MPTS Medical Practitioners Tribunal Service

Record of Determinations – Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 04/09/2023 - 12/09/2023

Medical Practitioner's name:	Dr Kareem IBRAHIM
GMC reference number:	7754576
Primary medical qualification:	MB BCh 2011 Zagazig University

Type of case	Outcome on facts	Outcome on impairment
New - Deficient professional performance	Facts relevant to impairment found proved	Impaired

Summary of outcome

Erasure

Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr David Raff
Lay Tribunal Member:	Mr Darren Shenton
Medical Tribunal Member:	Dr Jill Edwards

Tribunal Clerk:	Ms Kanwal Rizvi

Attendance and Representation:

Medical Practitioner:	Present and not represented
Medical Practitioner's Representative:	N/A
GMC Representative:	Mr Nigel Grundy, 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 - 07/09/2023

Background

1. Dr Ibrahim qualified in 2011 with a MB BCh at Zagazig University in Egypt. He underwent surgical training in Egypt and passed his MRCS (UK) in 2017. Dr Ibrahim was employed by the Western Health and Social Care Trust (the Trust) in Northern Ireland between October 2019 and June 2020. He was initially employed at Specialty Training Year 1 (ST1) level in General Surgery but was downgraded to Foundation Year 1 (FY1) level. Following the end of his contract with the Trust, Dr Ibrahim worked as a surgical resident in New Kasr Al Ainy teaching hospital, Egypt from August 2020 until March 2021. He is currently employed as a General Practitioner by Babylon Medical Services, in Oman.

2. Dr Ibrahim was referred to the GMC by the Trust in July 2020 because of issues that had arisen during his employment. Concerns about Dr Ibrahim's clinical and communication skills were raised during his induction period and, after 4 weeks of shadowing and a further 4 weeks of close supervision, it was considered that he was not safe to work independently due to patient safety concerns. The Trust decided that Dr Ibrahim should be downgraded to working at FY1 level; this occurred on 28 November 2019.

3. During his employment several additional incidents occurred that raised questions about his ability to work independently. These, and the concerns raised by his Educational Supervisor, formed the basis for a referral to the GMC in July 2020. The GMC decided that it was appropriate for him to undertake an Assessment of the standard of his professional performance. This was undertaken on 12 and 13 September 2022.

4. Dr Ibrahim's performance was found to be 'unacceptable' in all the areas able to be evaluated in the course of the Performance Assessment.

The Allegation and the Doctor's Response

5. The Allegation made against Dr Ibrahim is as follows:

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

1. Between 12 - 13 September 2022 you underwent a General Medical Council assessment of the standard of your professional performance. **Admitted and found proved**

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

   a. maintaining professional performance; **To be determined**

   b. assessment of patients' condition; **To be determined**

   c. clinical management; **To be determined**

   d. record keeping; **To be determined**

   e. relationships with patients; **To be determined**

   f. working with colleagues. **To be determined**

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

The Admitted Facts

6. At the outset of these proceedings, Dr Ibrahim made an admission to paragraph 1 of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced this paragraph of the Allegation as admitted and found proved.

The Facts to be Determined

7. In light of Dr Ibrahim's response to the Allegation made against him, the Tribunal is required to determine whether Dr Ibrahim's professional performance was unacceptable in the following areas: maintaining professional performance; assessment of patients' condition; clinical management; record keeping; relationships with patients and working with colleagues.

Witness Evidence

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

- Dr A, Team Leader of the Performance Assessment, and
- Dr B, Medical Assessor.

9. The Tribunal also heard oral evidence from Dr Ibrahim.

Documentary Evidence

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

- GMC letter to Dr Ibrahim, inviting him to undergo a Performance Assessment, dated 22 September 2020;
- Dr Ibrahim's updated Work Details Form, dated 29 September 2020;
- Performance Assessment Portfolio completed by Dr Ibrahim, including declaration he is willing to have the assessment, dated 16 October 2020;
- Email from Dr Ibrahim providing current CV, completed performance assessment portfolio and updated Work Details Form, dated 4 March 2022;
- Performance Assessment Report, dated September 2022.

The Tribunal's Approach

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

The Tribunal's Analysis of the Evidence and Findings

12. The Tribunal had regard to the Assessors' Report, dated September 2022 which outlined:

> *'The Team's unanimous decision was that Dr Ibrahim's performance was deficient and he did not meet the standard required to practice as a Foundation Level doctor.*

This decision was based on the 6 out of 8 areas of Good Medical Practice on which the doctor was assessed. His practice was found unacceptable in all categories. Many themes were observed throughout the assessment. In particular, his history and examination skills were disorganised, poorly structured, and lacked depth. This caused him either to miss the salient points of histories, or jump to the wrong conclusions, resulting in the wrong investigations or treatments. His management plans similarly lacked structure, even when dealing with resuscitation scenarios in which an A-E approach is expected, from the most junior of doctors. His disorganised approach was also observed when talking to patients and colleagues. He was considered to be a risk to patient safety in all of the areas assessed.

Additionally, the Team noted that these areas of concern were despite having been a qualified doctor for more than 11 years and passing his UK surgical membership 5 years ago – the timescale in which a doctor would ordinarily progress through a training programme and be ready to become a consultant. The fact that his practice was still below the level of a newly qualified doctor was highly concerning. As a result, given these facts, the Team found him not fit to practice.'

13. The Assessment's team overall assessment of Dr Ibrahim's performance in each category is set out below:

Category	Overall Assessment
Maintaining Professional Performance	Unacceptable
Assessment of Patient's Condition	Unacceptable
Clinical Management	Unacceptable
Operative/Technical Skills	Not assessed
Record Keeping	Unacceptable
Safety and Quality	Not Assessed
Relationship with Patients	Unacceptable
Working with Colleagues	Unacceptable

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

15. The Tribunal was presented with contemporaneous and structured records of the Performance Assessment. It found the Performance Assessment in its recognised format to

be comprehensive and credible with clear cross references * to the detailed evidence which supported its conclusions. The Tribunal heard witness evidence from Dr A and Dr B which demonstrated a clear and appropriate methodology in formulating and evaluating the assessment. Their evidence was in all respects consistent with the terms of the Performance Assessment.

*NB in order to achieve greater clarity for the benefit of the reader of this determination, in citing extracts from the Performance Assessment report, the lettering and numbering of cross references have been omitted.

16. Dr A, in her oral evidence, explained that the decision to test Dr Ibrahim at Foundation Year Level 2 (FY2) (being a level lower than at which he had initially employed) was taken so as to give him the '*best opportunity to shine*' and demonstrate the knowledge that he should have had. She stated that it was recognised that Dr Ibrahim had been demoted from ST1 to FY1. Dr A explained that there would have little purpose in examining Dr Ibrahim at FY1 level since doctors at this level operated with little autonomy and under extremely tight supervision. It was therefore fair to Dr Ibrahim to undertake the Performance Assessment at FY2. The Tribunal was thus satisfied that this was an appropriate and fair level at which to test Dr Ibrahim's performance.

17. The Tribunal also noted from Dr A's evidence that the Assessors had come to their opinions as to Dr Ibrahim's performance independently, before reaching their unanimous conclusions and producing their report.

18. As to the content of the assessment and in particular the content of the Objective Structured Clinical Examinations (OSCE's) Dr A explained that they were designed to be pertinent to Dr Ibrahim's speciality as a surgeon and the Tribunal was satisfied that the contents therefore represented a fair test of Dr Ibrahim's performance as he himself acknowledged in his evidence.

<u>Paragraph 2(a)</u>

19. The Tribunal had regard to the Performance Assessment report in relation to Maintaining Professional Performance. This included keeping up-to-date; knowledge of guidelines and regulations; CPD; audit and review; reflection and responding to feedback.

20. The Tribunal considered the evidence and the following conclusions from the Performance Assessment report in relation to Maintaining Professional Performance. Dr Ibrahim did not dispute these findings.

> *'Conclusion*
> ***Overall assessment***
> *There is **sufficient evidence** in this category to reach an overall assessment.*
> *Dr Ibrahim's performance in the category of Maintaining Professional Performance was found to be **unacceptable**.*
>
> *The Team found Dr Ibrahim's performance in the category of Maintaining Professional Performance to be Unacceptable. There was evidence of repeated and persistent failure to comply with the professional standards appropriate to the work of an FY2 and his performance was not consistent with the professional standards described in Good Medical Practice.*
>
> *The Team considered Dr Ibrahim to be deficient in this category for the following reasons:*
>
> - *His knowledge test score was below the Angoff Set mark and the mean scores*
> - *While Dr Ibrahim did refer to the Oxford textbook, he did not have any other strategies for keeping up to date or maintaining his knowledge*
> - *He lacked knowledge of Local or National guidelines and stated he did not use them*
> - *He seemed unaware that guidelines may be advantageous or knowledge of them expected in managing patients*
> - *He was not up to date with his mandatory trust training courses*
> - *He was unable to submit any audit work in his portfolio and had not undertaken an audit since then, even after covid settled down*
> - *He did not accept responsibility for errors in which he was involved, nor accept that he had been downgraded to a lower role.*

The Tribunal noted that Dr Ibrahim's raw score for the knowledge test on 12 September 2022 was 56.67% compared to the Angoff standard set mark of 68.77% and a mean score of 86.23%. (The Angoff method is used internationally to set standards in tests of competence in medicine.)

21. In light of the evidence as set out in the Assessors' evaluations and the conclusions they reached; the Tribunal was satisfied that Dr Ibrahim's performance in the category of Maintaining Professional Performance was unacceptable. It therefore found paragraph 2(a) of the Allegation proved.

Paragraph 2(b)

22. The Tribunal had regard to the Performance Assessment report in relation to Assessment of Patients' Condition. This included history taking; examination; diagnostic investigations and reaching a diagnosis. The Tribunal considered the evidence and the following conclusions from the Performance Assessment report on the subject of Assessment of Patients' Condition:

> *'Conclusion*
> *There is **sufficient evidence** in this category to reach an overall assessment.*
>
> *Overall assessment*
> *The Team found Dr Ibrahim's performance in the category of Assessment of patients' condition to be **Unacceptable.** There was evidence of repeated and persistent failure to comply with the professional standards appropriate to the work of an FY2 and his performance was not consistent with the professional standards described in Good Medical Practice.*
>
> *His performance placed patients at risk.*
>
> *The Team considered Dr Ibrahim to be deficient in this category for the following reasons:*
> - *His histories were disordered and unstructured, making them difficult to understand*
> - *He did not focus on relevant factors in the history*
> - *Although he had some acceptable actions in his assessments, many of these were for basic skills such as introducing himself, asking the nurse for observations, or rudimentary generic skills such as asking about the topic described in the task instructions. These skills needed negligible training or medical skill to execute and would be expected of a medical student.*
> - *He did not use recognised standard formats to examine the patient such as an A-E approach (OSCE 2, 6, 9, 11)*

- *His examination technique was cursory and poor, for example failing to expose the patient when required. There was also a lack of structure. (OSCE 11)*
- *He missed obvious clinical signs when examining patients (OSCE 2, 11)*
- *He did not reassess patients after making an intervention (OSCE 2, 6, 11)*
- *He did not have a logical way to decide on relevant investigations (OSCE 6, 9)*
- *He jumped to multiple wrong conclusions about the diagnosis causing distress to the patient (OSCE 2, 9)*
- *He was difficult to understand due to speaking rapidly and mumbling and the patients had to ask frequently for clarifications.*

The team felt that all of these issues amounted to a patient safety concern.'

23. The Tribunal had regard to Dr Ibrahim's evidence that he disagreed with some of the criticism contained within the Performance Assessment conclusions on this point. However, the Tribunal found Dr Ibrahim's responses to be inconsistent, lacking structure and credibility when compared with the comprehensive and concise information in the report and the contemporaneous notes which supported the conclusions. By way of example, Dr Ibrahim stated that he did not believe he was required to examine the patient at OSCE 2. The Tribunal found this explanation implausible as there would have been little point in undertaking the exercise if the doctor was not actually required to examine the patient. Moreover, the GMC was able to provide evidence to the contrary (i.e. that the doctor had been required to assess the patient) and Dr Ibrahim then acknowledged that he must have misremembered the OSCE 2 station instructions. Dr Ibrahim also asserted that he had followed an appropriate methodology. However, the Tribunal preferred the contemporaneously noted evidence of the Assessors that he did not follow the recognised A-E methodology.

24. The Tribunal found that, as set out in the Performance Assessment report Dr Ibrahim's approach was haphazard in that he missed obvious clinical signs when examining patients, placing patients at risk. It particularly had regard to the example cited by the Assessors in relation to OSCE 2, which stated:

> *'In OSCE 2, a patient with anaphylaxis secondary to a flucloxacillin reaction, Dr Ibrahim did not take a clear history from the patient and neither the patient nor the nurse understood what he was trying to ask. He initially made a misdiagnosis of adult respiratory distress syndrome. His examination was haphazard and incomplete. He did not approach with an A-E structure, which is standard convention, resulting in a delay to recognise airway compromise which could have resulted in loss of life. He did not*

expose the chest and therefore did not see the rash on the patient. His chaotic approach meant he was not able to pick out the salient points, resulting in a delay in appreciating that the patient had anaphylaxis. This is a patient safety concern.'

25. In the light of the evidence set out in the Assessors' evaluations and the conclusions they reached the Tribunal was satisfied that Dr Ibrahim's performance in the category of Assessment of Patients' Condition was unacceptable. Accordingly, it found paragraph 2(b) of the Allegation proved.

Paragraph 2(c)

26. The Tribunal had regard to the Performance Assessment report in relation to Clinical Management. This included providing treatment, advice to patients or a referral; safety netting; follow-up; timeliness; working within the limits of competence.

27. The Tribunal noted that Dr Ibrahim had accepted the conclusions of the Performance Assessment outlined below:

'Conclusion
*There is **sufficient evidence** in this category to reach an overall assessment.*

Overall assessment
*The Team found Dr Ibrahim's performance in the category of Clinical Management to be **Unacceptable.** There was evidence of repeated and persistent failure to comply with the professional standards appropriate to the work of an FY2 and his performance was not consistent with the professional standards described in Good Medical Practice.*

His performance placed patients at risk.

The Team considered Dr Ibrahim to be deficient in this category for the following reasons:
- *His management plans were disordered and unstructured, and difficult to follow.*
- *His prescribing of salbutamol, a common medication for acute asthma, was incomplete, muddled, and unsafe (OSCE 4).*
- *He arranged investigations or treatments that were not indicated or required*
- *He gave unclear, confusing, and inappropriate advice (OSCE 2, 6, 9, 10, 11).*
- *He did not call his senior team to assist him when patients were deteriorating (OSCE 6, 11).*

- *He did not consider the patient's comfort when seeing them. For example in OSCE 3, insertion of a catheter, when he was unable to complete the procedure, he did not support the patient, nor explain what would happen next. It is an expectation that a Foundation Year doctor is able to insert a urinary catheter in a simulation manikin.*
- *In more complex cases, such as Acute Kidney Injury, he did not appreciate that there was a difference between being dehydrated post operatively, compared to being in renal failure with no urine output for many hours (OSCE 6). Therefore, although his initial management to give fluids was correct, this was more by default than through knowledge.*
- *In cases when he did take the correct actions, this was often done too slowly, or in the wrong order, causing safety concerns and risking life (OSCE 2).*
- *He would often jump to the conclusion that a patient needed High Dependency or Intensive Care, before having assessed the patient or instigated any medical management. In a real scenario the patient would not have been accepted or the team would not have understood what the issues were (OSCE 2, 6)*

The team felt that this was a patient safety concern.'

28. The Tribunal had particular regard to the examples cited by the Assessors in relation to OSCE 6 and 11, which stated:

'In OSCE 6, a patient with Acute Kidney Injury, Dr Ibrahim requested a cannula that was too small. He did not have a strategy for managing a patient with acute renal failure, for example, blood gases, urinalysis, renal ultrasound or input from more senior members of the medical or renal teams. He did not re-assess the patient after making an intervention. He had a scattergun approach to managing the patient, suggesting various options with no clear rationale - insertion of a central venous catheter on an HDU without having first fluid resuscitated adequately; giving TPN because he was nil by mouth; looking for an infection despite there being no signs of sepsis, coupled with inadequate evaluation looking for this condition. These ideas suggested that he did not understand what the important factors were and what his priorities should be. When asked what information should be relayed to the consultant, he was difficult to understand and had no structure to giving such information, which would make it difficult for team members to follow on from his care.'

'In OSCE 11, SIM Acute upper GI bleeding, Dr Ibrahim failed to call his seniors to help him with an unstable, unwell patient with a reduced Glasgow Coma Score of 9. He suggested calling the gastroenterology team for an endoscopy prior to stabilising the patient but did not convey the seriousness of the situation to them. These are patient safety concerns.'

29. In light of the evidence set out in the Assessors' evaluations and the conclusions they reached the Tribunal determined that Dr Ibrahim's performance in the category of Clinical Management was unacceptable. Accordingly, the Tribunal found Paragraph 2(c) of the Allegation proved.

Paragraph 2(d)

30. The Tribunal had regard to the Performance Assessment report in relation to Record Keeping.

31. The Tribunal had regard to Dr Ibrahim's evidence in which he seemed to be suggesting that he was not given the necessary information during the course of assessment in order to complete the medical certificate for cause of death. The Tribunal considered that it might have been the case that Dr Ibrahim was unable to locate the correct information but found the suggestion that he was not given the required information to complete the task set out to be implausible.

32. The Tribunal considered the evidence and the following conclusions from the Performance Assessment report on the subject of Record Keeping:

'Conclusion
Overall assessment
Based on the evidence, the Team's opinion of Dr Ibrahim's performance in the category of Records ***is Unacceptable*** *and did not comply with the professional standards described in Good Medical Practice as his performance places patients at risk.*

It is standard practice for the team not to review medical records of doctors working at Foundation level. In the OSCEs, there were two stations which involved record-keeping. The team felt it important to look at this aspect of Dr Ibrahim's practice and found that in both tasks his work was of an unacceptable standard. There were acceptable judgements, but these were only for writing the patient's name on a form

and writing his own first name on the form, whereas there were several unacceptable observations.'

33. *The Tribunal had regard to the example of OCSE 1, which stated:*

'In OSCE 1, completing a medical certificate for cause of death, Dr Ibrahim completed the certificate in pencil rather than pen. The certificate was barely legible. He used only his first name on the certificate, excluding his surname, so this was incomplete. The second part of the certificate was not filled in at all, so there was no cause of death stated and no additional information. As a result the death certificate would not have been usable, and this would delay families in arranging a funeral.'

34. In light of the evidence set out in the Assessors' evaluation and the conclusions they reached, the Tribunal was satisfied that Dr Ibrahim's performance in the category of Record Keeping was unacceptable. Accordingly, the Tribunal found Paragraph 2(d) of the Allegation proved.

Paragraph 2(e)

35. The Tribunal had regard to the Performance Assessment report in relation to Relationships with Patients. This included communication; information sharing; respect for patients; supporting self-care; obtaining consent and maintaining trust.

36. The Tribunal considered the evidence and the following conclusions from the Performance Assessment report on the subject of Relationships with Patients:

'Conclusion
There is sufficient evidence in this category to reach an overall assessment.
Overall assessment
The Team found Dr Ibrahim's performance in the category of Relationships with Patients to be ***Unacceptable.*** *There was evidence of repeated and persistent failure to comply with the professional standards appropriate to the work of an FY2 and his performance was not consistent with the professional standards described in Good Medical Practice.*

His performance placed patients at risk.

Although at times he introduced himself and asked patients how they were feeling by way of a greeting, the team considered Dr Ibrahim to be deficient in the category of Relationship with Patients for the following reasons:

- *His discussions with patients were difficult to understand, confused and contradictory.*
- *His discussions were chaotic and unstructured.*
- *He jumped from diagnosis to diagnosis, making them difficult to follow and incomprehensible (OSCE 5, 9, 10).*
- *He frequently used jargon that patients could not understand.*
- *After breaking bad news, he gave false reassurance that he could not follow through on (OSCE 9, 10).*
- *He did not empathise when a patient was in pain or distressed (OSCE 3, 5, 6, 10).*
- *He gave contradictory advice - for example reassurance that a patient need not worry, followed by suggesting they may have an incurable condition that needed complex surgical intervention.*
- *He did not check patient's understanding.*
- *He stated that he would just know if a patient had understood. This demonstrates a lack of insight about his own communication style as it was clear several patients had not understood the information he was trying to impart (OSCE 9, 10).*

The team felt that Dr Ibrahim's interactions with patients could confuse and frighten them, while not imparting useful knowledge or plans.'

37. The Tribunal had particular regard to the examples cited by the Assessors in relation to OSCE 5 and 10, which stated:

'In OSCE 5, explaining a diagnosis of oesophageal cancer, Dr Ibrahim did not offer the patient an opportunity to bring someone in the room to support her while he was breaking bad news. He did not establish a rapport with the patient or show empathy and there was no sense of him engaging with the patient while delivering a devastating diagnosis. Dr Ibrahim was very blunt in delivering the news, with no preamble or establishing what she already knew or understood. His explanation was confusing and frightening, on the one hand falsely reassuring her that she would have

a "good life" and would not die, then offering contradictory statements about her condition possibly being untreatable.

He used jargon frequently, such as vascularity or plastic or metal stents. Throughout he was difficult to understand, and the patient had to ask him to repeat himself several times, but still he did not slow down or attempt to clarify using different terminology. When asked how he ensured that the patient had understood, Dr Ibrahim replied that it "will be apparent if she understands or not" but this is not the case – often patients do not externalise their feelings. This would be very distressing for patients.'

'In OSCE 10, history and management of altered bowel habit, Dr Ibrahim did not establish a rapport with the patient despite telling her she had numerous serious diagnoses. He was difficult to understand, and many questions needed repeating several times. Dr Ibrahim wrongly suggested she might have a variety of conditions, jumping around between them, until the patient was very confused and did not seem to understand what was going on. He told the patient "You have bowel cancer" without any clear rationale, but then told her not to worry or think about this condition. He moved on to use jargon such as "use of stents" and evaluation of "whether the bowel cancer had spread through the body and caused obstruction". This exchange of information would be distressing for patients.'

38. In disagreeing with the findings of the Assessors, Dr Ibrahim told the Tribunal that he was discussing the options of the treatment with the patients. Whether or not that was his intention, it was clear from the contemporaneous notes in the Performance Assessment report that Dr Ibrahim's communication with the patients was unstructured, poorly thought out and likely to lead to considerable distress.

39. In light of the evidence set out in the Assessors' evaluations and the conclusions they reached the Tribunal was satisfied that Dr Ibrahim's performance in the category of Relationships with Patients was unacceptable. Accordingly, the Tribunal found Paragraph 2(e) of the Allegation proved.

Paragraph 2(f)

40. The Tribunal had regard to the Performance Assessment report in relation to Working with Colleagues. This included teamwork; leadership; teaching and training; transfer of care.

41. The Tribunal considered the evidence and the following conclusions from the Performance Assessment report in relation to Working with Colleagues. Dr Ibrahim did not dispute these findings.

> *'Conclusion*
> *There is* ***sufficient evidence*** *in this category to reach an overall assessment.*
> ***Overall assessment***
> *The Team found Dr Ibrahim's performance in the category of Working with Colleagues to be* ***Unacceptable****. There was evidence of repeated and persistent failure to comply with the professional standards appropriate to the work of an FY2 and his performance was not consistent with the professional standards described in Good Medical Practice.*
>
> *His performance placed patients at risk.*
>
> *The Team considered Dr Ibrahim to be deficient in this category for the following reasons:*
>
> - *He lacked any standard structure for communicating with colleagues, such as use of handover tools, for example, SBAR (Situation, Background, Assessment, Recommendation) which meant that his exchanges were chaotic and difficult to follow (OSCE 6)*
> - *He was consistently difficult to understand because he spoke very quickly and mumbled. Even after being asked many times for clarifications, he did not slow down or project his voice more clearly (OSCE 2, 6, 7)*
> - *It would be difficult to take over care based on his phone calls (OSCE 12)*
> - *He would try to make referrals to intensive care without having evaluated the patient first, which would not be successful in a real scenario (OSCE 6, 11)*
> - *Even when all of the details were on a discharge letter, as in OSCE 12, discharge of a palliative care patient, his relaying of the information was difficult to follow and jumbled. Important details in the care of the patient would be lost in this handover, and medication handover errors were made involving controlled drugs.'*

42. The Tribunal had particular regard to the example cited by the Assessors in relation to OSCE 12, which stated:

> *'In OSCE 12, contacting the GP prior to discharge of a palliative care patient, Dr Ibrahim lacked fluency and the phone call was disorganised. It would have been difficult to take*

over care from the call. When asked who within the multi-disciplinary team would be most helpful to have involved, Dr Ibrahim relayed a list of professionals with no prioritising for this patient compared to another. The Team felt this was a rote answer and lacked understanding of what those different people could contribute. Dr Ibrahim specified the wrong dose of morphine which could be a patient safety concern.'

43. In light of the evidence set out in the Assessors' evaluations and the conclusions they reached the Tribunal was satisfied that Dr Ibrahim's performance in the category of Working with Colleagues was unacceptable. Accordingly, the Tribunal found Paragraph 2(f) of the Allegation proved.

The Tribunal's Overall Determination on the Facts

44. The Tribunal has determined the facts as follows:

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

1. Between 12 - 13 September 2022 you underwent a General Medical Council assessment of the standard of your professional performance. **Admitted and found proved**

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

    a. maintaining professional performance; **Determined and found proved**

    b. assessment of patients' condition; **Determined and found proved**

    c. clinical management; **Determined and found proved**

    d. record keeping; **Determined and found proved**

    e. relationships with patients; **Determined and found proved**

    f. working with colleagues. **Determined and found proved**

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

Determination on Impairment - 11/09/2023

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

The Evidence

46. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal heard further evidence from Dr Ibrahim.

Dr Ibrahim's oral evidence

47. Dr Ibrahim told the Tribunal that the reason he failed to perform well in the Performance Assessment was that he did not prepare sufficiently. He also told the Tribunal that following its receipt, he did not discuss the Performance Assessment report with anybody else.

48. In response to the Tribunal questions, he stated that his role with the Western Health and Social Care Trust (the Trust) in Northern Ireland had been his first job in the UK. He had previously been working as a General Surgery Resident in Egypt for six years. Dr Ibrahim said that he had experienced considerable stress working for the Trust which he felt affected the quality of his practice. He told the Tribunal that his Clinical supervisor had repeatedly suggested that that his deficient performance may lead to the end of his contract with the Trust. Dr Ibrahim stated that he felt under threat of being required to leave the UK from the time he had started his employment at the Trust.

49. Dr Ibrahim told the Tribunal that he was now studying for the Membership of the Royal College of Emergency Medicine (MRCEM) primary exam alongside his role as a GP in Oman at an Outpatient Clinic. Dr Ibrahim informed the Tribunal that he is supervised by his Medical Director and treats an average of 32 patients per day.

50. In response to the Tribunal's questions as to steps and courses undertaken to remediate the issues identified in the Performance Assessment, Dr Ibrahim stated that he had taken two online courses including one on advanced life support (ALS). He also told the Tribunal that he was pursuing training in Emergency Medicine with a view to taking the MRCEM examination. In response to questions from the Tribunal, he said that he had not

undertaken any specific activities to address the deficiencies identified in the Performance Assessment. However, he stated that he hoped to return to practise in the UK and would plan to undertake further training in the areas where deficiencies were identified in the Performance Assessment.

Submissions

51. On behalf of the GMC, Mr Grundy submitted that Dr Ibrahim's fitness to practise is impaired by his deficient professional performance. He invited the Tribunal to adopt the opinion of the Assessors to that effect. Mr Grundy noted that the Tribunal had found the Allegation proved in all particulars and reiterated Dr A's evidence that the concerns covered a broad spectrum of Good Medical Practice.

52. Mr Grundy submitted that Dr Ibrahim has shown little insight into the deficiencies outlined in the Performance Assessment report. He stated that the Assessors gave Dr Ibrahim the opportunity during the case-based discussions to see if he had any insight into any of the difficulties that had surfaced during the OSCE Assessment. However, Dr B, in her evidence, indicated that Dr Ibrahim did not demonstrate any insight at the time.

53. In relation to remediation, Mr Grundy submitted that Dr Ibrahim has not produced any evidence before the Tribunal to demonstrate he has taken any steps to remediate the deficiencies set out in the Assessment report. Mr Grundy referred the Tribunal to Dr A's evidence in which she highlighted the broad spectrum of deficiencies in Dr Ibrahim's performance and stated that it would be '*very challenging*' for him to demonstrate remediation and that it would take him a long time to do so. Mr Grundy also referred to Dr B's evidence in which she stated that Dr Ibrahim seemed unable to reflect and that remediation would require a real change in attitude, due reflection on the matters of concern and extensive retraining.

54. Mr Grundy submitted that if Dr Ibrahim were to return to the UK to practise, the concerns would simply arise again and would likely be repeated. Mr Grundy therefore invited the Tribunal to conclude that Dr Ibrahim's fitness to practise is impaired.

The Relevant Legal Principles

55. 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.

56. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first it was required to consider whether the facts found proved amounted to deficient professional performance. If it did find deficient professional performance, then it would go on to consider whether the Doctor's fitness to practise is impaired. In determining the issue of deficient professional performance, the Tribunal would consider whether Dr Ibrahim's performance was unacceptably low. It would direct its attention to his actual performance in the assessment as opposed merely to his competence in terms of his knowledge and skills.

57. If it did determine that Dr Ibrahim's professional performance was deficient, the Tribunal would be required to determine whether Dr Ibrahim's fitness to practise is impaired today, taking into account Dr Ibrahim's performance at the time of the assessment and any relevant factors since then. These would include his insight into the deficiencies in his professional performance, whether the matters are remediable, whether they have been remedied and any likelihood of repetition.

58. The Tribunal referred to the first three questions put forward by Dame Janet Smith in her 5th Shipman report, in respect of impairment, which Mrs Justice Cox endorsed in the case of *CHRE* v *NMC and Grant* [2011] EWHC 927 (Admin) (*'Grant'*):

> *'a) Whether the registrant has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;*
>
> *b) Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;*
>
> *c) Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession. … '*

59. The Tribunal was mindful of the statutory overarching objective which is 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.

The Tribunal's Determination on Impairment

Deficient Professional Performance

60. When considering whether Dr Ibrahim's conduct at the Assessment amounted to deficient professional performance, the Tribunal first turned to the assessment report, which concluded that his performance was 'unacceptable' in all six categories that were able to be evaluated.

61. The Tribunal considered that the six areas in which Dr Ibrahim was evaluated encompassed a broad spectrum of medical practice. It further noted that the Assessors had concluded that Dr Ibrahim's failings had the potential to place patients at an unwarranted risk of harm and indeed could have caused loss of life. It noted the Assessors unanimously concluded that Dr Ibrahim's performance was deficient and that he was not fit to practise.

62. The Tribunal therefore determined that, in all the circumstances outlined, Dr Ibrahim's performance was unacceptably low and fell so far short of the standards of performance reasonably to be expected of a doctor as to amount to deficient professional performance.

Impairment

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

64. The Tribunal first considered whether, in the past, Dr Ibrahim has acted so as to put patients at unwarranted risk of harm.

65. The Tribunal had regard to the fact that the Performance Assessment report had determined that in each of the six categories in which he was evaluated, Dr Ibrahim's performance had been unacceptable. Moreover, the report had specifically indicated that his performance would have placed patients at risk and in at least one instance could have caused a loss of life. Accordingly, the Tribunal concluded that his performance would have put patients at unwarranted risk of harm.

66. The Tribunal then considered whether Dr Ibrahim has, in the past, breached a fundamental tenet of the profession. It considered Good Medical Practice (GMP) (2013) and, based on the Assessment report, determined that Dr Ibrahim had departed from the standards set out in the following paragraphs:

'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.

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

8 You must keep your professional knowledge and skills up to date.

9 You must regularly take part in activities that maintain and develop your competence and performance.

11 You must be familiar with guidelines and developments that affect your work.

13 You must take steps to monitor and improve the quality of your work.

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

> *a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
>
> *b promptly provide or arrange suitable advice, investigations or treatment where necessary*

16 In providing clinical care you must:

> *a ...*
>
> *b provide effective treatments based on the best available evidence*
>
> *c take all possible steps to alleviate pain and distress whether or not a cure may be possible*
>
> *d consult colleagues where appropriate*

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

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.

31 You must listen to patients, take account of their views, and respond honestly to their questions.

32 You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.

44 You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

> *a share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers*

46 You must be polite and considerate.

49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:

> *a their condition, its likely progression and the options for treatment, including associated risks and uncertainties*
>
> *b the progress of their care, and your role and responsibilities in the team.'*

67. The Tribunal concluded that Dr Ibrahim's departure from such a broad range of the standards set out in multiple paragraphs of the GMP constituted a breach of the fundamental tenets of the medical profession and brought the profession into disrepute.

Insight

68. The Tribunal then considered whether Dr Ibrahim has shown insight into his deficient professional performance.

69. The Tribunal was of the view that the first step to developing insight should have been to carefully consider the conclusions of the Assessors and reflect in a self-critical manner on the examples they had cited. However, the Tribunal had not been provided with any evidence that Dr Ibrahim had reflected on the seriousness of the findings. It was therefore unable to conclude that Dr Ibrahim had demonstrated insight in relation to his clearly identified deficient performance.

70. The Tribunal was mindful that Dr Ibrahim had had the best part of a year to consider the findings of the assessment and the areas of concern and had not in that time shared its contents with other colleagues or a mentor. He had not taken any steps to address the serious deficiencies that had been identified. The Tribunal took note of Dr Ibrahim's evidence regarding insight, that he intended to study further and gain relevant experience in order to improve in those areas. However, the Tribunal considered these to be mere rote statements which did not evidence any sense of the urgency, or the importance of the steps required to address his serious failings. Nor did Dr Ibrahim provide any testimonials or evidence of any relevant courses undertaken.

71. The Tribunal observed that Dr Ibrahim did not demonstrate any appreciation of how far his level of performance fell below the minimum expected standards. It noted that Dr Ibrahim's explanation for his underperformance was a lack of preparation. However, given his length of experience as a surgeon, this provided no justification for his inability to undertake basic medical procedures and assessments. As the Assessors commented, the fact that his practice was still below the level of a newly qualified doctor was '*highly concerning*'. It also noted that Dr Ibrahim suggested that he planned to work towards membership of the Royal College of Emergency Medicine whilst, in the Tribunal's view, omitting to address his failings in the fundamentals of professional competencies identified by the Assessors.

72. The Tribunal therefore concluded that Dr Ibrahim had shown no meaningful insight into his deficient professional performance.

Remediation

73. The Tribunal next considered whether Dr Ibrahim's deficient professional performance was capable of being remediated and whether it had been or was in the course of being remediated. The Tribunal noted that successful remediation would entail ongoing and targeted learning, practice, training, supervision, and adequate support.

74. It bore in mind, in particular, Dr A's evidence that the deficiencies in Dr Ibrahim's performance were wide-ranging and significant and that they would be '*very challenging*' to remediate. The Tribunal noted that in the absence of insight, Dr Ibrahim had demonstrated no meaningful evidence of any remediation nor any appropriate steps in that direction.

Risk of Repetition

75. The Tribunal then considered whether there is a risk that Dr Ibrahim may repeat his deficient professional performance in the future. The Tribunal, taking into account the lack of remediation and insight, determined that there is a real risk that Dr Ibrahim's deficient professional performance would continue in the future and therefore put patients at significant unwarranted risk of harm.

Conclusion

76. The Tribunal therefore determined that a finding of impairment is necessary in order to protect, promote and maintain the health, safety and wellbeing of the public.

77. The Tribunal was mindful that doctors can and do make mistakes. However, it considered that the public would expect those doctors to accept evidence of their failings and work towards improving their practice. The Tribunal determined that Dr Ibrahim's failure to carry out proper remediation or develop insight, means that there is a public interest in making a finding of impairment, to uphold public confidence in the profession and to promote and maintain proper professional standards. The Tribunal was of the view that 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 Dr Ibrahim's case.

78. For the reasons stated above, the Tribunal has therefore determined that Dr Ibrahim's fitness to practise is impaired by reason of deficient professional performance.

Determination on Sanction - 12/09/2023

79. Having determined that Dr Ibrahim's fitness to practise is impaired by reason of deficient professional performance, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

80. The Tribunal has taken into account evidence received during the earlier stages of the hearing, where relevant, in reaching a decision on sanction.

Submissions

81. On behalf of the GMC, Mr Grundy referred the Tribunal to relevant paragraphs of the Sanctions Guidance (November 2020) ('the SG') and submitted that the appropriate and proportionate sanction in this case was one of suspension.

82. Mr Grundy submitted that there are no exceptional circumstances in this case to justify taking no action and given that the deficiencies are wide-ranging and broad across Good Medical Practice (GMP) an order of conditions would not deal with the issues identified. Further, Dr Ibrahim has demonstrated little insight, nor has he taken any practical steps to remediate his deficiencies. The Tribunal could not be confident that the public would be protected by the imposition of an order of conditions.

83. Mr Grundy submitted that there are obvious concerns, and a period of suspension would provide a last chance for Dr Ibrahim to demonstrate that he has proper insight and take the numerous steps that would be needed to satisfy a Tribunal that he was safe to return to practice. Mr Grundy stated that mitigating factors which might be considered in this case are that Dr Ibrahim is a relatively young doctor with surgical experience and is taking steps to improve his clinical skills by taking the Membership of the Royal College of Emergency Medicine (MRCEM) exam. In respect of the aggravating factors, Mr Grundy submitted that there is a broad spectrum of deficiencies found in the Assessment and reflected in the Tribunal's previous determinations. He stated that Dr Ibrahim has shown little insight despite having 12 months or so to digest the assessment report and has not taken any practical steps to remediate.

84. Mr Grundy invited the Tribunal to impose a lengthy period of suspension with a review. He stated that given the findings, a review would be required to ensure that Dr

Ibrahim's insight and remediation is complete. Mr Grundy added that if the Tribunal concluded that suspension was insufficient to protect the public, the only appropriate sanction would then be one of erasure.

85. Dr Ibrahim told the Tribunal that he is currently working as a GP and would try to improve himself in general practice and to remediate in the areas of deficiencies identified. Dr Ibrahim submitted that he would address this by seeing more patients and gaining more experience in this field: taking some courses in Emergency Medicine and preparing for and taking the MRCEM exam.

86. In response to questions from the Tribunal regarding remediation, Dr Ibrahim submitted that he would learn about the systematic approaches and procedures used in the UK. He needed to know more about UK practice and to improve his language and accent which he believed created difficulty with patients.

The Tribunal's Determination on Sanction

87. The Tribunal received Legal Advice from the Legally Qualified Chair as to the approach to be taken at the sanction stage.

88. The decision as to the appropriate sanction, if any, to impose in this case is a matter for the Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken the SG into account and borne in mind the over-arching objective.

89. The Tribunal reminded itself that the main reason for imposing any sanction is to protect the public and that sanctions are not imposed to punish or discipline doctors, even though they may have a punitive effect. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Ibrahim's interests with the public interest.

90. The Tribunal has already set out its decision on the facts and impairment which it took into account during its deliberations on sanction. Before considering what action, if any, to take in respect of Dr Ibrahim's registration, the Tribunal considered and balanced the mitigating and aggravating factors in this case.

Mitigating and Aggravating Factors

91. The Tribunal considered whether the fact that Dr Ibrahim was a relatively young doctor and that his role with the Trust was his first post as a doctor in the UK could be considered as mitigating factors. However, it bore in mind that Dr Ibrahim qualified as a doctor in 2011 and had been working, mainly in general surgery, in Egypt until coming to the UK in 2019. In his submissions to the Tribunal, Dr Ibrahim accepted that he had not taken the necessary steps to prepare to work as a doctor within the UK. Further, his performance was found to be deficient by the Trust and he had been demoted to working at FY1 level. Dr Ibrahim expressed his desire to return to the UK and stated that he would prepare himself in advance if given that opportunity. However, he was unable to articulate to the Tribunal what steps he would take other than a recitation of improving the areas identified within the Performance Assessment report.

The Tribunal was mindful, in particular, of the following sections of the SG:

> *'28 Many doctors joining the medical register have previously worked, lived or were educated overseas, where different professional standards and social, ethnic or cultural norms may apply. Doctors are expected to familiarise themselves with the standards and ethical guidance that apply to practising in the UK before taking up employment, although experience of working as a doctor in the UK plays a key role in their development.'*

The Tribunal noted that by Dr Ibrahim's own admission, he had failed to prepare himself sufficiently to work in the UK. Accordingly, the Tribunal attached limited weight to the fact that this was Dr Ibrahim's first post in the UK as a mitigating factor.

> *'30 In cases involving … serious poor performance – …*
> *– the stage of the doctor's UK medical career will have limited influence on the tribunal's decision about what action to take. Serious poor practice … is not acceptable simply because the doctor is inexperienced.'*

In the light of the findings the Tribunal has made as to Dr Ibrahim's unacceptably low performance across a broad range of areas of practice, the stage of the doctor's career must have limited influence on its decision about what action to take.

92. Having reviewed potentially mitigating factors in this case, the Tribunal considered the aggravating factors.

93. The Tribunal found that there was a broad spectrum of serious deficiencies in Dr Ibrahim's performance which gave rise to patient safety concerns and indeed the potential risk of loss of life. The Tribunal concluded, in its finding of impairment, that Dr Ibrahim had shown no meaningful insight into his deficient professional performance. This was demonstrated by the lack of any evidence that Dr Ibrahim had reflected on the seriousness of the findings. He had not taken any practical steps to address his serious failings nor provided any testimonials or evidence of any relevant courses undertaken.

94. The Tribunal then considered each sanction in ascending order of severity, starting with the least restrictive.

No action

95. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances. The Tribunal determined that there are no such exceptional circumstances in this case and that, given the seriousness of its findings, it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

96. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Ibrahim's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable. The Tribunal noted, in particular, the provisions of paragraph 82 of the SG:

> *'82 Conditions are likely to be workable where:*
>
> *a the doctor has insight*
>
> *b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings*
>
> *c ...*

d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.'

97. The Tribunal considered that Dr Ibrahim had shown no meaningful insight into his deficient professional performance. It also bore in mind that Dr Ibrahim had undertaken a period of supervised practice as a FY1 doctor in UK for a period of 6 months and notwithstanding that, his performance at the Assessment had been unacceptable in all areas evaluated. Thus, the Tribunal was not satisfied that the criteria set out in sub-paragraphs 82 a,b and d were met. The Tribunal further considered that no workable or measurable conditions could be formulated which would address the wide-ranging nature and seriousness of Dr Ibrahim's deficient performance. It thus concluded that conditions would be insufficient to protect the public, maintain public confidence in the profession or to promote and maintain standards for members of the profession.

<u>Suspension</u>

98. The Tribunal next considered whether imposing a period of suspension on Dr Ibrahim's registration would be the appropriate and proportionate sanction in this case. The Tribunal had regard to paragraphs 94 and 97 of the SG.

'94 Suspension is also likely to be appropriate in a case of deficient performance or lack of knowledge of English in which the doctor currently poses a risk of harm to patients but where there is evidence that they have gained insight into the deficiencies and have the potential to remediate if prepared to undergo a rehabilitation or retraining programme.'

'97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.

b In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.

c …

d ….

e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f …

g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'

99. The Tribunal had regard to its findings that Dr Ibrahim had breached a broad range of the standards set out in multiple paragraphs of the GMP which constituted a breach of the fundamental tenets of the medical profession The Tribunal was satisfied that the identified breaches represented a significant departure from GMP.

100. The Tribunal also had regard to its findings as to a lack of meaningful insight or any evidence of remediation. Despite his being given several opportunities to do so, Dr Ibrahim had shown scant recognition of the extent to which he falls so far short of the required level of safe medical practice. Thus, there was no evidence upon which the Tribunal could place reliance that Dr Ibrahim had the potential for remediation nor that any such engagement would be successful, given his previous practice history. Indeed, the failure of the six months period of closely supervised work at the Trust to address the serious deficiencies in his performance indicated that remediation or retraining was unlikely to succeed. The Tribunal was not satisfied that Dr Ibrahim did not pose a significant risk of repeating behaviour. In light of all these factors, the Tribunal was not satisfied that the criteria in SG paragraph 97 indicating that a suspension may be appropriate had been met.

101. The Tribunal noted that imposition of an order of suspension on Dr Ibrahim's registration could be argued to protect patients in the short term. In light of the serious findings of unacceptable performance across all areas that were subject to assessment

(including failings which extended to potential risk to life) and Dr Ibrahim's failure to remediate and continuing lack of insight, it considered that an order of suspension would not be an appropriate or proportionate sanction. It would neither maintain public confidence in the profession nor uphold proper professional standards.

Erasure

102. The Tribunal then went on to consider the sanction of erasure. It considered the following paragraphs of the SG in particular:

> '*107 The tribunal may erase a doctor from the medical register in any case – except one that relates solely to the doctor's health and/or knowledge of English – where this is the only means of protecting the public.*
>
> *108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.*
>
> *109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> > *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.*
> >
> > *b ...*
> >
> > *c Doing serious harm to others (patients*
> > *or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients.*

103. The Tribunal reiterated that based on the Assessment report it had found fundamental and wide-ranging failings in Dr Ibrahim's performance when measured against the standards set out in GMP. Moreover, the failings identified could potentially cause serious harm to patients, including loss of life. The Tribunal was further satisfied that Dr

Ibrahim has not remediated or demonstrated the potential for remediation or retraining. The Tribunal found that was because he lacked meaningful insight into the extent of his failings. The deficiencies in Dr Ibrahim's performance, taken together with his lack of meaningful insight and failure to remediate, were so serious and wide ranging that they amounted to behaviour fundamentally incompatible with being a doctor.

104. Throughout its deliberations the Tribunal have had regard to the principle of proportionality, balancing the doctor's interests against the public interest. The Tribunal found that Dr Ibrahim's deficient professional performance taken together with his lack of insight and failure to remediate would undermine the public's confidence in the medical profession, represented a failure to maintain proper professional standards and was fundamentally incompatible with continued registration. Accordingly, the Tribunal concluded that erasing Dr Ibrahim's name from the medical register was the only means of protecting the public, maintaining public confidence in the profession, and declaring and upholding proper standards and conduct.

105. The Tribunal therefore directs that Dr Ibrahim's name be erased from the Medical Register.

Determination on Immediate Order - 12/09/2023

106. Having determined to that Dr Ibrahim's name be erased from the Medical Register, the Tribunal considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

107. On behalf of the GMC, Mr Grundy invited the Tribunal to impose an immediate order on Dr Ibrahim's registration and to revoke the interim order currently in place. He stated that it would not be appropriate, if Dr Ibrahim chooses to come to the UK and appeal the Tribunal's decision, for him to continue in unrestricted practice before the substantive order takes effect.

108. Dr Ibrahim made no submissions on Immediate Order.

The Tribunal's Decision

109. In reaching its decision, the Tribunal considered the relevant paragraphs of the SG and exercised its own independent judgement. In particular, it took account of paragraphs 172, 173 and 178 which state:

> '172 *The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> …
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'*

110. The Tribunal determined that, for all the reasons it has already set out in making its determination on sanction, in particular as to the risks Dr Ibrahim poses to patient safety, it is necessary for the protection of members of the public, and otherwise in the public interest for an immediate order of suspension to be made on Dr Ibrahim's registration. It is in the public interest for an immediate order to be made to protect public confidence in the profession.

111. This means that Dr Ibrahim's registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

112. The interim order will be revoked when the immediate order takes effect.

113. That concludes this case.