PUBLIC RECORD

Dates: 21/09/2020 - 24/09/2020

Medical Practitioner's name:	Dr Issa ASHHAB
GMC reference number:	7458324
Primary medical qualification:	MBBS 2004 University of Karachi - Dow Medical College

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

Summary of outcome

Warning

Tribunal:

Legally Qualified Chair	Mr David Clark
Medical Tribunal Member:	Mr Ghulam Mufti
Medical Tribunal Member:	Dr Louis Savage

Tribunal Clerk:	Ms Angela Carney

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Robert Dacre, Counsel, instructed by RadcliffesLeBrasseur Solicitors
GMC Representative:	Mr Tim Grey, 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 and Impairment - 24/09/2020

Facts

Background

1. Dr Ashhab qualified as a doctor in Pakistan in 2004, after which he went to Jordan to work. Dr Ashhab started his anaesthetic training in Jordan 2008 and completed this in 2012. He worked at consultant level in Jordan for the following two years. Dr Ashhab came to the UK in 2014 and commenced work at University Hospital Southampton. He worked as a clinical fellow until 2018 when he was promoted to the position of a specialty doctor in cardiac anaesthesia.

2. At the time of the events Dr Ashhab was practising as a specialty doctor in cardiac anaesthesia, at University Hospital Southampton. He was conducting independent anaesthetic lists and also had responsibilities in the Cardiac Intensive Care Unit (CICU).

3. The allegation that has led to Dr Ashhab's hearing can be summarised that on on 21 June 2016, Dr Ashhab retrospectively altered the medical records of Patient A from those recorded on 15 June 2016 and included information that was untrue. It is further alleged that on 18 April 2018, following a meeting with senior managers and the Trust's legal representative, Dr Ashhab sent an email to Dr E, Consultant in Cardiac Anaesthesia and Cardiac Intensive Care, in which he made misleading claims regarding his clinical management of Patient A. It is alleged that Dr Ashhab's actions were dishonest.

4. Patient A was a 75-year-old male, referred for an aortic valve replacement and coronary artery bypass graft. The surgery took place on 7 June 2016 and consisted of an aortic valve replacement and triple coronary artery bypass graft. On 8 June 2016 Patient A had to return to theatre for a suspected pericardial tamponade and bleeding. No bleeding point was found but a clot was removed. The next day Patient A was readmitted to the CICU with worsening renal function.

5. On 14 June 2016, there was increasing concern that Patient A's hand was looking pale and cold. There was no palpable pulse. Patient A's hand was elevated, and intravenous heparin was started. Vascular review confirmed absence of pulses and an urgent brachial embolectomy was performed. Good blood flow was restored but the hand remained ischaemic-looking. The following day ischaemia of the hand progressed. Blood tests showed

that the patient's platelet count significantly dropped on 15 June 2016. The diagnosis of HITT (Heparin Induced Thrombocytopenia Thrombosis) was made and the heparin stopped that afternoon. That evening a review by the orthopaedic and vascular surgeons concluded that the upper limb was no longer salvageable, and an amputation was carried out the following day.

6. Patient A was transferred back to CICU after the surgery. The heparin had been stopped due to the diagnosis of HITT and he was given intravenous argatroban instead. The diagnosis of HITT was confirmed two days later with specific tests.

7. Patient A did not recover as expected after the surgery, he developed pyrexia and positive blood cultures. A brain scan showed evidence of small vessel disease and there was an absence of motor response to pain. Therefore, palliative care measures were put in place on 22 June 2016 and Patient A sadly passed away at Petersfield Hospice on 25 June 2016.

8. On 5 July 2016 a Serious Incident Requiring Investigation (SIRI) meeting determined that this was an unexpected clinical outcome. The Trust's subsequent investigations of the case concluded that there were no patient safety issues or missed opportunities during Patient A's clinical management. A Coroner's inquest took place in November 2018 and the Coroner's independent expert concluded the same. The Trust, pathologist and independent expert had all concluded that the essential cause of death in this case was HITT.

The Allegation and the Doctor's Response

9. At the outset of these proceedings, through his counsel, Mr Dacre, Dr Ashhab made admissions to all of the paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved, as follows:

> 1. On 21 June 2016 you retrospectively altered the medical records of Patient A from those recorded on 15 June 2016 at 00:09 to:
>
> a. remove the words 'continue heparin infusion';
> Admitted and Found Proved
>
> b. add the words 'stop heparin infusion for now and discuss with the day consultant ([XXX]) the need for a haematology review tomorrow to rule out the possibility of (HITT), as he fits the criteria of HITT (>50% drop in his platelate [sic] count + day 5 post CBP heparin + and evidence of thrombosis) IMA'.
> Admitted and Found Proved

2. You removed information in the altered medical record that was true as you had continued the heparin infusion.
Admitted and Found Proved

3. You added information in the altered medical record that was untrue in that you:

a. had not stopped heparin infusion;
Admitted and Found Proved

b. did not discuss the need for a haematology review with the day consultant;
Admitted and Found Proved

c. identified the possibility of heparin induced thrombocytopenia ('HITT');
Admitted and Found Proved

d. had not seen the platelet test result.
Admitted and Found Proved

4. You knew that information you:

a. removed at paragraph 1.a. was true;
Admitted and Found Proved

b. added at paragraph 1.b. was untrue.
Admitted and Found Proved

5. Your actions as described at paragraph 1 were dishonest by reason of paragraphs 2, 3 and 4.
Admitted and Found Proved

6. On or around 18 April 2018 you sent an email to Mr B claiming that:

a. '…*HITT came to my mind as I saw the platelet count and thought about the other criteria.'* ;
Admitted and Found Proved

b. Dr C '…came early on that morning and I REMEMEBER VERY WELL now talking to her about this thing before the handover.'
Admitted and Found Proved

6. You had not:

a. seen the platelet test result;

Admitted and Found Proved

b. identified HITT;
Admitted and Found Proved

c. spoken to Dr C about the prospect of a HITT diagnosis.
Admitted and Found Proved

7. You knew that the claims at paragraph 6 were untrue.
Admitted and Found Proved

8. Your actions as described at paragraph 6 were dishonest by reason of paragraphs 7 and 8.
Admitted and Found Proved

Impairment

The Evidence

10. The Tribunal has taken into account all the documentary evidence received during the facts stage of the hearing, which included the following:

- Statement from Dr E, Consultant in Cardiac Anaesthesia and Cardiac Intensive Care
- Trust investigation statement Dr E, dated 4 November 2016
- Trust interview note Dr E, dated 4 June 2018
- Email chain between Dr E and Dr Ashhab, dated 19 April 2018
- University Hospital Southampton NHS Foundation Trust, dated 27 January 2020
- Statement from Ms D, Head of Patient Safety at University Hospital Southampton NHS Foundation Trust, dated 11 February 2020
- Trust interview note Ms D, dated 11 June 2018
- Trust Investigation report, dated 18 June 2018
- Patient A's medical records
- Dr Ashhab's Inquest Statement, dated 18 April 2018
- Trust interview note Dr F, Consultant in Cardiac Anaesthesia and Cardiac Intensive Care, dated 19 June 2018
- Trust interview note Ms F, Patient Safety Advisor, dated 8 June 2018
- Email from Ms F, dated 19 April 2018
- Trust interview note Dr Ashhab, dated 12 June 2018
- Emails from Dr Ashhab, dated 20 and 21 April 2018
- Undated text message from Dr H

11. In addition, the Tribunal received further evidence as follows. At the impairment stage, the GMC provided a short bundle of documents which included letter from DAC

Beachwood dated 19 April 2018; an unredacted coy of certain pages from the Trust Investigation report; and a statement from the Responsible Officer at University Hospital Southampton dated 23 January 2020.

12. Dr Ashhab gave oral evidence and provided the following documentary evidence, which included:

- Reflections on XXX Professional Boundaries Course, dated 23 March 2020
- Reflections, dated 2 May 2018
- Reflections on record keeping and communication skills, dated 3 October 2018
- Further reflections on record keeping and probity, dated 3 October 2018
- Further reflections on case of Patient A, dated 20 August 2019
- Reflection on conduct and practice during pandemic, dated 23 May 2020
- Reflections on GMC Good Medical Practice (GMP), dated 2 October 2018
- Reflections on law and ethics in medical practice, dated 2 October 2018
- Reflections on the importance of ethics in the healthcare system, dated 2 October 2018
- Further reflections on XXX Professional boundaries, dated 1 April 2020
- Final reflections dated 17 September 2020
- Notes from reflective meetings with colleagues, dated 8 May 2018
- Notes from twenty-three reflective meetings with Dr I from May 2018 to July 2020
- Evidence of Continuing Professional development (CPD)
- Summary of 360 Degree Appraisal, dated 19 August 2020

Dr Ashhab's oral evidence

13. At the outset Dr Ashhab acknowledged that his two incidents of dishonesty amounted to misconduct.

14. Dr Ashhab confirmed that he has had twenty-three meetings with Dr I, Consultant in Cardiac Anaesthesia and Cardiac Intensive Care, to examine issues around probity, medical ethics and governance. He also met with a number of other colleagues to discuss his actions. After his meeting with Dr I in May 2018 Dr Ashhab explained his reflections in the following particular terms:

> *'This was a totally dishonest action that I took, and I am deeply ashamed of what I have done. However, I did not do it to hide any medical error or failing in his management. I feel that I have let down my colleagues, and the hospital I work for. Also, I feel that I have damaged the trust that patients would have in their doctors.'*

15. Dr Ashhab also referred the Tribunal to his reflections dated 15 October 2019:

> *'In the case investigated by the GMC. I Admitted sending a dishonest email to a colleague regarding my involvement in that case. I explained the reasons why I think I*

sent that email, that I was caught in a whirlwind of overwhelming events resulting in sending this dishonest email in a complete misjudgment from me to the consequences of this email.'

16. Dr Ashhab told the Tribunal that he still fully accepts today that his actions were dishonest. He stated that his thought processes have changed. At the time his reason for amending Patient A's medical records was to make it appear that he had considered the possibility of HITT even though he knew that his action was totally dishonest.

17. In relation to honesty and probity, Dr Ashhab told the Tribunal that, when he sees his patients they are usually sedated, which puts more responsibility on him to be open and honest. He said he was ashamed that he did not practise to the standard expected in relation to these events, and that his reflections and meetings have affirmed that view.

18. Dr Ashhab said that he understands the frustration and pain he caused to Patient A's family and the Trust because of his dishonesty. He said that he was sorry about his conduct towards Patient A and the Trust and fully understands that if he had been open and honest, the Coroner's inquest would not have been adjourned.

19. Dr Ashhab told the Tribunal that since 2016 until now, which is over four years, he has been challenged by cases that were more complex than Patient A's case. He said that as a result of his reflections, the practical steps he has taken and with the help of colleagues, he is confident that he can manage complex situations. Dr Ashhab confirmed that at the beginning of the Trust's investigation, but prior to the referral to the GMC, he re-read parts of GMP, made notes and reflected upon its content.

20. Dr Ashhab told the Tribunal that at the time of his original dishonesty, he thought he would be blamed in some way for contributing to Patient A's deterioration, but he should have realised that he was a junior clinical fellow and the treating consultant had overall responsibility for Patient A's care.

21. Dr Ashhab told the Tribunal that he undertook a course on law and medical ethics in medical practice in October 2018. Dr Ashhab said that the course explored ethics and cultural backgrounds. He said that the course reinforced to him that dishonesty is dishonesty, regardless of the cultural background.

22. Dr Ashhab told the Tribunal about the professional boundaries course he attended in March 2020 and explained that during this course he had had the opportunity to share his dishonest actions with the group. He said speaking to the group had helped him be open and honest.

23. Dr Ashhab told the Tribunal that he has been undertaking a project to assist junior doctors, as he felt that his experience throughout this process would help them to avoid making the mistakes he had made and finding themselves in a similar position.

24. Dr Ashhab said that he now understands that there was no reason for him to have felt that he was at risk of criticism in relation to his medical care of Patient A. He said that he recognised that he needed to consider carefully the lack of blame in the UK's medical culture. He said this was helpful and emphasised that he was not putting this forward as a justification for his actions.

25. Dr Ashhab referred the Tribunal to his May 2020 reflections, wherein he states:

> *'My answers and reflection on his questions were that I realized that I was dishonest in my record keeping when I reviewed [Patient A's] note after the meeting in the Patient Safety Office at UHS. My feelings were a mixture of shame, disappointment and anger in myself because of the action I took. The answer for his second question was that the UHS induction was perfectly clear about the importance of probity and honesty. Finally, my feelings about this action are still shame and disappointment. But I also started to feel relief after having the opportunity to talk about this dishonesty openly through my reflection.'*

26. Dr Ashhab said that he still feels embarrassed when talking to colleagues and that he had let them down.

27. Dr Ashhab referred again to his undertaking regular monthly meetings with Dr I to discuss matters of probity and professional ethics. Notes of these sessions were provided to the Tribunal. At the meeting on 26 September 2019, Dr Ashhab explored what the outcome would have been had he been open and honest from the outset with regard to the management of Patient A's care.

28. Dr Ashhab confirmed that he discussed his misconduct with his peers and other members of staff and that there have been no further concerns about his probity since his actions in April 2018. Dr Ashhab said that as a result of the remediation process he understands that probity is as important as a patient's clinical care. Dr Ashhab said that he recognises the damage his dishonesty caused to Patient A's family, the public, the Trust, the GMC and the MPTS. He said that he fully appreciates that his actions led to considerable damage.

29. Dr Ashhab said that the reflective process helped him to learn a lot and to develop more sensitivity to probity. He also said that it had helped him to assist junior overseas doctors. He said he created a support plan for junior doctors based on GMP and that he used examples of probity which doctors might face in clinical practice. He said that he also wished to encourage junior doctors to undertake more non-clinical learning, such as ethics courses.

30. He told the Tribunal that he is overwhelmed with the support that he has received from his Medical Director and his colleagues in the cardiac department. He said that he will keep reflecting on his dishonesty but wants to demonstrate that he has learned from his mistakes. He intends to work towards a consultant role and has taken some preliminary steps in that regard.

31. Dr Ashhab said that he fully appreciates the seriousness of his actions and fully recognises the role of the GMC and the MPTS, in that they must protect the public. He fully accepted his misconduct and the impact this has had on public confidence. He said his dishonesty should not have happened in the first place but that it would never happen again because of his reflections on probity. He said that he has also acknowledged the effect of dishonesty on patients and the public.

32. He said that between 2016 and April 2018 he felt the incident was closed. He said he had buried it inside himself and the call to the meeting on 18 April 2018 came out of the blue. He said that he had been working when called to the meeting and was not sure what it was about. He said he felt anxious, concerned and uncertain. Dr Ashhab confirmed that at that meeting he was asked about his entries in Patient A's medical records and he said that after two years he could not remember specific details. Dr Ashhab admitted that, at the time of this meeting, he was aware that he had changed Patient A's record. He said that during his meetings with Dr I they discussed the impact his dishonesty had on the inquest, the Trust and the importance of honesty, especially in relation to the inquest.

33. Dr Ashhab told the Tribunal that Patient A's deterioration was gradual, but he was hoping that the patient would survive. He said that he amended his notes in Patient A's medical records after seven days when the patient had reached a stage beyond recovery. The direct cause of Patient A's death was thought to be HITT. He said he was worried that if the notes were scrutinised he might be blamed for missing the diagnosis of HITT. He also said that if the patient had improved, he would not have amended the notes. He said that Patient A's continuing decline created confusion and anxiety in his mind about others commenting about his care of Patient A.

34. He said if he ever found himself in a similar situation, he would refer to a senior colleague or educational supervisor. He said that honesty is paramount and that he would fully cooperate with any investigation by the Trust or at an inquest.

35. Dr Ashhab told the Tribunal that he has developed a personal strategy called 'SPARK' from different courses he had attended.

S- ***S****tudy the case carefully.*
P- P*atients rights and safety comes first.*
A- A*ssess the ethical implications, **A**sk for senior help.*
R - R*eference to the GMC's 'Good Medical Practice' guidelines.*
K- K*nowledge of the consequences of poor practice on patient's and public trust.*

He said that he uses the SPARK strategy when facing challenging situations. He said that he has used this strategy during the pandemic, in relation to a Covid-19 patient.

36. Dr Ashhab said that he fully understands the impact his dishonesty has had on Patient A's family. He said the family was entitled to expect not just good care but also full honesty

from the medical team. He said he recognised that the inquest adjournment would have caused Patient A's family to feel frustrated and angry, and would have put extra burden on the court and resources. He said that he wished he had had the opportunity to apologise to Patient A's family for the loss of a loved family member.

37. Dr Ashhab said that he recognised the impact on the Trust. He said that although he works in a large department, he has close relationships with his colleagues and feels that he has let down his department and his colleagues as they were expecting him to act honestly. He said he also recognised the impact of his dishonesty on the Trust, in that time and resources spent on the investigation could have been used more fruitfully.

38. He said that his dishonesty would have damaged the public's trust in doctors, and he feels ashamed and embarrassed about his actions at his age and level of education. He said that he fully understands that the public expect full honesty from medical professionals. He said that he has developed a heightened awareness of probity issues since the start of his case. He said that the public expect doctors looking after patients to be fair and honest.

39. In addition, the Tribunal received testimonial and oral evidence from the following witnesses on Dr Ashhab's behalf:

- Dr I, Consultant Cardiac Anaesthetist & Cardiac Intensivist, University Hospital Southampton.
- Dr J, Consultant Cardiac Anaesthetist, University Hospital Southampton
- Dr K, Consultant Anaesthetist and Care Group Clinical Lead, University Hospital Southampton.

40. The Tribunal also received, in support of Dr Ashhab, a number of testimonials from senior colleagues, all of which it has read. One of the testimonials was from Dr L, the Medical Director, University Hospital Southampton.

Dr I's oral evidence

41. Dr I confirmed that he is fully aware of the Allegation against Dr Ashhab. He stated that he was not Dr Ashhab's supervising consultant prior to these events. He stated that he was present at the Trust's investigation interview of Dr Ashhab on 24 May 2018. Initially his role was within the cardiac consultant group to understand what had gone on and to calibrate the support for Dr Ashhab. It was felt that support was appropriate and as part of that he developed a framework to look at historical events, current strategies and to develop strategies in the future grounded in medical ethics and to develop a robust framework to support Dr Ashhab in his clinical practice in the future.

42. Dr I confirmed that he and Dr Ashhab have spent many hours looking at his actions and through his development and remediation Dr Ashhab is in a very different position. He said that Dr Ashhab's medical ethics and clinical governance are much more robust from where he was in 2018.

43. Dr I said that during the meetings they used robust examples of challenges to honesty and ethics within medical practice. He stated that Dr Ashhab has undertaken background reading, and completed courses on the internet and in person where specific examples within clinical practice were discussed. He stated that the process, which has been very successful, has provided Dr Ashhab a framework and clarity for the future. He stated that Dr Ashhab has developed his own individual framework 'SPARK', to ensure that he makes the right decisions in the future.

44. Dr I told the Tribunal that from the beginning Dr Ashhab recognised what he had done was dishonest. He stated that Dr Ashhab's involvement and engagement were absolute, in that he understood the rationale for the meetings. Dr I stated that he could see that Dr Ashhab's thinking was robust and found him to be genuinely committed to the process. Dr I said that Dr Ashhab fully recognised that he was wrong and that he continues to be fully engaged.

45. Dr I confirmed that Dr Ashhab felt ashamed not only about his actions but also that his behaviour had embarrassed his clinical colleagues. He stated that Dr Ashhab was remorseful about how his actions impacted Patient A and his cardiac colleagues, as his behaviour had reduced the team's trust in him. He stated that Dr Ashhab fully understood that his behaviour had reduced the public's trust in the profession.

46. Dr I told the Tribunal of Dr Ashhab's career history at the Trust and that it was identified early on that he should work towards becoming a specialty doctor. Dr I confirmed that there have been no concerns about Dr Ashhab's clinical care whether in CICU, the operating theatre, as part of a cardiac team or when working solo. Dr I told the Tribunal that Dr Ashhab's working environment is intense and has been even more so during the current pandemic. He stated that Dr Ashhab rose to what was needed and has produced excellent work throughout this period.

47. In relation to Dr Ashhab's current probity Dr I stated that from very early on he genuinely reflected and had insight into what he had done wrong. Dr I stated that Dr Ashhab's demonstration or proof of change has been robust and real and he feels a high level of trust in Dr Ashhab's probity now. Dr I stated that he and the cardiac team never had any concerns about Dr Ashhab's clinical practice. Dr I stated that he was confident in Dr Ashhab's probity and there has been no further evidence of lack of probity during the intensive investigation. Dr I told the Tribunal that Dr Ashhab now has a structural framework as well as personal resilience to avoid the risk of repetition in the future.

48. Dr I confirmed that during the current pandemic elective cardiac surgical services had been reduced. He told the Tribunal that, as a result, there is an increased waiting list for elective cardiac cases and Dr Ashhab is crucial to the department's ability to address this. Dr I stated that the dishonesty occurred four years ago, and the investigation was over two years ago.

49. Dr I suggested that Dr Ashhab's learning is ongoing and identified that it would be appropriate for a period of two years to continue with monthly meetings, later reducing to three-monthly intervals. Dr I clarified that he was not saying Dr Ashhab 'needed' further mentoring, but that he 'should' have further mentoring so as not to 'allow a gap in the armour'. It would be a missed opportunity if they did not carry on with the mentoring process. Dr I confirmed that he had no doubt that Dr Ashhab would continue to fully engage in the meetings.

50. Dr I confirmed that he, the Trust and the department would fully support a future CESR (Certificate of Eligibility for Specialist Registration) application from Dr Ashhab.

51. Dr I told the Tribunal that the answers from Dr Ashhab as to the reason for his dishonesty have always been consistent although he has not found these to be completely satisfactory. On questioning by the Tribunal, Dr I suggested that Dr Ashhab's professional and geographical background may have had a bearing on his decision making. He confirmed that Dr Ashhab had not done anything wrong in his treatment of Patient A. Dr I stated the cardiac environment can be very stressful and opined that Dr Ashhab's internal stresses led him to a position where he felt that he had to amend the medical record, albeit that it was a dishonest action. He said that he believes, in the spur of the moment, Dr Ashhab made an ill-advised decision. He stated that Dr Ashhab has changed sufficiently in his understanding how the team works and how the NHS system works to avoid this happening again.

Dr K's oral evidence

52. Dr K confirmed that at Dr Ashhab's instigation she met with him and during that meeting he demonstrated regret and was remorseful about his dishonest behaviour. The events in question had taken place before she was appointed. She stated that prior to the meeting Dr Ashhab had done some learning and reflection and she felt confident that as a result he was in a position that he would not behave dishonestly again. She stated that she had no concerns about Dr Ashhab's probity. Dr K commented that there is a culture of openness and honesty within the team.

53. Dr K confirmed that there is an increased waiting list due to the pandemic, and that Dr Ashhab's clinical expertise is invaluable to the Trust. If he were to be suspended it would have a detrimental impact on the department, but she recognised that any sanction is a matter for the Tribunal to decide.

Dr J's oral evidence

54. Dr J confirmed that he was aware of the Allegation and confirmed that he was involved in the initial appointment of Dr Ashhab and in his subsequent promotion to a permanent specialty doctor post.

55. Dr J stated that he gave evidence at the inquest, where he confirmed that Dr Ashhab's dishonesty had not been an attempt to cover up any errors on his part and had not

contributed to the death of Patient A. Mr J clarified that, having spoken to Patient A's family after the inquest, they were reassured that Dr Ashhab's actions had not contributed to his death.

56. Dr J stated that the cardiac team had been working with Dr Ashhab since 2014 and knew the high level of his clinical expertise. He stated that Dr Ashhab had shown deep and profound remorse and regret for his actions and the cardiac team felt that it was appropriate for him to remain in the department. He said that Dr Ashhab recognised that his dishonesty had impacted on the cardiac team, Patient A's family and the Trust. Dr J confirmed that, having seen Dr Ashhab's remorse, how he works, his interaction with colleagues, his reflections and his making amends, that he was confident that this would not happen again. He said that if he had any doubts, he would not have written the testimonial for Dr Ashhab or been able to support him.

57. Dr J stated that he is confident in Dr Ashhab's clinical skills and commended his input during the pandemic, which was invaluable, often volunteering for additional shifts. He considered Dr Ashhab to be an asset to the team, the Trust, the NHS and to patients.

58. Dr J told the Tribunal that Dr Ashhab's actions were discussed at several consultants' meetings. The team had initial concerns, in the light of Dr Ashhab's dishonesty, about his integrity and probity. However, having heard the full details of his actions and seeing the steps he took to remediate, the team unanimously supported him. Dr J went as far as to say to the Tribunal that he would confidently allow Dr Ashhab to anaesthetise a member of his family.

Mr Grey's Submissions

59. On behalf of the GMC, Mr Grey stated that the GMC and Dr Ashhab are in agreement that his fitness to practise is impaired. He referred the Tribunal to paragraphs 19, 61, 65, 71 and 73 of GMP, as follows:

> *'19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
>
> *61. You must respond promptly, fully and honestly to complaints and apologise when appropriate. You must not allow a patient's complaint to adversely affect the care or treatment you provide or arrange.*
>
> *65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> *71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.[16] You must make sure that any documents you write or sign are not false or misleading.*

a. You must take reasonable steps to check the information is correct.

b. You must not deliberately leave out relevant information.

73. You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality.'

60. Mr Grey submitted that there is substantial dishonesty in this case and therefore Dr Ashhab has breached the principles of GMP. He stated that Dr Ashhab's dishonesty occurred on two occasions, in amending Patient A's clinical record and writing an email to suggest a set of circumstances that were not true. Mr Grey submitted that the first act of dishonesty was something that has a 'hybrid status' as it is a dishonest record but also significant as it was a medical record made in a health care setting. Mr Grey submitted that the second action aggravated the original dishonesty. He stated that the email was not solicited and came after a meeting with the Trust. He said that Dr Ashhab chose to send the email and knowingly lied in that email. He submitted that this was not a 'spur of the moment action'. Mr Grey submitted that Dr Ashhab's dishonest actions represent serious misconduct.

61. Mr Grey confirmed there is no suggestion that Dr Ashhab's actions led to Patient A's demise.

62. Mr Grey submitted that Dr Ashhab's misconduct should result in a finding of impairment. He stated that there were residual concerns about a doctor who had amended medical records and there may be a potential risk to patients if those actions were to be repeated.

63. Mr Grey stated in relation to the public interest that a finding of impairment should be made in order to mark the misconduct and to maintain public confidence in the profession and in the wider public interest.

64. In relation to whether dishonesty is remediable, Mr Grey acknowledged that Dr Ashhab has made efforts to remediate. However, he reminded the Tribunal that Dr Ashhab cannot give a clear account of why it occurred in the first place. He submitted that it is difficult to see whether or not Dr Ashhab's dishonesty has been remediated or if it is remediable.

65. Mr Grey stated that it would not appropriate to make a finding of no impairment based against the difficulties in the NHS due to the current circumstances of the pandemic.

66. Mr Grey submitted that in all the circumstances, a finding of impairment is necessary.

Mr Dacre's submissions

67. On behalf of Dr Ashhab, Mr Dacre confirmed there is no dispute by Dr Ashhab that his dishonesty amounts to misconduct. He confirmed that he did not seek to submit that the current pandemic has any bearing on Dr Ashhab's impairment.

68. Mr Dacre stated that Dr Ashhab accepts that his fitness to practise is currently impaired. He reminded the Tribunal that Dr Ashhab has expressed shame about his actions and that he fully accepts that it is difficult to gain the trust of his colleagues and the public, following his dishonesty. Mr Dacre submitted that Dr Ashhab accepts that his dishonesty amounts to misconduct, which demonstrates his insight.

69. Mr Dacre stated that it is open to the Tribunal to conclude, notwithstanding the concessions made by Dr Ashhab, that he no longer poses a risk to patients. Mr Dacre stated that there is clear evidence that Dr Ashhab has expressed remorse which his colleagues found to be genuine. He reminded the Tribunal of Dr J's oral evidence in relation to this.

70. Mr Dacre reminded the Tribunal of Dr Ashhab's structured remediation and of Dr I's compelling oral evidence. He stated that Dr I considered that it was unlikely that Dr Ashhab would be repeat his dishonesty.

71. Mr Dacre reminded the Tribunal of Dr Ashhab's reflective pieces, and his creation of a formal structure to ensure his misconduct cannot happen again. He said that this was confirmed by Dr I. He stated that Dr Ashhab has spent a considerable amount of additional time on remediation, outside of the structured framework designed by the Trust. Mr Dacre confirmed that Dr Ashhab intends to continue working with Dr I, if the outcome of these proceedings allows that. Mr Dacre reminded the Tribunal that Dr Ashhab has the unanimous support of the departmental consultant body.

72. Mr Dacre submitted that it is open to the Tribunal to find that public confidence can be maintained, in view of all the remediation Dr Ashhab has undertaken, without a finding of impairment being made. He stated that there is no evidence of any deep-seated attitudinal problems. He stated that Dr Ashhab is realistic and aware that in cases of dishonesty the balance of the Tribunal's decision may fall on the side of finding impairment in order to maintain public confidence in the profession. He submitted that there are unusual circumstances in this case and suggested that the Tribunal should consider with real care, the wider question of the public interest and approach openly the issue of whether Dr Ashhab is currently impaired.

The Relevant Legal Principles

73. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision on impairment is a matter for the Tribunal's judgement alone.

74. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct and that the misconduct was serious, and then whether the finding of serious misconduct led to a finding of impairment.

75. The Tribunal must determine whether Dr Ashhab's fitness to practise is impaired today, taking into account his conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition. The Tribunal has borne in mind the judgment of Mrs Justice Cox in *CHRE v NMC and Grant [2011] EWHC 927 (Admin)* where, at paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

The Tribunal's Determination on Impairment

Misconduct

76. The Tribunal noted that at the outset Dr Ashhab conceded that his dishonesty amounted to misconduct. Nevertheless, a finding of either misconduct or impairment is a matter for the Tribunal. The Tribunal also noted that there is no evidence that the dishonest actions of Dr Ashhab impacted on the demise of Patient A.

77. The Tribunal found that in 2016 Dr Ashhab intentionally amended Patient A's medical records and failed to disclose to the Trust that he had altered the notes. Furthermore, two years later on 18 April 2018 Dr Ashhab compounded his dishonesty when he failed to tell the truth at a Trust meeting and later that day, he sent an unnecessary email to a senior colleague which contained a false account of events.

78. In terms of Dr Ashhab's motivation, the Tribunal accepted that there is no evidence of him amending the medical notes for personal financial gain. This motivation is often a feature in dishonesty cases but is absent in this instance. The Tribunal noted that Dr Ashhab had previously worked in Jordan and was relatively new to medical practice in the UK. The Tribunal noted the opinion of Dr I regarding the environment in which Dr Ashhab worked before he came to the UK, to the effect that there may have been something of a 'blame culture'. The Tribunal had no evidence on this point, but it took into account the fact that Dr Ashhab himself said that the culture in the UK was more open and transparent. By his own account, Dr Ashhab felt that he may be criticised for failing to request that Patient A's heparin be stopped. The Tribunal considered that Dr Ashhab's motivation was effectively to cover up what he perceived to be any possible criticism that may have been be made against him, informed perhaps by his years working in other countries. The Tribunal considered that

Dr Ashhab's motivation for his second act of dishonesty in 2018 was initially to try to conceal what he had done in 2016 although he readily admitted his actions at an early stage of the Trust's investigation.

79. The Tribunal found that there were elements of premeditation in both acts of dishonesty. In 2016, Dr Ashhab opened the medical records and deliberately added a lengthy entry which he knew was false and inaccurate. He did not need to send the email in 2018 but did so in the knowledge that what he had written was again false and inaccurate. The Tribunal noted that even though Dr Ashhab's dishonesty in 2016 was repeated in 2018, it was of the opinion that the second act of dishonesty arose out of the circumstances of his actions in 2016. Whilst there were two dishonest acts, they were linked and do not, in the view of the Tribunal, constitute a persistent course of dishonest conduct.

80. The Tribunal found that Dr Ashhab's dishonest actions caused the Coroner's inquest to be delayed which added to the anxiety of Patient A's family and resulted in a detailed and lengthy investigation by the Trust, diverting hospital staff from their other duties. The Tribunal found that Dr Ashhab's dishonest actions had the initial effect of causing his senior colleagues to doubt his integrity. His actions would inevitably have had an adverse effect on public confidence as well.

81. Although Dr Ashhab was relatively new to UK practice he had been working in a position of some seniority since 2014 and then from March 2018 he was promoted to a permanent position of Specialty doctor. It was reasonable to expect that a person in his position would act as a role model to more junior colleagues, particularly following his promotion.

82. The Tribunal has borne in mind the principles in GMP. It also bore in mind that breaching those principles does not necessarily lead to a finding of misconduct. The Tribunal noted paragraph 19 of GMP and considered that it is engaged in this case; firstly, because Dr Ashhab amended his notes in Patient A's medical record, and secondly the amended notes were not made contemporaneously, but retrospectively.

83. The Tribunal noted paragraph 65 of GMP and considered that it is engaged in this case. Dr Ashhab acted in a dishonest manner on two occasions, in a clinical setting. This would undermine the trust placed in doctors by patients and would undermine the public's confidence in the profession. Furthermore, the Tribunal considered that fellow medical professionals would find Dr Ashhab's dishonest actions unacceptable.

84. The Tribunal noted paragraph 71 of GMP and considered that it is also engaged in this case. Dr Ashhab's actions, in amending Patients A's medical records, resulted in the records being both false and misleading.

85. The Tribunal determined that Dr Ashhab's dishonest conduct breached the principles in GMP outlined above. There were undoubtedly some serious features to the misconduct.

However, taking all of the circumstances set out above into account, the Tribunal was satisfied that Dr Ashhab's dishonesty was not at the higher end of the scale.

86. The Tribunal determined that Dr Ashhab's actions fell short of the standards reasonably to be expected of a doctor and that his actions amount to misconduct.

Impairment

87. The Tribunal, having found that the facts admitted and found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Dr Ashhab's fitness to practise is currently impaired. The Tribunal first considered whether there were any patient safety concerns raised by Dr Ashhab's case. The Tribunal has already noted that Dr Ashhab's actions caused no harm to Patient A.

88. The Tribunal did not consider that Dr Ashhab demonstrates a propensity towards dishonesty. There is no evidence of his having acted dishonestly prior to these events. As the Tribunal has already noted although there were two acts of dishonesty, they do not constitute a persistent course of dishonest conduct. Furthermore, the Tribunal also noted that following the incident the Trust undertook a robust audit of Dr Ashhab's medical entries and no concerns about his probity were identified. In relation to the audit the Trust's investigation report stated:

> *'… was asked, as part of this investigation to look at all the entries made by IA on Metavision. She produced a large spreadsheet of changes that IA had made to records.*
> *…*
>
> *These entries were examined more closely. She concluded that of all the entries that IA had made that there had not been any other significant changes in the medical management documented. It appears that the majority of the changes he made were entries where he had effectively started a 'new' copy of a form (eg admission form) without creating a new copy of it, or where instances where no change had been made but the form was saved again at some time after the original entry. It would seem on a number of occasions he simply read an entry and saved the entry against his own name rather than simply closing it. There was nothing further in her investigation to indicate a problem other than greater need for education in the use of Metavision.'*

89. The Tribunal acknowledges that dishonesty is difficult to remediate. However, the Tribunal considered there is a substantial amount of evidence before it to demonstrate how Dr Ashhab has gained insight and remediated his misconduct. Dr Ashhab's remediation is evidenced in his reflective statements and in the online and in person courses that he has completed. Dr Ashhab has fully engaged with the governance framework put into place for him at the Trust and he cooperated fully with his mentor, Dr I.

90. The Tribunal was reassured by the confirmation that Dr Ashhab will continue with his reflections and mentoring with Dr I. The Tribunal also has a high degree of confidence that the department and the Trust will continue to support Dr Ashhab. It was also clear to the Tribunal that there is a robust governance framework in place, as explained by Dr K, and the Tribunal was further reassured by this.

91. The Tribunal took account of the independent evidence from three professional colleagues, Dr I, Dr J and Dr K, who attended the hearing in their capacity as senior departmental clinicians. The Tribunal had no reason to doubt their objectivity. All three doctors were very clear that Dr Ashhab has gained insight into his dishonest conduct. The Tribunal particularly noted the twenty-three meetings Dr Ashhab has had with Dr I, which focused on probity, medical ethics and governance. Dr I stated that Dr Ashhab could not have sensibly done any more to demonstrate that he has reflected on his dishonesty and gained insight.

92. The Tribunal was satisfied that Dr Ashhab has genuinely reflected on his dishonest actions and gained full insight. As a result of Dr Ashhab's insight, the Tribunal considered that the risk of repetition is highly unlikely and therefore the risk to patients is minimal. Given the extensive steps Dr Ashhab has undertaken, and continues to undertake, the Tribunal was satisfied that a finding of impairment on the grounds of patient safety or public protection, would not be justified.

93. The Tribunal went on to consider whether a finding of current impairment was required on wider public interest grounds. In this context, the public interest includes promoting and maintaining public confidence in the medical profession, and promoting and maintaining proper professional standards and conduct for the members of the profession. The Tribunal reminded itself that there are a number of High Court authorities which make it clear that it would be unusual for dishonesty not to lead to a finding of impairment on public interest grounds. In most cases where a member of the medical profession has acted dishonestly, the damage caused to public confidence in the profession will require such a finding. Similarly, the need to demonstrate to the profession that dishonest acts cannot in any way be condoned will usually require a finding of current impairment to be made against the doctor. However, the Tribunal also bore in mind that there is a scale of seriousness in cases of dishonesty, as described by Mr Justice Kerr in *Lusinga v NMC [2017] EWHC 1458 (Admin)* where, at paragraph 103, he said: *'…dishonest conduct can take various forms; some criminal, some not; some destroying trust instantly, others merely undermining it to a greater or lesser extent.'* There are instances where the appellate courts have upheld decisions by fitness to practise panels that a finding of impairment does not necessarily follow in cases of dishonesty. Two such cases are *PSA v GMC and Uppal [2015] EWHC 1304 (Admin)* and *PSA v NMC and M [2017] CSIH 29*. In both cases, the courts considered that professional standards and public confidence could be upheld by a '*rigorous regulatory process which resulted in a finding of misconduct.'*

94. With those principles firmly in its mind, the Tribunal considered whether a finding of impairment on public interest grounds should be made in this case. In doing so, the Tribunal

was assisted by its analysis of the seriousness of the misconduct. The Tribunal has already concluded that there are some serious features to the misconduct, but the dishonesty was not at the higher end of the scale. Using the helpful terminology employed by Mr Justice Kerr in *Lusinga*, this is not a case where the dishonesty would have the effect of destroying trust instantly although it is capable of undermining trust to a greater or lesser extent.

95. With regard to the need to promote and maintain public confidence in the medical profession, the Tribunal recognised that a member of the public would rightly be very concerned to learn that a doctor had dishonestly altered a medical record and, when challenged two years later, again acted dishonestly in giving a false explanation to a senior colleague. The fact that the doctor had recently been promoted at the time of the second incident, and the anxiety caused to the family of Patient A by the delay to the inquest, would also be of great concern to the public. However, the public would also recognise that there was no harm caused to Patient A by the dishonest alteration of the records, that the doctor readily admitted his actions during the Trust investigation, and that there were no other reasons to doubt the doctor's probity or clinical skills. The dishonest actions were fully aired at the inquest, in public and in the presence of the family.

96. The Tribunal gave careful consideration to the relevance of Dr Ashhab's remediation to the question of public confidence. The Tribunal raised this with Mr Grey during his submissions on behalf of the GMC. Mr Grey, quite correctly, pointed out that remediation primarily goes to the issue of the likelihood of repetition and thus the risk of harm being caused to patients or the public in the future. Mr Grey urged the Tribunal to proceed with caution if it was minded to extend the relevance of remediation to public confidence. The Tribunal has proceeded with caution; but it has concluded that remediation must have some relevance to the question of public confidence. A fully informed member of the public would expect a doctor who had committed a serious act of professional misconduct to take all possible steps to rebuild the trust and confidence that had been damaged. The fact that Dr Ashhab has demonstrated genuine remorse and has undertaken extensive remediation would undoubtedly go towards satisfying the public that Dr Ashhab was, once again, a doctor in whom confidence could be placed.

97. The Tribunal also considered whether the suggestion by Dr I in his evidence that Dr Ashhab should have further mentoring on professional ethics would lead the public to doubt whether he was capable of unrestricted practice. The Tribunal noted the choice of words adopted by Dr I at this point in his evidence; he said that it was not that Dr Ashhab 'needed' further mentoring, but that he 'should' have further mentoring. He explained this by going on to say that it would be wrong to 'allow a gap in the armour' and that a failure to continue with the mentoring would be to miss an opportunity for personal and professional development. The Tribunal decided the question it should ask itself was not whether further mentoring might be appropriate, but whether the steps already taken by Dr Ashhab were sufficient to re-establish himself in the eyes of members of the public as a medical professional in whom trust could be placed. The Tribunal was satisfied that the answer to that question was that Dr Ashhab has successfully re-established himself.

98. The Tribunal concluded that a finding of current impairment was not required in order to maintain public confidence in the medical profession. Dr Ashhab has taken all possible steps to restore the public's confidence in him and in the medical profession. His actions have been the subject of public scrutiny through the inquest process and through these fitness to practise proceedings. A finding of professional misconduct has been made against him. The need to maintain public confidence in the medical profession would not be undermined if a finding if impairment were not made in these circumstances.

99. With regard to the need to promote and maintain proper professional standards and conduct, the Tribunal considered this in two separate but interlinked parts. First, it considered whether Dr Ashhab had succeeded in rebuilding the trust of his professional colleagues; second, whether the Tribunal should make a finding of current impairment in order to demonstrate to the wider medical profession that serious misconduct of this nature will not be accepted.

100. In relation to rebuilding the trust of his professional colleagues, the Tribunal noted the evidence of Dr I and Dr J that, initially, the team of cardiac consultant anaesthetists was very concerned by Dr Ashhab's actions and needed time to consider how to respond. This is very understandable; his actions reflected poorly on their unit, on the Hospital and on the wider medical profession. They were concerned that there might be a pattern of inaccurate and misleading records. They were unsure whether they could continue to place trust in Dr Ashhab, a junior colleague whom they had recently promoted to a permanent position. Notwithstanding those initial concerns, the Tribunal was struck by the position adopted by the consultants once they had the benefit of hearing from Dr Ashhab about his remorse, reflection and remediation. They also saw the results of the investigation and audit into Dr Ashhab's record keeping. Dr J described how the consultants unanimously decided to support Dr Ashhab. The Tribunal further noted that, in a written testimonial provided on behalf of Dr Ashhab, Dr L, the Trust Medical Director, said:

> *'…. I am aware of the allegations and circumstances of the case, having at the time been asked to contribute to the coroner's enquiry and subsequently in my capacity as UHS case manager and lead for GMC liaison. I discussed this with our GMC ELA last week. This is to confirm that he has exceptionally strong support from his colleagues, peers and mentors, as well as his clinical leads. He is performing to a high level, including independent practice. He is very reflective and remorseful and has insight into this inappropriate action at the time, a moment of madness, so to speak. The team have no concerns over his behaviour and performance since that time and will strongly support him in providing high quality care for many patients in the future.'*

101. The Tribunal recognised that it is not only Dr Ashhab's immediate colleagues who would be affected by his actions. It considered whether the medical profession as a whole would remain concerned by Dr Ashhab's actions. The Tribunal was of the view that most medical professionals would initially be very critical of Dr Ashhab, but they would recognise the remediation he had undertaken and would, themselves, take into account the views expressed by Dr Ashhab's senior colleagues. Other medical professionals would also

recognise the importance of Dr Ashhab using his personal experiences to help inform junior colleagues about the importance of probity and medical ethics.

102. The Tribunal went on to consider whether a finding of impairment was needed in order to send a message to the medical profession that misconduct of this nature will not be tolerated. The Tribunal noted that Dr Ashhab had been given a final written warning by the Trust and, although it would be wrong for the Tribunal to attach any significant weight to this, it does demonstrate that firm action was taken by his employer. The Tribunal is aware that, pursuant to section 35D(3) of the Medical Act 1983, it has power to issue a warning in the absence of a finding of current impairment. Bearing in mind that the purpose of regulatory proceedings is not to punish the doctor, it would be disproportionate to find current impairment purely on the grounds that this was needed to deter other members of the profession from acting in a similar way.

103. In the absence of any ongoing patient safety or public protection issues, and given the Tribunal's conclusion that a finding of impairment is not required on wider public interest grounds, the Tribunal determined that Dr Ashhab's fitness to practise is not currently impaired by reason of his misconduct.

Determination on Warning - 24/09/2020

1. As the Tribunal determined that Dr Ashhab's fitness to practise was not impaired, it considered whether, in accordance with section 35D(3) of the 1983 Act, a warning was required.

Submissions

2. On behalf of the GMC, Mr Grey stated the Tribunal found that there has been a significant departure from Good Medical Practice (November 2019) (GMP). He referred the Tribunal to the following paragraphs in the Guidance on Warnings (February 2018) (the Guidance).

> '*14. Warnings should be viewed as a deterrent. They are intended to remind the doctor that their conduct or behaviour fell significantly below the standard expected and that a repetition is likely to result in a finding of impaired fitness to practise. Warnings may also have the effect of highlighting to the wider profession that certain conduct or behaviour is unacceptable.*
>
> *16. A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:*
>
> - *there has been a significant departure from Good medical practice, or*

- *there is a significant cause for concern following an assessment of the doctor's performance.*

20. The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.

a. There has been a clear and specific breach of Good medical practice or our supplementary guidance.

b. The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor's fitness to practise has not been found to be impaired.

c. A warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely relating to a doctor's health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.

d. There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).'

3. Mr Grey submitted that a warning is required in the wider public interest in order to reflect the seriousness of the misconduct. He said that whilst there is a low risk of repetition, any repetition would be particularly grave given the circumstances of the case currently before the Tribunal.

4. Mr Grey specifically referred the Tribunal to paragraph 24 of the Guidance which deals with dishonesty and states:

'24. There is a presumption that the GMC should take some action when the allegations concern dishonesty. There are, however, cases alleging dishonesty that are not related to the doctor's professional practice and which are so minor in nature that taking action on the doctor's registration would be disproportionate. A warning is likely to be appropriate in these cases. An example of this might include, in the absence of any other concerns, a failure to pay for a ticket covering all or part of a journey on public transport.'

5. Mr Grey submitted that a warning is appropriate, desirable and necessary to mark what is clearly a significant departure from GMP.

6. On behalf of Dr Ashhab, Mr Dacre told the Tribunal that Dr Ashhab accepted that a warning is likely to be appropriate and he did not seek to challenge Mr Grey's submission that a warning was necessary. Mr Dacre reminded the Tribunal that Dr Ashhab had accepted right from the start of the hearing that his conduct represented a serious departure from GMP.

The Tribunal's Determination on Warning

7. The Tribunal has had regard to the Guidance and the relevant paragraphs, 61 to 65, of the Sanctions Guidance (November 2019) and it has borne in mind its power to issue warnings. The Tribunal reminded itself of the overarching objective. The Tribunal noted that a warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS Tribunal.

8. In deciding whether to issue a warning the Tribunal has applied the principle of proportionality, weighing the interests of the public with those of the doctor. The Tribunal has borne in mind that warnings do not restrict the doctor's practice and should only be considered once the decision maker is satisfied that the doctor's fitness to practise is not impaired.

9. The Tribunal noted that Dr Ashhab accepted that there had been a departure from GMP and that he did not seek to argue that a warning was unnecessary. The Tribunal reminded itself that it had found dishonest misconduct in this case, albeit not at the higher end of the scale. It also found there was a significant departure from GMP. The Tribunal also considered that all of the sub-paragraphs, a, b, c and d of paragraph 20 of the Guidance are engaged in this case.

10. In considering whether a warning was appropriate and proportionate the Tribunal had regard to the seriousness of the misconduct. The Tribunal also bore in mind the significant remediation that Dr Ashhab continues to undertake, although this does not detract from the seriousness of his misconduct which cannot be condoned.

11. The Tribunal had regard to the effect of a warning on Dr Ashhab. However, it considered that the public interest, in marking this behaviour as unacceptable to the public and the rest of the profession, outweighed his interests in this regard.

12. The Tribunal therefore determined to impose the following warning on Dr Ashhab's registration:

'Dr Ashhab

On 21 June 2016, you retrospectively altered the medical records of Patient A from those recorded on 15 June 2016 and included information that was untrue. On 18 April 2018, following a meeting with senior managers and the Trust's legal representative, you sent an email to a senior colleague, in which you made misleading claims regarding your clinical management of Patient A. Your actions were dishonest.

This conduct does not meet with the standards required of a doctor. It risks undermining public confidence in the profession and it must not be repeated. The required standards are set out in Good Medical Practice and associated guidance. In this case, paragraphs 19, 65 and 71 of Good Medical Practice are particularly relevant. Paragraphs 19, 65 and 71 state:

> *19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
>
> *65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> *71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.16 You must make sure that any documents you write or sign are not false or misleading.*

Although this warning does not place any restriction on your registration, it is a necessary response to your misconduct.'

13. This warning will be published on the List of Registered Medical Practitioners (LRMP) in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy.'

14. That concludes this case.

Confirmed
Date 24 September 2020 Mr David Clark, Chair