PUBLIC RECORD

Dates: 15/02/2022 - 11/03/2022
25/04/2022 – 29/04/22

Medical Practitioner's name: Dr Omar Ali

GMC reference number: 4728870

Primary medical qualification: MB BS 2000 University of London

Type of case
New - Misconduct

Outcome on impairment
Not Impaired

Summary of outcome
No warning

Tribunal:

Legally Qualified Chair	Mr Colin Chapman
Lay Tribunal Member:	Mrs Sue Wadham
Medical Tribunal Member:	Dr Helen Crabtree

Tribunal Clerk:	Sewa Singh

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Owain Thomas, QC, instructed by RadcliffesLeBrasseur Solicitors
GMC Representative:	Ms Kathryn Johnson, 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 Facts - 27/04/2022

Background

1. Dr Ali qualified in 2000 at the University of London. He was awarded a PhD from Imperial College London, in 2010. Dr Ali undertook specialist training in Cardiology during which he completed a seven month international interventional fellowship in 2013 at the Erasmus Medical Center and Maasstad Hospital in Rotterdam.

2. Dr Ali completed his specialist training in 2013. Dr Ali was subsequently appointed as a locum Consultant Cardiologist at the Wexham Park Hospital ('the Hospital'), part of Frimley Health NHS Foundation Trust ('the Trust') and in November 2014 to a substantive post. At the time of the events before the Tribunal, he was working at the Hospital.

3. The allegations that have led to Dr Ali's hearing relate to four patients, and can be summarised as follows:

Patient A

4. Patient A, a 75 year old male, underwent a Percutaneous Coronary Intervention (PCI) procedure on 10 November 2016, performed by Dr Ali. Patient A died in the evening of the same day. The allegation against Dr Ali in this respect is that when he met with Patient A on 10 November 2016, he failed to adequately obtain consent from him regarding the PCI procedure by failing to outline any of the heightened benefits and risks of the procedure specific to Patient A, and that he did not record any discussion he had with Patient A regarding this in his Hospital medical notes.

5. It is also alleged that at the end of the PCI procedure, Dr Ali failed to recognise that Patient A's angiogram showed occlusion of the first and second septal arteries. Further, it is

alleged that he made an inaccurate record of Patient A's PCI procedure in that he recorded 'no complications' when Patient A suffered from side branch occlusion.

Patient B

6. Patient B, a 52 year old female, underwent a PCI on 19 January 2017, performed by Dr Ali. Patient B died in the evening of the same day. The allegation against Dr Ali in this respect is that between 9 December 2016 and 19 January 2017, he failed to adequately obtain consent from Patient B for the PCI procedure in that he did not personally consult with her to discuss her current symptoms, or available treatment options, or the reasons for any recommendations or conclusions made or reached by the Multi-Disciplinary Team (MDT).

7. It is also alleged that during the PCI procedure, Dr Ali failed to identify a coronary perforation or carry out a number of procedures, including: undertaking prolonged low pressure balloon inflation to control the perforation; undertaking or arranging an emergency echocardiogram in the catheter laboratory; making preparations for immediate pericardiocentesis; or undertaking prolonged low pressure balloon inflation or inserting a covered stent to seal the perforation. Further, it is alleged that at the conclusion of the PCI procedure, Dr Ali requested Patient B be given 3000 international units ('iu') of heparin when it was inappropriate to do so.

8. It is also alleged that on 19 January 2017, Dr Ali requested an echocardiogram to be performed once Patient B had returned to the ward, but failed to ask to be informed of the result or request confirmation as to when it had taken place. Further, it is alleged that during his review of Patient B around 1930 hours when he became aware the echocardiogram had not been carried out, he failed to arrange for it to be done immediately and failed to provide any explanation to Patient B about the outcome of the procedure or why an overnight stay at the Hospital was required.

9. It is also alleged that Dr Ali recorded incorrect information regarding Patient B in a Datix report and in a witness statement provided to the Coroner in which he described the complication as a coronary dissection and that he provided evidence at Patient B's inquest about the procedure on Patient B which was untrue. It is alleged that these actions were dishonest.

Patient C

10. Patient C, a 70 year old female, underwent a PCI procedure on 19 January 2017, performed by Dr Ali. The allegation against Dr Ali in this respect is that he failed to: adequately review Patient C's case; adequately obtain consent from Patient C for the PCI; challenge the decision of Dr E and the MDT to proceed to PCI to the circumflex coronary artery; and that he made the decision to undertake the PCI when it was inappropriate to do. It is alleged that during the procedure, Dr Ali failed to anticipate the finding of an un-dilatable stenosis and used a non-compliant balloon to try to dilate the coronary artery at a pressure which was inappropriate to do so.

11. It is further alleged that Dr Ali caused Patient C to have a perforation of the coronary artery and failed to respond appropriately in that he failed to: undertake or arrange for an emergency echocardiogram in the catheter laboratory; consider and/or make preparations for immediate pericardiocentesis; to adequately consider and/or make preparations for insertion of a covered stent to seal the perforation; and to recognise and/or record that Patient C had suffered from major side branch occlusion leading to myocardial infarction.

12. It is also alleged that Dr Ali failed to communicate adequately with Patient C following the procedure, make an appropriate note of the procedure including the complications encountered or a note of any discussions with Patient C regarding the complications and any apology given.

Patient D

13. Patient D, a 74 year old male, underwent a PCI procedure on 30 May 2017, performed by Dr Ali. The allegation against Dr Ali in this respect is that on or about 12 May 2017, he inappropriately recommended that Patient D undergo invasive coronary angiography rather than non-invasive functional imaging. It is also alleged that on 22 May 2017, during a consultation with Patient D, Dr Ali recommended that Patient D should proceed to invasive coronary angiography with a view to angioplasty without first assessing the impact of escalation of optimal medical therapy on Patient D's symptoms.

14. Further, it is alleged that between 22 May 2017 and 30 May 2017 Dr Ali failed to consider other treatment options with an MDT for Patient D, that he failed to appropriately obtain consent from Patient D for the angiography and angioplasty procedure as he did not discuss the risks and benefits of the procedure, nor any alternative treatments available, and that he failed to record having undertaken these actions.

15. The matters in the case of Patient D came to the attention of the GMC following a self-referral by Dr Ali.

The Outcome of Applications Made during the Facts Stage

16. The Tribunal granted three applications made by Ms Kathryn Johnson, Counsel for the GMC, pursuant to Rule 17(6) of the Rules, to amend paragraphs 1(c), 3(f), 5(c)(i) and (ii), 6(a)(ii), 15(h)(iv), 16, 19 and 20, of the Allegation. As all three applications were unopposed by Mr Owain Thomas QC, Dr Ali's Counsel, it was not necessary for the Tribunal to produce written determinations.

The Allegation and the Doctor's Response

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

Patient A

1. On 10 November 2016 you:

a. met with Patient A at which time you failed to:

i. adequately obtain consent from Patient A for the Percutaneous Coronary Intervention ('PCI') procedure in that you did not outline the benefits and the heightened risks of this procedure specific to Patient A;
To be determined

ii. record in Patient A's notes any discussion with Patient A regarding the benefits and heightened risks of PCI specific to Patient A.
To be determined

b. operated on Patient A at the end of which you failed to recognise that Patient A's angiogram showed occlusion of the first and second septal arteries;
To be determined

c. made an inaccurate record of Patient A's PCI procedure in that you recorded 'No complications' when Patient A suffered from ~~persistent~~ side branch occlusion.
(Amended following a Rule 17(6) application)
To be determined

Patient B

2. Between 9 December 2016 and 19 January 2017, you failed to adequately obtain consent from Patient B for the PCI procedure in that you failed to personally consult with Patient B to discuss:

a. her current symptoms;
To be determined

b. the treatment options available;
To be determined

c. the reasons for any recommendations or conclusions of an MDT.
To be determined

3. On 19 January 2017 you performed a PCI procedure ('the Procedure') on Patient B and you failed to:

a. identify a coronary perforation;

To be determined

b. undertake prolonged low pressure balloon inflation to control the perforation;
To be determined

c. undertake or arrange an emergency echocardiogram in the catheter laboratory;
To be determined

d. make preparations for immediate pericardiocentesis;
To be determined

e. undertake prolonged low pressure balloon inflation and/or insert a covered stent to seal the perforation;
To be determined

~~f. make any preparations for possible emergency cardiac surgery.~~
(Withdrawn following a Rule 17(6) application)

4. Following completion of the Procedure at 10:31 you requested Patient B be given 3000 iu of Heparin when it was inappropriate to do so.
To be determined

5. Following the Procedure on 19 January 2017 you requested an echocardiogram be performed once Patient B had returned to the ward and you failed to:

a. ask to be informed of the result;
To be determined

b. request confirmation as to when it had taken place;
To be determined

~~c. record in the alternative to paragraphs 5a and 5b having undertaken the actions as outlined at:~~

~~i. 5a;~~

~~ii. 5b.~~
(Withdrawn following a Rule 17(6) application)

6. During your review of Patient B on 19 January 2017 at around 19:30 hours you were aware that an echocardiogram had not been performed and you failed to:

a. arrange for it to be performed:

i. immediately;
To be determined

ii. ~~before you left the hospital;~~ as soon as possible
(Amended following a Rule 17(6) application)
To be determined

b. provide any explanation to Patient B as to:

i. the outcome of the Procedure;
To be determined

ii. why an overnight hospital stay was required;
To be determined

c. record in the alternative to paragraph 6b having undertaken the actions as outlined at paragraph 6b.
To be determined

7. You failed to accurately record the Procedure in Patient B's notes in that you:

a. did not record the coronary perforation;
Admitted and found proved

b. incorrectly indicated that Patient B had suffered a localised dissection.
Admitted and found proved

8. On 23 April 2017 you completed a Datix report in respect of Patient B in which you described the complication that had occurred as a coronary dissection.
Admitted and found proved

9. On or around 27 April 2017 you signed a witness statement to be provided to the Coroner hearing Patient B's inquest in which you described the complication that had occurred as a coronary dissection.
To be determined

10. You knew as at the dates that you signed the datix report and statement to the coroner that the complication that had occurred was a coronary perforation given that you had recognised and described it as such at a:

a. Multidisciplinary team meeting on 26 January 2017;
To be determined

b. Mortality and Morbidity meeting on 16 March 2017.
To be determined

11. Your actions as outlined at paragraphs 8 and 9 above were dishonest by reason of paragraph 10.
To be determined

12. On 27 February 2018 you gave evidence at Patient B's inquest at which time you stated:

a. 'The third image in that series is actually the balloon tamponade and it is in run 20…', or words to that effect;
Admitted and found proved

b. 'The third inflation is of the same balloon but at low pressure to seal the leak', or words to that effect.
To be determined

13. You knew that this was untrue as you had not performed balloon tamponade (prolonged balloon inflation) as:

a. the NC Trek balloon inflation at run 20 did not cover the site of the perforation;
To be determined

b. none of the post-dilation inflations of the NC Trek balloon were inflated at low pressure;
To be determined

c. none of the post-dilation inflations of the NC Trek balloon were appropriately prolonged to occlude or seal a perforation.
To be determined

14. Your actions as outlined at paragraph 12 above were dishonest by reason of paragraph 13.
To be determined

Patient C

15. On 19 January 2017 you:

a. failed to adequately review Patient C's case;
To be determined

b. failed to adequately obtain consent from Patient C for the PCI procedure;
To be determined

c. failed to challenge the decision of Dr B and the MDT to proceed to PCI to the circumflex coronary artery;
To be determined

d. made the decision to proceed to PCI when it was inappropriate to do so;
To be determined

e. failed to anticipate the finding of an un-dilatable stenosis that you encountered during the PCI procedure;
To be determined

f. used a 4.0mm non-compliant balloon at a pressure of 30 atmospheres to try and dilate the coronary artery when it was inappropriate to do so;
To be determined

g. caused Patient C to have a coronary perforation;
Admitted and found proved

h. failed to respond appropriately when Patient C suffered a coronary perforation in that you failed to:

i. undertake or arrange an emergency echocardiogram in the catheter laboratory;
To be determined

ii. consider and/or make preparations for immediate pericardiocentesis;
To be determined

iii. consider and/or make preparations for insertion of a covered stent to seal the perforation;
To be determined

iv. ~~consider and/or make preparations for emergency cardiac surgery;~~
(Withdrawn following a Rule 17(6) application)

j. failed to recognise and/or record that Patient C had suffered from major side branch occlusion leading to myocardial infarction;
To be determined

k. failed to communicate adequately with Patient C following the procedure;
To be determined

l. failed to make an appropriate note of the PCI procedure to include the complications encountered;
To be determined

m. failed to make a note of any discussions with Patient C regarding the complications encountered and any apology given.
To be determined

Patient D

16. On or about 12 May 2017, ~~you wrote to Patient D and~~ you inappropriately recommended invasive coronary angiography rather than non-invasive functional imaging.
(Amended following a Rule 17(6) application)
To be determined

17. On 22 May 2017, you consulted with Patient D and you inappropriately recommended for Patient D to proceed to invasive coronary angiography with a view to angioplasty (PCI) without first assessing the impact of escalation of optimal medical therapy on Patient D's symptoms.
To be determined

18. Between 22 May and 30 May 2017 you failed to:

a. consider with an MDT other options for treatment that were available to Patient D;
To be determined

b. appropriately obtain consent from Patient D for the angiography leading to angioplasty procedure ('the Procedure') to be undertaken in that you did not discuss:

i. the risks and benefits of the Procedure;
To be determined

ii. alternative treatments which were available;
To be determined

c. record having undertaken the actions as set out at paragraphs:

i. 18a;
To be determined

ii. 18b.
To be determined

~~19. On 3 July 2017, you ceased private practice and failed to arrange to transfer Patient D's care to a named individual colleague.~~
(Withdrawn following a Rule 17(6) application)

~~20. On 25 September 2019, you wrote to Patient D in response to his complaint and you:~~ (Withdrawn following a Rule 17(6) application)

~~a. inappropriately included an academic paper in your response;~~

~~b. failed to explain fully to Patient D the nature and impact of stent fracture.~~

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

The Admitted Facts

18. At the outset of these proceedings, through his Counsel, Dr Ali made admissions to some 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'). The Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved, in accordance with Rule 17(2)(e) of the Rules. The admissions are reflected in the above paragraphs.

The Facts to be Determined

19. In light of the above, the Tribunal then determined the disputed allegations.

Evidence

20. The Tribunal received oral evidence on behalf of the GMC from the following witnesses, together with their witness statement:

- Mrs F, witness statement dated 15 September 2021;
- Miss G, witness statement dated 7 October 2021;

- Dr H, witness statement dated 14 February 2019;
- Dr I, witness statement dated 20 March 2019;
- Patient C, witness statement dated 30 September 2021;
- Patient D, witness statement dated 24 September 2021;
- Dr B (Dr E), witness statement dated 3 February 2022.

21. The Tribunal received witness statements on behalf of the GMC from the following who were not called to give evidence:

- Ms S (Nurse), witness statement undated but approved on 17 September 2021;
- Ms U (Nurse), witness statement dated 23 September 2021.

22. The Tribunal also received oral evidence from the GMC expert, Dr J, together with his reports in relation to Patients A – D as follows:

- Regarding Patient B dated 1 June 2018;
- Regarding Patient B dated 4 August 2020 (supplementary);
- Regarding Patient A and C dated 20 August 2019;
- Regarding Patients A and C dated 20 December 2019 (supplementary);
- Regarding Patient D dated 14 August 2020;
- Regarding Patients A – D dated 23 March 2021 (supplementary);
- Regarding Patients B – D dated 11 October 2021 (further supplementary);
- Regarding Patients A – D dated 15 February 2022 (further supplementary).

23. Dr Ali provided a witness statement regarding Patients A, B and D dated 7 February 2022, and a further witness statement dated 11 February 2022 regarding Patient C. Dr Ali also gave oral evidence at the hearing.

24. The Tribunal also heard testimonial evidence on behalf of Dr Ali from the following witnesses, and received their written testimonies:

- Dr K – testimony dated 20 May 2021;
- Dr L – testimony dated 3 January 2021;
- Dr M – testimony dated 1 March 2022.

25. The Tribunal also received written testimonies on behalf of Dr Ali from the following:

- Dr N – dated 29 December 2021;
- Dr O – dated 20 January 2022;
- Dr P – dated 1 February 2022;
- Dr Q – dated 4 February 2022;
- Dr R – dated 1 March 2022.

Documentary Evidence

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

- Hospital medical records for Patients A, B, C and D;
- Dr Ali's first and second statements to the Coroner dated 27 April 2017 and 7 July 2017 respectively;
- Manuscript and typed notes of Dr Ali's meetings with Dr H and Dr I on 22 June 2017 and 26 June 2017;
- Transcript of Dr Ali's interview dated 10 November 2017;
- Transcript of the oral evidence provided by Dr Ali to the Coroner's inquest in relation to Patient B dated 27 February 2018;
- Dr Ali's statement dated 11 June 2018;
- Dr Ali's slides presented to the Morbidity and Mortality (M&M) meeting on 16 March 2017;
- Schedule of Timings for Imaging re Patient B provided by Dr Ali;
- Dr Ali's Curriculum Vitae (CV).

The Tribunal's Approach

27. In reaching its decision on facts, the Tribunal reminded itself that the burden of proof rests on the GMC and it was for the GMC to prove the Allegation. Dr Ali did not need to prove anything. The standard of proof was that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it was more likely than not that the events occurred as alleged.

28. The Tribunal considered each of the four Patients and each outstanding paragraph of the Allegation separately and evaluated the evidence to make its findings on the facts. Those paragraphs which were admitted and found proved, or amended following a Rule 17(6) application, have also been included below for completeness.

The Tribunal's Analysis of the Evidence and Findings

29. In relation to each Patient, the Tribunal has first set out a summary of the background leading to each Patient being treated by Dr Ali which it thought would assist in understanding the context of the outstanding paragraphs of the Allegation. In each case, our summary of the background is based on evidence before us which was not disputed by the parties. After setting out the background, we have then considered each allegation separately regarding that Patient.

30. The Tribunal heard evidence about certain terms regarding patient management which were common to the allegations concerning each of the four Patients. It considered that it might be helpful to explain its understanding of those terms before setting out its findings regarding each Patient and each outstanding paragraph of the Allegation.

Coronary Angiography

31. Coronary angiography, also known as cardiac catheterisation, is a procedure which uses a cardiac catheter. This is a thin flexible tube which is inserted into an artery in the wrist or groin and then guided into the area of the heart which needs to be examined or treated. This is used to inject dye into the coronary arteries and a series of X-rays are taken to monitor and assess the flow of blood and any stenosis (narrowing) of the artery caused by plaque build-up, a condition known as atherosclerosis.

32. An angiogram therefore provides information which can be used to treat the condition. The images are taken by a camera which moves over the body of the patient and takes images from different positions. The images can either be seen as still images or in a 'loop' view which are moving images which continuously replay.

Coronary Angioplasty

33. Coronary angioplasty is a procedure which uses the catheter to deliver a balloon to the area of stenosis. The balloon is inflated to widen the stenosis so that blood can flow more easily when the balloon is removed.

Percutaneous Coronary Intervention

34. A percutaneous coronary intervention ('PCI') is also known as a coronary angioplasty with a stent insertion. A stent is placed around the balloon. The stent expands when the balloon is inflated and remains in place when the balloon is deflated and removed.

35. The Tribunal noted that the terms 'PCI', 'PCI procedure', and 'the Procedure', were used in the paragraphs of the Allegation and in the evidence presented to the Tribunal. The Tribunal has adopted the term 'PCI' throughout the remainder of this determination.

Coronary Artery Dissection

36. A coronary artery dissection ('dissection') is a complication that can occur during PCI. A dissection is a tear in one of the inner layers of a coronary artery, which means that blood flows into the space between the layers and a blood clot may form blocking the artery. This can lead to myocardial infarction (heart attack) during or after the procedure. The blood remains contained within the walls of the artery.

37. A dissection is usually treated using the balloon and stent already inserted, expanding them further to push the vessel layers together.

Coronary Artery Perforation

38. A coronary artery perforation ('perforation') is a rare complication that can occur during PCI. A perforation occurs when there is a breach of the full thickness of the wall of a

coronary artery, essentially a hole. This leads to blood flowing out of the artery, known as 'extravasation', into the pericardium. The pericardium is the sac surrounding the heart which holds the heart in place and helps it to work properly.

39. Following a perforation, blood may build in the pericardium ('pericardial effusion'). The effusion if large enough, can put pressure on the heart and prevent it from working properly. If the perforation is not sealed, the effusion may increase in size, leading to heart failure or cardiac arrest. This is known as cardiac tamponade. Cardiac tamponade may occur during or up to 24 hours after the PCI and is treated by pericardiocentesis (a procedure removing the blood from the pericardium).

40. A perforation requires urgent treatment to stop the leak of blood into the pericardium. Measures might include pressing a balloon against the perforation for a prolonged period until it seals; deployment of further stents, including covered stents to seal the perforation; immediate echocardiography to ascertain the extent of the pericardial effusion; or if necessary, emergency cardiac surgery.

Multi-Disciplinary Team Meetings

41. The Tribunal heard evidence that multi-disciplinary team meetings ('MDT') took place weekly at the Hospital to discuss the management and treatment options for patients. Most patients were NHS patients, but private patients were not excluded.

42. The Tribunal heard evidence that the MDT was attended by several skilled and experienced members of the cardiology team along with cardiothoracic surgeons. The purpose of the MDT was to discuss and recommend strategies for treating individual patients having reviewed the patient's history along with any imaging available such as coronary angiography.

Consent

43. The Tribunal heard evidence about the way in which consent was obtained and recorded at the Hospital for cardiology procedures. It saw examples of consent being obtained by the operator of the procedure, by a suitably qualified nurse on the operator's behalf, or by the consultant in charge of a patient's care but who was not performing the procedure on the patient.

44. A pre-printed sticker was used to act as a prompt to the person explaining the risks and benefits of the procedure. This sticker was then attached to a consent form which was signed and dated by the patient and the person obtaining consent. An example of a sticker used for a procedure in which an angiogram was to be performed, followed if required by angioplasty and stenting shows:

> *'Name of proposed procedure or course of treatment: Coronary angiography +/- Coronary angioplasty/ Stenting'*

'I have explained the procedure to the patient in particular, I have explained:

Intended benefits: for diagnosis +/- treatment (treat narrowed or blocked heart arteries with balloons or stents

Serious or frequent occurring risks
Common complications: pain and bruising at the arterial access site.
Less common: 1 in 100 risk of complications which include death, heart attack, stroke, bleeding or damage of the artery access site or the need for emergency heart surgery if we proceed to an angioplasty, otherwise a 1 in 1000 risk'.

45. The Tribunal noted that the nature of the procedure, the intended benefits, and the risks are all recorded on the sticker.

46. Consent was also recorded by the operator who could activate an electronic entry on the Catheter Laboratory Procedure report ('CLR') indicating that consent had been obtained. The Tribunal heard evidence that this was usually done at the end of the procedure by the operator activating a tick-box when completing the CLR. When activated, the tick-box caused an entry in the CLR immediately below the time and date of the procedure which states:

'The procedure was explained in detail to the patient. Risks, complications and alternative treatments were reviewed. Written consent was obtained'

47. The Tribunal also heard evidence that the practice at the Hospital was that the clinical management of a patient was considered to be a continuing, evolving, and shared process which can involve several medical professionals each speaking to the patient at different times, each explaining different aspects of the patients' treatment, each checking that what has happened and said before has been understood, before explaining and obtaining the necessary consent for any planned investigation or treatment.

48. The Tribunal was referred to the GMC guidance at the time of the events entitled ***'Consent: patients and doctors making decisions together'*** (2008) which expands on Good Medical Practice ('GMP'). This requires doctors to be satisfied that they have consent from a patient, or other valid authority, before undertaking any examination or investigation, providing treatment, or involving patients in teaching and research.

49. The Tribunal noted that both paragraphs 18 and 23 of the guidance referred to involving other members of the healthcare team in the consent process. Paragraph 18 includes *'involve other members of the healthcare team in discussions with the patient..'*, and paragraph 23 states:

23 It is sometimes difficult, because of pressures on your time or the limited resources available, to give patients as much information or support in making

decisions as you, or they, would like. To help in this, you should consider the role that other members of the healthcare team might play….'.

50. The Tribunal was referred to paragraphs 26 and 27 of the guidance which permit delegation of the consent process to others. They state:

'26 If you are the doctor undertaking an investigation or providing treatment, it is your responsibility to discuss it with the patient. If this is not practical, you can delegate the responsibility to someone else, provided you make sure that the person you delegate to:

a is suitably trained and qualified
b has sufficient knowledge of the proposed investigation or treatment, and understands the risks involved
c understands, and agrees to act in accordance with, the guidance in this booklet.

27 If you delegate, you are still responsible for making sure that the patient has been given enough time and information to make an informed decision, and has given their consent, before you start any investigation or treatment.'

51. The Tribunal was satisfied from this evidence that the practice and procedures used at the Hospital for recording and obtaining consent were in accordance with the GMC Guidance and that Dr J did not disagree with this in his evidence. Dr J, however stressed that the ultimate responsibility for obtaining individualised, informed consent remained that of the operator of the procedure, and the Tribunal has noted this when considering those allegations involving the issue of consent.

Patient A

Background

52. Patient A was 75 years old in November 2016. He had a previous myocardial infarction in 2014. Subsequent treatment included stenting and medication for coronary artery disease ('CAD'). He was admitted to the Accident and Emergency Department on 4 November 2016 following a fall two days earlier. At the Hospital, it was found that he had chest pain and abnormal blood tests (raised serum troponin levels) indicative of a myocardial infarction. He was seen by the cardiology team.

53. On 7 November 2016 an angiogram was performed by Dr R. It was noted that Patient A now had high grade CAD with longstanding occluded right coronary artery, an occluded left anterior descending artery, and severe proximal circumflex disease. Dr R noted that Patient A was not an ideal candidate for surgery. Patient A's management was discussed at the MDT on 9 November 2016, following which Patient A was referred for PCI.

54. Dr Ali's involvement with Patient A was to perform the PCI. He performed the procedure on 10 November 2016. The Tribunal noted that, following the procedure, Dr Ali completed the CLR in which he summarised the background leading to the procedure, and what he had found and done during the procedure. He recorded that there had been a *'Good final result'* and that there were *'No complications'*.

Paragraph 1(a)(i) of the Allegation

1. On 10 November 2016 you:

a. met with Patient A at which time you failed to:

i. adequately obtain consent from Patient A for the Percutaneous Coronary Intervention ('PCI') procedure in that you did not outline the benefits and the heightened risks of this procedure specific to Patient A;

55. The Tribunal noted the evidence about how consent had been obtained from Patient A for the two procedures on 7 and 10 November 2016.

56. Regarding the angiogram undertaken on 7 November 2016, the Tribunal noted that consent was recorded using the standard sticker which indicated that the procedure was to be 'Coronary angiography +/- Coronary angioplasty/ Stenting'. It recorded benefits of the procedure and stated that the main risks included: *'1 in 100 risk of complications which include death, heart attack, stroke, bleeding or damage of the artery access site or the need for emergency heart surgery if we proceed to an angioplasty, otherwise a 1 in 1000 risk'.* The procedure itself was undertaken by Dr R who used the tick-box entry to make the standard entry that, at the beginning of the procedure, it had been explained to Patient A, risks, complications, and alternative treatments reviewed and consent obtained.

57. Next, the Tribunal had a copy of a note in Patient A's medical records, dated 9 November 2016, in which it is recorded that an explanation was provided to Patient A about the plans for his treatment at that time, which appears to include a discussion of treatment options including a bypass, and referral to MDT... It reads:

'WR Dr V
Silent MI
Presented w/fall, off legs for 2/7
Trop (arrow upwards) 2420 [ ]
Tx as NSTEMI
IP Angio (arrow to the right) high grade CAD
Explained to pt [ ] cardiothoracic MDT tomorrow ? bypass. Pt happy with this.
Echo: [ ] 467 akinetic apex, mid lateral
(P) [ ] MDT outcome'

58. Then, regarding the procedure performed by Dr Ali on 10 November 2016, the Tribunal noted that consent was obtained by Dr Ali in the same way as had been done on the earlier occasion. The standard sticker was used to indicate that the proposed procedure or course of treatment was 'Coronary angioplasty/Stenting', and to record the intended benefits. The main risks included: *'1 in 100 risk of complications which include death, heart attack, stroke, bleeding or damage of the artery access site or the need for emergency heart surgery.'*

59. The Tribunal noted that the description of the intended procedure and the risks differed from those on the consent sticker used three days earlier. On this occasion, there was no reference to risks of 1 in 1000 but only to the 1 in 100 risks. The Tribunal considered that these differences indicated that, although a standard sticker had been used, it had been varied to specify the risks for PCI.

60. The Tribunal also had a copy of Patient A's CLR relating to the PCI on 10 November 2016 on which Dr Ali had used the tick-box to record that consent had been obtained and the risks, complications and alternative treatments reviewed.

61. The Tribunal was therefore satisfied from these contemporaneous records that Dr Ali had obtained adequate consent from Patient A for the 1 in 100 risks associated with the PCI he was about to undergo on 10 November 2016.

62. Dr J's evidence was that Dr Ali should have discussed with Patient A, and recorded, that Patient A was at 'heightened risk' from the procedure. At paragraph 3.59 of his report dated 20 August 2019 Dr J states:

> *'There is no record of what discussion took place between Dr Ali and Patient [A] particularly the risks and benefits of PCI for Patient [A]. The risks quoted on the consent form appear to be the generic risks of routine cases. Patient [A] was at higher than usual risk of complications of PCI given the severity of his coronary artery disease'*

63. The Tribunal noted that the consent taken by Dr Ali relating to Patient A's PCI on 10 November 2016 specifically stated that the benefits of the PCI were to treat narrow or blocked heart arteries with stents/balloons and that these benefits were explained to Patient A. Therefore, the Tribunal considered that the benefits had been explained.

64. Regarding risks, the Tribunal noted the consent form sticker for coronary angiography and stenting stated there was a 1 in 100 risk of complications. The phrase regarding 1 in 1000 risks was not included. The Tribunal considered that, compared to the risks explained before the procedure on 7 November 2016, this showed that the risks were greater and therefore higher, or 'heightened' in relation to the procedure Dr Ali was about to perform.

65. Further, the Tribunal noted that neither in his report nor in his oral evidence was Dr J able to explain what the heightened risks were over and above the 1 in 100 risks cited on the

standard sticker. When questioned about this, Dr J was unable to explain what was heightened about the risk which made it a greater risk than the 1 in 100 already noted. He confirmed that in the United Kingdom there is no approved PCI risk calculator.

66. In his statement dated 7 February 2022, at paragraph 11, Dr Ali states:

> *'Patient A (A)'s angiogram would have been reviewed in our hospital MDT and his suitability for revascularisation with PCI discussed in detail. In this case, I would expect that Dr (R) would have had a copy of his Catheter lab report with him, or another part of the patient's records to prompt the discussion. I have no recollection of a heightened risk (beyond the 1:100 mentioned) for this patient being brought up in the MDT discussion. If it had been the consensus of the MDT that he was a particularly high risk, then I would tell the patient that.'*

67. In his evidence before the Tribunal Dr Ali stated that, although he was aware that Patient A was frail, there was no information in Patient A's medical or clinical notes to suggest that he was at a higher risk. Dr Ali told the Tribunal that in his view, the risks quoted to Patient A as part of the consenting process were sufficiently high to cover the risks which Patient A faced in undergoing the angioplasty procedure on 10 November 2016.

68. The Tribunal noted that several clinical staff had been involved in the treatment of Patient A and that his treatment had been discussed at the MDT following the findings made about the extent of his CAD during the angiography procedure on 7 November 2016. It noted the continuing and shared patient management process and that it was not presented with any significant evidence to suggest that any of the clinical staff involved in Patient A's care, before Dr Ali, considered that Patient A was at a higher risk than the 1 in 100 referred to when Dr Ali obtained Patient A's consent, before the procedure on 10 November 2016.

69. The Tribunal has already explained its understanding of the MDT at which Patient A's treatment was discussed before Dr Ali performed the PCI. It noted that there was no evidence to suggest that the MDT considered Patient A to be at heightened risk beyond that referred to in the consent obtained by Dr Ali before the PCI on 10 November 2016.

70. The Tribunal noted Dr J's retrospective opinion about the consent process which was partly based on the lack of records about what was actually said to Patient A during the consent process, but also noted that he could not be more specific about the nature or extent of the heightened risks. In these circumstances, the Tribunal preferred the contemporaneous records, and the evidence regarding the MDT, that Patient A was not considered to be at any more of a risk than the 1 in 100 about which there is evidence in the consent process.

71. The Tribunal therefore found paragraph 1(a)(i) of the Allegation not proved.

<u>Paragraph 1a(ii) of the Allegation</u>

ii. record in Patient A's notes any discussion with Patient A regarding the benefits and heightened risks of PCI specific to Patient A.

72. The Tribunal noted the comments made by Dr J at paragraph 3.59 of his report dated 20 August 2019 which are set out above.

73. The Tribunal had regard to the consent form dated 10 November 2016, signed by both Dr Ali and Patient A. In his evidence, Dr Ali said that he would have had some discussion with Patient A prior to the PCI. Although he accepted that he did not make a separate written record of what he said to Patient A, the very fact there is a sticker setting out the benefits and risks suggests that this is what was discussed. In relation to heightened risk, Dr Ali added that as there was no heightened risk, he would have had no reason to record such a risk.

74. In view of its finding in relation to paragraph 1(a)(i) above and in the light of Dr Ali's evidence, the Tribunal was not satisfied that the GMC had discharged the burden of proof regarding this allegation. It therefore found paragraph 1(a)(ii) of the Allegation not proved.

Paragraph 1b of the Allegation

b. operated on Patient A at the end of which you failed to recognise that Patient A's angiogram showed occlusion of the first and second septal arteries;

75. The Tribunal had regard to Dr J's evidence that the angiogram of Patient A's PCI shows that the procedure was complicated by occlusion (blocking) of the first and second septal arteries. He stated that occlusion of significant side branches may lead to myocardial infarction. The occlusion of significant side-branches is a recognised complication of a PCI. Dr J stated that the side branch occlusions are 'clearly evident' on the angiogram of Patient A's PCI.

76. Dr K provided two still images taken from the PCI, Dr Ali undertook on Patient A. Dr J's evidence was that the first image (Figure.3) (timed at 17:10:10) showed the septal branches before stenting took place. The second image (Figure.4) (timed at 18:39:59) was taken after stenting but the septal branches are not visible. Dr J's evidence was that this was because they had become occluded.

77. Dr J explained that in a PCI, a stent may be placed across the origin of a side branch of the vessel being stented. This is described as 'jailing' the side branch. A 'jailed' side branch can, but does not necessarily, have impaired blood flow and there may be no immediate adverse consequences from the 'jailing'. However, a 'jailed' side branch can also be significant because it may cause impaired access if further treatment is needed.

78. Dr Ali's evidence was that during the procedure, he inserted four stents. He stated that the image timed at 18:39:18 shows all four stents in place and that both the first and second septal branches are occluded. He went on to state, however, that the images timed at

18:39:59 and 18:40:18 show contrast in the septal branches which indicated there was now some flow down those branches. He said that the septal vessels had been 'jailed' rather than occluded. Dr Ali's evidence was that Dr J's reliance on the still images, frozen at a point in time chosen by Dr J, was insufficient to present the whole picture. His evidence was that reliance should be placed on the moving images, particularly if the images are viewed in a loop.

79. The Tribunal therefore had sight of the moving images. Dr J maintained that there was occlusion of the septal branches. He stated that if there was anything left visible in the septal branches it was contrast dye which had been trapped in the branch and not blood flow. Dr Ali stated that by comparing the moving images from the beginning and the end of the procedure it was clear that those at the end showed some blood flow in the branches at the end of the procedure thereby demonstrating that the branches were 'jailed' but not occluded.

80. Dr Ali told the Tribunal that he did not record on the CLR in writing that he had observed the occlusion of the first and second septal arteries because he recognised them as being 'jailed', and as being sub-totally occluded as there was partial flow of blood in those arteries. He added that this had no significance to the technical outcome of the PCI. He did accept, however, that he would now document his findings more fully to include mentioning the observed jailing or sub-total occlusion of the side vessels: *'If I saw now what appears on the previously described images, I would write that I had jailed and sub-totally occluded the septal branches, that is the S1 and S2. By sub-totally occluded I mean that there is impaired flow.'*

81. The Tribunal noted that in the CLR, written by Dr Ali immediately following the PCI, Dr Ali had recorded there had been a *'Good final result'* and that there were *'No complications'*. Although Dr Ali now accepts that he would not now write this and would document 'jailing' or sub-total occlusion, the Tribunal considered that he should have understood the importance of doing so at the time.

82. The Tribunal did not have the expertise to interpret the images of the procedure itself. It had conflicting evidence from Dr J and Dr Ali about whether the images showed occlusion at the end of the PCI.

83. In resolving this conflict, the Tribunal considered the experience and expertise of Dr J and his very clear, sustained, opinion after reviewing the images during his oral evidence, and after hearing Dr Ali's alternative explanation, that there was occlusion of the first and second septal arteries. It also considered the contemporaneous record made by Dr Ali at the time. Having considered these factors, the Tribunal decided that it preferred the evidence of Dr J to that of Dr Ali.

84. For these reasons, the Tribunal determined that Dr Ali did fail to recognise that Patient A's angiogram showed occlusion of the first and second septal arteries. It therefore found paragraph 1b of the Allegation proved.

Paragraph 1c of the Allegation

> c. made an inaccurate record of Patient A's PCI procedure in that you recorded 'No complications' when Patient A suffered from ~~persistent~~ side branch occlusion.
> (Amended following a Rule 17(6) application)

85. The Tribunal had regard to its finding in relation to paragraph 1b above which was that there had been occlusion of the septal branches.

86. The Tribunal noted the explanation provided by Dr Ali in his statement regarding the record he made in the CLR following the procedure on Patient A:

> *'In my report of Patient [A]'s PCI procedure I recorded my overall judgement on the technical outcome of the PCI procedure to the LAD when I wrote that there had been 'No complications". I documented that I had not been able to complete the procedure by dealing with the LCx. My judgement at the time was that it was a good final result and I recorded my judgement. That was my judgement in respect of the stenting of the LAD. There had been no complications that I thought worthy of note at the time. Having reviewed the matter in the course of preparing this statement, I would not write 'No complications' and my practice had already changed. I now write much more in my narrative account of the PCI. I do not agree that the record was inaccurate.'*

87. The Tribunal reminded itself of Dr J's evidence that the occlusion of significant side-branches is a recognised complication of a PCI and indicates the result was sub-optimal. It also reminded itself of Dr J's evidence that 'jailing' can lead to impaired blood flow and have consequences for further treatment should it be necessary to pass another wire, balloon, or stent, through the 'jailed' area. In the light of this evidence, the Tribunal decided that neither an occlusion nor a 'jailing' can be described as 'No complication'.

88. The Tribunal found that Dr Ali did not record that there had been an occlusion, nor did he record that there had been a 'jailing'. Instead, he recorded, there had been a *'Good final result'* and that there were *'No complications'*.

89. It therefore found, as a matter of fact, that Dr Ali made an inaccurate record of Patient A's PCI in that he recorded 'No complications' when Patient A suffered from side branch occlusion.

90. The Tribunal also considered that, even if Dr Ali had only seen 'jailing' with impaired flow, then the record of the PCI he made was inaccurate for failing to record these findings.

91. The Tribunal therefore found paragraph 1c of the Allegation proved.

Patient B

Background

92. Patient B was 52 years old when she was seen at the Hospital by Dr A, a consultant cardiologist, after a referral by her G.P. because of an abnormality of her heart rhythm. She was referred for a procedure known as a 'catheter ablation' which was undertaken on 23 June 2016.

93. When she was reviewed after the ablation in November 2016, she reported occasional chest pain consistent with angina and it was therefore arranged for her to undergo a coronary angiogram to see if there was any narrowing of the coronary arteries which might be the cause of the angina.

94. The angiogram took place on 9 December 2016 performed by Dr M who obtained Patient B's consent for the procedure. The procedure was said to be uncomplicated and showed there to be stenosis of the mid left anterior descending artery with long segments of stenosis of 90%. It was arranged for Patient B to undergo a pressure wire study and possible insertion of a stent into the left anterior descending artery. Patient B was seen at a pre-assessment clinic on 12 January 2017.

95. Patient B attended the Hospital on 19 January 2017 for the PCI which was carried out by Dr Ali. Dr Ali had not been involved in Patient B's care before then. Consent for the PCI was taken by a trained nurse and evidenced by a standard sticker on the form. The PCI on Patient B started at 09:55 and finished at 10:34. Dr Ali completed the CLR for Patient B, it was signed electronically by him at 10:50.

96. Following the PCI, Patient B was transferred to the ward and died later that day.

97. A Coroner's inquest into Patient B's death took place in February 2018. Dr Ali prepared a statement for the Coroner and gave evidence at the inquest on 27 February 2018.

98. In considering the allegations against Dr Ali in relation to Patient B, the Tribunal had regard to the allegations against Dr Ali in relation to Patient C. In the case of Patient C, the GMC has not alleged that Dr Ali failed to, or did not, identify a perforation, but rather, essentially, that the quality of the treatment and management plan was not appropriate. Therefore, when considering some of the allegations in relation to Patient B, the Tribunal had to make a comparison with the management plan Dr Ali instigated for Patient C in order to reach its decisions.

Paragraph 2(a), (b) and (c) of the Allegation

> 2. Between 9 December 2016 and 19 January 2017, you failed to adequately obtain consent from Patient B for the PCI procedure in that you failed to personally consult with Patient B to discuss:
>
> a. her current symptoms;
>
> b. the treatment options available;

c. the reasons for any recommendations or conclusions of an MDT.

99. In his report of 1 June 2018 at paragraph 3.4, Dr J noted that the CLR for the PCI on Patient B contains the standard electronic entry but stated that there was no evidence of what information was presented to Patient B other than the potential complications of the PCI.

100. Later, at paragraph 4.1, Dr J states that Dr Ali should have seen Patient B before the PCI and discussed her current symptoms and treatment options available. He referred to GMC guidance on consent, acknowledging that the taking of consent can be delegated but that the ultimate responsibility remains with the person starting any treatment or investigation.

101. Dr J stated at paragraph 4.4 that he would not grade Dr Ali's failure in this respect to be seriously below the required standard *'because other members of the multi-disciplinary team may have adequately consented Patient [B] and Dr Ali's involvement may not have changed Patient [B]'s decision to undergo the Procedure.'*

102. The Tribunal has already found that consent was not necessarily taken solely by the doctor carrying out the intervention.

103. Dr Ali's evidence to the Tribunal, contained in his statement of 7 February 2022 at paragraphs 27 to 29, was:

> *27. I expect that the discussion with Patient B about the planned PCI procedure would have started before she came under my care on 19 January 2017, initially with my colleague, Dr M, and then in the Pre-assessment clinic. I was asked to carry out the PCI procedure on my list on 19 January 2017.*
>
> *28. I see in the copy records that a nurse took the patient's consent and signed it (p.612). She used one of the pre-printed stickers and it gave an overall risk for the stated complications of angioplasty of 1:100, and 1:1,000 if an angiogram only was performed. The copy form has been annotated 'Sedation required please' (p.612) but I do not know who wrote that. The page of the Consent Form signed by the patient on 19 January 2017 (p.613) records that if the treatment had been planned in advance, the patient would have already had the risks and benefits explained to them.*
>
> *29. I would have checked with Patient B when she arrived in the Catheter Lab that she knew what was planned, would have enquired about her current symptoms, would have told her of the risks and benefits of PCI, checked the medications she was on, and checked that she was happy for me to proceed. I would have told her that her case had been discussed at the MDT when cardiologists and a cardiothoracic surgeon would have been present and we would have looked at the images. I would have gone on to say that PCI was the consensus decision reached on what to offer her. However, by that time she had already been seen in a Pre-assessment clinic for PCI, when she would have had the opportunity to ask questions. I did not personally discuss with Patient B different treatment options or the reasons for the*

recommendations or conclusions of the MDT. That was the process at Wexham Park Hospital at the time and I do not agree that I failed in respect of the consent process.'

104. The Tribunal was provided with a copy of Patient B's consent form dated 19 January 2017 which was signed by Patient B and a nurse. The Tribunal noted that attached to the consent form is the standard sticker, headed 'Coronary angiography +/- Coronary angioplasty/ Stenting', and setting out the benefits and risks of the PCI.

105. The Tribunal also had the CLR which was completed by Dr Ali within a short time of the PCI ending. This contained the standard paragraph confirming that there had been a discussion about the PCI and risks.

106. The Tribunal noted that the first contact Dr Ali had with Patient B was when she was brought into the Catheter Laboratory ('Cath Lab'), after consent had already been obtained. It noted Dr Ali's evidence was that, as per his normal practice, he would have checked with Patient B when she arrived in the Cath Lab about her understanding of the procedure she was about to undergo, as well as the risks and benefits. It noted that Dr Ali's evidence is supported by the record made in the CLR report.

107. The Tribunal was satisfied from the evidence before it that Patient B had undergone a discussion with several individuals involved in her care prior to the involvement of Dr Ali regarding the PCI including at the pre-assessment clinic when she signed the consent form. Consent was taken as per Hospital practice and therefore Dr Ali was not required to fully re-consent Patient B when she had attended for her PCI. The Tribunal was satisfied that prior to the PCI, Patient B's symptoms, treatment options, and the recommendations of MDT would have been explained to her, and her consent to go ahead with the PCI obtained as a result.

108. For these reasons, the Tribunal found paragraph 2(a), (b) and (c) of the Allegation not proved.

<u>Paragraph 3(a) of the Allegation</u>

3. On 19 January 2017 you performed a PCI procedure ('the Procedure') on Patient B and you failed to:

a. identify a coronary perforation;

109. The Tribunal had regard to its earlier findings regarding the difference between a dissection and a perforation, and the different ways each should be managed. In a dissection, the artery wall remains intact and no fluid escapes from the artery. In a perforation, there is a puncture or hole in the artery wall which causes fluid to escape.

110. The Tribunal considered that in layman's terms, a perforation could be described as a 'leak'. It heard evidence that this is how it might also be referred to by healthcare professionals. It noted, for example; that Dr J himself referred to a leak in his report dated 1 June 2018 at paragraph 3.31: *'The last angiogram showed a persistent leak from the coronary perforation'*; in the 'Ellis" research paper used as a source by Dr J: *'…and many develop tamponade before any balloon can be placed over the*

leak'; and that Dr J used the term *'**leak**'* on occasions during his oral evidence to describe what happens when there is a perforation of the coronary artery wall.

111. The Tribunal therefore accepted that when the word '***leak***' was used in evidence it was more likely than not to be indicating that there had been a perforation rather than a dissection. The Tribunal accepted that no extravasation, i.e., leak, occurs with a dissection.

112. The Tribunal noted in respect of this paragraph of the Allegation that there was no dispute between the parties that Patient B suffered a perforation during the PCI performed by Dr Ali. Dr J stated at paragraph 3.16 of his report dated 1 June 2018 that there was an: '*obvious coronary perforation'.* Dr Ali stated at 39(n) of his statement dated 7 December 2021: *'I consider that the blush is a leak, that is an extravasation, and in this case it shows a perforation of the vessel*'.

113. The issue for the Tribunal to determine was not, therefore whether there was a perforation, but whether Dr Ali ***identified*** a perforation.

114. The Tribunal noted that Dr Ali's evidence was that he did identify a perforation. This can be seen from the above extract from his statement and what follows which was to the effect that, having identified the perforation, he treated it by way of balloon tamponade (i.e., applying pressure to the perforation so that it became re-sealed). His evidence at paragraph 39(p) of his statement was:

> *'Either I, or Nurse S at my direction, inflated the balloon, seeking to achieve tamponade. I managed by inflating the same balloon to tamponade the vessel, as shown in run 20 (10.30.21). Prolonged balloon inflation can be an appropriate treatment and I undertook such an inflation in this case. How long it needs to be is a matter of clinical judgment and I was guided by the patient's clinical status and the images I was looking at. The haemodynamics report shows that the NC balloon was inflated to 12 atm, 14 atm, 14 atm, and 14 atm for the first four inflations. The fifth and last inflation recorded to be at 10 atm and to be longer at 27 seconds (p.499) than the earlier inflations, that is more than double the length of the previous 4 inflations. I believe that I captured that run, numbered 20, to document the tamponade. The tamponade is also documented in the Haemodynamics Procedure Report (p.498); I inflated, or asked, that the balloon be slowly inflated. I would not have asked for slow inflation, or used slow inflation, if I was seeking to further expand the stent. I also held the balloon up for about 27 seconds, and even allowing for the time taken to slowly inflate and then to deflate the balloon that is not what I would do if I was attempting to further expand the stent. The part of the stent shown on that run did not look particularly under-deployed on the earlier images, and there was no need to attempt to expand the stent repeatedly and with a lower pressure than I had used in the previous inflations. The only purpose of that last inflation was my attempt at tamponade. At the time, with runs 18 and 19 in mind, my aim was to inflate the balloon where it was to obstruct the flow of blood through the perforation. At the time, I considered that the balloon position was adequate to cover the proximal end of the stent and the perceived site of contrast leak in the middle of the stent. It should be borne in mind that it can be difficult to be certain about the precise site of the perforation. The balloon inflation stopped the flow of blood from the perforation and would allow clotting. The site of the observed perforation is*

already covered by the stent. I do not accept that the balloon can be kept inflated for a long period of attempted tamponade. It is obstructing blood flow and I was taught that it should be periodically deflated to allow flow to resume and then re-inflated. That may have to be done several times as you seek to stop the extravasation.'

115. The GMC case, however, was that Dr Ali failed to identify the perforation at the time. It relied on several evidential factors which Ms Johnson submitted led to this conclusion. On the other hand, Mr Thomas submitted there were several evidential factors which supported Dr Ali's case that he did identify the perforation. The Tribunal considered these factors carefully before reaching its conclusion on this issue.

Factors suggesting Dr Ali did not identify a perforation.

116. The GMC relied on the CLR which Dr Ali completed immediately after the PCI on Patient B on 19 January 2017. This showed that the PCI was started at 09:55, ended at 10:34, and that the report was signed by Dr Ali at 10:50. The Tribunal noted the following information:

'Entry Locations
Percutaneous access was performed through the Radial artery. Hemostasis was successfully obtained using TR Band.
Entry Comments: attempt by O Ali
……
Complications: Coronary dissection.
……
Conclusions
Procedure Summary
52 yr old female. Elective PWS +/- PCI to LAD for exertional chest pain. Discussed in MDT.

Findings
Tight and long mid LAD stenosis in a large caliber vessel. I decided to proceed to PCI of LAD: lesion predilated with 2.5x15 balloon. Lesion is tough and calcified and required further predilation with 3.0x15 balloon. Resolute Onyx 4x38 deployed and post dilated with NCB 4.5x12. Localised dissection noted. Patient had no chest pain, ECG changes and remained haemodynamically stable throughout the procedure.
Recommendations
DAPT for 1 yr then aspirin life long
Secondary prevention measures
Echo today
Patient can go home if remains stable'

117. The Tribunal noted that there was no reference made to a perforation in this report nor any reference to having treated a perforation by way of balloon tamponade. The Tribunal noted that only a dissection was recorded in both the findings and complications sections, and '*Patient can go home if remains stable*'. It heard evidence that such an outcome was unlikely had the patient suffered a

perforation because close monitoring and urgent echocardiography would have been required to ensure that if cardiac tamponade did occur, it would be promptly treated.

118. The GMC submitted that these factors showed that Dr Ali had not identified a perforation at the time of the PCI. The GMC also submitted that Dr Ali was an experienced consultant who was unlikely to use the word 'dissection' if he had seen and treated a perforation. He would appreciate the importance of using the correct term because it could affect the future treatment of the patient by others. In this respect, the Tribunal noted that Dr Ali had been appointed as a consultant in 2013 and his evidence was that he had successfully performed many similar procedures. He stated that he had not previously experienced the complication of a perforation as an operator. This was consistent with Dr J's evidence that perforations are very rare occurrences.

119. The GMC also relied on Dr J's evidence about the potentially serious consequences of a perforation and the need for appropriate immediate treatment. He describes at paragraph 3.22 of his report dated 1 June 2018 that an emergency echocardiogram should be performed in the Cath Lab whilst the wire is still in place in the coronary artery so that corrective treatments such as prolonged (10 – 15 minutes) low pressure balloon inflation or covered stent placement, and preparation for emergency pericardiocentesis (an emergency procedure to remove the fluid from around the heart) can take place. The GMC submitted that the failure to do any of these things was an indication that Dr Ali had not identified the perforation in the first place.

120. Further, Dr J's evidence was that to treat a perforation by way of balloon tamponade, prolonged pressure is required at low pressure to seal the perforation. He describes this at paragraph 3.28 onwards of his report dated 4 August 2020:

> *'Guidance in the literature on the management of coronary perforations includes 'A balloon (with a balloon to artery ratio of approximately 1.0) should initially be positioned over the site of contrast extravasation and inflated for at least 10 minutes.'*
>
> *This is the immediate step that should be taken to stop bleeding into the pericardium. The usual technique is to inflate a balloon at low pressure (e.g., 3 - 4 atm) over the site of the perforation and check whether this is sufficient to eliminate extravasation by taking an angiographic image. If necessary, the pressure can be slowly adjusted until it is just enough to occlude the perforation demonstrated by elimination of extravasation on angiography. Balloon inflation at the site of a perforation to stop bleeding can also be called balloon tamponade i.e., using the balloon to press on and block the bleeding point.'*

121. Dr J then goes on to consider what Dr Ali did during the PCI, noting the timings and lengths of the balloon inflations which Dr Ali states to be his attempt to seal the perforation. Dr J notes: '*The final post-dilation balloon inflation was timed at 27 seconds'*, which he notes coincides with the scrub nurse's recollection of 30 seconds. Dr J' conclusion about this was set out at paragraphs 3.49 and 3.50 of his 4 August 2020 report:

> *' Therefore, regarding prolonged balloon inflation to seal the perforation I believe that the evidence shows: there were no inflations at low pressure; there were no inflations*

accompanied by an angiogram to show occlusion of the perforation; there is no evidence that any of the inflations are appropriately prolonged to occlude a perforation; there is no evidence that any of the inflations are prolonged enough to attempt to seal a perforation; the inflation in run 20 does not cover the site of the perforation; the inflation in run 20 lasted about 30 seconds.

I believe that Dr Ali's failure to perform prolonged balloon inflations to occlude the perforation and attempt to seal the perforation was not in accordance with standard guidance for the management of coronary perforations.'

122. Based on Dr J's evidence, the GMC case was that Dr Ali was not treating a perforation and this was further evidence that he had not identified a perforation.

123. The GMC also relied on evidence from the nursing staff who were present at the time of Dr Ali undertaking the PCI. The Tribunal considered their evidence as follows.

124. Nurse S was the scrub nurse assisting Dr Ali perform the PCI on Patient B. Her evidence was agreed by the parties. She recalled that Dr Ali was re-inflating a balloon. She stated:

'*Patient [B] seemed fine and was talking at that point, so I asked Dr Ali why he was re-inflating the balloon. Dr Ali said there was a dissection and he wanted to 'balloon it' I understood Dr Ali to mean that he was going to seal the leak. I believed Dr Ali was trouble shooting a problem, so I thought there must be a leak, which is why I asked him.'*

'I could see the extravasation of dye on the screen, and it looked like a dissection to me, but I might be wrong. I cannot remember how it looked on my screen. My main focus was the patient, and she was stable at that point and no complaints whatsoever. If it was a perforation, the patient would become very sick immediately. That is why I state in my statement that I would have been very worried if it was a perforation.'

'I assumed Dr Ali was troubleshooting the problem…. I was not worried, as Patient [B] was fine when she left the cath lab room, …'

125. Nurse S recalled that Dr Ali: *'kept the balloon inflated for about 30 seconds…it seemed to me that he kept the balloon inflated for longer than normal'.* She recalled that at the end of the PCI, Dr Ali said that Patient B should have an echocardiogram.

126. Nurse U was the 'runner' on the day. Her evidence was agreed by the parties. She did not recall the PCI due to the passage of time but did recall that Dr Ali spoke to Patient B at the end. She recalls that he told Patient B that he had said *'that it had gone well or words to that effect, and told her there was a small dissection…. That is why I wrote dissection in my procedure notes'*.

127. Mrs F was the cardiac physiologist on the day. She gave evidence to the Tribunal but could not recall much beyond that written in her statement which was *'…nothing significant happened during the procedure…Dr Ali was happy with the Patient and she was discharged back to the ward'*.

128. The Tribunal noted that the witnesses had been asked to make statements some considerable time after the PCI and that their recollections may not have been wholly accurate or complete. Mrs F, for example, gave evidence that the PCI took place in the evening which was clearly incorrect.

129. The Tribunal considered that, in part, the evidence of these witnesses supported both parties. It supported the GMC case in that they refer to dissection rather than perforation and say that Patient B did not become ill. However, Nurse S's evidence supports Dr Ali in that she confirms that he was using balloons to seal a leak, this being a possible reference to a perforation, and that he did so for 30 seconds which was a longer period than normal. The Tribunal noted that Nurse S's evidence in this respect is entirely consistent with Dr Ali's evidence.

Factors suggesting Dr Ali did identify a perforation.

130. As set out above, Dr Ali's evidence was that he identified and treated a perforation. The Tribunal noted that Dr Ali was an experienced interventional cardiologist at the time. The Tribunal took into account the testimonials provided on Dr Ali's behalf. The Tribunal considered there was no reason to believe that he was not sufficiently trained and experienced so as not to able to recognise and treat a perforation.

131. The Tribunal has already referred to the evidence of Nurse S that Dr Ali appeared to undertake a prolonged balloon inflation for around 30 seconds. This is consistent with Dr Ali's evidence. It is also consistent with the Haemodynamic Procedure Report ('HDR') which confirms that at 10:28:50 a balloon was inflated for 27 seconds.

132. The Tribunal was next referred to the case of Patient C. This related to a PCI which Dr Ali performed later the same day as that of Patient B between 13:07 and 14:37. Patient C's PCI was complicated by a perforation. The Tribunal noted that in the CLR report written and signed by Dr Ali at 14:55, he described the perforation as a complication, but also in setting out his findings, he stated: *'The dissection was sealed and the patient became stable'.*

133. The Tribunal noted that there was no evidence that in the case of Patient C there was a dissection. Neither Dr J nor Dr Ali identify a dissection. The Tribunal considered that this was evidence that on that day Dr Ali was using the words 'perforation' and 'dissection' without accuracy, if not interchangeably.

134. Dr Ali's evidence was that he was in error each time he had mistakenly called the complication a 'dissection' when what he meant was 'perforation'.

135. Although when pressed on this in cross-examination, Dr Ali said he could not explain the error, one explanation he did provide was set out at paragraph 24 of his statement dated 7 December 2021. There he described his workload that day. He recalled that during the PCI on Patient B, he was told of the arrival of a heart attack patient who he then had to attend following Patient B's PCI. He then had to perform a pressure wire study between 10:58 and 11:30, and an angiography between 12:12 and 12:26 before commencing the PCI on Patient C starting at 13:07. In other words, Dr Ali was ascribing

the inaccuracy to the pressure of work on the day. The Tribunal noted that Trust records obtained by Dr Ali supported the timings he gave in his statement, and there was no evidence to contradict his account that he saw the heart attack patient.

136. Next the Tribunal considered Dr Ali's evidence, at paragraph 57 of his statement of 7 February 2022, that later that day: *'I discussed patient [B] with Dr T, but I do not recall if I discussed Patient [B] with him the same day. I told him about Patient B and that the PCI I had performed that day on Patient [B] had been complicated by a perforation.'* If accepted, this was significant evidence that, notwithstanding having written in the CLR for Patient B that there had been a dissection, Dr Ali in fact recognised there had been a perforation.

137. Dr T was the clinical lead for the Cardiology Department at the time of the events. Notwithstanding the potential significance of his evidence, Dr T had not provided a witness statement, nor was he called to give oral evidence. At one point during the hearing, Ms Johnson indicated that enquiries would be made about the possibility of giving evidence, but the Tribunal was not informed of the outcome of those enquiries.

138. Instead, the Tribunal was presented with what it considered to be a *'fait accompli',* given that a considerable amount of evidence had already been redacted by agreement between the parties, in that it was presented with a statement which had been agreed between Ms Johnson and Mr Thomas. The statement read:

> *'The GMC accepts that Dr T provided a written statement to the Trust in which he confirms that he was told by Dr Ali of the perforations in the cases of Patient B and C in the afternoon of 19th January 2017 before patient B collapsed and that Dr Ali told him that in the case of patient B he had performed a balloon tamponade. Dr T also states that he asked Dr Ali whether a transthoracic echo was performed but Dr Ali indicated that because she was very stable in the lab he said that the echo was not performed in the lab but he had requested for it to be performed urgently on the ward.'*

139. Whilst the Tribunal considered this statement to provide no explanation as to the absence of direct evidence from Dr T, it decided that, since it was evidence agreed by the GMC, it had to accept the statement at face value. It therefore decided that it corroborated Dr Ali's account that, at least by the time he spoke to Dr T, he had identified that the PCI's of Patient B and Patient C had each been complicated by a perforation, and that in the case of Patient B, he had performed a balloon tamponade.

140. The Tribunal considered that the above factors were those that support Dr Ali having identified a perforation on the day of the PCI, but the Tribunal went on to consider events after that date which also supported his evidence that he had identified a perforation in Patient B.

141. Dr Ali states, at paragraphs 59 and 60 of his statement firstly that the treatment of Patient B was discussed at an MDT on 26 January 2017 at which he presented the case as a PCI to the left anterior descending artery complicated by a perforation, and secondly, that he presented Patient B's case as a perforation at an M&M meeting chaired by Dr T on 16 March 2017. The Tribunal was

presented with the minutes of the M&M meeting and Dr Ali's presentation slides confirming that Patient B's case was presented as a perforation.

142. The Tribunal was also presented with further evidence that Dr Ali used the terms 'dissection', perforation, and 'leak' without accuracy as evidence to support his evidence that he had not done so when recording the outcome of Patient B's PCI in the CLR whilst under pressure on 19 January 2017.

143. The Datix was used as an example. The Tribunal noted that Datix is an electronic recording system used generally in hospitals to report incidents. This was completed by Dr Ali on 23 April 2017. By this time, Dr Ali had already presented Patient B's case to the MDT and also the M&M meeting as a perforation, yet in the report he states that the PCI was *'complicated by coronary dissection'* yet goes on to state *'The leak was treated…'.* As the Tribunal has already noted, these expressions are inconsistent with each other because a dissection does not cause a leak.

144. A similar example of this was presented using the statement Dr Ali prepared for the Coroner's inquest on or around 27 April 2017. In this Dr Ali stated:

> *'The images showed a leak from the artery at the site of the coronary stent (coronary dissection). Multiple images were taken to confirm the leak is localised to one area. I decided to place an inflated balloon inside the stent to stem the leak which is a treatment option to help reduce the leak.'*

145. Again, the Tribunal noted that Dr Ali was using terms which are not consistent. There were further similar examples which show that Dr Ali was using the word "dissection" to describe the features of, and treatment for, perforation. They occur on several occasions in the meetings between Dr Ali and the two Deputy Medical Directors on 22 June 2017 and 26 June 2017.

146. The Tribunal considered that these several examples showed that Dr Ali did not use the term 'dissection' accurately. Whilst these several examples all occurred after the day of the PCI on Patient B, they provide support to Dr Ali's evidence that he was not using the term accurately on the day itself and in the contemporaneous documents he made on that day.

Conclusion - Paragraph 3(a) of the Allegation

147. The Tribunal therefore considered there to be relevant factors for and against the allegation that Dr Ali failed to identify the perforation in Patient B which it summarised as follows.

148. On the one hand: Dr Ali did not describe a perforation in the CLR but a dissection; Dr J's evidence was that Dr Ali did not treat a perforation nor take any of the urgent steps required to do so; nurses present during the PCI recall the word dissection being used; and Dr Ali continued to use the term dissection when describing the complication subsequently.

149. On the other hand: Dr Ali's evidence is that he identified and treated a perforation by way of balloon tamponade; Nurse S noted an unusually lengthy balloon inflation to seal the leak; on the same day Dr Ali described a perforation and tamponade to Dr T; he did so also at the MDT and at the M&M

meeting, and subsequently described a perforation in his evidence to the Coroner; and Dr Ali's evidence has been consistent.

150. The Tribunal considered these factors carefully but noted that it had to determine whether Dr Ali identified the perforation at the time of performing the PCI rather than subsequently, and therefore considered these factors to be of less significance than the evidence which was more contemporaneous.

151. In this respect, the Tribunal considered the evidence of Dr J and Dr Ali to be significant. Dr J opined that Dr Ali did not identify the perforation because he did not treat it properly nor did he take appropriate steps such as emergent echocardiography and that what Dr Ali was doing was continuing the inflation of the balloon post-stenting, rather than undertaking a balloon tamponade which would seal the perforation.

152. Yet, the Tribunal noted that in his evidence Dr J failed to explain how an experienced consultant as Dr Ali would not see the extravasation at the time when it appeared reasonably obvious when pointed out even to the untrained eyes of the Tribunal Members. Dr J did not clearly explain why Dr Ali might be performing a balloon inflation of 27 seconds if it was not to perform a tamponade. Even if this was not for anything like the prolonged period required for a tamponade, it was still a considerably longer period than the other inflations during the PCI. Dr J's evidence also fails to explain why Nurse S thought that there was a lengthy inflation of around 30 seconds to seal a leak. For these reasons, the Tribunal was left with some unanswered questions after considering Dr J's evidence carefully.

153. On the other hand, the Tribunal considered that in his evidence Dr Ali explained that he had identified the perforation and that he had tried to treat it by way of balloon tamponade which is consistent with the 27 second inflation. His evidence is supported by Nurse S who recalls that a complication arose during the PCI. Albeit not at the time of the PCI, it is also supported by the agreed evidence of Dr T that later that day Dr Ali reported both the perforation and his attempt at balloon tamponade.

154. On balance, the Tribunal preferred Dr Ali's evidence about what happened during the PCI because he performed the procedure. Although the Tribunal accepted Dr J's expertise in these matters, his opinion was based on a retrospective view of events which did not take into account all the factors that the Tribunal has had to consider.

155. Based on the evidence before it, and on the balance of probabilities, the Tribunal was satisfied that Dr Ali did identify the perforation when he performed the PCI on Patient B, albeit it was entirely satisfied that Dr Ali did not manage and treat the perforation appropriately.

156. For these reasons, the Tribunal found paragraph 3(a) of the Allegation not proved.

<u>Paragraph 3(b) of the Allegation</u>

b. undertake prolonged low pressure balloon inflation to control the perforation;

157. The Tribunal has already considered the evidence from the CLR and the HDR that the longest inflation of the balloon during what Dr Ali described as his attempt at a tamponade to resolve the perforation which he had identified was 27 seconds, and at a pressure of 10 atmospheres. In his evidence to the Tribunal, Dr Ali accepted that 27 seconds was not a long enough period to keep the balloon inflated.

158. In his report dated 1 June 2018, Dr J stated at paragraph 3.28: *'Dr Ali did not undertake prolonged low pressure balloon inflation'.* Dr J's evidence was that the balloon should have been inflated for 10 – 15 minutes. In his supplementary report dated 4 August 2020, at paragraph 3.49 Dr J states:

> *'Therefore, regarding prolonged balloon inflation to seal the perforation I believe that the evidence shows: there were no inflations at low pressure; there were no inflations accompanied by an angiogram to show occlusion of the perforation; there is no evidence that any of the inflations are appropriately prolonged to occlude a perforation; there is no evidence that any of the inflations are prolonged enough to attempt to seal a perforation; the inflation in run 20 does not cover the site of the perforation; the inflation in run 20 lasted about 30 seconds.'*

159. The Tribunal had regard to the 'Algorithm for treating coronary dissections and coronary perforations' which comes from NICE CG 126 'Stable angina: management':

> *'Inflate conventional balloon or perfusion balloon over perforation site for 10-15 minutes. Consider CABG if major Type III perforation'*

160. The Tribunal also had regard to the article entitled 'Cardiovascular Revascularization Medicine', at paragraph 2.1 headed *'Immediate blocking balloon'* which states:

> *'The first step after diagnosis of CAP is to stop extravasation with inflation of a balloon (1:1 balloon:vessel size) proximal to or at the site of perforation for about* ***5–10 min*** *at a low pressure* ***(maximum 8 atm****). The maximum tolerated time to occlude a coronary artery without causing significant myocardial damage is about 20 min and therefore repeated 5–10 min inflations can be done until either successful sealing of the perforation or evidence of significant ischaemia.'* ***(emphasis added)***

161. The Tribunal also had regard to the article entitled 'Increased Coronary Perforation in the New Device Era' which stated:

> *'The vast majority of type II perforations were treated with balloon dilation* ***(median duration, 13 minutes)'*** ***(emphasis added)***

162. The Tribunal accepted Dr J's evidence about the requirement to treat a perforation by undertaking prolonged low pressure balloon inflation to control the perforation by effectively sealing

it and preventing further extravasation into the pericardium. Dr J's evidence was supported by the source material which he referenced in his report.

163. The Tribunal therefore found paragraph 3(b) of the Allegation proved.

Paragraph 3(c) of the Allegation

c. undertake or arrange an emergency echocardiogram in the catheter laboratory;

164. Dr J states in his report dated 1 June 2018 at paragraphs 3.18 – 3.22:

'3.18) Coronary perforation is a recognised but rare complication of coronary interventions including stenting (0.3 – 0.6%, References 1 and 2).

3.19) Perforation has a high risk of morbidity (mainly cardiac tamponade) and death.

3.20) Cardiac tamponade is due to bleeding from the coronary perforation into the pericardial space around the heart (FIGURE 9). Cardiac tamponade may occur immediately (most usual with Type II and Type III perforations) but may be delayed up to 24 hours (with Type I or Type II perforations). The accumulation of blood in the pericardial space around the heart presses on the heart and prevents it from pumping normally. This can cause low blood pressure, PEA cardiac arrest and death. Immediate steps should be undertaken to minimise these risks.

3.21) The high risk of coronary perforations has been well documented in the medical literature including the initial description/classification in 1994 (reference 1) and a comprehensive review in 2004 (reference 2). The literature provides estimates of the risk of serious consequences that increases from Type I perforations <10% risk to Type II >10% risk and to Type III >20% risk. The literature provides guidance on the current best approaches to patient management (Figure 8).

3.22) Once a perforation has been seen to occur an emergency echocardiogram should be performed to detect any accumulation of blood around the heart (Figure 8). This echocardiogram should be performed in the catheter laboratory whilst the coronary guide wire is still in place in the coronary artery. This could allow further corrective treatments such a prolonged (10 -15 minutes) low pressure balloon inflation or covered stent placement to take place if a significant pericardial collection is detected (Figure 8).'

165. Dr Ali accepted that an echocardiogram was not undertaken in the Cath Lab. In paragraph 44 of his statement of 7 February 2022, he states:

'I acknowledge that I did not undertake or manage to arrange an echocardiogram on Patient B while she was in the Catheter Laboratory on 19 January 2017.'

166. However, Dr Ali goes on to explain in the same paragraph:

'I did not see the need to keep the wire in place in the coronary vessel, with the patient in the Catheter Lab, while further searches were made for the Echo machine and had it been brought to the Catheter Lab. That is because the patient presented as stable with the leak sealed, as I describe above. Seeking an emergency echo implies that the patient was at risk of an impending haemodynamic collapse and that was not what I observed at the time.'

167. Dr Ali continued:

'I asked for an Echocardiogram to be done "today". If I had been treating a dissection I would not have asked for an Echo that day; given that Patient B was stable I would have been content with an Echocardiogram being carried out at some point in the future to assess for any muscle damage. The request for an Echocardiogram on the same day was to look for a pericardial effusion, which I anticipated may occur following the leak during the procedure. We did not hold Patient B in the Coronary Care Unit for any length of time. I recall that there was an issue over finding a bed for her. She was transferred initially to an angio-recovery bed and then to a bed in the angio-escalation ward.'

168. The Tribunal noted that in Patient B's CLR, Dr Ali stated *'Echo today'*. The Tribunal considered that this did not convey the urgency which the situation required as explained, and reasoned, by Dr J in his evidence. The Tribunal noted that Nurse S recalled that Dr Ali requested an echocardiogram, but she did not describe any urgency being attached to that request. The Tribunal further noted that in the case of Patient C, Dr Ali recorded in the CLR: *'Urgent echo today'*. The difference in language also suggests that Dr Ali did not consider there to be any urgency in the case of Patient B.

169. Whilst the Tribunal accepted that Dr Ali did request an echocardiogram for Patient B, it did not accept that he requested that one be undertaken when Patient B was still in the Cath Lab, to rule out the possibility of a pericardial effusion.

170. The Tribunal determined that Dr Ali should have undertaken an echocardiogram at the point he identified the perforation, i.e., while Patient B was in the Cath Lab.

171. It therefore found paragraph 3(c) of the Allegation proved.

<u>Paragraph 3(d) of the Allegation</u>

d. make preparations for immediate pericardiocentesis;

172. In his report dated 1 June 2018, Dr J stated:

'3.23) Equipment to deal with a coronary perforation is considered part of the mandatory institutional facilities for undertaking PCI. BCIS (British Cardiovascular Intervention Society) standards state "Availability of covered stents to treat perforation, pericardiocentesis sets to treat tamponade and an accessible echocardiography machine is mandatory" (Reference 3).

3.24) Once a perforation has been seen preparation should be made for emergency pericardiocentesis. Pericardiocentesis is the placing of drain in the pericardium to drain any fluid or haemorrhage and to relieve any pressure on the heart.

3.25) Even if no significant pericardial collection is identified by echocardiography whilst still in the catheter laboratory and even if the patient does not immediately develop cardiac tamponade consideration should be given to a) prolonged low pressure balloon inflation b) covered stent insertion c) emergency cardiac surgery (Figure 8).'

173. In his statement of 7 February 2022, at paragraph 40, Dr Ali stated:

'40. I did not make preparations for immediate pericardiocentesis because there was no need. I believed that I had stabilised Patient B without pericardiocentesis being actively prepared for. The pericardiocentesis kit is available in the Catheter Lab, to be used if it is ever needed. It is pre-packed and there is a kit in each lab. In the event, Patient B was transferred to the ward and her observations were stable, until she collapsed that evening. I do not agree that was a failure on my part.'

174. In oral evidence, Dr Ali said words to the effect that there was no need to make preparations for immediate pericardiocentesis because *'the kit is stored on the shelves in the lab'*.

175. The Tribunal accepted Dr Ali's evidence that the pericardiocentesis kit was available in the Cath Lab as he described. There was no evidence before the Tribunal to suggest otherwise. The Tribunal was therefore unable to identify what other preparations Dr Ali could have made in the event of immediate pericardiocentesis being necessary beyond knowing that the kit was available and where it was kept.

176. It therefore found paragraph 3(d) of the Allegation not proved.

<u>Paragraph 3(e) of the Allegation</u>

e. undertake prolonged low pressure balloon inflation and/or insert a covered stent to seal the perforation;

177. Dr Ali in paragraph 41 of his statement of 7 February 2022 states *'I did not insert a covered stent because I did not consider it was needed and I do not agree that was a failure on my part.'* Dr Ali in his written and oral evidence maintained that he thought he had sealed the perforation because Patient B was haemodynamically stable.

178. The Tribunal has already found, in relation to paragraph 3(b) above, that Dr Ali did carry out a longer lower pressure balloon inflation for 27 seconds at 10 atmospheres. This was neither sufficiently prolonged nor at an appropriate pressure, and the perforation was not sealed.

179. The Tribunal again had regard to Dr J's evidence that the next step in managing a perforation is the use of a covered stent.

180. The Tribunal determined that as Dr Ali had not successfully sealed the perforation, he should have proceeded to use a covered stent to seal the perforation.

181. The Tribunal therefore found paragraph 3(e) of the Allegation proved.

Paragraph 3(f) of the Allegation

> ~~f. make any preparations for possible emergency cardiac surgery.~~
> (Withdrawn following a Rule 17(6) application)

182. This paragraph of the Allegation was withdrawn and was not considered by the Tribunal.

Paragraph 4 of the Allegation

> 4. Following completion of the Procedure at 10:31 you requested Patient B be given 3000 iu of Heparin when it was inappropriate to do so.

183. The Tribunal noted that heparin is an anticoagulant which is routinely given during PCI to prevent blood clotting in the coronary artery and in the guide catheters. Dr J said in paragraph 3.17 of his report dated 4 August 2020 that the practice varies regarding how much heparin to give during a PCI:

> *'Some operators use a standard dose for all patients e.g., 10000 iu, while others use a weight adjusted dose e.g. a dose between 60 iu/kg to 100 iu/kg.'*

184. In essence, Dr J's view, which he maintained throughout his oral evidence, was that Dr Ali should not have given Patient B a further dose of heparin. In paragraph 3.19, Dr J states:

> *'The anticoagulant effect of heparin can be measured by testing a blood sample to measure the ACT (activated clotting time). ACT is a measure of how long it takes blood to clot. Heparin prolongs the ACT from the normal of 70 – 120 seconds. Opinions vary as to how prolonged the 'target' ACT should be during a PCI procedure, but a common standard is in the range of 250 to 350 seconds.'*

And at paragraph 3.21:

> *'This ACT result was below the desirable range. An ACT to measure the effect of a bolus dose of heparin can be taken 3 minutes after the dose is given and it would have been appropriate to have checked an ACT earlier in the procedure (e.g., at 10.06) to detect this sub-optimal ACT and given extra heparin to provide adequate anticoagulation during the procedure'*

185. In paragraph 3.23 Dr J states:

'At 10.31, having completed the procedure, if there had been no complications, then it would have been reasonable for Dr Ali to give no further heparin since the procedure was finished and late thrombotic complications are unusual under such circumstances. On the other hand, it would have been reasonable for Dr Ali to give further heparin to reduce the small risk of late thrombotic complications. In the absence of complications either course of action, no further heparin or extra heparin, would have been reasonable.'

186. In his evidence, Dr Ali accepted that given there was an ongoing leak of blood, it was inappropriate to prescribe heparin in those circumstances. However, he said that he thought he had sealed the perforation. His position was that he merely gave Patient B a further dose to maintain heparin at a therapeutic level.

187. In his statement of 7 February 2022, at paragraph 43, Dr Ali states:

'Having concluded that I had completed the PCI and dealt with the leak from the perforation (as I thought that I had) I then wished to optimise the prospect of the intervention working, and that required securing therapeutic ACT. I add that, with a subtherapeutic ACT, there would have been no need to reverse the anticoagulant effect of the Heparin already given, if that was the concern. However, I was weighing the risk of further bleeding against the risk of thrombosis of the stent. At that stage I was optimising the prospect of a successful PCI. I therefore prescribed 3,000 international units of Heparin. Although, I had recognised that there had been a perforation with extravasation of contrast, I thought that I had sealed the leak with the balloon tamponade. Patient B's observations showed that she was haemodynamically stable.'

188. The Tribunal had regard to the 'Algorithm for treating coronary dissections and coronary perforations' referred to in Dr J's report which states:

'Repeat prolonged balloon inflation
Consider heparin reversal with protamine'

189. Whilst the Tribunal noted Dr Ali's evidence as to why he gave Patient B a further dose of heparin, the Tribunal accepted Dr J's evidence. Dr Ali accepted that he did not seal the perforation. The relevant literature suggests that heparin should not be given in a case where the perforation is not sealed and, in any event, should not be given where the perforation is sealed with a balloon tamponade rather than a stent.

190. The Tribunal concluded, based on the evidence before it, that as Dr Ali attempted to seal the perforation with a balloon tamponade, and failed to do so, giving Patient B more heparin was inappropriate.

191. It therefore found paragraph 4 of the Allegation proved.

<u>Paragraphs 5(a) and (b) of the Allegation</u>

5. Following the Procedure on 19 January 2017 you requested an echocardiogram be performed once Patient B had returned to the ward and you failed to:

a. ask to be informed of the result;

b. request confirmation as to when it had taken place;

~~c. record in the alternative to paragraphs 5a and 5b having undertaken the actions as outlined at:~~

~~i. 5a;~~

~~ii. 5b.~~

(Withdrawn following a Rule 17(6) application)

192. The Tribunal considered paragraphs 5(a) and (b) together. Paragraph 5 (c) was withdrawn and was not considered further.

193. At paragraph 3.35 of his report dated 1 June 2018, Dr J stated:

'Dr Ali asked for an echocardiogram to be performed on Patient [B] when she returned to the ward. Dr Ali did not ask to be informed of the result or to be given confirmation when it had taken place.'

194. The Tribunal had regard to the CLR in which Dr Ali recorded *'Echo today'*. It noted that Dr Ali visited Patient B later in the evening of 19 January 2017. The Tribunal noted that in Patient B's medical notes, there is a record made by Dr Ali (timed at 19:30) which states *'Echo'*.

195. In paragraph 46 of his statement of 7 February 2022, Dr Ali stated:

'I took Patient B out of the Catheter Lab myself and handed over her care to a nurse who was to be caring for her in the angio-recovery bed. I asked that nurse to inform me of the result of the echocardiogram when it was carried out. I acknowledge that I did not write in the records that I had asked to be informed about that. I do not recall the exact words I used or which details I gave about the complication. My plan was for the patient to stay overnight and the note that she could go home that night was a mistake.'

196. In cross examination, Dr J conceded that it was not necessary for Dr Ali to have recorded the request in the patient's medical notes, and that there is no duty to record this request.

197. On balance, the Tribunal was not satisfied that Dr Ali failed to ask to be informed of the result of the echocardiogram, or that he failed to request confirmation as to when it had taken place.

198. The Tribunal was not satisfied that paragraphs 5(a) and (b) of the Allegation had been proved.

Paragraph 6(a)(i) of the Allegation

> 6. During your review of Patient B on 19 January 2017 at around 19:30 hours you were aware that an echocardiogram had not been performed and you failed to:
>
> a. arrange for it to be performed:
>
> i. immediately;

199. Dr J in his report dated 1 June 2018 states at paragraph 3.37:

> *'An echocardiogram should have been undertaken as soon as the complication had been recognised. The failure to arrange and review the result of an echocardiogram meant that there was no opportunity to detect any haemorrhage around Patient [B]'s heart that could have alerted the medical team of the risk of Patient A developing cardiac tamponade.'*

200. The Tribunal noted in Patient B's medical records Dr Ali had recorded 'Echo' when he visited Patient B at 19:30 on 19 January 2017. The Tribunal considered that this entry made clear that Dr Ali knew an echocardiogram had not been carried out when he visited Patient B. Dr Ali stated in evidence that he had the ability to perform and interpret an echocardiogram himself.

201. In his evidence at paragraph 56 of his statement of 7 February 2022, Dr Ali states:

> *'….I did not arrange for an echocardiogram to be carried out immediately that night. Ordinarily, the echo physiologists do not work at night and one would have had to be called in. I could have arranged for the echo machine to be brought to the ward and performed the echo myself, but I thought that the patient was stable. …'*

202. Based on this evidence, the Tribunal determined that Dr Ali did fail to arrange for an emergency echocardiogram to be performed immediately when he reviewed Patient B at around 19:30 hours.

203. It therefore found paragraph 6(a)(i) of the Allegation proved.

Paragraph 6(a)(ii) of the Allegation

> ii. ~~before you left the hospital;~~ as soon as possible
> (Amended following a Rule 17(6) application)

204. By virtue of its finding in relation to paragraph 6(a)(i), the Tribunal did not need to consider this paragraph of the Allegation, as it was said to be an alternative to paragraph 6(a)(i).

205. It determined that paragraph 6(a)(ii) of the Allegation was not proved.

Paragraph 6(b)(i) and (ii) of the Allegation

b. provide any explanation to Patient B as to:

i. the outcome of the Procedure;

ii. why an overnight hospital stay was required;

206. In his report dated 1 June 2018, Dr J states:

'3.44) When Dr Ali saw Patient A on the ward after the procedure he did not make any notes of any explanation he gave to Patient A of the outcome of the Procedure, (2.34).

3.45) GMC Good Medical Practice guidelines indicate that a doctor must include in clinical records the information given to patients.'

207. In his evidence to the Tribunal, Dr Ali maintained that he would have explained the outcome of the procedure to Patient B. The Tribunal was referred to the record made by Dr Ali in Patient B's medical notes which states:

'Pt well
No c/p
Mobilising on ward
….'

and

'Echo
Home tomorrow
Close Cardiac monitoring overnight'

208. The Tribunal also noted that in Patient B's notes there is a record made by another member of staff at 18:30 which states:

'Patient returned to ward post PCI to Cx via Radical approach. …Vital observation … Refreshment given and tolerated well. …. Recovery as per protocol. Mobilised without incident. Post 4 hours monitored bed rest. Has passed urine. Family aware of overnight admission into Angio escalation. To be monitored overnight and possible discharge home 20/01/16'. (sic)

209. The Tribunal considered that the date in the last line was mistakenly entered as 2016 and should have read '2017'.

210. From the evidence before the Tribunal, it considered that there was a plan for Patient B to remain in the Hospital for overnight monitoring. There is also a record that Patient B's family were made aware of this. Given this information, the Tribunal considered it is more likely than not that Dr Ali, or another member of staff on his behalf, would have provided an explanation to Patient B as to the outcome of the PCI and why an overnight stay was required.

211. The Tribunal therefore found paragraph 6(b)(i) and (ii) of the Allegation not proved.

Paragraph 6(c) of the Allegation

> c. record in the alternative to paragraph 6b having undertaken the actions as outlined at paragraph 6b.

212. In paragraph 54 of his statement, Dr Ali states:

> *'Once the patient was back on the ward, normal nursing practice is to inform the consultant responsible for the case/procedure of any unexpected deterioration of the patient for any advice or possible further intervention. Although the patient was monitored in the recovery area, her continued nursing care would normally have been in CCU. This did not happen due to a lack of available bed on CCU. I informed the patient of the complication that occurred during the procedure. I did so at the time of the procedure and when I last reviewed the patient at 19:30 pm on the 19 January 2017. I believe that I used the word 'leak' rather than either of the words 'perforation' or 'dissection'.'*

213. The Tribunal considered that the totality of Patient B's notes showed that Patient B and her family were made aware of what had occurred during the PCI and why an overnight stay was required. It did not consider that there was a need for Dr Ali to make an additional and repetitive note to this effect.

214. The Tribunal determined, therefore, that there was no duty for Dr Ali to separately record in Patient B's notes, when he visited her at 19:30, that the outcome of the PCI had been explained to her and why an overnight stay was required.

215. It therefore found paragraph 6(c) of the Allegation not proved.

Paragraph 7 of the Allegation

> 7. You failed to accurately record the Procedure in Patient B's notes in that you:
>
> a. did not record the coronary perforation;
> Admitted and found proved
>
> b. incorrectly indicated that Patient B had suffered a localised dissection.
> Admitted and found proved

216. These paragraphs of the Allegation were admitted and found proved. The Tribunal did not consider them further.

Paragraph 8 of the Allegation

> 8. On 23 April 2017 you completed a Datix report in respect of Patient B in which you described the complication that had occurred as a coronary dissection.
> Admitted and found proved

217. This paragraph of the Allegation was admitted and found proved. The Tribunal did not consider it further.

Paragraph 9 of the Allegation

> 9. On or around 27 April 2017 you signed a witness statement to be provided to the Coroner hearing Patient B's inquest in which you described the complication that had occurred as a coronary dissection.

218. This allegation is based on a statement Dr Ali made which was to be provided to the coroner which was dated 27 April 2017. The Tribunal noted that the relevant paragraphs of the statement read:

> *'The procedure was performed through an artery in the right wrist (right radial artery access) under local anaesthesia in our catheter laboratory room at 9:55 am. [Patient B] had requested intravenous sedation (Diazemuls 2.5 mg) because of feeling anxious and this was given at the start of the procedure. Standard artery catheters (hollow tubes passed through the artery and up to the heart) were used to image the coronary artery using a special dye visible under X-ray. This showed a tight and long mid artery narrowing. Given her symptoms and significant artery narrowing I elected to treat this with coronary angioplasty. The artery narrowing was calcified and tough and a note of this was made in the procedure report. This type of coronary narrowing is well known to be difficult to treat and can be associated with complications such as blood leak (coronary dissection).'*
>
> and
>
> *'After the stent was fully implanted, I took further images to assess the result. The images showed a leak from the artery at the site of the coronary stent (coronary dissection). Multiple images were taken to confirm the leak is localised to one area. I decided to place an inflated balloon inside the stent to stem the leak which is a treatment option to help reduce the leak. At this point I asked [Patient B] whether she had any symptoms but she denied any chest pain. Her observations including her ECG, heart beat and blood pressure remained stable. Given her stable condition, localised leak and based on my clinical judgement at the time I decided not to implant a second stent. If [Patient B] had any symptoms or was clinically unstable it would have been my standard practice to consider placing a second stent inside the original coronary stent. As part of her ongoing management, I called our*

cardiology manager [Mrs …..] to send a physiologist to perform an echocardiogram to rule out significant leak into the lining of the heart (pericardial effusion). Unfortunately the echocardiogram was never done. [Patient B] was in the catheter laboratory for a total of 38 minutes including observation time. By the end of the procedure her heart beat was 107 beats per minute and her blood pressure was 141/81 (At the start of the procedure her heart beat was 88 beats per minute and blood pressure 118/67).'

219. The allegation was that Dr Ali described the complication that occurred during Patient B's PCI as a dissection. The Tribunal noted that, on the face of it, this is what the statement says. The GMC case was that Dr Ali carefully crafted the statement so that the reader, including the coroner who may be a lawyer with no medical background, would realise he was referring to a perforation, even though he was using the word 'dissection'. The Tribunal considered this might have been the case, if Dr Ali had not also identified and spoken about the complication as a perforation, as the Tribunal has already found.

220. The Tribunal, in considering the contents of Dr Ali's statement to the Coroner, noted that it does not include the term 'perforation', but that it does include the words 'blood leak' and 'leak', which, as the Tribunal has already considered, are terms used in connection with a perforation and not a dissection.

221. The Tribunal also considered that the statement should be read in its entirety and as a whole rather than attaching significance to individual words or phrases. It considered that when this is done, it is clear that Dr Ali is describing that he was treating a perforation. The Tribunal acknowledges that Dr Ali uses the word 'dissection' twice in the statement, but the explanation he provides relates consistently to 'perforation'.

222. The Tribunal considered that whilst describing perforation, Dr Ali has labelled it as 'dissection', which as the Tribunal found when considering paragraph 3 of the Allegation was something that Dr Ali did at the time of the Patient B's PCI and subsequently. His statement to the Coroner sets out a step-by-step account of what he did during the PCI to treat a perforation. The Tribunal reminded itself of the agreed evidence that Dr Ali told Dr T that he was dealing with a perforation, and its findings that he presented the complication as a perforation both to the MDT and the M&M meeting.

223. For these reasons, although the Tribunal accepted that Dr Ali used the term 'dissection' in the statement, it determined that he had not 'described' (the word used in the allegation) the complication as a dissection.

224. It therefore found paragraph 9 of the Allegation not proved.

<u>Paragraphs 10(a) and (b) of the Allegation</u>

10. You knew as at the dates that you signed the datix report and statement to the coroner that the complication that had occurred was a coronary perforation given that you had recognised and described it as such at a:

a. Multidisciplinary team meeting on 26 January 2017;

b. Mortality and Morbidity meeting on 16 March 2017.

225. The Tribunal considered paragraphs 10(a) and (b) together.

226. The Tribunal was provided with the Datix completed by Dr Ali dated 23 April 2017 in which he stated under the heading 'Description':

> *'Patient admitted for elective PCI to LAD. PCI was undertaken by was complicated by coronary dissection….'*

227. At paragraph 64 of his statement dated 7 February 2022, Dr Ali states:

> *'I was asked to attend a second meeting with Dr I and Dr H, which took place on 26 June 2017. I acknowledged that I had made a mistake in labelling the complication as a coronary dissection when it was a coronary perforation, both in my statement dated 27 April 2017 and in the original PCI record. I explained that I had presented the complication in two meetings as a coronary perforation, and I was referring to the MDT on 26 January 2017 and the M&M meeting on 16 March 2017. I agreed to write a clarifying report, which I did, and it is dated 7 July 2017.'*

228. The Tribunal noted that in the slides Dr Ali presented to the M&M meeting a week or so after Patient B's PCI, he described the complication as a perforation.

229. The Tribunal has already determined that Dr Ali identified a perforation at the time of Patient B's PCI. It was also satisfied that, by the time he completed the Datix and signed the statement for the Coroner, Dr Ali knew that the complication that had occurred was a perforation.

230. It therefore found paragraphs 10(a) and (b) of the Allegation proved.

<u>Paragraph 11 of the Allegation</u>

> 11. Your actions as outlined at paragraphs 8 and 9 above were dishonest by reason of paragraph 10.

231. The Tribunal had regard to the CLR completed at the end of the PCI in the Cath Lab. In the CLR, dated 19 January 2017, against the heading 'Complications', Dr Ali stated *'Coronary dissection'*.

232. The Tribunal has already found that Dr Ali used the words 'dissection' and 'perforation' interchangeably, but inaccurately in: documentation; in the meetings with Dr I and Dr H; during the Trust's internal investigation; and in relation to the Coroner's Inquest. In the notes of the meetings with Dr I and Dr H, it is recorded that Dr Ali called the procedure a 'dissection' when in fact it was a perforation, and that he said he always knew it was a perforation, and had made a mistake calling it a dissection.

233. The Tribunal considered that the contemporaneous notes showed that Dr Ali had, as far as he was concerned, treated a perforation, although, at various times, he continued to label the complication as a dissection. This is consistent with the evidence he gave to the Tribunal.

234. In paragraph 66 of his statement of 7 February 2022, Dr Ali stated:

> *'I deny that I was being dishonest when I used the word 'dissection' in describing the complication in the Trust Datix report dated 23 April 2017 and in the statement that was provided for the Coroner, dated 27 April 2017. Clumsily, I used the words 'dissection' and 'perforation' interchangeably in my clinical records and in my professional communications at that time. I was not being mindful of the impact of using these words interchangeably. I recognise now that was a mistake. I had always intended the inclusion of the word 'leak' in my reports to communicate that there was a perforation.'*

235. The Tribunal again noted that Dr Ali had presented the complication to the MDT and also the M&M meeting as a perforation; and that after Patient B's PCI, Dr Ali had discussed the case with Dr T as a perforation.

236. The Tribunal considered what Dr Ali's knowledge and belief were at the time of completing the Datix and his statement to the Coroner. It was the Tribunal's view that in Dr Ali's mind, he had identified and treated a perforation. Whilst he labelled it 'dissection' at times, the description of the complication was of a perforation and he treated it accordingly.

237. The Tribunal reminded itself that when a dissection occurs, there is no escape of blood or dye from the artery so there is no leak. In contrast, when a perforation occurs there is an escape of fluid. The Tribunal considered it credible that Dr Ali's frequent reference to the word 'leak' referred to perforation. The Tribunal also found it credible because of the number of occasions when it happened and in different circumstances.

238. For these reasons, notwithstanding the fact that the Tribunal has found paragraph 10 of the Allegation proved, it was not satisfied that Dr Ali's actions in describing the complication as a 'dissection' in the Datix report or in his witness statement to the Coroner were dishonest. It therefore found paragraph 11 of the Allegation not proved.

<u>Paragraphs 12(a) and (b) of the Allegation</u>

> 12. On 27 February 2018 you gave evidence at Patient B's inquest at which time you stated:
>
> a. 'The third image in that series is actually the balloon tamponade and it is in run 20…', or words to that effect;
>
> Admitted and found proved

b. 'The third inflation is of the same balloon but at low pressure to seal the leak', or words to that effect.

239. Dr Ali accepts, at paragraph 67 of his statement of 7 February 2022, that he used words to the effect of those described in both limbs, and the phrases used in both are recorded in the transcript of the inquest.

240. Paragraph 12(a) was admitted by Dr Ali at the beginning of the hearing.

241. The Tribunal determined that Dr Ali did give evidence in the Coroner's Inquest at which time he did use the words alleged in paragraph 12(b) above.

242. The Tribunal therefore also found paragraph 12(b) of the Allegation proved.

Paragraphs 13(a), (b) and (c) of the Allegation

13. You knew that this was untrue as you had not performed balloon tamponade (prolonged balloon inflation) as:

a. the NC Trek balloon inflation at run 20 did not cover the site of the perforation;

b. none of the post-dilation inflations of the NC Trek balloon were inflated at low pressure;

c. none of the post-dilation inflations of the NC Trek balloon were appropriately prolonged to occlude or seal a perforation.

243. The Tribunal considered paragraphs 13(a), (b) and (c) together.

244. The Tribunal has already found proved, in relation to paragraph 3(a) of the Allegation, that Dr Ali failed to undertake prolonged low pressure balloon inflation to control the perforation, that 10 atmospheres was not low pressure, and 27 seconds was not prolonged balloon tamponade.

245. In his evidence to the Coroner, when responding to questions put to him, Dr Ali stated:

'Q Right, so you have used it to try and seal the leak. Once you believed that had been achieved, you then inflated that same balloon further.
A No, sir.
Q No. Then that is the confusion, is it not?
A So what I did, the stent is inside. I recognise that the stent is not fully deployed. I use a 4.5 millimetre balloon to expand the stent. I did so twice, so two post-dilations, at the pressure I think it is described in the report. The third-- Then I realised that there was a perforation. The third inflation is of the same balloon but at low pressure to seal the leak.'

246. The Tribunal was of the view that Dr Ali was clearly describing the balloon tamponade which he performed when he identified the perforation, to seal the 'leak', albeit, not to the standard expected of a reasonably competent interventional cardiologist, as it has already found above.

247. The Tribunal determined, based on the evidence before it, that Dr Ali's evidence to the Coroner was not untrue because his belief was that he had performed a balloon tamponade and sealed the perforation.

248. It therefore found paragraphs 13(a), (b) and (c) of the Allegation not proved.

Paragraph 14 of the Allegation

> 14. Your actions as outlined at paragraph 12 above were dishonest by reason of paragraph 13.

249. By virtue of its findings in relation to paragraphs 13 above, the Tribunal determined that Dr Ali's actions as outlined at paragraph 12 were not dishonest.

250. It therefore found paragraph 14 not proved.

Patient C

Background

251. Patient C was 70 years old when she was treated by Dr Ali. She had a history of a previous myocardial infarction in 2014 which was treated with stenting to the right coronary artery in 2014. She was taking medication for CAD. On 29 September 2016, she was seen at the Hospital's cardiology outpatient clinic by a clinical nurse specialist for symptoms of dizziness and sweating which were considered could be anginal. It was recommended that she increase her dosage of Bisoprolol (a beta-blocker) and undergo coronary angiography.

252. On 24 October 2016, she consented to the angiography and the procedure was performed that day by Dr E, a consultant cardiologist at the Hospital. The angiogram showed significant narrowing in the right coronary artery, and disease in the left anterior descending and circumflex arteries. After discussion of the angiogram at the MDT, Dr E recommended a perfusion scan.

253. Patient C was again reviewed by Dr E on 30 November 2016 when he explained the findings of the scan and treatment options to her. She was keen to proceed to angioplasty and stenting of the circumflex artery in the hope of improving her symptoms. Her case was discussed again at the MDT on 8 December 2016 when other treatment options were considered. Dr E concluded in his update to Patient C's GP, following the MDT, that as Patient C was keen to improve her symptoms further, he would refer her for angioplasty.

254. Dr Ali performed the procedure on 19 January 2017.

Paragraphs 15(a) (b) (c) and (d) of the Allegation

15. On 19 January 2017 you:

a. failed to adequately review Patient C's case;

b. failed to adequately obtain consent from Patient C for the PCI procedure;

c. failed to challenge the decision of Dr E and the MDT to proceed to PCI to the circumflex coronary artery;

d. made the decision to proceed to PCI when it was inappropriate to do so;

255. The Tribunal considered paragraphs 15(a), (b), (c) and (d) together.

256. Dr J, in his report dated 20 August 2019, at paragraphs 3.4 considered the appropriateness or recommending PCI by reference to NICE CG126 'Stable angina: management', which indicates that PCI should be considered if symptoms are not adequately controlled by beta-blockers and calcium antagonists. He stated at paragraph 3.6:

'The decision to proceed to PCI to treat Patient [C] was not in accordance with contemporary guidelines as Patient SC had only been treated with a single anti-anginal drug (a beta-blocker) i.e. Patient [C] had not been optimally treated to see if drug therapy would satisfactorily control her symptoms. Therefore, I believe that the decision to proceed to PCI was not appropriate.'

257. In his report dated 20 December 2019, Dr J referred to Dr Ali performing the procedure on 19 January 2017. He stated at paragraph 3.6:

'… Dr Ali became a) responsible for ensuring that the planned procedure was appropriate for Patient [C] b) responsible for ensuring appropriate consent has been obtained and c) responsible for undertaking the procedure safely and effectively.'

258. Dr J goes on to state in paragraph 3.9:

'On 19 1 17 Dr Ali became responsible for ensuring that the planned procedure was appropriate for Patient [C]. Dr Ali should have reviewed Patient [C's] case in detail before the procedure and noted that she had not been optimally treated with medical therapy and he should have concluded that proceeding to PCI of the circumflex artery was not appropriate as it was not in keeping with current guidelines.'

259. At paragraph 3.10 Dr J states:

'Under this circumstance Dr Ali should have explained the basis of his disagreement with Dr E and the MDT's recommendation to Patient [C[. Dr Ali should have explained to Patient [C]

the alternative management plan of instituting optimal medical therapy to help improve her symptoms….'

260. Further, Dr J states at paragraphs 3.14, 3.16 and 3.18:

'3.14 There is no evidence in the medical notes that Dr Ali had met Patient [C] before she entered the cardiac catheterisation laboratory. There is no evidence in the medical notes that Dr Ali responded to any concerns raised by Patient [C] before the PCI procedure commenced.

3.16 The Datix report completed on 25 4 17 after Dr Ali's meeting with Patient [C] on 20 4 2017 suggests that Dr Ali had become aware that Patient [C] had 'unanswered questions' when she entered the catheterisation laboratory on 19 1 17. It also says that Patient [C] 'was given an opportunity to ask the questions in the catheter laboratory'.

3.18 It is likely that for Patient [C] entering the catheterisation laboratory for a PCI procedure whilst having unanswered questions about the procedure was a stressful event. I believe it was not appropriate for Patient [C] to be expected to conclude the consent process under such circumstances. ….'

261. The Tribunal had regard to the consent form completed and signed by Dr E and Patient C on 24 October 2016, when the angiogram had been performed. The Tribunal noted on the form what appears to be a standard department sticker which states:

'Name of proposed procedure or course of treatment
Coronary angiography
Statement of health professional
I have explained the procedure to the patient in particular, I have explained:
Intended benefits: ….
Serious or frequent occurring risks
Common complications – pain and bruising at the site of the arterial access site
Less common – 1 in 1000 risk of complications including death, heart attack, stroke, bleeding or damage of the artery access site.
……'

262. The Tribunal was also provided with a copy of Patient C's CLR from the PCI on 24 October 2016. In this Dr E states under the heading 'Recommendations'

'Symptoms are atypical but clearly has coronary heart disease
The Cx disease is straight forward to PCI, I imagine the RCA disease would be managed medically. The LAD disease does not appear flow limiting.
Discussion at MDT
In the meantime for treadmill to assess exercise capacity and symptoms further
Echo to assess the interior wall'

263. There was before the Tribunal a copy of a letter, dated 30 November 2016, from Dr E to Patient C's GP setting out his findings after his consultation with Patient C. In the letter Dr E sets out Patient C's diagnosis and medications, and goes on to state *'It was delight to meet the above patient again today, who was accompanied by her husband….'* and it goes on to state:

> *'As you know she does have severe stenosis in the mid circumflex coronary artery, which would be amenable to angioplasty and stenting. I have explained that we could continue to manage her symptoms medically with the medications that she is taking.*
>
> *Alternatively, if she feels strongly, we would be able to offer her angioplasty and stent to this vessel in the hope that we could improve the blood flow to the lateral wall of her heart. We would hope that this may have a beneficial effect on her breathing as well as reducing her symptoms of sweats when she exercises. The risks would include bleeding, bruising, heart attack, stroke and death (approximately 1% for the last three). ….*
>
> *She is quite pragmatic about her symptoms. Her husband also was in the room and I made it clear that a stent would be to improve her symptoms rather than to improve the overall life expectancy. Both [Patient C] and her husband were keen to have the PCI procedure in the hope that it may improve her symptoms. They acknowledged the above risks and would be keen for the procedure to take place as soon as possible.'*

264. Dr E's letter goes on to state:

> *'UPDATE*
>
> *I have now re-discussed her angiogram and myocardial perfusion scan findings at an MDT meeting (8.12.16). We did consider the possibility of coronary artery bypass surgery, in view of the occluded right artery. However, in view of the lack of significant ischaemia in this territory and that the distal right coronary artery appears unattractive for by-pass grafting, it was decided that [Patient C] could be offered angioplasty and stenting or they continue with medical therapy…*
>
> *As outline above, although [Patient C] has improved with medical therapy, both herself and her husband would be keen to undergo angioplasty in the hope it might help her symptoms of breathlessness. ...'*

265. In a further letter to Patient C's GP, dated 21 December 2016, Dr E set out the discussion which had taken place at the MDT, the decision reached, and the risks which had been explained to Patient C and her husband at the consultation on 30 November 2016 (as set out in the letter above). Dr E also stated:

> *'During the MDT it was also suggested that we could attempt to re-open the chronically occluded right coronary artery. I think in the first instance I would like to bring [Patient C] back for repeat coronary angiography and angioplasty to the circumflex vessel. If this goes*

well, we will then reconsider angioplasty to the right coronary artery at a later date. However, for the time being I would not like to commit to this plan of action.'

266. The Tribunal heard from Dr E. He confirmed the sequence of events as set out in his letters to Patient C's GP and the treatment options which had been considered and agreed with Patient C.

267. The Tribunal also heard from Patient C. She referred the Tribunal to her statement dated 30 September 2021 and expressed her concerns about the way she had been treated by Dr Ali during and after the PCI. Patient C confirmed that the only matter she wanted to raise with Dr Ali prior to the PCI was her concern about her blocked carotid artery, but that she was happy to proceed with the PCI. Patient C also confirmed that she did raise the matter of her blocked carotid artery with Dr Ali when she was in the Cath Lab but said that Dr Ali had been dismissive in his manner, as she had described in her statement.

268. In his statement of 11 February 2022, at paragraphs 13 to 15, Dr Ali states:

'13. I do not agree that I failed to review Patient C (SC) adequately before performing the PCI procedure or that I did not have her consent to the procedure. As I have explained earlier, it was common practice at Wexham Park Hospital at the time for senior nurses to take consent from the patient. I did not think at the time that there was an obligation on me to go through the consent process again.'

'14. I may well have seemed flustered given what I had already been doing that day, but my colleagues have told me that I appear calm in the Catheter Lab. I acknowledge that she may well have felt that I was dismissive of what she was saying about her carotid artery, but clinically a diseased carotid artery was not relevant to the intended PCI procedure and it is not uncommon in patients requiring PCI.'

'15. My recollection is that, in accordance with the usual practice at the time at Wexham Park Hospital, I would have discussed the planned procedure on Patient C (SC) with the Catheter Lab team, as they prepared the kit that would be needed for the procedure on Patient C (SC). I believe that I also reviewed her earlier angiography images in the Catheter Lab on 19 January 2017, prior to carrying out the procedure.'

269. The Tribunal had regard to the NICE Guidance CG126 for 'Stable angina: management'. It noted in the first paragraph under the heading 'Your responsibility' it states:

'The recommendations in this guideline represent the view of NICE, arrived at after careful considering of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.' (emphasis added by the Tribunal)

270. The Tribunal considered it clear from the evidence placed before the Tribunal that Dr E did explain the risks and benefits of the procedure when he consented Patient C before the angiography on 24 October 2016, and that he did so again, relating to the PCI, at the consultation with her on 30 November 2016.

271. The Tribunal has already found that at the Hospital, it appeared to be common practice that several different cardiologists were involved in the care of a patient at different times during the patient's journey, and that a patient's PCI may be performed by a different doctor to the one seeing them in the out-patient clinic or to one that had previously done an interventional procedure on the patient. The Tribunal has also found that consent for procedures was not necessarily taken by the operator but it was standard practice at the Hospital to delegate this process to a suitably trained nurse. The Tribunal noted that it was a trained nurse who obtained consent from Patient C for the PCI carried out by Dr Ali on 19 January 2017.

272. Patient C said in her oral evidence that her concern in relation to her blocked carotid artery was addressed by Dr Ali in the Cath Lab, albeit, in her view, dismissively. Dr J did not dispute Dr Ali's evidence that '*clinically a diseased carotid artery was not relevant to the intended PCI procedure, and it is not uncommon in patients requiring PCI'.* The Tribunal therefore considered that Dr Ali did adequately address Patient C's concerns in this respect.

273. Dr Ali's evidence to the Tribunal was that he reviewed Patient C's angiograms prior to commencing the PCI, that he did not need to consent Patient C again because she had the risks and benefits explained to her by Dr E, that the best treatment option for Patient C had been established as set out in Dr E's letter of 8 December 2016 which was for the PCI, and that this decision had been endorsed by the MDT, at which he was likely to have been present. His evidence was that, in these circumstances, it was not necessary for him to challenge or change that decision, and that it was not a failure on his part to decide to proceed with the PCI on Patient C on 19 January 2017.

274. Given the history of consultations by Dr E with Patient C, and the involvement of MDT, the Tribunal accepted Dr Ali's evidence. It noted Dr J's evidence which was based on the GMC guidance entitled ***'Consent: patients and doctors making decisions together'*** (2008), that the ultimate responsibility was that of Dr Ali. The Tribunal also noted that the guidance allows for delegation of consent taking. It considered that Dr J may not have taken the overall picture fully into account, including the practices at the Hospital, when providing his opinion.

275. The Tribunal therefore determined that Dr Ali had not failed to adequately review Patient C's case, had not failed to adequately obtain consent from Patient C, nor failed to challenge the decision of Dr E and the MDT to proceed to PCI of the circumflex coronary artery, nor made the decision to proceed to PCI when it was inappropriate to do so.

276. The Tribunal therefore found paragraphs 15(a), (b), (c) and (d) of the Allegation not proved.

<u>Paragraph 15(e) of the Allegation</u>

e. failed to anticipate the finding of an un-dilatable stenosis that you encountered during the PCI procedure;

277. At paragraph 3.11 of his report dated 20 August 2019, Dr J stated:

'Dr Ali undertook the PCI procedure and encountered difficulties with pre-dilation of the Cx stenosis (balloon inflations that precede stent insertion). The initial balloon chosen, a 2.5mm semi-compliant balloon, was not successful in opening the narrowing sufficiently to allow stent insertion, i.e., the Cx stenosis was un-dilatable.'

278. He continued at paragraphs 3.12 and 3.13:

'This difficulty could have been anticipated from careful review of the diagnostic coronary angiogram. The initial diagnostic angiogram of the left coronary artery shows the Cx to be a small calibre, diffusely diseased and heavily calcified coronary artery. The reason for the Cx stenosis being un-dilatable was the heavy calcification at the site of the Cx stenosis.

and

From the initial angiogram Dr Ali should have anticipated the finding of an undilatable stenosis. This should have led to Dr Ali making preparation for dealing with such an eventuality, e.g., having the option of rotablation available. There is no indication that Dr Ali had foreseen such a problem arising and no indication that alternative strategies had been considered.'

279. The Tribunal had regard to Dr E's letter to Patient C's GP, dated 30 November 2016, in which he stated: *'As you know she does have severe stenosis in the mid circumflex coronary artery, which would be amenable to angioplasty and stenting.'* The Tribunal took from this that the finding of an un-dilatable stenosis was not anticipated at this time by Dr E, or by any other clinicians involved in reviewing her case at the MDT prior to the PCI, otherwise it would not have been considered that the artery was amenable to angioplasty and stenting.

280. In his oral evidence, when asked about this, Dr E said words to the effect that with hindsight, it was a difficult artery and the images taken from the angiogram prior to the day of the PCI did not do it justice. Dr Ali went on to perform the PCI with the understanding that the recommendation for PCI had been considered by Dr E, discussed at two MDT's, and that no one had anticipated a finding of an un-dilatable stenosis.

281. Dr Ali, stated at paragraph 23 of his statement dated 11 February 2022:

'23. I acknowledge that I did not anticipate that I would be unable to dilate the stenosis using reasonable measures. It is difficult to anticipate that possibility with certainty and I recollect no discussion at the MDT about the possible need for rotablation. Rotablation was not available at Wexham Park Hospital and if the need had been anticipated, the patient would have been transferred to Frimley Park Hospital where rotablation was available.'

282. The Tribunal noted that 'rotablation' is a procedure which uses a cutting blade to open a blocked artery.

283. In his oral evidence, Dr J explained that the stenosis would not have changed since it was identified by Dr E during the angiogram in October 2016 and the day of the PCI. Dr Ali told the Tribunal that he took angiogram images on the day of the PCI and he saw nothing to suggest that there was or could be an un-dilatable stenosis. Therefore, the stenosis seen by Dr Ali was the same as had been seen by Dr E and the MDT when an un-dilatable stenosis had not been identified or predicted.

284. The Tribunal was of the view that, given that the un-dilatable stenosis had not been anticipated by Dr E or the MDT, and given that they had agreed that the PCI should go ahead, it was not reasonable to suggest that Dr Ali could anticipate the difficulty which he then encountered.

285. The Tribunal therefore found paragraph 15(e) of the Allegation not proved.

Paragraph 15(f) of the Allegation

> f. used a 4.0mm non-compliant balloon at a pressure of 30 atmospheres to try and dilate the coronary artery when it was inappropriate to do so;

286. Dr J in his report of 20 August 2019, at paragraphs 3.13 – 3.15 states:

> *'3.13 From the initial angiogram Dr Ali should have anticipated the finding of an undilatable stenosis. This should have led to Dr Ali making preparation for dealing with such an eventuality, e.g., having the option of rotablation available. There is no indication that Dr Ali had foreseen such a problem arising and no indication that alternative strategies had been considered.*
>
> *3.14 Having encountered this difficulty Dr Ali took an unusual approach to deal with an un-dilatable stenosis namely a step up from a semi-compliant 2.5mm balloon to a much larger 4.0mm non-compliant balloon (NCB) inflated to very high pressure of 30 atmospheres (usual maximal pressure, i.e., rated burst pressure, for this balloon is 20 atmospheres). This produced a coronary perforation. (2.20)*
>
> *3.15 The sudden change from a 2.5 mm balloon to a 4mm NCB is not usual practice. When using NCB balloons for lesions that don't dilate with standard semi-compliant balloons the usual practice is to keep to a balloon to artery ration of 1:1. Therefore it would be usual practice to have used a 2.5 mm NCB (or possibly 3mm if the initial 2.5mm balloon was thought to be a little undersized). Using oversized balloons increases the risk of complications such as coronary dissection or coronary perforation.'*

287. In his statement of 7 February 2022, Dr Ali states at paragraphs 20 – 22:

'20. The narrative note (p.683) made by me in the report expressly mentioned first that 'Coronary perforation was noted in mid vessel…' and that '…The dissection was sealed and the patient became stable' (p.684). The immediate symptoms that I observed, that is severe chest pain and bradycardia, were managed. I note that I once again used the word 'dissection' and in this case used it in the same paragraph that I used the word 'perforation'.

21. The stickers for the devices used have been attached to the records, as can be seen (p. 887). The stickers show that the following were used:

(a) NC Trek 3.0 mm x 8 mm;
(b) Xience Alpine 3.00 mm x 18 mm;
(c) Boston Scientific 2mm x 10 mm, cutting balloon;
(d) Trek 2.5 mm x 15 mm;
(e) Guidion;
(f) NC Trek 3.00 mm x 12 mm;
(g) Resolute Onyx 2.75 mm x 22 mm;
(h) Xience Alpine 2.5 mm x 12 mm; and
(i) Xience Alpine 2.75 mm x 12 mm.
I note that there is no sticker for the 4mm balloon.

22. Looking at the part of the record headed 'Dynamic notes' (HPR, p.26), I see that the sequence of balloons recorded is as follows:

(a) Trek RX 2.5mm x 15 mm, which was inflated six times to 10 atm, 13 atm, 18 atm, 18 atm, 20 atm, and 22 atm for different lengths of time between 13.35.09 and 13.37.23.
(b) NC Quantum Apex 4.00mm x 15 mm, which was inflated once to 20 atm and then six times to 25 atm for different lengths of time between 13.57.21 and 13.59.04; in parenthesis I note that there is no inflation numbered 11 but there are 2 inflations numbered 14; and
(c) NC Quantum Apex 4.00mm x 15 mm, which was inserted and inflated to 30 atm for 10 seconds at 14.05.38.'

288. In his evidence, Dr Ali stated that he did not recall the sequence of balloons he used during the PCI on Patient C but that he would be very surprised to go from a 2.5 mm balloon to a 4.0 mm balloon. He said that it was more likely he would have gone up to a 3.0 mm balloon. Dr Ali explained the sequence that takes places within the Cath Lab in respect of when a balloon is used. On the front of each balloon packet was a sticker showing its size. The sticker was passed to the physiologist, the balloon size entered onto the patient's CLR, and the sticker placed on the 'Invasive and Interventional Cardiology Integrated Care Pathway' record.

289. Dr Ali said that it was likely that the wrong balloon size was entered onto the CLR because there is no corresponding sticker. He accepted, however, that there is a reference to a 4.0mm balloon on the CLR but he was unsure as to whether he used it. He also accepted that it was inappropriate to inflate the balloon to a pressure of 30 atmospheres.

290. The Tribunal had regard to the stickers referred to by Dr Ali. It noted several stickers representing the balloons which had been used, but that there is no sticker for a 4.0 mm balloon. Dr

Ali stated that it is not his standard practice to go from a 2.5mm balloon to a 4.0mm balloon, and that he did not do so in the case of Patient C. Dr J agreed that it would be unusual to move upwards in size in one step.

291. The Tribunal also had regard to the CLR in which it is recorded under the 'Devices used':

NC Quantum Apex 4.0 mm x 15 mm. Diameter 15 mm. Length 4 mm. 1 inflation(s) to a max pressure of atm'

292. The Tribunal noted, from the evidence adduced during the proceedings, that a balloon would not be 15 mm wide and considered this therefore to be a typographical error in the CLR report. There were other similar examples in the report which suggested to the Tribunal that the data contained in the different reports is not wholly accurate and therefore not wholly reliable. It considered it possible that the size of the balloon could have been entered incorrectly.

293. The Tribunal therefore was not satisfied on the evidence before it that Dr Ali used a 4.0 mm balloon, as alleged, and it determined that the GMC had failed to discharge the burden of proof.

294. The Tribunal therefore found paragraph 15(f) of the Allegation not proved.

Paragraph 15(g) of the Allegation

g. caused Patient C to have a coronary perforation;
Admitted and found proved

295. This paragraph of the Allegation was admitted and found proved. The Tribunal did not consider it further at this stage.

Paragraph 15(h)(i) of the Allegation

h. failed to respond appropriately when Patient C suffered a coronary perforation in that you failed to:

i. undertake or arrange an emergency echocardiogram in the catheter laboratory;

296. Patient C's PCI commenced at 13:07 and concluded at 14:37.

297. Dr J, in his report of 20 August 2020, states at paragraphs 3.22 and 3.23:

'3.22 The literature provides guidance on the current best approaches to patient management and once a perforation has been seen to occur an emergency echocardiogram should be performed to detect any accumulation of blood around the heart (Figure 5).

3.23 This echocardiogram should be performed in the catheter laboratory whilst the coronary guide wire is still in place in the coronary artery. This will guide corrective treatments if a significant pericardial collection is detected (Figure 5).'

and at paragraph 3.26:

'3.26 Dr Ali did not undertake or arrange emergency echocardiography. This was inappropriate particularly as Patient [C] had signs of intrapericardial bleeding with low blood pressure (hypotension).'

298. The Tribunal noted the reference to 'Figure 5' comes from Dr J's evidence and is an 'Algorithm for treating coronary dissections and coronary perforations'. This states that when there is a perforation there should be *'emergent echocardiography'*.

299. Dr J's evidence was that an echocardiogram should have been performed while Patient C was still in the Cath Lab when the catheter wire was still in place to enable any further invasive steps to be taken should this be necessary such as the use of additional or covered stents. He stated that it would have been reasonable to keep Patient C in the Cath Lab for fifteen minutes or longer as necessary.

300. At paragraphs 29, 30 and 31 of his statement of 7 February 2022, Dr Ali states:

'29. As I have mentioned in relation to [Patient B], Echocardiography was not immediately available in the Catheter Lab at Wexham Park Hospital at the time or I would have performed on-table echocardiography. In the event an echocardiogram was performed on Patient C in the ward after she had been stabilised and transferred. My Catheter Lab report notes that I sought 'Urgent echo today' (p.684).

30. The Obtuse Marginal side branch was lost (occluded) at the time the coronary perforation had occurred and before stent deployment as can be seen in the image timed 14:11:56 (XA000574). I did not at the time think it was necessary to mention this in my final report.

31. Patient [C] became stable in the Catheter Lab and was transferred from the Catheter Lab to the Coronary Care Unit, with my note recording 'Patient transferred to CCU' (p.684'). As you will appreciate, this was the second patient on the same day where I had perforated a coronary vessel during the PCI procedure. I believe that the perforations in Patients B and C were the first in my career as a primary operator, although I had assisted colleagues to deal with perforations in the course of my training. When a perforation occurs, I would have a decision tree in mind, with a series of steps to be considered. The first was to see if I could seal the perforation and stabilize the patient. I did consider the possibility that I might have to carry out pericardiocentesis but, in the event, it was not clinically indicated. Performing an echo would have been a prior step to pericardiocentesis, and in the event there was no echo available immediately in the Catheter Lab but the need for an Echo as a prior step to pericardiocentesis did not arise. However, the kit for pericardiocentesis was available, pre-packed, and ready in the Catheter Lab.'

301. The Tribunal noted that in Patient C's CLR, Dr Ali recorded at 15:22 under 'Recommendations':

'Urgent echo today'

302. The Tribunal noted that an echocardiogram was performed on Patient C at 15:34, some 12 minutes later. It noted from Patient C's records that there was an entry made by Dr Ali timed at 15:35 when he visited Patient C. The entry states:

'Pt has no C/P
P 60 bpm
BP 96/55
Iv fluids being given → give as stat

Echo – shows good LV function
localized small posterior pericardial effusion
not causing Tamponade

Plan
Continue iv fluids
Close monitoring
Monitor U/O
Bloods – FBC/U+E/Trop level'

303. In his written and oral evidence, Dr Ali said that he did not arrange for an emergency echocardiogram of Patient C whilst she was in the Cath Lab because he was already aware from the PCI of Patient B earlier that day that a portable echocardiogram was not available. He added that there was a lot going on and because he had stabilised Patient C's symptoms, he considered it safe to transfer her to the ward, having arranged for an echocardiogram to be done there. He said that, had it then been necessary, he would have had taken Patient C back into the Cath Lab for further management.

304. The Tribunal heard from Miss G, who was the Cardiology Investigations Manager at the time and responsible for the echocardiogram service. In her evidence, she confirmed that an echocardiogram machine was not available in the Cath Lab. In her statement, she stated:

'In terms of the echo machine, this is something that would need to be called for if it was required. It was kept in the Cardiology Investigations Unit and is used in the department or on patients on the ward….

Generally, if a patient in the catheter lab needs an urgent echo to be performed during a procedure, a call will be made down to the Cardiology Investigations Unit and we would try and see if one of the echo physiologists is free or sometimes one of the cath lab staff will come down to the Cardiology Investigations Unit to collect the machine and ask one of the

staff to come to the cath lab urgently. This is normal practice for a patient on the table who is not very well.'

305. The Tribunal considered it to be clear, from Dr Ali's own evidence, that he did not arrange for an emergency echocardiogram to be done in the Cath Lab while Patient C was still in the laboratory. The Tribunal accepted Dr J's evidence of the reasoning behind, and the need for, *'emergent echocardiography'*.

306. The Tribunal considered that, although Dr Ali asked that an *'Urgent echo'* be done at the end of the PCI when he electronically completed the CLR, he should have undertaken or arranged for emergency echocardiogram at the time Patient C became unwell. From the evidence contained in the reports of the PCI, this was at 14:11, when her blood pressure dropped during the PCI. The Tribunal considered that if it had been requested, an echocardiogram machine could have been brought to the Cath Lab urgently.

307. The Tribunal therefore found paragraph 15(h)(i) of the Allegation proved.

Paragraph 15(h)(ii) and (iii) of the Allegation

ii. consider and/or make preparations for immediate pericardiocentesis;

iii. consider and/or make preparations for insertion of a covered stent to seal the perforation;

308. The Tribunal considered paragraphs 15(h)(ii) and (iii) together.

309. Dr J in his report dated 20 August 2020, states at paragraph 3.27:

'3.27 There is no indication that Dr Ali considered or made preparations for immediate pericardiocentesis, insertion of a covered stent to seal the perforation or possible emergency cardiac surgery.'

310. Dr J further accepts in paragraph 3.29 of his report:

'3.29 Fortunately, after the insertion of three coronary stents the angiogram showed coronary perforation was sealed. However, there was occlusion of the major OM branch of the Cx artery.'

311. The Tribunal accepted from the comments made in the CLR that Dr Ali was aware there was a perforation. The Tribunal had regard to paragraphs 31 and 32 of his statement dated 7 February 2022:

'31. Performing an echo would have been a prior step to pericardiocentesis, and in the event there was no echo available immediately in the Catheter Lab but the need for an Echo as a prior step to pericardiocentesis did not arise. However, the kit for pericardiocentesis was available, pre-packed, and ready in the Catheter Lab.'

'32. Covered stents are kept ready in the Catheter Lab, but they are not often required and frequently their life expires before they are used and they have to be replaced. The question: do we have in date covered stents is asked prior to carrying out PCI. I have seen and assisted in the placement of a covered stent put in by a colleague but I have not had to put a covered stent in. The possibility that I might have to place a covered stent in Patient C had been in the back of my mind as I sought to seal the perforation. Considering and preparing for emergency cardiac surgery was even further down the decision tree. I did not have to prepare Patient C for emergency cardiac surgery. At the time, as I mention earlier in this statement, the link was with Harefield Hospital. If the need had arisen, we would have telephoned the team at Harefield Hospital. They would have asked what I was doing to seal the perforation, but if the patient was to be transferred to Harefield Hospital we would have transferred Patient C to the ITU at Wexham Park Hospital first, and she might have been intubated and ventilated, and then transferred by blue light ambulance.'

312. As the Tribunal has noted from the guidance presented to it, the next possible steps in managing a perforation include arranging for an emergency echocardiogram and, if necessary, a pericardiocentesis, and additional or covered stents. Dr J's evidence was that there was no indication that Dr Ali considered or prepared for these. However, because covered stents and the equipment for pericardiocentesis were immediately to hand, Dr J's evidence did not go so far as showing that Dr Ali did not consider or prepare for these steps to be taken. Dr J explained that in the hospital where he worked, a code word, 'the third trolley' is used to indicate the need, but Dr Ali explained that no such code operated at the Hospital.

313. The Tribunal considered Dr Ali's evidence that *'The possibility that I might have to place a covered stent in Patient C had been in the back of my mind as I sought to seal the perforation',* and that pericardiocentesis was also in his thinking. The Tribunal determined that in the absence of evidence to the contrary, and given the availability of the equipment ready to hand, the GMC had not discharged the burden of proof regarding these allegations,

314. The Tribunal therefore found paragraphs 15(h)(ii) and (iii) of the Allegation not proved.

Paragraph 15(h)(iv) of the Allegation

iv. ~~consider and/or make preparations for emergency cardiac surgery;~~
(Withdrawn following a Rule 17(6) application)

315. This paragraph of the Allegation was withdrawn. The Tribunal did not consider it further.

Paragraph 15(j) of the Allegation

j. failed to recognise and/or record that Patient C had suffered from major side branch occlusion leading to myocardial infarction;

316. In his report dated 20 August 2019, at paragraph 2.23, Dr J stated:

'2.23 At 14.34 the angiogram (XA000584) taken at the end of Dr Ali's PCI procedure shows the perforation to be sealed and total occlusion of the main obtuse marginal branch (OM) of the Cx.'

At paragraph 3.31, he stated:

'3.31 Patient (c) had a myocardial infarction with chest pain and troponin rise. This complication appears not to have been noted'.

317. In his oral evidence during cross examination, Dr J accepted that it was possible Dr Ali did see the occlusion even though he did not record it in the CLR. Further, Dr J accepted that Dr Ali may have recognised the occlusion given his subsequent actions. However, Dr J maintained that Dr Ali should have recorded it and that not doing so was a failure on Dr Ali's part.

318. At paragraph 30 of his statement of 7 February 2022, Dr Ali states:

'30. The Obtuse Marginal side branch was lost (occluded) at the time the coronary perforation had occurred and before stent deployment as can be seen in the image timed 14:11:56 (XA000574). I did not at the time think it was necessary to mention this in my final report.'

319. During his oral evidence, Dr Ali accepted that he should have recorded the occlusion but maintained that he recognised it at the time. Dr Ali went on to say that because he recognised the occlusion, even though the perforation had been sealed, he ordered tests to be carried out after the PCI. This included a test for troponin levels which, if high, would indicate that there had been a myocardial infarction. In this respect, Dr Ali referred the Tribunal to paragraph 39 of his statement which states:

'39. The ECG showed that she was in sinus rhythm and that there were no acute ischaemic changes. The echocardiogram showed that there was no significant effusion that required a drain at that time. In this case a peri-procedural myocardial infarction was likely given the perforation and subsequent side branch occlusion and would be diagnosed by significantly raised Troponin level.'

320. Based on the evidence of Dr Ali that he did not record the occlusion, and the concession made by Dr J in evidence that he may have recognised the occlusion but not recorded it, the Tribunal determined that Dr Ali did recognise the occlusion but that he failed to record it.

321. The Tribunal noted that the allegation is in the alternative. It therefore found paragraph 15(j) of the Allegation proved in that Dr Ali failed to record that Patient C suffered from major side branch occlusion leading to myocardial infarction.

<u>Paragraph 15(k) of the Allegation</u>

k. failed to communicate adequately with Patient C following the procedure;

322. Dr J's evidence, in his report dated 20 August 2019, at paragraphs 3.33 and 3.34, was:

'3.33 Dr Ali saw Patient (C) after the procedure. Dr Ali's notes do not include a record of any explanation to Patient [C] of the major complications of the PCI procedure, i.e. coronary perforation and pericardial bleeding; coronary branch occlusion and myocardial infarction. Dr Ali's notes do not include any apology for the complications. Dr Ali's notes do not include any explanation of consequences of the complication.'

'3.34 GMC Guidance - Openness and honesty when things go wrong, Professional Duty of Candour includes - tell the patient when something has gone wrong; apologise to the patient, offer an appropriate remedy or support to put matters right (if possible, explain fully to the patient the short and long term effects of what has happened. GMC Good Medical Practice includes Record your work clearly accurately and legibly - 21 Clinical records should include - the information given to patients.'

323. The Tribunal had regard to Patient C's discharge letter, dated 6 February 2017 which states:

'Diagnosis at Discharge
Elective admission for PCI to left coronary – developed coronary artery rupture
pericardial effusion
HAP
AKI
Dresslers syndrome'
……
Complications
coronary artery rupture
pericardial effusion'

324. Dr Ali, in his statement of 7 February 2022 stated, and maintained during his oral evidence, that he explained the complication to Patient C while she was still in the Cath Lab. At paragraph 36 of his report Dr Ali states:

'My recollection is that I explained to Patient C the complication which had occurred, during the course of managing that complication while the patient was in the Catheter Lab. She had been given analgaesia but not a general anaesthetic. I believe that I had a further conversation with her when I saw her in the ward that afternoon but readily acknowledge that she would, or might, not have taken those explanations in. From my subsequent conversation with Patient C it became apparent that she had no recollection of my reviewing her in person on the ward on the afternoon of 19 January 2017.'

325. Dr Ali went on to state at paragraphs 37:

'Patient [C] was seen again at 21.45 and the note by the CMT2 doctor includes a note that the PCI to the Left Circumflex had been 'complicated by coronary artery rupture [ ] sealed in angio' (p.689).'

326. The Tribunal heard from Patient C. In her oral evidence, Patient C said that she could not at all recall Dr Ali explaining the complication to her, either in the Cath Lab or on the ward. She accepted that she had been given strong analgesia and this might have been the reason she could not recall or take in any explanations which were given to her at the time.

327. In his evidence during cross examination, Dr J accepted that it was not fair to blame Dr Ali for Patient C's inability to recollect the conversations he had with her in relation to the complications in the Cath Lab or on the ward.

328. The Tribunal had regard to notes recorded by Dr Ali's colleagues when they visited Patient C on the ward. One note, timed, at 18:45 on 19 January 2017, and another timed at 21:45, make no mention that Patient C had any difficulty communicating or understanding what was being said to her.

329. The Tribunal considered that the absence of any notes in Patient C's clinical records does not mean that Dr Ali did not explain the complication to Patient C, or that he failed to adequately communicate with her. Dr J accepted this during his evidence.

330. Having heard from Patient C and having considered the information recorded in her records, the Tribunal was not satisfied that Dr Ali failed to adequately communicate with Patient C following the PCI.

331. It therefore found paragraph 15(k) of the Allegation not proved.

<u>Paragraph 15(l) of the Allegation</u>

> l. failed to make an appropriate note of the PCI procedure to include the complications encountered;

332. Dr J states in paragraph 3.33 of his report of 20 August 2019:

'3.33 Dr Ali saw Patient [C] after the procedure. Dr Ali's notes do not include a record of any explanation to Patient [C] of the major complications of the PCI procedure, i.e. coronary perforation and pericardial bleeding; coronary branch occlusion and myocardial infarction. Dr Ali's notes do not include any apology for the complications. Dr Ali's notes do not include any explanation of consequences of the complication.'

333. The Tribunal noted the complications as set out in Dr J's paragraph 3.33. These were: perforation; pericardial bleeding; coronary branch occlusion; and myocardial infarction.

334. The Tribunal had regard to the CLR completed by Dr Ali immediately following the PCI. It records the perforation as a complication and refers to the 'dissection' being sealed.

335. It had regard to the clinical notes made by Dr Ali at 15:35 when he saw Patient C in the ward. It notes that the echocardiogram showed '*localized small posterior pericardial effusion not causing Tamponade'*.

336. In relation to myocardial infarction, Dr Ali could not have recorded this complication at the time because it had not been confirmed by the investigations which he had requested.

337. The Tribunal therefore determined that Dr Ali did not fail to make an appropriate note of these complications.

338. The Tribunal has already found that Dr Ali failed to record the coronary branch occlusion in relation to allegation 15(j) above. The Tribunal considered it would be 'double counting' to find the same matter proved under the head of another allegation.

339. The Tribunal therefore found paragraph 15(l) of the Allegation not proved.

Paragraph 15(m) of the Allegation

> m. failed to make a note of any discussions with Patient C regarding the complications encountered and any apology given.

340. The Tribunal has already found paragraph 15(k) not proved in that Dr Ali did not fail to adequately communicate with Patient C after the PCI on 19 January 2017. It noted the content of the note he made of his visit to her at 15:35 that day. Although the Tribunal considered that Dr Ali had adequately communicated with Patient B, it noted that there is no record of any discussion, for example what he said to her or her reaction, nor is there a note of any apology.

341. The Tribunal also had regard to Dr Ali's note of his visit to Patient C at 08:00 the following morning: a

> *"Dr Omar Ali Consultant*
> *Pt complained of chest pain after vomiting this morning.*
> *Obs stable P 55 BP 124/63 O2 sat 98% R/A*
> *passing urine* └_____┘
> \
> *improved haemodynamics*
>
> *Plan*
> ① *ECG now □ SR; No acute ischaemic changes.*
> ② *Rpt echo this am*
> ③ *Keep pt on CCU for close monitoring*
> ④ *Please keep me informed of her progress.'*

342. The Tribunal noted that there is again no record of any discussion with Patient C.

343. In his statement dated 7 February 2022, at paragraph 36 Dr Ali stated:

> *'36. My recollection is that I explained to Patient C the complication which had occurred, during the course of managing that complication while the patient was in the Catheter Lab. She had been given analgaesia but not a general anaesthetic. I believe that I had a further conversation with her when I saw her in the ward that afternoon but readily acknowledge that she would, or might, not have taken those explanations in. From my subsequent conversation with Patient C it became apparent that she had no recollection of my reviewing her in person on the ward on the afternoon of 19 January 2017.'*

344. Further at paragraph 43, he stated:

> *'43. I did not document the full content of the discussions I had with Patient C on 19 January and 20 January 2017.'*

345. The Tribunal considered that, whilst Dr Ali may have discussed with Patient C the complications she suffered during the PCI, and may have apologised to her, it is a matter of fact that there is no record of these discussions in the clinical notes.

346. It therefore found paragraph 15(m) of the Allegation proved.

Patient D

Background

347. Patient D was 74 years old when he was treated by Dr Ali as a private patient in May 2016.

348. On 30 March 2017, Patient D was seen by a nurse in the Assessment of Suspected Angina outpatient clinic at the Hospital following a referral by his GP. He had a history of chest pain but with no change or limitation in his exercise tolerance. A CT-coronary angiogram ('CTCA') took place on 9 May 2017. This showed that Patient D had stenosis of the right coronary artery, the left anterior descending artery, and the circumflex artery.

349. Dr Ali reviewed the results on 12 May 2017. He did not see Patient D for this review. He recommended an urgent invasive coronary angiogram and an increase in Patient D's medical therapy with the addition of Atorvastatin and Bisoprolol.

350. Dr Ali saw Patient D on 22 May 2017 privately. The Tribunal had a copy of Dr Ali's handwritten note of the consultation, and the letter Dr Ali wrote to Patient D's G.P. afterwards. Dr Ali was told that Patient D had a history of shortness of breath and episodes of central chest pain which were unpredictable or brought on by exertion. Dr Ali noted that Patient D attended Accident and Emergency on 20 May 2017 complaining of these

symptoms. Dr Ali's summary of the CTCA was *'three vessel disease with severe mid LAD stenosis'*. Dr Ali's plan was to commence Aspirin and Clopidogrel in addition to his other tablets, restart Amlodipine, and for Patient D to have an angiogram proceeding to PCI. He advised Patient D to stop smoking.

351. Dr Ali carried out the PCI procedure on Patient D on 30 May 2017. He performed an angiogram and then proceeded to PCI, inserting four stents. The CLR indicates there were no complications. However, Patient D suffered a cardiac arrest due to ventricular fibrillation a few hours after the PCI from which he was successfully resuscitated. He was discharged home on 1 June 2017.

352. Dr Ali next saw Patient D on 12 June 2017 when he referred him to a cardiac rehabilitation programme. Dr Ali was not involved in Patient D's care after 12 June 2017.

353. The Tribunal noted that there were no allegations regarding the performance of the PCI itself performed by Dr Ali on 30 May 2017, or about its outcome. The allegations concerning Patient D relate to the appropriateness of the treatment recommended by Dr Ali and the obtaining of consent for that treatment.

Paragraph 16 of the Allegation

> 16. On or about 12 May 2017, ~~you wrote to Patient D and~~ you inappropriately recommended invasive coronary angiography rather than non-invasive functional imaging.
> (Amended following a Rule 17(6) application)

354. The Tribunal noted that this allegation related to Dr Ali's review of Patient D on 12 May 2017.

355. The Tribunal considered Dr J's report dated 14 August 2020, in which he considered Patient D's history. He noted that the CTCA showed CAD with significant stenosis sufficient to cause ischaemic heart disease or lack of blood supply to the heart. A typical symptom of these conditions is angina which occurs during exercise when the blood flow to the heart is insufficient to meet the demands caused by exercise.

356. The letter to Patient D's GP following the appointment on 30 March 2017 recorded:

> *'[Patient D] presents with a three-month history of left chest ache, no triggers associated flush feeling, no shortness of breath, nausea or sweating. Symptoms come on gradually and last 5 to 10 minutes and gradually relieve aided with rubbing his chest. There has been no change in his exercise tolerance. He continues to do everything as normal. He has quite physical job. He is an MOT mechanic and does love walking around and does heavy lifting within his job.'*

357. Dr J's view was that Patient D had chest pain which was not consistently related to exertion and therefore not typical of angina. He referred the Tribunal to ***NICE Guideline CG95: 'Chest pain of recent onset'*** dated November 2016, which recommends non-invasive functional imaging if a person has confirmed CAD but there is uncertainty about whether the chest pain is caused by ischaemia.

358. Dr J's opinion was that Patient D should have been referred for non-invasive functional imaging as the next step of his assessment and that it was inappropriate to recommend the invasive angiogram which Dr Ali did recommend on 12 May 2017.

359. Dr Ali's evidence was that he considered Patient D to be a typical angina patient. He stated that he had discussed Patient D with the nurse who saw him, and as a result, he was concerned about the symptoms of angina that were described to him. He stated that he would not have recommended 'urgent' invasive angiography lightly and that he considered it appropriate to do so because he knew that Patient D had CAD and because he was worried about the severity of the CAD.

360. The Tribunal had regard to the clinical notes made by Dr Ali when he saw Patient D on 22 May 2017. In the notes Dr Ali recorded amongst other things *'chest pain on exertion'*. It also had regard to the CLR written following the PCI procedure on 30 May 2017 in which, it was stated that Patient D *'has been experiencing angina pain.'*. The Tribunal considered that these records corroborated Dr Ali's account that he considered Patient D to have symptoms of angina and that he was making clinical decisions with that in mind.

361. The Tribunal noted that in oral evidence Dr J was asked about these factors. He conceded that in the light of the conclusion drawn by Dr Ali that Patient D presented with typical angina, there was no need for non-invasive functional imaging to be carried out. The Tribunal considered this to be significant evidence regarding this allegation.

362. The Tribunal was also referred to the 'Disclaimer' paragraph in NICE Guidance CG95, which emphasises that role of the guidance alongside the need for healthcare professionals to exercise their clinical judgement. It states:

> '*Healthcare professionals are expected to take NICE guidelines fully into account when exercising their clinical judgement. However, the guidance does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient and, where appropriate, their guardian or carer.'*

363. Taking all of the evidence into account, the Tribunal was satisfied that it was not inappropriate for Dr Ali to have recommended invasive coronary angiography rather than non-invasive functional imaging.

364. It therefore found paragraph 16 of the Allegation not proved.

Paragraph 17 of the Allegation

> 17. On 22 May 2017, you consulted with Patient D and you inappropriately recommended for Patient D to proceed to invasive coronary angiography with a view to angioplasty (PCI) without first assessing the impact of escalation of optimal medical therapy on Patient D's symptoms.

365. The Tribunal noted that this allegation related to Dr Ali's assessment of Patient D during and after the consultation which took place on 22 May 2017.

366. The Tribunal noted that, although in respect of the previous allegation, Dr J conceded that Dr Ali's recommendation for PCI was not inappropriate for the treatment of stable angina, Dr J maintained the opinion set out in his report that it was inappropriate to move to that step without first moving to optimal medical therapy, in other words by using medication to control the symptoms of angina.

367. In doing so, Dr J referred to ***NICE Guideline CG126: 'Stable Angina: Management'*** which states:

> *'1.4.1 Offer people optimal drug treatment for the initial management of stable angina. Optimal drug treatment consists of one or two anti-anginal drugs as necessary plus drugs for secondary prevention of cardiovascular disease.'*
>
> and
>
> *'1.5.1 Consider revascularisation (coronary artery bypass graft [CABG] or percutaneous coronary intervention [PCI]) for people with stable angina whose symptoms are not satisfactorily controlled with optimal medical treatment.'*

368. Dr J noted that when Dr Ali saw Patient D on 22 May 2017, Patient D's only anti-anginal drug therapy was Bisoprolol, and that Dr Ali appropriately added Amlodipine as an additional anti-anginal drug. However, Dr J considered that Dr Ali did not allow sufficient time to assess the impact of the additional medication before making the recommendation to proceed to PCI. Dr J considered it possible that medication alone would have been sufficient to satisfactorily control Patient D's symptoms, and therefore the recommendation to proceed directly to PCI was not the appropriate next step.

369. It was pointed out to Dr J during his oral evidence that the PCI took place on 30 May 2017, eight days after Patient D started his additional anti-anginal medication. Dr J accepted that a period of five days or more was a suitable period to assess whether the Amlodipine which was prescribed by Dr Ali on 22 May 2017 would have had any impact upon Patient D's symptoms.

370. Dr Ali's evidence was that it was not inappropriate to proceed to PCI. He referred to: the significant stenosis on the CTCA; that Patient D had been taken to hospital by ambulance

only three days before the consultation on 22 May 2017 complaining of chest pain; and that at the consultation on 22 May 2017 Patient D had again complained of chest pain radiating to his neck. Dr Ali said in his statement:

> *'78. I did assess the impact of changes in medical therapy for Patient D but I did not think that it was appropriate to delay the planned angiogram/angioplasty to review the impact of the medication. He had already been on medical therapy for some months, and had stopped taking the Amlodipine on his own initiative. Medication alone would not have treated his symptoms.'*

371. The Tribunal had regard to the letter which Dr Ali wrote to Patient D's GP following the consultation in which Dr Ali set out his opinion at the time regarding medication and the decision to proceed to PCI. The Tribunal considered that the contents of the letter, which was written at the time, supported the evidence which Dr Ali gave to the Tribunal. It stated:

> *'His current medications include Atorvastatin 40 mgs once daily. Bisoprolol 1.25 mgs once daily and had been on Amlodipine which was stopped recently.'*
>
> And:
>
> *'As you know he was recently referred to the suspected angina clinic and had a CT coronary angiogram which showed three vessel disease with severe mid LAD stenosis. I explained this to [Patient D] today and have started him on Aspirin and Clopidogrel in addition to his other tablets. I have also asked him to restart his Amlodipine at 5 mgs once daily. I am arranging for him to have an angiogram with a view to proceeding to angioplasty shortly. He will also need an echocardiogram to assess his LV function.'*

372. The Tribunal did not have a copy of the consent form regarding Patient D's PCI. However, Dr Ali in his written and oral evidence told the Tribunal that he would have enquired if Patient D remained symptomatic with a view to establishing whether the additional medication had any impact. The Tribunal has already noted Dr J's evidence that a period of five days was sufficient to assess the impact of the Amlodipine on Patient D's symptoms of angina.

373. The Tribunal accepted that the NICE guidance recommends a staged process so that invasive procedures are only carried out when necessary, given the increased risks associated with these procedures. However, it bore in mind that the guidance contains a substantive paragraph under the heading 'Your Responsibility' which is similar to the 'disclaimer' paragraph contained in CG95, which is set out above, making clear that the guidance does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient.

374. Based on the evidence before it, the Tribunal considered that Dr Ali had assessed the impact of escalation of optimal medical therapy on Patient D's symptoms. Taking account of

this, together with the medical history provided by Patient D to Dr Ali on 22 May 2017, and the results of the CTCA report, it was not satisfied that it was inappropriate for Dr Ali to have recommended for Patient D to proceed to PCI.

375. The Tribunal therefore found paragraph 17 of the Allegation not proved.

Paragraph 18(a) of the Allegation

18. Between 22 May and 30 May 2017 you failed to:

a. consider with an MDT other options for treatment that were available to Patient D;

376. The GMC case was based on the opinion of Dr J who referred to ***NICE Guideline CG126: 'Stable Angina: Management'***. This recommends at paragraph 1.5.8 that the MDT should discuss the risks and benefits of continuing drug treatment, PCI, or coronary artery bypass grafting ('CABG') for people with stable angina. It states:

'Treatment strategy should be discussed for the following people, including but not limited to:

- *people with left main stem or anatomically complex three-vessel disease*

- *people in whom there is doubt about the best method of revascularisation because of the complexity of the coronary anatomy, the extent of stenting required or other relevant clinical factors and comorbidities.'*

377. Dr J's opinion was that Patient D required extensive stenting to treat his diffusely diseased left anterior descending artery, and therefore his case should have been discussed at an MDT before a decision was made to proceed to PCI.

378. The Tribunal noted again that the guidance is not mandatory and does not override clinical responsibility, as set out in paragraph 373 above.

379. Dr Ali stated, in his statement at paragraph 80:

'I did not take Patient D's future management to an MDT for their consideration between 22 May and 30 May 2017 because I saw no need. I thought that any MDT would recommend the course that I recommended. I have been taking part in MDTs in the hospitals that I have since worked in as a locum, which has included lengthy periods at St George's Hospital, Dorset County Hospital, Croydon Hospital and more recently Kingston Hospital. In all those hospitals patients presenting as Patient D are recommended an angiogram with the possibility of proceeding to angioplasty. In my recent appointment at Kingston Hospital, I regularly attend the coronary artery disease MDT meeting where non-invasive CT coronary angiography images are reviewed, and I saw many patients who had CTCA findings similar to patient D (JG)

referred for invasive coronary angiography. I also note that his Ca (Calcium) result was 1009 on the CTCA report (p.1001), followed by the comment 'High risk patient'.

380. The Tribunal considered that Dr Ali had reviewed and made a judgment based on the results of the CTCA report, his conversations with the nurse, and his own consultation with Patient D.

381. In the event, Patient D required four stents during the PCI but there was no evidence before the Tribunal that Dr Ali could have known or anticipated the extent of stenting which would be required prior to the commencement of the PCI. It noted that during his oral evidence, Dr J accepted that the issue of complexity, or otherwise, of the coronary anatomy was a matter of clinical judgment.

382. The Tribunal heard evidence from Dr E that not all patients undergoing intervention at the Hospital were discussed at the MDT. His evidence was that there was no requirement to do so, and that private patients could be discussed at the MDT but the decision to do so was up to the individual consultant.

383. The Tribunal considered that Dr Ali was in a better position than Dr J to anticipate the likely outcome of that MDT, and whether a case should be referred there. In the absence of any specific evidence that Patient D's case was one that should have been referred to an MDT, the Tribunal concluded that there was no failure on the part of Dr Ali in deciding not to refer Patient D's case to an MDT.

384. It therefore found paragraph 18(a) of the Allegation not proved.

<u>Paragraph 18(b)(i) of the Allegation</u>

> b. appropriately obtain consent from Patient D for the angiography leading to angioplasty procedure ('the Procedure') to be undertaken in that you did not discuss:
>
> i. the risks and benefits of the Procedure;

385. The Tribunal has regard to Dr J's report of 14 August 2020. At paragraph 3.51 Dr J acknowledges that Dr Ali, in his response dated 25 September 2019 to Patient D's complaint letter, stated that *'Sister J would have explained the procedure'* and *'I explained to you the procedure with its benefits and risks and you signed the consent form dated 30/5/2017'*.

386. The GMC case was based on Dr J's opinion, in paragraph 3.53 of the same report was that *'Dr Ali's hand-written consultation notes and clinic letters do not include details of what Dr Ali told Patient [D] about the risks and benefits of angiography proceeding to angioplasty. There is no documentation of what alternative treatments were discussed and offered to Patient [D].'*

387. Dr J then continued by referring to the GMC guidance on consent which states that: *'the doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment.',* and: *'You must use the patient's medical records or a consent form to record the key elements of your discussion with the patient.'*

388. The Tribunal heard evidence from Patient D. He adopted the contents of his statement in which he said:

> *'During the appointment Dr Ali did not discuss any other options to treat the blocked veins,* ***other than to recommend using stents****. I was also not informed of any risks associated with this type of procedure. I do recall that* ***Dr Ali explained that using stents would be beneficial as the stents would enlarge my veins.*** *Dr Ali reassured me that there would be no problems as he had undertaken this procedure before without any issues or complaints. Dr Ali didn't provide me with any leaflets regarding the procedure I was going to have but assured me it was straightforward.'* ***(emphasis added by the Tribunal).***

389. In his evidence Patient D was quite adamant that Dr Ali did not inform him of the risks and benefits of the PCI when he saw Dr Ali on 22 May 2017, although he did recall a discussion about stents. He also recalled that he had signed a consent form which he described as a 'disclaimer'. Patient D told the Tribunal that he could clearly recollect the details of his consultation with Dr Ali and other events near that time leading up to it. However, it became apparent during cross examination, that Patient D could not recall all details fully. For example, three days prior to his consultation with Dr Ali, Patient D was taken to A&E via ambulance, but thought this had taken place after the PCI.

390. The Tribunal noted that this would have been one consultation amongst several others which Patient D would have had around that period, either with Dr Ali or with other clinicians. It was not a criticism of Patient D that he could not be expected to recollect every detail almost four years later. It therefore considered that it could attach limited weight to the evidence of Patient D regarding this allegation.

391. The Tribunal also had sight of a complaint letter from Patient D to the Trust in June 2019. The Tribunal noted that his letter was not one in which the issue of consent was raised, and that Patient D makes no mention that he was not informed about the risks and benefits of the PCI, or that he did not understand them if they were.

392. Dr Ali's evidence was:

> *'76. I believe that Patient D was accompanied by his wife. I would have explained the findings of the CTCA. I followed my usual practice and would have said that there was a 1:1000 risk of heart attack, stroke, and death from the proposed angiogram and that the risks changed to 1:100 if I put in a stent. I would have said that I would not necessarily proceed to put in a stent or stents; that depended on*

what I found. I would only put in a stent if I needed to. I would have said to him that if I found extensive disease that I could not treat with stents then I would take his case to an MDT with the surgeons for discussion about the best next treatment. The benefit of the proposed procedure was an improvement in blood flow and the alleviation of the reported chest pain. It was not my practice to talk about an improvement in mortality risks. I may have said that angioplasty might improve the symptoms of breathlessness, but I would not have said that it would take those symptoms away. I would have said that the more common complication is a bruise or haematoma at the access site to the radial artery. I would not have asked him to sign a consent form at that consultation. I would not have mentioned medication as a feasible alternative for him at that time.

393. Patient D acknowledges in paragraph 6 of his statement that *'Dr Ali explained that using stents would be beneficial as the stents would enlarge my veins.'* The Tribunal did not have a copy of the consent form regarding Patient D's PCI, but it has seen consent forms for other patients which do include an explanation of the risks and benefits. The CLR for the PCI records:

'The procedure was explained in detail to the patient. Risks, complications and alternative treatments were reviewed. Written consent was obtained.'

394. The Tribunal considered it likely that any discussion of a PCI with Patient D would have included an explanation about the risks and benefits.

395. It therefore found paragraph 18(b)(i) of the Allegation not proved.

Paragraph 18(b)(ii) of the Allegation

ii. alternative treatments which were available;

396. The Tribunal had regard to paragraph 3.53 of Dr J's report of 14 August 2020 (as set out above).

397. At paragraph 77 of his statement of 7 February 2022, Dr Ali states:

'I did not talk to Patient D about alternative treatments but I do not agree that I should have had such a conversation. I was concerned that he reported having stopped taking some of the medication that he had been prescribed for him before seeing me on 22 May 2017, that is the Amlodipine. I explained to him why it was important that he re-started the Amlodipine and took the medication I prescribed, that is Aspirin and Clopidogrel. I would not have given such firm advice about medication if I had not been concerned about the risks to him if he was not taking that medication.'

398. The Tribunal has already found that Dr Ali considered the possibility of alternative treatments in finding paragraph 18(a) of the Allegation not proved, as set out above.

399. In paragraphs 78 and 79 of his statement, Dr Ali states:

> *'I did assess the impact of changes in medical therapy for Patient D but I did not think that it was appropriate to delay the planned angiogram/angioplasty to review the impact of the medication. He had already been on medical therapy for some months and had stopped taking the Amlodipine on his own initiative. Medication alone would not have treated his symptoms.*
>
> *I did not discuss a possible referral for CABG surgery. The CTCA had shown that it was likely that only 1 coronary vessel would require treatment and, in any event, a cardiac surgeon would want an angiogram before operating in any event. I knew that if I found disease that was not treatable by angioplasty, the patient case would then have been discussed in an MDT with view to refer him for cardiac bypass surgery if it was felt appropriate. Patient D (JG) coronary disease was not of a surgical pattern.'*

400. The Tribunal considered it was clear from the evidence that Dr Ali had, by this point, tried optimal medical therapy, albeit for a relatively short period of time. It had no effect in improving Patient D's symptoms, and Dr Ali was concerned regarding the severity of Patient D's CAD. Dr Ali arranged for Patient D to undergo angiogram with a view to proceeding to PCI only if necessary, and based on the results of Patient D's CTCA. Dr Ali's opinion was that this was the most appropriate management option. Whilst Dr Ali could have discussed alternative treatment options for Patient D at an MDT, the Tribunal was not persuaded that by this point, given Patient D's CTCA report, that there was any need to do so.

401. The Tribunal also noted that the CLR for the PCI records:

> *'The procedure was explained in detail to the patient. Risks, complications and* ***alternative treatments were reviewed****. Written consent was obtained.'* (emphasis added by the Tribunal)

402. For these reasons, the Tribunal found paragraph 18(b)(ii) of the Allegation not proved.

<u>Paragraph 18(c)(i) and (ii) of the Allegation</u>

> c. record having undertaken the actions as set out at paragraphs:
>
> i. 18a;
>
> ii. 18b.

403. The Tribunal again noted Patient D's written and oral evidence that he did sign a consent form, albeit he described it as a 'disclaimer'.

404. The Tribunal did not have a copy of the consent form, so could not assess what was written on it, but it has seen consent forms for other patients. The Tribunal did have the CLR which was completed by Dr Ali soon after completion of the PCI on which Dr Ali confirmed in the standard format that:

> *'The procedure was explained in detail to the patient. Risks, complications and alternative treatments were reviewed. Written consent was obtained.'*

405. Based on this evidence, the Tribunal was satisfied that there was a record of Patient D having been consented, and that there was a record of the actions set out at paragraphs 18(a) and (b) of the Allegation, having been undertaken.

406. It therefore found paragraph 18(c)(i) and (ii) of the Allegation not proved.

Paragraphs 19 and 20 of the Allegation

~~19. On 3 July 2017, you ceased private practice and failed to arrange to transfer Patient D's care to a named individual colleague.~~
(Withdrawn following a Rule 17(6) application)

407. This paragraph of the Allegation was withdrawn. The Tribunal did not consider it further.

~~20. On 25 September 2019, you wrote to Patient D in response to his complaint and you:~~ (Withdrawn following a Rule 17(6) application)

~~a. inappropriately included an academic paper in your response;~~

~~b. failed to explain fully to Patient D the nature and impact of stent fracture.~~

408. This paragraph of the Allegation was withdrawn. The Tribunal did not consider it further.

The Tribunal's Overall Determination on the Facts

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

Patient A

1. On 10 November 2016 you:

a. met with Patient A at which time you failed to:

i. adequately obtain consent from Patient A for the Percutaneous Coronary Intervention ('PCI') procedure in that you did not outline the benefits and the heightened risks of this procedure specific to Patient A;
Found not proved

ii. record in Patient A's notes any discussion with Patient A regarding the benefits and heightened risks of PCI specific to Patient A.
Found not proved

b. operated on Patient A at the end of which you failed to recognise that Patient A's angiogram showed occlusion of the first and second septal arteries;
Found proved

c. made an inaccurate record of Patient A's PCI procedure in that you recorded 'No complications' when Patient A suffered from ~~persistent~~ side branch occlusion.
(Amended following a Rule 17(6) application)
Found proved

Patient B

2. Between 9 December 2016 and 19 January 2017, you failed to adequately obtain consent from Patient B for the PCI procedure in that you failed to personally consult with Patient B to discuss:

a. her current symptoms;
Found not proved

b. the treatment options available;
Found not proved

c. the reasons for any recommendations or conclusions of an MDT.
Found not proved

3. On 19 January 2017 you performed a PCI procedure ('the Procedure') on Patient B and you failed to:

a. identify a coronary perforation;
Found not proved

b. undertake prolonged low pressure balloon inflation to control the perforation;
Found proved

c. undertake or arrange an emergency echocardiogram in the catheter laboratory;
Found proved

d. make preparations for immediate pericardiocentesis;
Found not proved

e. undertake prolonged low pressure balloon inflation and/or insert a covered stent to seal the perforation;
Found proved

~~f. make any preparations for possible emergency cardiac surgery.~~
(Withdrawn following a Rule 17(6) application)

4. Following completion of the Procedure at 10:31 you requested Patient B be given 3000 iu of Heparin when it was inappropriate to do so.
Found proved

5. Following the Procedure on 19 January 2017 you requested an echocardiogram be performed once Patient B had returned to the ward and you failed to:

a. ask to be informed of the result;
Found not proved

b. request confirmation as to when it had taken place;
Found not proved

~~c. record in the alternative to paragraphs 5a and 5b having undertaken the actions as outlined at:~~

~~i. 5a;~~

~~ii. 5b.~~
(Withdrawn following a Rule 17(6) application)

6. During your review of Patient B on 19 January 2017 at around 19:30 hours you were aware that an echocardiogram had not been performed and you failed to:

a. arrange for it to be performed:

i. immediately;
Found proved

ii. ~~before you left the hospital;~~ as soon as possible
(Amended following a Rule 17(6) application)
Found not proved

b. provide any explanation to Patient B as to:

i. the outcome of the Procedure;
Found not proved

ii. why an overnight hospital stay was required;
Found not proved

c. record in the alternative to paragraph 6b having undertaken the actions as outlined at paragraph 6b.
Found not proved

7. You failed to accurately record the Procedure in Patient B's notes in that you:

a. did not record the coronary perforation;
Admitted and found proved

b. incorrectly indicated that Patient B had suffered a localised dissection.
Admitted and found proved

8. On 23 April 2017 you completed a Datix report in respect of Patient B in which you described the complication that had occurred as a coronary dissection.
Admitted and found proved

9. On or around 27 April 2017 you signed a witness statement to be provided to the Coroner hearing Patient B's inquest in which you described the complication that had occurred as a coronary dissection.
Found not proved

10. You knew as at the dates that you signed the datix report and statement to the coroner that the complication that had occurred was a coronary perforation given that you had recognised and described it as such at a:

a. Multidisciplinary team meeting on 26 January 2017;
Found proved

b. Mortality and Morbidity meeting on 16 March 2017.
Found proved

11. Your actions as outlined at paragraphs 8 and 9 above were dishonest by reason of paragraph 10.
Found not proved

12. On 27 February 2018 you gave evidence at Patient B's inquest at which time you stated:

a. 'The third image in that series is actually the balloon tamponade and it is in run 20…', or words to that effect;
Admitted and found proved

b. 'The third inflation is of the same balloon but at low pressure to seal the leak', or words to that effect.
Found proved

13. You knew that this was untrue as you had not performed balloon tamponade (prolonged balloon inflation) as:

a. the NC Trek balloon inflation at run 20 did not cover the site of the perforation;
Found not proved

b. none of the post-dilation inflations of the NC Trek balloon were inflated at low pressure;
Found not proved

c. none of the post-dilation inflations of the NC Trek balloon were appropriately prolonged to occlude or seal a perforation.
Found not proved

14. Your actions as outlined at paragraph 12 above were dishonest by reason of paragraph 13.
Found not proved

Patient C

15. On 19 January 2017 you:

a. failed to adequately review Patient C's case;
Found not proved

b. failed to adequately obtain consent from Patient C for the PCI procedure;
Found not proved

c. failed to challenge the decision of Dr B and the MDT to proceed to PCI to the circumflex coronary artery;
Found not proved

d. made the decision to proceed to PCI when it was inappropriate to do so;
Found not proved

e. failed to anticipate the finding of an un-dilatable stenosis that you encountered during the PCI procedure;
Found not proved

f. used a 4.0mm non-compliant balloon at a pressure of 30 atmospheres to try and dilate the coronary artery when it was inappropriate to do so;
Found not proved

g. caused Patient C to have a coronary perforation;
Admitted and found proved

h. failed to respond appropriately when Patient C suffered a coronary perforation in that you failed to:

i. undertake or arrange an emergency echocardiogram in the catheter laboratory;
Found proved

ii. consider and/or make preparations for immediate pericardiocentesis;
Found not proved

iii. consider and/or make preparations for insertion of a covered stent to seal the perforation;
Found not proved

iv. ~~consider and/or make preparations for emergency cardiac surgery;~~
(Withdrawn following a Rule 17(6) application)

j. failed to recognise and/or record that Patient C had suffered from major side branch occlusion leading to myocardial infarction;
Found proved

k. failed to communicate adequately with Patient C following the procedure;

Found not proved

l. failed to make an appropriate note of the PCI procedure to include the complications encountered;
Found not proved

m. failed to make a note of any discussions with Patient C regarding the complications encountered and any apology given.
Found proved

Patient D

16. On or about 12 May 2017, ~~you wrote to Patient D and~~ you inappropriately recommended invasive coronary angiography rather than non-invasive functional imaging.
(Amended following a Rule 17(6) application)
Found not proved

17. On 22 May 2017, you consulted with Patient D and you inappropriately recommended for Patient D to proceed to invasive coronary angiography with a view to angioplasty (PCI) without first assessing the impact of escalation of optimal medical therapy on Patient D's symptoms.
Found not proved

18. Between 22 May and 30 May 2017 you failed to:

a. consider with an MDT other options for treatment that were available to Patient D;
Found not proved

b. appropriately obtain consent from Patient D for the angiography leading to angioplasty procedure ('the Procedure') to be undertaken in that you did not discuss:

i. the risks and benefits of the Procedure;
Found not proved

ii. alternative treatments which were available;
Found not proved

c. record having undertaken the actions as set out at paragraphs:

i. 18a;
Found not proved

ii. 18b.
Found not proved

~~19. On 3 July 2017, you ceased private practice and failed to arrange to transfer Patient D's care to a named individual colleague.~~
(Withdrawn following a Rule 17(6) application)

~~20. On 25 September 2019, you wrote to Patient D in response to his complaint and you:~~ (Withdrawn following a Rule 17(6) application)

~~a. inappropriately included an academic paper in your response;~~

~~b. failed to explain fully to Patient D the nature and impact of stent fracture.~~

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

Determination on Impairment - 29/04/2022

1. 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, Dr Ali's fitness to practise is impaired by reason of his misconduct.

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary, including testimonials from Dr Ali's clinical colleagues.

Dr Ali provided a Stage 2 bundle. This included:

- his Appraisals for 2018/2019, 2019/2020, and 2020/2021;
- certificates of Continuing Professional Development (CPD) relevant to the matters before this Tribunal. These included, amongst others:
  The importance of good clinical record keeping;
  Duty of Candour;
  Mastering difficult interaction with patients workshop;
  Coronary PCI: Coronary physiology - intravascular imaging and management of a complex calcified LAD;
  Management of coronary and access complications;
  Complex PCI;
  Lessons from PCI complications.

- Colleague and Patient 360 degree Feedback;
- Details of a Supervised Mentorship Programme for PCI;
- Feedback from Resilience Teaching undertaken by Dr Ali.

3. The Tribunal also received a reflective statement from Dr Ali. In this Dr Ali stated that he has reflected on the GMC process, including his giving evidence as a witness, and on Dr J's evidence. Dr Ali stated he had *'learnt valuable lessons during this process'* and that he would *'continue to reflect on this phase of my professional life and draw further conclusions which I am positive will help keep me deliver care in a safe and effective ways.'* He added *'I have reflected on the determination of the Tribunal and I acknowledge the deficiencies that the Tribunal have found.'*

4. Dr Ali provided examples of the lessons he has learnt which included accurate note keeping, and he stated that he had already changed his practice in this regard and *'was now more aware of the need to keep accurate and complete notes and ensuring complications are recorded.'*

5. In a further example, he stated *'I will continue to do this in my capacity as a consultant but also help disseminate this important lesson to less senior members of the team. I have already done this through my work with junior doctors, medical students and physician assistants when I ran the Resilience At Work session.'* Dr Ali went on to explain that this session, led by him, addressed ways in which professionals could learn from practice failures and how to promote resilience in a high pressured NHS environment. Dr Ali added that he used his experiences from the case of Patient B as a framework for the discussions.

6. Dr Ali went on to say *'Reflecting on Dr J's evidence and my own reading of the literature, it has reinforced to me the need for emergency on the table echocardiography in cases of coronary perforation and this valuable lesson is now ingrained in my management algorithm of coronary perforations.'* He further added *'I have also reflected on my practice of dealing with heavily calcified coronary lesions. And whilst my training did involve high pressure ballooning of such lesions, having reflected on the risk this can cause in terms of coronary perforation, I now perform such inflations to much lower pressures and certainly in keeping with the designated burst pressure. I believe this is a safer way of managing such lesions. I believe I have a better sense of when to stop the procedure if the calcification is not treatable and I use more recently developed technologies such ShockWave, which I used at Dorset County Hospital. While not directly relevant to Patient C, I also had the chance to use Rotablation with one of the consultant cardiologists.'*

7. Dr Ali explained that having undertaken supervised mentorship at Dorset County Hospital in PCI as part of his six month locum post, he was *'re-trained in performing percutaneous coronary intervention in a supervised and gradual manner which led to independent practice by the end of mentorship.'* He said that this helped him to re-establish his skills and the confidence to perform such procedures.

8. Dr Ali said that whilst the last five years have been difficult, he remained committed to a career as an interventional cardiologist and was keen to restart working having taken a break for the past two months whilst engaging with these proceedings. He said *'I am determined to work to a high standard and I am sorry that I did not do so in the ways identified by the Tribunal, particularly for those patients concerned.'*

Submissions for the GMC:

9. Ms Johnson submitted that Dr Ali's fitness to practise is impaired. She referred the Tribunal to Dame Janet Smith's 5th Shipman Report in which she set out four reasons why a doctor's fitness to practise may be impaired.

10. Ms Johnson reminded the Tribunal of the overarching objective and of the two-stage process when considering misconduct. She referred the Tribunal to relevant case law, and to the paragraphs of Good Medical Practice ('GMP') which she submitted were engaged in this case. She also referred the Tribunal to its determination on the facts of this case. Ms Johnson acknowledged, however, that the fact that Stage 2 of these proceedings is a separate stage shows that it is not intended that every case of proved misconduct results in a finding of impairment.

11. Ms Johnson noted that Dr Ali's proved failings related to the standard of care he afforded to Patient's A, B, and C, on 10 November 2016 and 19 January 2017. She said the failures proved and admitted show incompetence by Dr Ali in carrying out PCI's, in dealing with the complications of the procedures, and in failing to record the complications. Ms Johnson referred to Dr J's written and oral evidence in relation to each patient. She highlighted, by reference to Dr J's reports and the paragraphs of GMP, the areas where she submitted that Dr Ali's actions fell short of the standards expected of a reasonably competent interventional cardiologist.

12. Ms Johnson submitted that Dr Ali's failures breached fundamental tenets of the medical profession and that his failures amounted to serious misconduct. However, in relation to paragraphs 8, 10, and 12 of the Allegation, which the Tribunal also found proved, Ms Johnson conceded on behalf of the GMC these findings do not amount to serious misconduct.

13. Ms Johnson accepted there was evidence before the Tribunal of the steps taken by Dr Ali to remediate his misconduct, adding that the passage of time since these events had allowed Dr Ali the opportunity to address his failings. However, she submitted that, because Dr Ali had contested some aspects of the case which the Tribunal subsequently found proved, he had not demonstrated complete insight.

14. Ms Johnson submitted that a finding of impairment was required to satisfy the public confidence in the medical profession and to maintain proper standards of conduct. She said that Dr Ali's actions had placed patients at unwarranted risk of harm and therefore, public

confidence in the medical profession would be undermined if a finding of impairment were not made.

Submissions for Dr Ali

15. Mr Thomas submitted that the facts found proved did not support findings of misconduct or serious misconduct. Even if they did, he submitted that Dr Ali's fitness to practise is not currently impaired. He submitted that the facts found proved were now reduced to discrete areas of practice and were not widespread. He submitted that the main findings were concerned with a rare complication, and that its rarity was relevant.
Mr Thomas also reminded the Tribunal of the evidence and proved findings of fact made in respect of Patients A, B, and C, responding in each case to the submissions made by Ms Johnson.

16. Mr Thomas drew the Tribunal's attention to those areas of Dr J's reports which he submitted did not support Ms Johnson's submissions that Dr Ali's actions amounted to serious misconduct and that his fitness to practise is impaired. He submitted that some of Dr J's conclusions that Dr Ali's conduct was seriously below the standard required were based on facts which the Tribunal had found not proved. For example, in relation to Patient C, Dr J had assumed that Dr Ali had used a 4.0 mm balloon, when the Tribunal has found to the contrary.

17. Mr Thomas noted that there was no criticism of the conduct of the PCI in Patient A's case. Overall, Mr Thomas submitted, Dr Ali had failed to manage two PCI's complicated by perforations (Patients B and C). He reminded the Tribunal that these were the first perforations Dr Ali had encountered in his career and that these were invasive procedures which are known to carry risks.

18. Mr Thomas submitted that in the case of Patients B and C, Dr Ali's conduct amounted to misjudgements rather than serious misconduct. In the case of Patient B, his judgement was affected because she remained haemodynamically stable in the Cath Lab and remained stable for some time afterwards on the ward. In the case of Patient C, Dr Ali's judgement was affected because he considered that he had sealed the perforation. Mr Thomas submitted that although the Tribunal's findings may indicate that Dr Ali's actions were negligent, they did not reach the threshold for a finding of misconduct.

19. Regarding impairment, Mr Thomas reminded the Tribunal that it should be looking forward and not back. He submitted that the submissions made by the GMC were focused on Dr Ali's failings almost five years ago and that the five-year period is a relevant factor in considering impairment. He noted that the GMC make no criticism about the steps Dr Ali has taken to remediate the deficiencies identified in his clinical practice. He submitted that Dr Ali's failings are remediable and that he has provided significant evidence of remediation, especially regarding the key findings made by the Tribunal about the management of a perforation and accurate record-keeping.

20. Mr Thomas submitted that Dr Ali 's approach to remediation, reflection and insight has been comprehensive and demonstrated through learning, training, a change of attitude, and significantly a structured return to PCI through a six-month structured mentorship programme instigated by Dr Ali in which he has returned to interventional cardiology.

21. In relation to insight, Mr Thomas submitted that Dr Ali has shown that he recognised and identified the failings. He reminded the Tribunal that Dr Ali admitted some paragraphs of the Allegation at the outset of these proceedings, when it was said that the admissions made were not exhaustive because Dr Ali wanted the Tribunal to hear the full context of his treatment of the patients. Mr Thomas submitted that there was a clear acceptance by Dr Ali of his responsibility in respect of Patient C, and a clear and emotional acceptance of responsibility in relation to Patient B.

22. Mr Thomas referred the Tribunal to the testimonials provided at the facts stage and the further evidence presented at this stage of the hearing. He also referred the Tribunal to: Dr Ali's appraisals; positive colleague and patient 360 degree feedback; training courses completed by Dr Ali especially those relating to record keeping and PCI's; and Dr Ali's reflections on his learning.

23. Mr Thomas also pointed out that Dr Ali has, of his own volition, organised teaching sessions on resilience, attended by and to benefit other healthcare professionals, at which Dr Ali has shared his experiences in relation to these matters. Mr Thomas said that this demonstrated Dr Ali's openness and transparency, and willingness to reflect and learn from his experiences.

24. Of great significance, Mr Thomas submitted, has been Dr Ali's participation in a six month structured mentorship programme for PCI procedures at Dorset County Hospital which has enabled Dr Ali to return to clinical practice performing PCI's, at first under supervision but then independently. Mr Thomas referred the Tribunal to the programme content, the testimonials provided by his mentors, and to a selection of Cath Lab reports and reflections completed by Dr Ali following PCIs in which he had participated.

25. Mr Thomas submitted that Dr Ali has gone to considerable lengths to change his practice where necessary and remediate fully. He submitted that the evidence before the Tribunal demonstrated that it was highly unlikely that Dr Ali would repeat the actions, which have led to the matters found proved against him. It was highly unlikely, for example, that he would not call for an emergency echocardiogram or call a perforation a 'dissection' in the future.

26. In relation to the public interest, Mr Thomas submitted that in a case such as this, where Dr Ali has taken such significant steps to remediate matters which took place five years ago, the public would be more concerned about the doctor's current practice and any risks posed, and the lessons he had learnt, rather than whether the doctor had been punished. Mr Thomas submitted that a finding of impairment would have a punitive effect and would not serve the public interest.

The Relevant Legal Principles

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

28. 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.

29. The Tribunal must determine whether Dr Ali'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.

30. Throughout its deliberations, the Tribunal has been mindful of its responsibility to uphold the overarching objective as set out in the Medical Act 1983 (as amended). That objective is the protection of the public and involves the pursuit of the following:

a. to protect, promote and maintain the health, safety and wellbeing of the public
b. to maintain public confidence in the profession
c. to promote and maintain proper professional standards and conduct for members of the profession

The Tribunal's Decision

Misconduct

31. The Tribunal first considered whether the facts found proved are a sufficiently serious departure from the standards of conduct reasonably expected of Dr Ali, to amount to misconduct. In its deliberations, the Tribunal had regard to the current version of GMP (March 2013). It also noted that misconduct is not defined by statute but it has been said to be serious professional misconduct or conduct which a fellow professional would regard as deplorable.

32. The Tribunal had regard to the following paragraphs of GMP which had been referred to by Ms Johnson in her submissions:

'Good medical practice describes what it means to be a good doctor.

It says that as a good doctor you will:

- *make the care of your patient your first concern*

•be competent and keep your professional knowledge and skills up to date…..
•establish and maintain good partnerships with your patients ….

'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 …..

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.

11 You must be familiar with guidelines and developments that affect 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
c. refer a patient to another practitioner when this serves the patient's needs.

'21 Clinical records should include:

a. relevant clinical findings
b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c. the information given to patients
d. any drugs prescribed or other investigation or treatment
e. who is making the record and when.'

23 To help keep patients safe you must:
a. contribute to confidential inquiries
b. contribute to adverse event recognition
c. report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at risk
d. report suspected adverse drug reactions
e. respond to requests from organisations monitoring public health. When providing information for these purposes you should still respect patients' confidentiality

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
c. who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care
d. any other information patients need if they are asked to agree to be involved in teaching or research

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. 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.'

Patient A

In relation to Paragraph 1(b)

33. The Tribunal was mindful of Dr J's evidence and Dr Ali's evidence, as set out in its determination on facts, and the differences in their interpretation of the images. It was also mindful that it had found this allegation proved given Dr J's experience and expertise in this area of clinical practice.

34. However, as to whether this amounted to misconduct, it was Dr Ali's evidence that having inserted four stents, the image timed at 18:39:18 showed all four stents in place and that both the first and second septal branches were occluded. He added, however, that the images timed at 18:39:59 and 18:40:18 showed contrast in the septal branches which indicated there was now some flow down those branches. Dr Ali's evidence was that by comparing the moving images from the beginning and the end of the procedure it was clear that those at the end showed some blood flow in the branches at the end of the procedure thereby demonstrating that the branches were 'jailed' but not occluded.

35. Mr Thomas's submission, on behalf of Dr Ali, was that it is a matter of interpretation as to whether the first and second septal arteries were occluded. Dr Ali accepts now that he did not recognise the occlusion because he thought he had 'jailed' the arteries. The Tribunal noted that Dr J did not consider this to be seriously below the standard required in his report of 20 August 2019.

36. The Tribunal has taken into account that this is a known complication of PCI's. It was the Tribunal's view, based on the above, that Dr Ali made an 'an error of judgement' in not recognising the occlusion. Whilst this was a failing, taken as a whole, the Tribunal considered it did not, in itself, amount to misconduct.

In relation to paragraph 1(c)

37. At paragraph 3.30 of his supplementary report, dated 20 December 2019, Dr J stated:

> *'Occlusion of significant side branches will lead to myocardial infarction (death of the heart muscle supplied by those branches). The occlusion of significant side-branches is a recognised complication of a PCI procedure and indicates the final result was suboptimal.'*

38. Dr J was of the opinion that Dr Ali should have made a record of the occlusion in Patient A's CLR.

39. In its determination on facts, the Tribunal found that Dr Ali did not record 'occlusion' or 'jailed' in Patient A's CLR and that he recorded 'No Complications' which was inaccurate. It noted that Dr J's opinion that Dr Ali's conduct in relation to Patient A was seriously below the standard expected of a competent interventional cardiologist, as set out in paragraph 3.42 of the same report. However, this opinion was not only based on the facts found regarding the occlusion, but on a combination of matters, some of which the Tribunal has found not proved.

40. Dr Ali told the Tribunal that he did not record on the CLR in writing that he had observed the occlusion of the first and second septal arteries because he recognised them as being 'jailed', and as being sub-totally occluded as there was partial flow of blood in those arteries. He added that this had no significance to the technical outcome of the PCI. He did accept, however, that he would now document his findings more fully to include mentioning the observed jailing or sub-total occlusion of the side vessels: *'If I saw now what appears on the previously described images, I would write that I had jailed and sub-totally occluded the septal branches, that is the S1 and S2. By sub-totally occluded I mean that there is impaired flow.'*. Instead, Dr Ali recorded there had been a *'Good final result'* and that there were *'No complications'*.

41. Whilst the Tribunal notes that Dr Ali would document 'jailing' or sub-total occlusion, it considered that by not recording any complication at the time, as he should have, this amounted to misconduct. However, in itself, it did not amount to serious misconduct. In reaching this conclusion, the Tribunal took into account that Patient A did not suffer any adverse outcomes directly as a result of the PCI performed by Dr Ali. Furthermore, there was no evidence before the Tribunal to suggest that any further treatment might have been, or was, required.

Patient B

In relation to paragraphs 3(b), (c) and (e)

42. In his report dated 1 June 2018, at paragraph 3.18, Dr J stated:

'Coronary perforation is a recognised but rare complication of coronary interventions including stenting (0.3 – 0.6%, References 1 and 2).'

43. At paragraph 3.50 of his supplementary report, dated 4 August 2020, Dr J stated:

'I believe that Dr Ali's failure to perform prolonged balloon inflations to occlude the perforation and attempt to seal the perforation was not in accordance with standard guidance for the management of coronary perforations.'

44. In paragraph 3.96, Dr J states:

'Because prolonged balloon inflations to occlude and seal the coronary perforation could have been life saving for Patient DM, I believe that Dr Ali's failure to perform prolonged balloon inflations was seriously below the standard expected of a reasonably competent Consultant Cardiologist.'

45. The Tribunal notes that Dr J's comments are based on the premise that Dr Ali did not recognise a perforation, which the Tribunal has already determined he did. Further, the Tribunal has already determined that Dr Ali attempted to treat the perforation, albeit inadequately.

46. The Tribunal has taken into account that the occurrence of a perforation is a rare incident, but a recognised risk of a PCI. As an interventional cardiologist, the Tribunal considered that Dr Ali should have been aware of how to treat such incident in accordance with the relevant guidance. The Tribunal acknowledged that this was the first time Dr Ali had experience of such a complication, but that did not detract from his duty to treat it appropriately. The Tribunal noted Dr Ali inflated the balloon for 27 seconds at an inappropriate pressure when the guidance suggests that the balloon should be inflated for ten minutes or more at a low pressure. Furthermore, Dr Ali failed to arrange an emergency echocardiogram, as is suggested in the guidance.

47. Dr J in his oral evidence said that while there may have been a 'brisk' recognition of the complication, an emergency echocardiogram should still have been carried out in the Cath Lab, despite Patient B being haemodynamically stable.

48. The Tribunal had regard to paragraphs 1 and 7 of GMP as set out above.

49. In the circumstances, the Tribunal concluded that Dr Ali's failure to undertake prolonged low pressure balloon inflation to control the perforation, and to undertake or

arrange an emergency echocardiogram in the Cath Lab, amounted to misconduct which is serious.

50. In relation to paragraph 3(e), to undertake prolonged low pressure balloon inflation and/or insert a covered stent to seal the perforation, the Tribunal determined that this did not amount to misconduct. The Tribunal accepted Dr Ali's evidence that he thought he had sealed the perforation, and that therefore he considered, at the time, there was no need for further action.

In relation to paragraph 4

51. The Tribunal has already found that Dr Ali's actions, in respect of paragraph 3(e) above did not amount misconduct. For the same reasons, namely that he thought he had sealed the perforation, that the Tribunal finds Dr Ali's actions in relation to paragraph 4 do not amount to misconduct.

In relation to paragraph 6(a)(i)

52. Dr Ali's evidence was that he had, or at least he thought, he had sealed the perforation. He told the Tribunal that Patient B was still haemodynamically stable at 19:30. The Tribunal had regard to paragraphs 200 and 201 of its determination on facts which state:

> *'200. The Tribunal noted in Patient B's medical records Dr Ali had recorded 'Echo' when he visited Patient B at 19:30 on 19 January 2017. The Tribunal considered that this entry made clear that Dr Ali knew an echocardiogram had not been carried out when he visited Patient B. Dr Ali stated in evidence that he had the ability to perform and interpret an echocardiogram himself.*
>
> *201. In his evidence at paragraph 56 of his statement of 7 February 2022, Dr Ali states:*
>
> > *'….I did not arrange for an echocardiogram to be carried out immediately that night. Ordinarily, the echo physiologists do not work at night and one would have had to be called in. I could have arranged for the echo machine to be brought to the ward and performed the echo myself, but I thought that the patient was stable. …'*

53. The Tribunal found, as it did in respect of paragraph 3(c) above, that Dr Ali failed to treat Patient B in accordance with the relevant guidance. It was incumbent upon him to have arranged for an emergency echocardiogram to be carried out when he became aware one had not been done. The Tribunal found Dr Ali's failure amounted to misconduct which is serious.

In relation to paragraphs 7(a) and (b)

54. The Tribunal had regard to paragraph 21 of GMP which states:

'21 Clinical records should include:

a. relevant clinical findings
b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c. the information given to patients
d. any drugs prescribed or other investigation or treatment
e. who is making the record and when.'

55. Dr Ali admitted that he did not record the perforation in Patient B's CLR, even though he did recognise it.

56. By not recording the complication as a perforation, but as a dissection, not only did Dr Ali fail to adhere to paragraph 21 of GMP, but his actions may have had serious implications in respect of any subsequent care and treatment provided to Patient B. The Tribunal considered this to be a failure which amounts to misconduct which is serious.

In relation to paragraph 8

57. Dr Ali admitted this paragraph of the Allegation. Ms Johnson accepted in her submissions that this was not serious misconduct based on Dr J's report.

58. The Tribunal had regard to the Datix completed by Dr Ali. In this Dr Ali recorded *'Patient admitted for elective PCI to LAD. PCI was undertaken but was complicated by coronary dissection. …'*

59. Dr J considered this failing to be below but not seriously below the standard required.

60. However, the Tribunal noted that Dr Ali goes on to state *'Patient remained haemodynamically stable throughout the procedure with no symptoms to report or ECG changes. The leak was localised and was treated with balloon inflation inside the stent.'*

61. The Tribunal noted that Dr Ali recorded the complication as a 'dissection' rather than a 'perforation'. The Tribunal determined his actions to amount to misconduct but not serious misconduct.

In relation to paragraphs 10 and 12

62. In her submissions, Ms Johnson submitted that the GMC did not consider these matters to amount to serious misconduct.

63. The Tribunal, considered these as matters of fact. They were not matters which led to a finding that his conduct was below the standard required. It therefore considered Dr Ali's actions did not amount to misconduct.

Patient C

In relation to paragraph 15(g)

64. Dr Ali admitted that he caused Patient C to have a perforation. The Tribunal again reminded itself that a perforation is a rare occurrence, albeit a known risk of a PCI. The Tribunal reminded itself of its findings in relation to paragraphs 15(a) – (f) of the Allegation.

65. Although the Tribunal accepted, and Dr Ali admitted, that he caused the perforation by virtue of being the operator of the PCI. There was no significant evidence before the Tribunal that in causing the perforation, he had fallen below the standard required of a competent interventional cardiologist.

66. It therefore determined that this finding did not amount to misconduct.

In relation to paragraph 15(h)

67. At paragraph 3.26 of his report dated 20 August 2019, Dr J stated:

> *'Dr Ali did not undertake or arrange emergency echocardiography. This was inappropriate particularly as Patient SC had signs of intrapericardial bleeding with low blood pressure (hypotension).'*

68. The Tribunal had regard to paragraphs 1 and 7 of GMP as set out above.

69. The Tribunal reminded itself that a perforation is a rare occurrence, but one which is a known risk of a PCI. The Tribunal therefore considered that Dr Ali should have been aware of how to treat such a complication in accordance with the relevant guidance. The Tribunal acknowledged that this was the first time Dr Ali had caused a perforation, but that did not detract from his duty to treat it appropriately. These are the same considerations as the Tribunal applied in finding serious misconduct in relation to paragraphs 3(b) and (c) above.

70. The Tribunal therefore determined Dr Ali's failing in this respect amounted to misconduct which is serious.

In relation to paragraph 15(j)

71. In his evidence, Dr J accepted that Dr Ali may have recognised Patient C suffered from major side branch occlusion. Dr Ali's evidence was that he did recognise it, although he did not record it. The Tribunal noted that after Patient C's PCI, Dr Ali ordered investigations to be

carried out, including troponin levels. It is clear that Dr Ali was investigating complications arising from the PCI.

72. In view of the above, the Tribunal considered that whilst Dr Ali's failure to record that Patient C had suffered from major side branch occlusion, the evidence suggests he did recognise it and had taken the necessary actions. It therefore concluded that this amounted to misconduct but not serious misconduct.

In relation to paragraph 15(m)

73. The Tribunal had regard to paragraph 21(c) of GMP, as set out above.

74. Dr J, in his report dated 20 August 2019, at paragraph 3.34 stated:

> *'GMC Guidance - Openness and honesty when things go wrong, Professional Duty of Candour includes - tell the patient when something has gone wrong; apologise to the patient, offer an appropriate remedy or support to put matters right (if possible, explain fully to the patient the short and long term effects of what has happened. GMC Good Medical Practice includes Record your work clearly accurately and legibly - 21 Clinical records should include - the information given to patients.'*

75. The Tribunal found, as set out in its facts determination, that Dr Ali may have apologised to Patient C, as per his evidence. However, Dr Ali acknowledged that he did not record this in the notes.

76. In light of the above, and its findings at stage 1, the Tribunal concluded that Dr Ali's failure to record his discussions with Patient C in the notes or that he had apologised, did amount to misconduct but not serious misconduct.

Impairment

77. The Tribunal found no serious misconduct relating to Patient A.

78. The Tribunal found that there was serious misconduct relating to Patient B in that Dr Ali: failed to undertake prolonged low pressure balloon inflation to control the perforation; did not undertake an emergency echocardiogram in the Cath Lab, or when he reviewed Patient B later in the day; did not accurately record the perforation in Patient B's notes; and incorrectly indicated that Patient B had suffered a localised dissection.

79. The Tribunal found there was serious misconduct relating to Patient C in that Dr Ali failed to undertake or arrange an emergency echocardiogram in the Cath Lab.

80. The Tribunal reminded itself that the misconduct relating to Patient B and Patient C both occurred on the same day, 19 January 2017, which is now over five years ago.

81. In considering current impairment, the Tribunal noted that Ms Johnson accepted that Dr Ali has provided evidence of remediation, and that the passage of time has given him the opportunity to address his failings, which she accepted is to Dr Ali's credit.

82. The Tribunal had regard to Dr Ali's statement about remediation and the evidence he has provided.

83. The Tribunal noted that Dr Ali has kept his medical skills up to date since July 2018 whilst employed in several hospitals, undertaking roles which have maintained his knowledge and skills in aspects of cardiology even if he has not been able to undertake PCIs in all these roles. The Tribunal noted Dr Ali's appraisals which show that he has worked hard to maintain his skills, that he has performed well in each role and is highly regarded by his colleagues.

84. The Tribunal noted that Dr Ali has kept his medical knowledge up to date. He has attended training courses and read literature, not only aimed at keeping his knowledge updated but aimed at learning more about the aspects of his work which the Tribunal has found to be deficient, namely dealing with complications, including perforations in PCIs, and record keeping.

85. The Tribunal noted the colleague and patient 360 degree feedback. Dr Ali's patients speak of his professionalism, and good communication skills. His colleagues describe him as extremely conscientious, committed, and hard working. There were only two negative comments suggesting that Dr Ali might be a little more decisive and that his time management could be better. These were, however, isolated comments and did not reflect the positive nature of the feedback from nearly forty participants in the feedback provided in 2019.

86. The Tribunal noted that between November 2020 and May 2021, Dr Ali was appointed to a six-month locum consultant cardiology post at Dorset County Hospital delivering inpatient and outpatient services. A supervised mentorship was agreed for him to re-establish his interventional skills by undertaking PCIs. The programme started with a period of direct and then indirect supervision, followed by a period of independent practice but with regular feedback and critique of cases by his mentor, Dr K, clinical lead. The Tribunal heard evidence from Dr K at Stage 1 of the hearing and had a written testimonial from one of the supervisors of the programme, Dr P. Their evidence was that they considered Dr Ali to demonstrate good clinical judgement, to be safe and decisive in his decisions, but also to be ready to seek advice if required.

87. The Tribunal was provided with several Cath Lab reports along with reflections completed by Dr Ali following PCIs he undertook during this period. The Tribunal noted that they had been completed in a much more comprehensive manner, explained the procedures undertaken, and their outcomes in considerable detail. The Tribunal noted that Dr Ali had either undertaken himself, or jointly with others, both elective and emergency PCIs, including complex stenting, and one in which there was the complication of a dissection. The Tribunal

noted that in the case involving the dissection, Dr Ali had recorded that he had apologised to the patient.

88. The Tribunal considered that this period at Dorset County Hospital to be highly significant in that it demonstrated that Dr Ali has returned to interventional cardiology, and that he did so in a safe manner. The Tribunal also considered that it showed, particularly in the CLRs, that Dr Ali had addressed the deficiencies found proved in his medical terminology, and in his record keeping. This was also shown in the handwritten reflective notes that Dr Ali completed after each PCI. This evidence also demonstrates that there have been no further concerns identified in Dr Ali's practice.

89. Overall, the Tribunal considered that Dr Ali has presented comprehensive evidence to show that he has remediated the serious misconduct which occurred in 2017. The Tribunal considered that by recognising the deficiencies which needed to be addressed, he has shown insight, and that he has taken significant steps to address those deficiencies. Indeed, the Tribunal considered that there was little more that Dr Ali could have done to demonstrate that his fitness to practise is no longer impaired.

90. For these reasons, the Tribunal considered there is no risk of Dr Ali repeating his misconduct. It considered that Dr Ali has spent the last five years learning from his mistakes. Mindful of the overarching objective, the Tribunal is satisfied that Dr Ali has demonstrated that he is now in a position to undertake interventional cardiology safely and that there is no risk to the public.

91. Given that Dr Ali has shown that he has learnt from his mistakes and remediated fully, the Tribunal considered that a finding of impairment is not required to maintain proper professional standards and maintain public confidence.

92. The Tribunal therefore determined that Dr Ali's fitness to practise is not impaired.

Determination on Warning - 29/04/2022

1. As the Tribunal determined that Dr Ali's fitness to practise was not impaired, it considered whether in accordance with s35D(3) of the 1983 Act and under Rule 17(2)(m) of the Rules, a warning was required.

Submissions

<u>On behalf of the GMC</u>

2. Ms Johnson submitted that a warning should be imposed in this case. She referred the Tribunal to the GMC's Guidance on Warnings (March 2021) ('the Guidance'), particularly paragraphs 32, which sets out factors to be considered when deciding whether a warning is appropriate.

3. She said that there have been a number of failings by Dr Ali which the Tribunal found amounted to serious misconduct. This indicated a significant departure from GMP. She said a warning is appropriate in this case.

On behalf of Dr Ali

4. Mr Thomas submitted that a warning would serve no purpose. He referred to the factors set out in paragraph 32, which he said were relevant, including demonstrating insight, remediation, the lapse of time, a warning is not required. He referred the Tribunal to its determination on impairment, particularly paragraphs 88 - 90. He submitted that a warning should not be imposed.

The Tribunal's Determination on Warning

5. The decision on whether or not to issue a warning is a matter for the Tribunal alone to determine exercising its own professional judgement. In making its decision the Tribunal has taken into account the submissions of both parties, and had regard to the Guidance.

6. Throughout its deliberations, the Tribunal had regard to the statutory overarching objective. In that regard, it bore in mind that its power to issue a warning is an important feature of its role of protecting the public, which includes protecting patients, maintaining public confidence in the profession, and declaring and upholding proper standards of conduct and behaviour.

7. The Tribunal applied the principle of proportionality, and weighed the interests of the public against Dr Ali's interests. The Tribunal bore in mind that a warning would not restrict Dr Ai's practice, however, current and future employability may be significantly affected by the imposition of a warning and the requirements to disclose it. If a warning was to be imposed, it would be published on the medical register via the GMC's website for a two-year period. After that period, they are no longer disclosed to general enquirers, but they are kept on record and disclosed to employers indefinitely on request.

8. The Tribunal bore in mind that a warning has a deterrent effect and sends out a signal to the doctor, the profession, and the public about what is regarded as unacceptable behaviour whilst maintaining public confidence in the profession and upholding proper professional standards and behaviour.

9. In making its decision, the Tribunal had regard to the Guidance, and in particular it had regard to paragraphs 13, 14, 16, 20, 21, 26, and 32 which state:

> 13 *'Although warnings do not restrict a doctor's practice, they should nonetheless be viewed as a serious response, appropriate for those concerns that fall just below the threshold for a finding of impaired fitness to practise.'*

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, …'*

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).'

21 'Given the terms and function of a warning, it will normally be appropriate to issue a warning following a specific breach of Good medical practice or allegation of misconduct rather than more generalised concerns about the standard of a doctor's practice.'

26 'In deciding whether to issue a warning the decision maker should apply the principle of proportionality, weighing the interests of the public with those of the practitioner. It is important to bear in mind, of course, that warnings do not restrict

the practitioner's practice and should only be considered once the decision maker is satisfied that the doctor's fitness to practise is not impaired.'

32 'If the decision makers are satisfied that the doctor's fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of factors to determine whether a warning is appropriate. These might include:

a. the level of insight into the failings
b. a genuine expression of regret/apology
c. previous good history
d. whether the incident was isolated or whether there has been any repetition
e. any indicators as to the likelihood of the concerns being repeated
f. any rehabilitative/corrective steps taken
g. relevant and appropriate references and testimonials.'

10. The Tribunal carefully considered the submissions made by Ms Johnson and Mr Thomas, and had regard to its findings at the Facts and Impairment stages.

11. At the Impairment stage the Tribunal identified that Dr Ali's actions breached a number of paragraphs of GMP. Whilst the Tribunal found that there was no current impairment of Dr Ali's fitness to practise, it was satisfied that the first limb of the test for a warning was met, as outlined at paragraph 16 of the Guidance.

12. Additionally, the Tribunal considered that the factors as outlined at paragraph 20 of the Guidance were relevant in this case. The Tribunal considered that there had been a clear and specific departure from GMP, as outlined in its determination on impairment. The doctor's fitness to practise had not been found to be impaired. It considered that if such misconduct was to be repeated, it would very likely lead to a finding of impaired fitness to practise in the future. However, the Tribunal considered, as set out in its determination on impairment, that Dr Ali presented no risk of repeating his misconduct. The matters before the Tribunal occurred some five years ago and since then, it was satisfied that there was no need to formally record the particular concerns in a warning.

13. The Tribunal considered the factors set out at paragraph 32 of the Guidance. It was satisfied that Dr Ali had gained full insight into his misconduct, and expressed genuine regret for his actions. He has an otherwise unblemished career, with the misconduct in this case having occurred some five years ago, of which there had been no repetition. Dr Ali had taken corrective steps and had fully remediated, and been able to submit comprehensive evidence, as well as positive references and testimonials to demonstrate this. The Tribunal that all the factors set out in paragraph 32 of the Guidance were satisfied by Dr Ali.

14. The Tribunal noted that paragraph 21 of the Guidance that it would 'normally' be appropriate to issue a warning following a specific breach of GMP, but in Dr Ali's case, the Tribunal considered that it had to balance against this that he satisfied all factors in paragraph 32 and that he had not just fallen below the threshold for a finding of impaired

fitness to practise. The Tribunal reminded itself of its finding in relation to impairment and considered him to be well below that threshold.

15. The Tribunal considered the purpose that a warning would serve at this stage. It balanced the public interest in matters against the passage of time since the events occurred, and that since July 2018, Dr Ali has taken steps to address the deficiencies identified in his practice. The Tribunal bore in mind Dr Ali's remediation and insight and considered that in light of all the evidence before it, a warning would be punitive.

16. In these circumstances, the Tribunal considered that its findings have already sent a signal to Dr Ali, the profession, and the public about what is regarded as unacceptable behaviour whilst maintaining public confidence in the profession and upholding proper professional standards and behaviour.

17. Taking into account the factors set out in paragraph 32 of the Guidance, which the Tribunal has already found Dr Ali has demonstrated, it considered that issuing a warning would not be proportionate or appropriate in this case.

18. There is no interim order to revoke.

19. That concludes the case