because we can ask the doctor to undergo a performance assessment to demonstrate that in respect of their clinical knowledge and/or skills they are fit to practise without restriction. Doctors applying for restoration will bear the cost of performance assessments.*
>
> *44. There may however be cases involving allegations of poor performance where there is a public interest in the concerns being fully investigated and ventilated before a tribunal. This may be because the doctor's allegedly deficient performance has been linked to serious harm to patients or resulted in significant public concern. Although the circumstances of each case will need to be carefully considered , neither voluntary or administrative erasure should be allowed where it would be contrary to the public interest.'*

137. The Tribunal noted that this application was fully supported by the GMC. Further, it agreed with the submissions of both parties and particularly with Mr Brassington that Dr El Teraifi's case fell squarely into paragraphs 41, 43 and 44 of the Guidance as set out above. His case involves poor performance and therefore the future risk to patients arising from any restoration application is low, because the doctor will have to demonstrate his fitness to

practise by undergoing an objective assessment. Although the Tribunal did not proceed to the impairment stage it was aware that both experts agreed that on three occasions Dr El Teraifi's clinical practice fell seriously below the standards expected. The Tribunal did not hear any evidence as to whether, or not, Dr El Teraifi had remediated but bore in mind that, if this VE application was granted, these concerns could be revisited were he to apply for restoration and the matter could be resolved by Dr El Teraifi undergoing a performance assessment. In the meantime, the public would be protected as Dr El Teraifi would not be able to work.

138. The Tribunal noted that there is no evidence before it that Dr El Teraifi's poor performance resulted in serious harm to patients or in significant public concerns. Further, he was of an age whereby it would be expected that he would retire and therefore not seek to return to the Register in the future.

139. Accordingly, the Tribunal could not see how Dr El Teraifi's application for voluntary erasure would be contrary to the public interest. Further, the Tribunal believes that a concerned member of the public fully aware of the circumstances of this particular case would be satisfied that voluntary erasure and the protection that ensues was a sufficient and appropriate outcome.

140. The Tribunal agreed with the submissions of both parties and accordingly, the Tribunal determined to grant Dr El Teraifi's application for voluntary erasure.

141. Having granted the application for Voluntary Erasure, the Tribunal took into account the submissions by both parties that the current FTP proceedings should simply be stayed. It's findings against Dr El Teraifi would be preserved and therefore could be reactivated if needed. Accordingly, the Tribunal directs that no further action should ensue in the FTP proceedings and that they are now stayed.

142. Case concluded.