PUBLIC RECORD

Date: 14/07/2023

Medical Practitioner's name: Dr Maher MOHAMMAD

GMC reference number: 6127216

Primary medical qualification: MB BS 1997 University of Karachi

Type of case

Review - Misconduct

Outcome on impairment

Not Impaired

Summary of outcome

Suspension revoked

Tribunal:

Legally Qualified Chair	Miss Megan Larrinaga
Medical Tribunal Member:	Dr Deborah Brooke
Medical Tribunal Member:	Dr Leigh-Anne Hill

Tribunal Clerk:	Mr Larry Millea

Attendance and Representation:

Medical Practitioner:	Present and not represented
GMC Representative:	Mr Neil Shand, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Impairment - 14/07/2023

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

The Outcome of Applications Made during the Impairment Stage

2. The Tribunal granted the GMC's application, made pursuant to Rule 41 of the Rules, that the Tribunal sit in private when considering matters relating to XXX. This application was not opposed by Dr Mohammad.

3. This determination will be read in private. However, as this case concerns Dr Mohammad's misconduct a redacted version will be published at the close of the hearing.

Background

4. Dr Mohammad qualified in 1997, obtaining a MB BS from the University of Karachi. At the time of the events, Dr Mohammad was practising as a locum middle grade doctor in Obstetrics and Gynaecology at South Lakes Birth Centre at Furness General Hospital ('the Hospital').

5. The facts found proved at Dr Mohammad's hearing which took place from December 2022 to January 2023 ('the 2022 Tribunal') can be summarised as that on 9 November 2019, Dr Mohammad failed to provide good clinical care to Patient A. The 2022 Tribunal found that Dr Mohammad failed to request the assistance of a senior colleague, or take any steps to inform a senior colleague that a potential complication had occurred during his treatment of

Patient A, and, failed to request the support of the duty Consultant Obstetrician or inform them that difficulties had been encountered. It was also found that Dr Mohammad failed to keep adequate records. The initial concerns were raised with the GMC on 12 February 2020 by Patient A's partner via an online referral form.

6. This is the first review of Dr Mohammad's case, which was first heard by the 2022 Tribunal, at which Dr Mohammad was neither present nor represented. However, he did provide a written response to the Allegation through his representatives and a bundle of documents which the 2022 Tribunal considered in reaching its determinations.

7. The 2022 Tribunal considered whether Dr Mohammad's actions amounted to misconduct. In doing so it bore in mind the expert witness evidence that the overall standard of care provided by Dr Mohammad was seriously below the standard expected of a reasonably competent Middle Grade doctor in Obstetrics and Gynaecology and that his failure to keep adequate records fell below, but not seriously below, the standards expected. The 2022 Tribunal was satisfied that Dr Mohammad's overall standard of care placed Patient A at serious risk of harm.

8. The 2022 Tribunal determined that Dr Mohammad's actions breached multiple paragraphs of Good Medical Practice (2013) ('GMP') and considered a previous finding of misconduct against Dr Mohammad in 2021 which resulted in a two-month suspension. The 2021 finding of misconduct related to Dr Mohammad's care and treatment of a patient in 2018 and involved matters similar to that which were before the 2022 Tribunal.

9. Given the 2022 Tribunal's findings on facts, the expert evidence, the requirements of GMP, and the similar nature of the previous misconduct, it determined that fellow members of the profession and members of the public would regard Dr Mohammad's misconduct as particularly serious. Therefore, the Tribunal found that Dr Mohammad's actions fell far below the standards expected of a registered doctor and found that this amounted to misconduct, which was serious.

10. In considering impairment, the 2022 Tribunal noted that the misconduct in respect of providing poor clinical care and maintaining poor records could reasonably be expected to be remediated.

11. The 2022 Tribunal acknowledged that Dr Mohammad had reflected on this incident and had developed some insight. This led the 2022 Tribunal to consider that the risk of

repetition had reduced. However, this evidence of insight was balanced with the previous finding of impairment 11 months previously and the 2022 Tribunal was satisfied that a risk of repetition remained.

12. In respect of remediation, the 2022 Tribunal considered the evidence of training and development. It could not be sure when the courses alluded to by Dr Mohammad in his representations were completed. It was of the view that the courses would have been undertaken prior to July 2022 as that bundle had accompanied his Rule 7 Response to the GMC. The 2022 Tribunal was not provided with certificates for the courses it considered to be particularly important, specifically *Communication Skills, Caesarean complexity - RCOG, and Bladder Injury during caesarean delivery*. The 2022 Tribunal considered that Dr Mohammad's reflections on these last two important courses lacked sufficient detail to demonstrate his learning in the areas of causes, frequency, detection, and management of these clinical challenges.

13. The 2022 Tribunal considered that insufficient evidence had been provided by Dr Mohammad to demonstrate that he:

- understood the importance of keeping his clinical records up to date and documenting his actions according to applicable guidance;
- had changed the way he investigated and managed operative complications;
- could be candid with colleagues and would be more proactive in seeking advice from them in the future, should things go wrong;
- had accepted responsibility for his shortcomings.

14. Without this information, the 2022 Tribunal could not be satisfied that Dr Mohammad had yet developed a sufficient level of insight.

15. The 2022 Tribunal considered that all three limbs of the Overarching Objective were engaged and that a finding of impairment was necessary in order to protect the public, maintain public confidence and to uphold and maintain standards for members of the profession. In reaching this determination, the 2022 Tribunal considered that a reasonable and well-informed member of the public would expect a finding of impairment to be made to mark the seriousness of the misconduct in the case and to maintain public confidence in the profession.

16. The 2022 Tribunal then went on to consider sanction. In doing so, it considered the previous finding of impairment 11 months previously, in a case similar to the Allegation before it, to be an aggravating factor. The 2022 Tribunal was of the view that Dr Mohammad would have been aware of ongoing inquiries as to the previous matter at the time of this incident. He knew his practice was under scrutiny and investigation at the time, and yet failed to provide a suitable standard of care to Patient A.

17. The 2022 Tribunal also considered that there were mitigating factors which included: Dr Mohammad's response and subsequent evidence demonstrating that he had developed some insight; Dr Mohammad's difficult personal circumstances at the time of the incident; the number of courses Dr Mohammad had undertaken to demonstrate his remediation; the positive testimonials provided on Dr Mohammad's behalf, and; his expressions of regret and apology.

18. Given the nature of Dr Mohammad's misconduct, which involved causing risk to patient safety, and was a second finding against him by the MPTS, the 2022 Tribunal was not satisfied there were any exceptional circumstances which would justify taking no action. Further, the 2022 Tribunal did not consider that conditions would be workable or that appropriate conditions could be formulated to address its concerns or that the imposition of conditions on Dr Mohammad's registration would sufficiently mark the gravity of the misconduct.

19. The 2022 Tribunal had concluded that Dr Mohammad's conduct represented a significant departure from the principles of GMP and presented a risk to patient safety and undermined public confidence in the profession. It considered that suspension would have a deterrent effect and would send a sufficiently robust signal to the profession and the public about the standards of conduct expected and how those standards are to be upheld. It determined that a period of suspension would maintain public confidence in the profession, as the public would understand that Dr Mohammad was prevented from working as a doctor for a period of time. This would protect patients as Dr Mohammad would be prevented from practising until he had remediated his misconduct. It concluded that all three elements of the overarching objective could be addressed by a period of suspension.

20. The 2022 Tribunal took the view that Dr Mohammad's conduct was unbefitting of a medical practitioner but fell short of being fundamentally incompatible with continued medical registration. The Tribunal concluded therefore that erasure would be a disproportionate sanction in the circumstances of this case.

21. The 2022 Tribunal concluded that a five-month period of suspension would be the appropriate sanction to reflect the seriousness of Dr Mohammad's misconduct. It considered that a shorter period of suspension would not give Dr Mohammad, who would have the persuasive burden of demonstrating his fitness to practise at a review hearing, sufficient time to remediate, given his current level of insight. The 2022 Tribunal considered that such a period would give Dr Mohammad the opportunity to develop further insight and demonstrate further remediation in relation to his actions.

22. The 2022 Tribunal indicated that a reviewing Tribunal may be assisted by:

- A detailed reflective statement which addresses Dr Mohammad's further development of his communication skills, clinical skills in recognising and managing operative complications including bladder injury during caesarean delivery and outlines the actions he has taken to assist his remediation and address the risk of repetition;
- Evidence of Continuing Professional Development which shows how Dr Mohammad has maintained his skills and kept his clinical knowledge up to date, and;
- Any other information which Dr Mohammad considered would assist the reviewing Tribunal.

The Evidence

23. The Tribunal has taken into account all the evidence received before it.

24. The Tribunal received two substantive bundles of documentary evidence, one on behalf of the GMC and the other on behalf of Dr Mohammad. These bundles included, but were not limited to:

- Record of determinations of the 2022 Tribunal;
- A number of emails and notes of telephone calls between Dr Mohammad and the GMC, between March and July 2023;
- Twelve CPD certificates of completion/diplomas undertaken by Dr Mohammad, various dates;
- A reflective statement from Dr Mohammad dated 6 July 2023.

Submissions

25. On behalf of the GMC, Mr Shand, Counsel, submitted that the GMC was neutral on whether Dr Mohammad's fitness to practise remained impaired.

26. Mr Shand reminded the Tribunal of the information the 2022 Tribunal considered would be useful when determining whether Dr Mohammad's fitness to practise remained impaired.

27. Mr Shand accepted that Dr Mohammad had provided an extensive reflective statement which addresses his further development in his communication skills and his clinical skills, notably including reflections on recognising and managing operative complications including bladder injury during caesarean delivery.

28. Mr Shand noted that some of the CPD certification predated the 2022 Tribunal. He submitted that this may have arisen as a result of it being identified at that hearing that no certificates had been provided for some of the courses referred by Dr Mohammad. Mr Shand also highlighted that many of the recent courses were from a recent and restricted period of time.

29. Dr Mohammad, in his submissions on impairment, apologised to Patient A for the serious adverse incident she experienced and the fact that she suffered an injury. He stated that the complication which arose in her case was a recognised complication of a caesarean section but acknowledged a more thorough assessment and other steps should have been taken in respect of Patient A. He acknowledged that he should have acted differently when treating her and identified steps he would now take to ensure the mistake was not repeated. Dr Mohammad apologised to the hospital and stated that he had learned his lesson. He submitted that he had worked in the UK for over 23 years in various parts of the country and this was the first occasion on which this complication had arisen. He stated that the case had a significant impact on his life, XXX, his ability to earn a living and had not been good for his family.

30. Dr Mohammad submitted that he recognised that he had made mistakes in his care of Patient A but had reflected, had done reading during his suspension and was currently undertaking a course (which was subsequently identified as a diploma in women's health). He invited the Tribunal to find that his fitness to practise is no longer impaired.

The Relevant Legal Principles

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

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

The Tribunal's Determination on Impairment

Misconduct

33. In reaching its determination, the Tribunal considered that Dr Mohammad's misconduct was remediable and did not breach fundamental tenets of the profession. It therefore considered whether Dr Mohammad had further developed his insight following the 2022 Tribunal and whether he had sufficiently and appropriately remediated the matters giving rise to the finding of misconduct.

34. The Tribunal noted from the evidence of the telephone calls between Dr Mohammad and the GMC prior to the review hearing where it appeared he did not accept the findings and considered he was being blamed for matters which were not his fault. However, the Tribunal attached little weight to this evidence, particularly in light of the fact that the content of the telephone calls had not been agreed by Dr Mohammad as being accurate. In any event, the Tribunal had regard to the fact that the telephone calls took place at a time when Dr Mohammad appeared to have been undergoing a period of significant stress XXX, there was difficulty in his family life, he was unable to work and there were concerns about his finances.

35. The Tribunal noted that the notes of the contents of the telephone calls pre-dated Dr Mohammad's extensive written reflective piece which runs to some 28 pages. The Tribunal noted that the reflective piece set out in detail the circumstances of Patient A, the symptoms

she experienced on the day, what he did and, of most significance to the Tribunal, how he should have reacted on encountering some of her symptoms including identifying possible causes of her complications and proposed treatments. The Tribunal noted that Dr Mohammed referred to discussing matters with other members of the delivery team including a senior experienced midwife and involving his Consultant at a much earlier stage. He also stated that he would ensure that notes were completed in an appropriate time and identified the benefits of accurate and timely record keeping.

36. It appeared to the Tribunal that Dr Mohammad had done extensive reading to support his reflective statement which also included a section titled *"Lessons Learned"* and evaluating his own fitness to practise in light of his previous conduct.

37. The Tribunal noted that in addition to his reflective piece, Dr Mohammad provided evidence of courses he had attended prior to the 2022 Tribunal and since his suspension. Those courses included *"Wound Healing after c-section"*, *"Neonatal Sepsis"*, *"Basic Life Support"* and *"Effective Communication Skills for Managers"*. The Tribunal also noted that Dr Mohammad was currently undertaking a diploma in women's health and his learning will post-date the conclusion of this review hearing.

38. The Tribunal was satisfied that the written reflective piece provided by Dr Mohammad would have taken a significant period to write and this was supported by the evidence during his telephone calls with the GMC where he referred to spending a period of weeks on it. The Tribunal also noted that Dr Mohammad requested an extension of time to complete his reflective piece, which was granted and that it was provided in time for the hearing.

39. The Tribunal was satisfied that the reflective piece demonstrated significant reflection by Dr Mohammad of his care and treatment of Patient A, identified what went wrong in the circumstances and also identified what he should have done differently in her case and would do differently in the future. The Tribunal considered that the reflective piece addressed the concerns of the 2022 Tribunal, not only in respect of his clinical skills, but also his communication skills and the actions he has taken to remediate. The Tribunal was also reassured that the reflective piece did not seek to place blame elsewhere for Patient A's outcome and that his insight had further developed during the period of his suspension.

40. The Tribunal went on to consider whether Dr Mohammad has provided the evidence suggested by the 2022 Tribunal, as set out above. In respect of communication skills, Dr

Mohammad has provided a CPD certificate dated 29 June 2023 in *Effective Communication Skills for Managers*. The Tribunal was satisfied that his CPD courses had addressed issues giving rise to the misconduct in respect of his clinical care and had maintained his medical knowledge and skills.

41. In light of the evidence before it, the Tribunal was satisfied that Dr Mohammad has fully addressed the concerns of the 2022 Tribunal such that it assessed the risk of repetition as being low. It further considered that Dr Mohammad did not otherwise represent a risk to patient safety. The Tribunal noted Dr Mohammad's repeated apologies both orally and in his written reflections, and accepted that these expressions were heartfelt and genuine.

42. As such, the Tribunal determined that Dr Mohammad's fitness to practise is no longer impaired by reason of misconduct.

43. The Tribunal, having determined that Dr Mohammad's fitness to practise is no longer impaired, also determined that the current order of suspension should be revoked with immediate effect.

44. That concludes this case.