PUBLIC RECORD

Dates: 14/02/2022 - 17/02/2022

Medical Practitioner's name: Dr Peter YEH

GMC reference number: 3614459

Primary medical qualification: MB BChir 1992 University of Cambridge

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 1 month.

Tribunal:

Legally Qualified Chair	Ms Louise Sweet
Medical Tribunal Member:	Dr Maria Broughton
Medical Tribunal Member:	Dr Jonathan Davies

Tribunal Clerk:	14/02/2022 – Mr Matthew Rowbotham 15/02/2022-17/02/2022 – Ms Maria Khan

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Andrew Colman, Counsel, instructed by MDU
GMC Representative:	Ms Georgina Goring, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts and Impairment - 16/02/2022

Background

1. Dr Yeh qualified in 1992 with a MB BChir from University of Cambridge. Dr Yeh went on to the Specialist Register in Obstetrics and Gynaecology (Maternal and Fetal Medicine) in 2012. He obtained membership of the Royal College of Obstetricians and Gynaecologists in 2001 and he was awarded fellowship in 2019.

2. At the time of the events with which this hearing is concerned Dr Yeh was practising as a Consultant Obstetrician and Specialist in Fetal Maternal Medicine at Northwick Park Hospital ('the Hospital'), which is part of London North-West University Healthcare NHS Trust ('the Trust'). Dr Yeh is currently practising as a Locum Consultant Obstetrician and Specialist in Fetal Maternal Medicine at North-West Anglia NHS Foundation Trust.

3. The allegation that has led to Dr Yeh's hearing can be summarised as obtaining consent from a patient, Patient A, for a Caesarean section ('c-section') without reviewing her antenatal clinic entries or obtaining an adequate history. In doing so it is alleged that Dr Yeh failed to obtain adequate consent for an appropriate procedure, which was a c-section and assessment and/or treatment of Patient A's left ovary, which had a cyst. Patient A subsequently passed away following complications relating to the cyst, which had become malignant.

4. It is also alleged that after failing to carry the review or obtaining an adequate history, Dr Yeh inappropriately (as he had not read the antenatal notes) delegated Patient A's c-section to a junior colleague, Dr B.

5. The initial concerns were raised with the GMC by Patient A's family, following a Serious Incident Investigation conducted by the Trust.

The Outcome of Applications Made during the Preliminary Stage

6. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that sub-paragraph 1d of the Allegation be withdrawn following Dr Yeh's admissions to the entirety of the remaining Allegation. Mr Coleman, on behalf of Dr Yeh, did not oppose the application. The Tribunal noted that sub-paragraph 1d of the Allegation was presented as an alternative to previous sub-paragraphs admitted by Dr Yeh. The Tribunal reasoned that Dr Yeh could not make a record of any activities he had admitted failing to carry out. It therefore found that it would not cause any injustice to either party if the sub-paragraph were removed.

The Allegation and the Doctor's Response

7. The Allegation made against Dr Yeh is as follows:

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

1. On 29 August 2017, you obtained consent from Patient A for a Caesarean section ('c-section') procedure and you failed to:
    a. review Patient A's antenatal clinic entries;
    b. obtain an adequate history in that you did not establish:
        i. the reason why the c-section procedure was being performed;
        ii. whether Patient A had any significant past medical history;
        iii. whether any complications had arisen in Patient A's current pregnancy;
    c. obtain consent for the appropriate procedure, which was a c-section with assessment and/or treatment of the left ovary;
    ~~d. record having undertaken the actions at paragraphs:~~
        ~~i. 1a;~~
        ~~ii. 1b.~~ Withdrawn under rule 17(6) by the Tribunal following admissions to the alternative

Admitted and found proved

2. On 29 August 2017, having failed to carry out one or more of the actions at paragraph 1.a. and/or 1.b., you inappropriately delegated Patient A's c-section to Dr B.

Admitted and found proved

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

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

Expert Witness Evidence

9. The Tribunal received oral evidence from Dr C, an expert witness on behalf of the GMC, who also provided a report dated 20 January 2021, and a supplemental report dated 29 September 2021.

9. At the time of writing the reports, Dr C had 15 years' experience as a Consultant Obstetrician and Gynaecologist in a district general hospital, working weekly as the duty Consultant on a delivery suite. Since 2005 Dr C had also acted as a clinical supervisor or educational supervisor of trainees in Obstetrics and Gynaecology. Dr C assisted the Tribunal in understanding the level of care Dr Yeh provided to Patient A.

Documentary Evidence

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

- The Trusts' serious incident report;
- Relevant extracts from Patient A's medical records, including ultrasound scan data and antenatal records;
- Hospital records regarding Patient A, including an operating theatre care document, and maternity theatre list from the day of the alleged incident;
- Patient A's consent form;
- Dr Yeh's job plan, rota, and theatre booking diary;
- Dr Yeh's CV, personal development plan, teaching feedback, awards, and certificates and;
- Testimonials on behalf of Dr Yeh.

Witness Evidence

12. Dr Yeh provided his own witness statement, dated 18 November 2021, and also gave oral evidence at the hearing.

Impairment

11. The Tribunal had 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 Yeh's fitness to practise is impaired by reason of misconduct.

Submissions

On behalf of the GMC

12. Ms Goring submitted that making a finding of impairment in this case is a two stage process. First, the Tribunal must find that Dr Yeh's behaviour amounted to serious misconduct, before going on to determine whether he was currently impaired because of this misconduct.

13. In addressing the first stage, Ms Goring submitted that the Tribunal should have regard to the definition of misconduct set out in the case of *Roylance v GMC [2001] 1 AC 311:*

> *'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Goring submitted that there had been a general agreement between Dr Yeh and the expert witness, Dr C, that there had been omissions in Dr Yeh's practice.

14. Ms Goring submitted that Dr Yeh had breached a fundamental tenet of the profession, and drew the Tribunal's attention to paragraph 15a of Good Medical Practice (2013 edition) ('GMP'), which states:

> *'You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> *a. adequately assesses 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'*

Ms Goring submitted that Dr Yeh had breached this paragraph when he failed to review Patient A's notes and/or take an adequate medical history of Patient A.

15. Ms Goring submitted that Dr Yeh had also breached paragraph 16b of GMP, which states:

> *'****16*** *In providing clinical care you must:*
> *[…]*
> *b. provide effective treatments* ***based on the best available evidence****'*

Ms Goring submitted that there was evidence available to Dr Yeh, in the form of Patient A's medical records, which he did not consider. She submitted that Dr C said a fundamental part

of treating a patient is understanding their medical history, which Dr Yeh had not done when assessing Patient A for her operation.

18. Further, Ms Goring submitted that when Dr Yeh delegated the care of Patient A to Dr B without reviewing Patient A's records, Dr Yeh breached paragraph 45 of GMP, which states:

> *'45 When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.'*

19. Ms Goring submitted that given these breaches and the opinion of Dr C that Dr Yeh's overall care of Patient A fell seriously below the standard expected of a doctor in his position, Dr Yeh's behaviours amounted to serious misconduct. Ms Goring submitted that Dr C remained of the view this was serious even where it was accepted that this was an isolated incident.

16. Ms Goring submitted that there is no evidence Dr Yeh's misconduct had caused Patient A's death. However, she submitted that the Tribunal could consider Patient A's condition and that this was a missed opportunity to treat Patient A sooner for her cancer.

17. When reaching its determination on impairment, Ms Goring submitted that the Tribunal should have regard to the case of *The Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)*, which states:

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

18. In addition, Ms Goring submitted that the Tribunal should have regard to the test for impairment set out in the case of *CHRE v NMC & Grant (2011) EWHC 927 (Admin).* The Tribunal is invited to consider whether its findings of fact showed that Dr Yeh's fitness to practise is impaired in the sense that he:

> *'a. Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
> *b. Has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
> *c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
> *(d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future' Not applicable on the facts of this case)'*

19. In addressing each limb of the test in turn, Ms Goring submitted that Dr Yeh had caused unwarranted risk of harm in not reviewing Patient A's medical records, as this created a gap of two months before Patient A's ovarian cancer was diagnosed.

20. With regard to the second limb of the test, Ms Goring submitted that, given the seriousness of the failings, the public's confidence in the GMC and the medical profession would be undermined if Dr Yeh's fitness to practise was not found to be impaired.

21. Ms Goring submitted that the third limb of the test was also engaged as Dr Yeh had breached a fundamental tenet by not making the care of patient A his first concern. This was illustrated by the clear breaches of GMP as set out.

22. Ms Goring acknowledged that Dr Yeh had shown insight into his actions, demonstrated remorse, had taken steps towards remediation, and had fully engaged with this regulator process. However, she submitted that Dr Yeh's failings are so serious that they must be marked as unacceptable by making a finding of impairment. Ms Goring submitted that only such a finding would protect the public, and not undermine their confidence in the medical profession.

<u>On behalf of Dr Yeh</u>

23. Mr Colman submitted that Dr Yeh admitted that his failure to read Patient A's records as well as his subsequent delegation of her c-section were serious failures, and that these would be seen as deplorable and affect public trust in doctors. However, he submitted, Dr Yeh remained at a loss as to how this had happened given his usual high standards.

24. Mr Colman submitted that this was the first and only time in Dr Yeh's career that such a mistake had occurred. Dr Yeh's usual approach was one of thorough diligence. He was a skilled and experienced doctor who was one of the few consultants to *"go the extra mile"* for patients. He stated Dr Yeh was mortified to have let Patient A and her family down.

25. Mr Colman submitted that Dr Yeh had repeatedly expressed remorse towards Patient A's family through his responses to his regulator and others. Although he felt he was unable to approach the family directly, Dr Yeh wished to convey his sincerest and heartfelt apologies to the family members.

26. Mr Colman highlighted the fact that there had been miscommunication and failings by others that exacerbated the consequences of Dr Yeh's failings. These included the fact that the patient notes were not available on the day, that it was a busy and chaotic day on the Maternity Unit, and that Dr Yeh fell short while doing his best to cope.

27. Mr Colman did not accept there had been a breach of the fundamental tenet that "a doctor must make the care of their patient their first concern", Dr Yeh had not been deliberately prioritising anything else and his only concern at the time was the care of Patient

A. It was at the degree of care that Dr Yeh had failed, rather than putting his own interests first.

28. If the Tribunal found serious misconduct in this case, Mr Colman submitted, it would then have to go on to consider whether Dr Yeh's fitness to practice is currently impaired.

29. Mr Colman reminded the Tribunal of the guidance set out in *Cohen v GMC [2008]* relating preliminary inquiries into single clinical incident cases. He submitted, subject to public confidence considerations, if there was satisfactory evidence of remediation, the Tribunal could conclude that the single clinical incident represented an isolated incidence of misconduct on the part of the doctor, and the chance of it being repeated was so small that their fitness to practice was not currently impaired.

30. Mr Colman submitted that Dr Yeh had undertaken appropriate and targeted steps to remediate and had also reflected on his actions, as highlighted in his witness statement. He had sought to learn from his mistakes and to improve the system for sharing clinical information. Mr Colman added that the GMC accepted that Dr Yeh has shown insight.

31. Mr Colman then drew the Tribunal's attention to Dr Yeh's extensive CV, his repeated nominations for 'Staff Excellence Awards' since 2017, and the number of testimonials from grateful patients and parents.

32. Mr Colman submitted that Dr Yeh was acutely aware that nothing could make up to Patient A's family for what happened to her but that he had done everything possible to ensure this didn't happen to anyone else. This was an isolated incident that was unlikely to be repeated, and Dr Yeh currently presented no risk to patient safety. The disciplinary procedure that Dr Yeh had already been through would be an adequate marker for the public, as well as the Tribunal declaring Dr Yeh's failings to be unacceptable. Therefore, Mr Colman submitted, the wider public interest did not require a finding of current impairment.

The Relevant Legal Principles

33. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision on impairment is a matter for the Tribunal's judgement alone. The Tribunal bore in mind that it must determine whether Dr Yeh's fitness to practise is currently impaired by reason of his misconduct.

34. Throughout its deliberations, the Tribunal has taken account of the statutory overarching objective of protecting the public, which includes protecting the health, safety and wellbeing of the public, maintaining public confidence in the profession, and promoting and maintaining proper professional standards and conduct for the members of the profession. The Tribunal placed the three limbs of the objective in equal balance.

35. 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 that misconduct which was serious could lead to a finding of impairment.

36. There is no statutory definition of misconduct, but it has been described in a number of cases. In *Nandi v GMC [2004] EWHC 2317 (Admin)* Collins J, at paragraph 31, adopted the observation of Lord Clyde in *Rylands v GMC [1999] Lloyd's Rep Med 139*:

> *'he described it as 'a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious.' The adjective 'serious' must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners…'*

37. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by the case of Grant (see above).

38. The Tribunal must determine whether Dr Yeh's fitness to practise is impaired today, considering Dr Yeh's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

The Tribunal's Determination on Impairment

39. The Tribunal firstly considered whether Dr Yeh's actions amount to serious misconduct.

40. The key omission was Dr Yeh's failure to read any clinical notes when taking consent before Patient A's planned operation. This failure meant he and others in theatre were insufficiently briefed as to her medical history, any risks she might face nor of the existence of an ovarian cyst that required removal. This key omission also led to inappropriate delegation of the operation to a junior colleague.

41. The Tribunal were conscious that Dr Yeh was keen to fulfil his rota duty at the Fetal Medical Centre where he had lead responsibility for especially difficult births. The Tribunal were also conscious that he was working in difficult circumstances with paperwork not readily to hand (both the patient list and the clinical notes were not to hand when Dr Yeh needed them) and this was an unusually busy Maternity Ward that morning. The Tribunal accepted that Dr Yeh was not the only clinician in error with regard to Patient A.

42. Nonetheless, Dr Yeh was the Consultant on duty. He was the person, before he delegated, who was to operate on Patient A. He had a responsibility to give her care his full focus which must, at a very basic level, require him to find and read her antenatal records. The Tribunal was of the view, in failing to do so, Dr Yeh had departed from a number of principles of GMP. In particular, he had breached paragraphs 15a, 16b, and 45[1].

[1] Including GMC further Guidance Delegation and Referral Published 25 March 2013

43. The Tribunal noted that there was no issue between parties that failing to read patient notes is serious misconduct that could readily be described as *'deplorable'.*

44. The Tribunal took into consideration the evidence of Dr C who stated not reading the records:

> *"fell seriously below the standard expected of a reasonably competent Consultant in Obstetrics and Gynaecology. I consider this to be a serious failure since omitting to read the clinical records would predictably increase the risk of an adverse outcome to the patient"*

45. Dr C added that failing to review a patient's medical records, even as an isolated incident, represented a *"fundamental error".*

46. The Tribunal further noted that in both his oral evidence and written statement, Dr Yeh accepted that he "*had not taken sufficient effort"* to retrieve Patient A's medical notes. Dr Yeh also accepted that there may have been some electronic notes available that he did not access, and that he could have reviewed the ultrasound scans, in the absence of antenatal notes.

47. Leaving aside any other gynaecological difficulties, the Tribunal noted the importance of reviewing antenatal notes prior to carrying out surgical procedures and in particular, c-sections, as summarised by Dr C in his evidence. He noted Important factors for a surgeon to be aware of included (not exhaustive):

i) any potential complications and potential difficulty in undertaking the procedure
ii) any past medical or surgical history
iii) any allergies and medication
iv) how the pregnancy has been progressing
v) any fetal complications up to that point
vi) the possibility of other complications e.g. abdominal adhesions from previous c-sections.

All of the above, Dr C stated, were examples that might give rise to intra-operative complexity.

48. In his evidence before The Tribunal, Dr Yeh admitted that his misconduct was properly described as deplorable by his fellow practitioners, and he acknowledged that the public would *"not think highly"* of him when learning of his failings. He acknowledged the adverse impact his failings would have on public confidence in the medical profession as a whole.

49. Dr Yeh made candid admissions in his evidence to the Tribunal. He stated *"I accept my failures risked patient harm, I agree it is a fundamental tenet to make my patient my first concern and I accept I have breached a fundamental tenet of medical profession"*

50. The Tribunal determined that Dr Yeh's actions were serious and represented a clear breach of a fundamental tenet of the profession by his failure to find and read patient notes before carrying out or delegating any surgical procedure, especially such a significant operation as a c-section. Whilst the Tribunal accepted the other admitted failings by themselves (a failure to take a history, failure to obtain consent for the additional treatment and inappropriately delegating the operation) were not of the same level of seriousness, they were serious misconduct when taken in combination with the key omission of not reading a patient's clinical notes before embarking on surgery. The failures were inextricably linked.

51. The Tribunal therefore concluded, taken as a whole, that Dr Yeh's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct.

52. The Tribunal having found that the facts admitted amounted to serious misconduct went on to consider whether, as a result of that misconduct, Dr Yeh's fitness to practise is currently impaired.

53. In its deliberations the Tribunal focused on the three limbs of the overarching objective. The Tribunal recognised that the reputation of the profession as a whole was more important than the interests of any individual doctor.

54. The Tribunal accepted this was a single isolated episode of misconduct.

55. The Tribunal noted the passage of time since the incident and that there was good evidence of remediation and insight expressed in Dr Yeh's written statement and in his evidence. The CPD courses that Dr Yeh had listed were relevant to the misconduct.

56. The Tribunal also considered Dr Yeh's otherwise excellent reputation amongst colleagues and patients alike.

57. The Tribunal was, in the light of all the material presented, of the view that this misconduct was highly unlikely to be repeated.

58. However, the Tribunal noted that Dr Yeh had breached a fundamental tenet of the medical profession by failing to make Patient A his first concern. The Tribunal noted that his failure was not self-motivated but, on the evidence, before it, Dr Yeh, under pressure, had prioritised other patients (in the Fetal Unit) and the efficiencies of the Maternity Unit as a whole, rather than focusing on the care of patient A.

59. The Tribunal considered whether the fact that this was a single mistake by a doctor of otherwise high standing and clinical excellence and who had set out to make sure neither he

nor others would repeat this mistake was enough to restore public confidence in a doctor who had seriously failed a patient by making such a basic mistake in not reviewing any clinical notes before surgery.

60. The Tribunal noted that Dr Yeh's seniority meant that he would have fully appreciated why the notes would need to be reviewed and the importance of taking time to obtain the notes, no matter what delays that might cause to others. The Tribunal were of the view that Dr Yeh should have made Patient A his first concern.

61. The Tribunal were of the view Dr Yeh's failings, by not finding any of the clinical notes, not reading them, not taking any medical history, and then delegating the surgical procedure to a junior doctor meant Patient A was exposed to unnecessary risks. In her case, a potential ovarian cystectomy was overlooked.

62. Public confidence in the medical profession as a whole remained at risk. These failings were so serious that public confidence in the profession would be undermined if a finding of impairment was not made.

63. The Tribunal has therefore determined that Dr Yeh's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 17/02/2022

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

The Evidence

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

Submissions

3. On behalf of the GMC, Ms Goring submitted that the most appropriate and proportionate sanction to impose on Dr Yeh's registration in this case, would be one of suspension.

4. Ms Goring referred the Tribunal to the paragraphs of the Sanctions Guidance (November 2020 edition) ('the SG'), which she submitted supported the imposition of suspension as being the appropriate sanction in this case.

5. Ms Goring submitted that taking no action was appropriate only in exceptional circumstances and there were none present in this case.

6. Ms Goring submitted that conditions were not appropriate for this type of misconduct, in that it was a single isolated incident. Conditions must also be appropriate,

proportionate, and workable. There were no conditions that would protect the public from a similar omission in the future. Moreover, looking at the seriousness of this case, conditions would not send a sufficient message to the profession and the wider public that such serious misconduct would not be tolerated by Dr Yeh's regulator.

7. Ms Goring submitted that for the same reasons as above, undertakings were not appropriate in this case.

8. Ms Goring referred the Tribunal to paragraphs 91 – 93, and paragraph 97 of the SG. She told the Tribunal that the GMC accepted that Dr Yeh had acknowledged the fault found by the Tribunal and that he had shown evidence of remediation and insight. Even though this had been an isolated incident of misconduct on Dr Yeh's part, it was nevertheless a fundamental error and the GMC considered Dr Yeh's misconduct was too serious to impose anything short of suspension. However, the misconduct fell short of being fundamentally incompatible with continued registration and a period of suspension would be the most appropriate sanction.

9. On behalf of Dr Yeh, Mr Colman submitted that the Tribunal should consider any sanction with regard to the principle of proportionality and weigh the interests of the public against those of the doctor.

10. Mr Colman submitted that in this case the public interest included the substantial interest in retaining and utilising the services of a doctor with the specialist expertise and experience of Dr Yeh.

11. Mr Colman reminded the Tribunal of its findings relating to mitigating factors as outlined in its determination at the previous stage and submitted that none of the aggravating features set out in the SG were pertinent in this case. Mr Colman further submitted even senior doctors can make mistakes that are fundamental and serious in their consequences as well as their nature and professional regulation did not demand an inhuman standard of perfection of doctors.

12. Mr Colman submitted that a period of suspension would be disproportionate as it would deprive the public of Dr Yeh's highly valued skills for a period of time. Dr Yeh's current employment would be interrupted, and he would have to reapply for work once the suspension was lifted, meaning an interruption in the continuity of patient care. Suspension would mark Dr Yeh's misconduct with excessive severity in a way that could be seen as punitive.

13. Mr Colman then submitted that imposing a short period of conditions on Dr Yeh's registration would be more appropriate. This would allow Dr Yeh to continue to provide his excellent and highly appreciated services to his patients without interruption while sending a message of regulatory response to meet the public interest in maintaining confidence in the profession and upholding standards.

14. Mr Colman submitted that should the Tribunal determine that a period of suspension was the required sanction in this case, that it should be for an exceptionally short period as anything more severe would be neither appropriate nor proportionate.

The Relevant Legal Principles

15. When considering sanction, the Tribunal must again have particular regard to the statutory overarching objective:

a. To protect, promote and maintain the health, safety and wellbeing of the public;
b. To promote and maintain public confidence in the medical profession; and
c. To promote and maintain proper professional standards and conduct for members of that profession.

16. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal exercising its own judgement, taking account of the SG. It must consider the least restrictive sanction first and then if necessary consider the other sanctions, taking into account the submissions that have been heard. The Tribunal must consider its determination on impairment and take those matters into account during its deliberations on sanction.

17. In reaching its decision, the Tribunal has taken into account the SG. It has borne in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it may have a punitive effect.

18. The Tribunal must apply the principle of proportionality; balancing the doctor's interests with the public interest.

The Tribunal's Determination on Sanction

19. Before considering what action, if any, to take in respect of Dr Yeh's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

Aggravating factors

20. The Tribunal identified the following aggravating factors in Dr Yeh's case:

i. It was a fundamental and serious error in not reviewing patient notes before they were about to undergo a significant surgical procedure. This represented a serious departure from the principles of *Good Medical Practice,* including breaches of paragraphs 15(a), 16(b), and 45.

ii It was a clear breach of fundamental tenets of the medical profession in failing to make Patient A his first concern.

iii Dr Yeh's seniority not only in his department but also within the medical profession demanded high standards and an example to others of conduct befitting of the medical profession.

iv Dr Yeh exposed his patient to risk and/or harm by not reviewing the patient notes.

v His failure to read the notes resulted in a delay in treatment for an ovarian cyst that was later diagnosed as malignant.

Mitigating Factors

21. The Tribunal balanced the aggravating factors with the following mitigating factors:

i There is evidence that Dr Yeh understands the consequence of his actions and has insight. In his Rule 7 response, Dr Yeh made early indications that he was admitting the facts relating to his misconduct. As well as this, he made candid admissions to the Tribunal in oral evidence about the impact of his failings on the patient, the patient's family, his own standards, and on the wider reputation of the medical profession.

ii Dr Yeh has apologised in his statement and in oral evidence.

iii Dr Yeh has made efforts to prevent a reoccurrence of the incident. He fully engaged with the Serious Incident Investigation carried out by the Trust assisting lessons to be learned. He also fully engaged with an appropriate PDP of training and retraining, including attending CPD courses such as 'Human Factors Training for Staff working in Maternity Services', 'Risk Management Masterclass for Obstetricians and Gynaecologists', 'Root Case Analysis (RCA) Investigation Training', and 'Management of Ovarian Cysts in Pregnancy', all also relevant to Dr Yeh's insight and remediation of his misconduct. Dr Yeh started this course of remediation soon after the incident and has continued, showing his ongoing efforts to further develop insight and remediate his failures.

iv Dr Yeh has remained in practice since the incident in 2017 and there has been no repetition of the misconduct. The Tribunal has also been presented with a bundle of testimonials from colleagues and patients, showing how Dr Yeh pushes himself to a high standard. The Tribunal noted that he provides the highest cover for other consultants in the department and frequently looks after patients even when he is off duty. One colleague in the same department at the Trust writes that when Dr Yeh did clinics, patients have his email address to contact him directly if needed. Dr Yeh also, takes part regularly in training medical students and is known for *"sharing good practice and learning from complex cases".* Dr Yeh has subsequently set up online referrals, and has realised the importance of handing over care between doctors. Another colleague writes, *"he represents an extremely valuable member of our department and of the medical profession at large. I would have no hesitation in*

recommending him for the care one of my family members." The Tribunal therefore recognised that not putting Patient A first was contrary to Dr Yeh's normal practice.

v The passage of time. It was now over 4 years since the incident and in that time, Dr Yeh had done a lot of work to remediate his misconduct.

vi In Dr Yeh's long and distinguished career there has been no other cause to question his commitment to his patients or his clinical expertise.

vii The Tribunal accepted that the day of the incident was a busy and chaotic one. Dr Yeh was keen to fulfil his commitments in the Fetal Medicine Department, cases had overrun in the morning and paperwork was not where it should have been. Also, whoever listed the case as simply a c-section made an inaccurate listing in the theatre diary and the subsequent operating list was therefore inaccurately transcribed. The Tribunal placed moderate but not excessive weight on this as a mitigating factor setting the context for the error.

22. The Tribunal noted that Dr Yeh had been open and honest about his failings. The fact that he has been candid from outset demonstrates his clear insight and regret for his failures.

23. The Tribunal were of the view that this misconduct was remediable and as set out Dr Yeh has shown determined efforts in this respect.

24. The Tribunal considered the impact of his failures on public confidence. The public want to be reassured that such a basic failing as not reading the antenatal notes before a c-section is not acceptable as the standard required of a competent doctor. The public will also appreciate that this was a single error, and that otherwise Dr Yeh is a competent and committed doctor. The Tribunal noted that he has continued to practise in a specialist field, has worked throughout the pandemic and was nominated a Covid Hero. Dr Yeh has made concerted efforts to restore public confidence in him and in the profession as a whole.

No action

25. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Yeh's case, the Tribunal first considered whether to take no action. The Tribunal considered that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

26. The Tribunal determined that given the seriousness of Dr Yeh's misconduct, and the absence of any exceptional circumstances in this case, taking no action was neither appropriate, proportionate nor in the public interest.

Conditions

27. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Yeh's registration. The Tribunal took account of paragraphs 81(b), 82, and 85 of the SG which state:

'81 Conditions might be most appropriate in cases:

a. …

b involving issues around the doctor's performance

c. …

d. …

82 Conditions are likely to be workable where:

a the doctor has insight

b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings

c the tribunal is satisfied the doctor will comply with them

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

85 Conditions should be appropriate, proportionate, workable and measurable.'

28. The Tribunal took into consideration its findings at the impairment stage and was of the view that Dr Yeh had worked hard and remediated enough since the incident to restore public confidence in his own competence as a doctor. There was no further training that is suggested to be required in this case.

29. Further, the concern now in this case was one of restoring public confidence in the profession as a whole rather than in Dr Yeh as an individual doctor.

30. The Tribunal concluded that conditions were not appropriate and would not address the seriousness of the misconduct in this case.

Suspension

31. In considering whether to impose a period of suspension, the Tribunal had regard to paragraphs 91, 92, 93, and 97 of the SG which state:

'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a

living as a doctor) during the suspension, although this is not its intention.

92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e., for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions.

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

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

b. to d. (not relevant)

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

f No evidence of repetition of similar behaviour since incident.

g The tribunal is satisfied that the doctor …. does not pose a significant risk of repeating behaviour.'

32. The Tribunal was of the view that failing to read patient notes before a significant operation fell far below the standards expected of a registered doctor and breached a fundamental tenet of the medical profession. This misconduct was so serious that an appropriate response was warranted. The Tribunal was required to take action to restore and maintain public confidence in the profession.

33. In arriving at its conclusion, the Tribunal took into consideration that Dr Yeh has acknowledged his failings and apologised. The Tribunal was more than satisfied that the incident was unlikely to be repeated. The Tribunal was satisfied that Dr Yeh had taken significant steps to remediate his misconduct.

34. The Tribunal was satisfied that Dr Yeh has full insight into how his failings created a risk to his patient and adversely affected not only his own reputation, but the reputation of the medical profession at large.

35. This was a single incident of misconduct of this type in a long career, and along with all the other factors considered above, the Tribunal was of the view that while Dr Yeh's misconduct was serious, it fell short of being fundamentally incompatible with continued registration.

36. The Tribunal was of the view that erasure of a highly skilled and specialist doctor from the UK NHS would be detrimental to the public and a disproportionate response to a serious but single incident that was not likely to be repeated.

37. The Tribunal therefore determined that a period of suspension would be the most appropriate and proportionate response.

Erasure

38. Neither party suggested this was a case that warranted Dr Yeh's name to be erased from the medical register. The Tribunal determined that as it was a single error not likely to be repeated, in a long history of otherwise clinical excellence, to erase a doctor as valuable to the public as Dr Yeh would be disproportionate.

Duration of Suspension

39. In determining the length of suspension, the Tribunal had regard to paragraphs 99 - 101 of the SG, which state:

> *'99 The length of the suspension may be up to 12 months and is a matter for the tribunal's discretion, depending on the seriousness of the particular case.*
>
> *100 The following factors will be relevant when determining the length of suspension:*
>
> *a the risk to patient safety/public protection*
>
> *b the seriousness of the findings and any mitigating or aggravating factors*
>
> *c ensuring the doctor has adequate time to remediate.*
>
> *101 The tribunal's primary consideration should be public protection and the seriousness of the findings…..'*

40. The Tribunal reviewed those matters set out the table on page 30 of the SG.

41. The Tribunal considered, first of all, the fact that Dr Yeh had seriously departed from the principles of *Good Medical Practice,* and that he had breached a fundamental tenet of the medical profession by not making Patient A his first concern.

42. The Tribunal noted Dr Yeh had risked patient safety and in doing so had damaged public confidence in the profession. The Tribunal was of the view that the public was entitled to expect that, at the very least, a doctor would read their patient's medical notes and/or take a medical history during a consultation for a surgical procedure.

43. Balancing this, the Tribunal noted Dr Yeh's subsequent steps after the misconduct. It was now more than 4 years since this incident and in that time, Dr Yeh had made concerted efforts to remediate his actions, to apologise, and to embed good practice for himself and for others, clearly learning lessons from what went wrong in 2017. Also, he has fully cooperated with his regulator and been candid about his failings therefore going further to restore public confidence in him and the medical profession a whole.

44. At the forefront of its considerations in setting the duration of suspension, the Tribunal's focus was the public interest. Dr Yeh has been practicing continuously since the incident, is a valuable clinician and is depended upon by the Fetal Medicine and Obstetric Unit.

45. As well as his commitment to his patients, Dr Yeh was also the highest ranked Consultant for providing cover for colleagues in the Unit:

> *"Dr Yeh has covered almost all the consultant colleagues (in Maternity) sickness absence since the covid pandemic from end of March to date, working extra shifts not only weekdays, but also weekends to ensure there is acute obstetric cover at all times for the department"*

46. The Tribunal was mindful to not deprive the public of a good doctor where clearly his services were heavily depended upon. As evidenced, Dr Yeh was a doctor who showed an outstanding commitment to patient care:

> *"I truly value that Mr Yeh is always accessible even on his off and annual leave days"*

47. The Tribunal noted Dr Yeh's highly specialist fetal services which would be removed if an extended period of suspension were to be imposed. This would potentially put mothers and babies who required specialist fetal medicine at risk:

> *"He is well liked by the patients who require highly specialist fetal medicine services especially scanning the babies at risk and babies that require specialist fetal medicine input. He expresses a good bed side manner, professionalism and good rapport with his patients."*

48. The Tribunal also considered the training that Dr Yeh provided. He is an expert in fetal medicine and fetal scanning and trains others in these specialist skills. It was important that he continues training other doctors given his level of expertise.

49. The Tribunal noted that the testimonials highlighted that Dr Yeh was a conscientious and hard-working member of his department, clearly well regarded by patients and colleagues alike, who are also members of the public.

50. Taking into consideration the pressures that the UK NHS is currently under, in combination with the above factors, the Tribunal was of the view taking Dr Yeh out of practice for a great length of time was not in the public interest or proportionate. Dr Yeh has shown insight and he is a valuable resource.

51. The Tribunal was of the view that it whilst it must mark the seriousness of his failures with his suspension it accepted that this must be to for the shortest length possible, consistent with its duties to protect the public.

52. The Tribunal was of the view that a suspension of one month would mark the significance of the breach and restore public confidence in the profession.

53. Accordingly, the Tribunal concluded that suspension of one month was the appropriate and proportionate sanction in this case.

54. Given the period of suspension, a review was not necessary.

Determination on Immediate Order - 17/02/2022

1. Having determined that Dr Yeh's registration be suspended for one month the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Yeh's registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Ms Goring referred the Tribunal to paragraphs 172 and 173 of the SG. She submitted that the GMC was in broad agreement with the Tribunal's determination on Sanction and did not invite the Tribunal to make an immediate order.

3. On behalf of Dr Yeh, Mr Colman submitted that it was not necessary to impose an immediate order to protect members of the public because there was no risk to patient safety. Mr Colman added the month suspension that was deemed necessary in the Tribunal's judgement to protect the public interest was adequate, balancing all factors.

The Tribunal's Determination

4. In reaching its decision, the Tribunal has exercised its own judgement and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose

an immediate order where it is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or is in the best interests of the practitioner. It has also borne in mind the guidance given in paragraphs 172 – 178 of the SG relating to immediate orders.

5. The Tribunal was of the view that imposing a period of one month's suspension met the principal concern in this case, which was the protection of the reputation of the medical profession as a whole, and therefore was adequate to restore public confidence.

6. The Tribunal determined that in the absence of any risk to the public, an immediate order is not necessary. The Tribunal therefore determined that no immediate order should be imposed in this case.

7. This means that Dr Yeh's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served upon him unless he lodges an appeal. If Dr Yeh does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

8. There is no interim order to revoke.

9. This concludes the case.