PUBLIC RECORD

Dates: 01/03/2021 - 05/03/2021

Medical Practitioner's name:	Dr Shahid AKHTAR
GMC reference number:	6156657
Primary medical qualification:	MB BCh 2007 University of Wales

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

Summary of outcome

Warning

Tribunal:

Legally Qualified Chair	Ms Melissa Coutino
Lay Tribunal Member:	Mr Robert McKeon
Medical Tribunal Member:	Dr Paolo De Marco

Tribunal Clerk:	Ms Fiona Johnston

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Ms Catherine Stock, Counsel, of Kings View Chambers
GMC Representative:	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 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 - 04/03/2021

1. Dr Shahid Akhtar qualified from the University of Wales, College of Medicine, Cardiff in 2007. He completed a BSc in Medical Imaging at Imperial College, London in 2005 alongside his studies. Dr Akhtar carried out his foundation training at the University Hospital of Wales from 2007-2009 and was awarded one of 13 themed trauma and orthopaedic core surgical training jobs in the Severn Deanery, Musgrove Park Hospital, Taunton where he worked from 2009-2011. Dr Akhtar undertook cosmetic training in toxins and fillers at the Aesthetox Academy and Cosmetic Courses in 2010, which consisted of two half day courses, which provided him with pro-forma consent forms.

2. Prior to the events which are the subject of the hearing Dr Akhtar set up a business with a school friend, called "Visify Aesthetics"; by 2012, he was a Founding Co-Director and Treatment Practitioner. His role as a Co-Director at Visify was primarily taking consultations and performing treatments on patients at the clinic. The clinic operated from three main sites, in Bristol, Cardiff and Vale where Dr Akhtar had hired a room in hotel spas for the exclusive use of Visify. The business model was designed to compete with private clinics who were providing more expensive treatments. Before Dr Akhtar wound up Visify, he allowed other practitioners to use his rooms, where patients would only know that they were being treated at "Visify" rather than this was a sub-letting arrangement.

3. Dr Akhtar saw Patient A on a number of occasions between October 2014 and June 2017 for lip filler treatment. The allegation that has led to Dr Akhtar's hearing can be summarised as follows: Between October 2014 and July 2016 Dr Akhtar carried out Botox and filler injections on Patient A. He failed to complete a written consent form on each occasion, failed to document the discussion about treatments, possible complications, what products were being used and the reason for their selection. Further, that he inappropriately injected residual amounts of filler.

4. Initial concerns were raised with the GMC by Patient A in December 2017.

The Allegation and the Doctor's Response

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

1. On 18 October 2014, you carried out filler injections ('Procedure One') on Patient A and:

    a. you failed to record:

        i. discussing pre-operatively with Patient A: **Admitted and found proved**

            1. the aims of the treatment, including whether the treatment would:

                a. increase lip volume; **Admitted and found proved**

                b. turn up and out the appearance of the lip; **Admitted and found proved**

            2. common or serious complications, such as:

                a. lumpiness; **Admitted and found proved**

                b. unevenness; **Admitted and found proved**

                c. redness at the injection site; **Admitted and found proved**

                d. asymmetry; **Admitted and found proved**

                e. skin necrosis; **Admitted and found proved**

                f. blindness; **Admitted and found proved**

            3. alternative options such as doing nothing; **Admitted and found proved**

            4. her reason for visiting the clinic; **Admitted and found proved**

5. what her expectations of the treatment were; **Admitted and found proved**

6. the filler being used, including the reason for its use; **Admitted and found proved**

ii. your decision making as to why the filler was used; **Admitted and found proved**

iii. who performed Procedure One; **Admitted and found proved**

b. in light of the omission outlined at paragraph 1. a. i., you failed to obtain informed consent. **Admitted and found proved**

2. On 25 October 2014, you carried out filler injections ('Procedure Two') on Patient A and you:

a. inappropriately injected residual amounts of uma jeunesse into Patient A which you previously banked; **Admitted and found proved**

b. failed to record:

i. your decision making as to why the uma jeunesse was used; **Admitted and found proved**

ii. who performed Procedure Two. **Admitted and found proved**

3. On 23 May 2015, you carried out filler injections ('Procedure Three') on Patient A and:

a. you failed to complete a further consent form as you were using a different product; **Admitted and found proved**

b. in light of the omission outlined at paragraph 3. a., you failed to obtain informed consent; **Admitted and found proved**

c. you failed to record:

i. your decision making as to why the filler was used; **Admitted and found proved**

ii. in relation to the products used:

1. batch numbers; **Admitted and found proved**

2. expiry dates; **Admitted and found proved**

3. signatures; **Admitted and found proved**

iii. who performed Procedure Three. **Admitted and found proved**

4. On 5 November 2015, you carried out filler injections ('Procedure Four') on Patient A and you:

a. inappropriately injected residual amounts of surgiderm into Patient A which you previously banked; **Admitted and found proved**

b. failed to record:

i. your decision making as to why the surgiderm was used; **Admitted and found proved**

ii. who performed Procedure Four. **Admitted and found proved**

5. On 23 July 2016, you carried out botox and filler injections ('Procedure Five') on Patient A and:

a. you failed to complete a further consent form as you were using a different product; **Admitted and found proved**

b. in light of the omission outlined at paragraph 5. a., you failed to obtain informed consent; **Admitted and found proved**

c. you failed to record:

i. your decision making as to why the filler was used; **Admitted and found proved**

ii. in relation to the products used:

1. batch numbers; **Admitted and found proved**

2. expiry dates; **Admitted and found proved**

3. signatures; **Admitted and found proved**

iii. who performed Procedure Five. **Admitted and found proved**

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

The Admitted Facts

5. At the outset of these proceedings, through his counsel, Ms Catherine Stock, Dr Akhtar made admissions to all 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.

Witness Evidence

6. The Tribunal received oral evidence on behalf of the GMC from:

- Mr D, Consultant Plastic, Reconstructive and Aesthetic Surgeon.

7. The Tribunal received oral evidence on behalf of the Dr Akhtar from:

- Mr C, Consultant Trauma and Orthopaedic Surgeon, Aneurin Bevan Health Board;
- Mr B, Clinical Director of Trauma and Orthopaedic, Aneurin Bevan Health Board.

8. Dr Akhtar provided his own witness statement, and also gave oral evidence at the hearing.

Documentary Evidence

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

- Expert Report of Mr D, dated 12 November 2018;

- Expert Bundle, dated 12 November 2018;
- Dr Akhtar's Rule 7 response; dated 18 October 2019;
- Supplemental Expert Report of Mr D, dated 14 April 2020 and October 2020;
- Expert Bundle, dated 7 October 2020;
- Witness Statement of Dr Shahid Farooq Akhtar, dated 13 December 2020;
- Various testimonials from colleagues.

The Tribunal's Determination on Impairment

10. 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 Akhtar's fitness to practise is impaired by reason of his misconduct.

Submissions

On behalf of the GMC

11. At the outset of her submissions, Ms Johnson reminded the Tribunal of the statutory overarching objective as defined in the Sanctions Guidance (November 2020 version) ('SG').

12. Ms Johnson submitted that Dr Akhtar had breached fundamental tenets of Good Medical Practice ('GMP') and that these breaches amount to misconduct. She submitted that whilst there is no suggestion that Dr Akhtar poses a risk to patients, a finding of impairment is necessary in the wider public interest.

13. Ms Johnson reminded the Tribunal of the guidance set out in the case of *CHRE v NMC and Paula Grant [2011] EWHC 927 Admin ('Grant')*.

14. Ms Johnson submitted that the facts admitted by Dr Akhtar relate to a series of clinical failings on his part. Mr D sets out in his report, and it has been accepted, that the standard of care afforded to Patient A was seriously below the required standard. The concerns set out in the admitted facts relate to five separate consultations spread over an extended period of time. Ms Johnson further submitted that Dr Akhtar accepts responsibility for providing a poor standard of care for his patient. In his Rule 7 response he appeared to be saying that the high standards he would apply to his work as an NHS orthopaedic surgeon, did not apply to the field of aesthetic fillers. She indicated that this may have been due to a belief that the work was less taxing, but issues of consent and record keeping have just as much relevance, and are important given the potential of patients seeking cosmetic treatment to be vulnerable, or to have unrealistic expectations as to what could be achieved.

Ms Johnson submitted thar Dr Akhtar now accepts the same standard of care applies to all his patients.

15. Ms Johnson highlighted the evidence of the GMC expert, Mr D. In Mr D's opinion, a lack of training contributed to the standard of poor care in relation to Patient A. Dr Akhtar was an orthopaedic trainee and should have known the same checks and balances which apply in the NHS, also have application to his private practice. Further, that the practice of "banking" filler, whereby a vial is opened and not used for a single patient, on a single occasion, but leftover product stored for reuse, although used by others in the same field, was not acceptable. Dr Akhtar's evidence was his practice was usually to reuse the filler within two weeks or at the most within six weeks. Dr Akhtar indicated in his evidence that these timescales were ones that he had arrived at due to practical reasons, e.g. a sensible time for follow-up appointments and to assess patient reaction and dispersal of the product, but also for infection limitation reasons, as he accepted that once the product was opened, it was no longer sterile, even if the sterile cap was replaced. He was unable to explain why his usual practice was not followed with Patient A when he injected the remains of the banked product from 23 May 2015 on 5 November 2015. It is therefore a serious failing that he used the filler after such a long period of time with an increased risk of infection.

16. Ms Johnson submitted that Dr Akhtar has maintained he believed that he did have the appropriate discussions with Patient A, as was his usual practice, but cannot recall the conversations. The record keeping failures are serious having not only the potential to impact on Patient A in relation to the provision of obtaining informed consent, but also to the wider public, as failure to record batch numbers would have caused difficulty in identifying and tracing the use of the product were the manufacturer to need to recall any of them.

17. Ms Johnson accepted on behalf of the GMC that the concerns are capable of being remedied and that Dr Akhtar has demonstrated some insight. However, his Rule 7 response, dated 18 October 2019 is of concern and it demonstrates a lack of insight at that point. His reflection has centred on the consent and record keeping failures. There has been insufficient reflection on the third aspect of this case: From Mr B's evidence any discussion he has had with him has been focussed on consent and record keeping issues. Without full insight being demonstrated and full remediation having been completed it is submitted that the Tribunal cannot be sure there is no risk of repetition.

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

18. Ms Stock submitted that the admissions made amount to misconduct but not that Dr Akhtar's fitness to practise is currently impaired by reason of that misconduct.

19. She submitted that Patient A is not here to give evidence and the GMC's case is not about what may or may not have been said in those consultations. Rather, this is a case about a poor standard of documentation in respect of Patient A and that the lack of documentation meant, that on paper there was no informed consent on the first patient consultation, and no re-consent on two subsequent occasions. She further submitted that there is an additional matter about the use of "banked" product. As can been seen from the documentation Dr Akhtar has from an early stage accepted many of the allegations he faced. The Tribunal should also however note that the current allegations have changed over time.

20. At the time of his Rule 7 response, Dr A accepted the allegations in relation to inadequate consent and documentation. At that time, he did not accept the allegations relating to the inappropriateness of using "banked" filler. Ms Stock submitted that Dr A was "comforted" by what appeared to be common practice within the industry.

21. Ms Stock submitted that Dr Akhtar has reflected at length about all aspects of this case. She said that Dr Akhtar has apologised for his actions from the outset and continues to make those apologies today. He has accepted the allegations in their totality and fully appreciates where he went wrong. He took steps on receipt of Patient A's complaint, to change procedures, and has undertaken remediation training, working with colleagues and mentors to explore where he went wrong. She submitted that Dr Akhtar's level of insight and remediation is such that there is no risk of any repeat of his past actions in an otherwise unblemished career.

The Relevant Legal Principles

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

23. 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 then whether the finding of that misconduct which was serious could lead to a finding of impairment.

24. The Tribunal must determine whether Dr Akhtar's fitness to practise is impaired today, taking into account Dr Akhtar'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.

25. The Tribunal had regard to the test set out in *CHRE v NMC and Paula Grant [2011] EWHC 927 Admin*. In particular, the Tribunal considered whether its findings of fact showed that Dr Akhtar's fitness to practise is impaired in the sense that he:

'[…]
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'

26. Throughout its deliberations, the Tribunal was 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 this includes:

a. to protect, promote and maintain the health, safety and well-being 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

The Tribunal's Determination on Impairment

Misconduct

Record keeping and consent

27. It is clear that a registered doctor must ensure that documents and records are accurate, clear and legible. The Tribunal noted that the duties outlined in paragraph 19 of GMP are phrased in terms of a mandate (i.e. you must), emphasising that legibility and record keeping are important in terms of patient safety and continuity of care. The required content of clinical records is expressed in terms of 'should' which indicates best practice rather than an overriding duty itself.

28. The Tribunal also reminded itself of the duties as outlined in paragraphs 20 and 21(c) of GMP:

20 You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.

21 Clinical records should include:

…….

(c) the information given to patients

29. The Tribunal found that Dr Akhtar had failed in his duties in relation to aspects of his clinical notes and the adequacy of his record keeping for Patient A. This covers both the obtaining of informed consent and the recording of relevant details. The former is important in managing patient expectations of any outcomes and the latter is important for a number of reasons, not least in potential information which would need to be reported by a "yellow card" to the Medicines & Healthcare Products Regulatory Agency to identify any product which causes an adverse reaction and which may lead to manufacturer recall.

30. With regard to his failure to record the batch numbers of products, failure to sign notes, and failure to identify the injector for Patient A, the Tribunal is satisfied that Dr Akhtar had not complied precisely with the contemporaneity requirements of paragraph 19. Further, the Tribunal noted that the GMC expert, Mr D was highly critical at the quality of some of the records.

> *'In my opinion the standard of record keeping by Dr Akhtar was seriously below standard, due to poor quality consent, lack of detailed consultation notes when a problem was realized, lack of recording of batch numbers and expiry dates of products, and the use of a selection of hyaluronic acid products without Patient A's clear understanding as to what she was having injected. The overall care provided by Dr Akhtar was seriously below standard……, it is not clear as to who has performed the treatments and much of the aftercare and liaison has been left to someone else.'*

31. In considering the matters relating to consent, the Tribunal had regard to the 'GMC guidance on consent' (2008) document.

32. Dr Akhtar only recorded consent for the initial Botox and filler injections and only for him to do these treatments on 04.10.2014 and 18.10.2014, even though he provided treatment to Patient A between 2014 and 2017. The Tribunal determined, in the absence of any adequate records, that Dr Akhtar's failure to record the potential complications as part of the written consent, fell seriously below the standards expected. The Tribunal noted that Dr Akhtar, in his oral evidence, explained that he believed that he would have had the appropriate discussions with Patient A before the treatment. Whilst Dr Akhtar has admitted not obtaining informed consent as part of the Allegation outlined above, and the Tribunal has

accepted that failure to obtain informed consent was seriously below the level expected, it considered these matters further.

33. The Tribunal considered that a reasonable inference in the fact that Patient A raised a complaint, is that she was not satisfied with her treatment, (which another practitioner had to correct). This may suggest that she did not fully appreciate possible outcomes. However, the Tribunal had regard to the absence of oral evidence from Patient A as to what was said to her by Dr Akhtar on the day of the procedure. In all the circumstances, the Tribunal considered that it did not have sufficient information before it to determine what had occurred during the consenting process throughout Patient A's treatment. It considered that at some occasions Patient A had signed a pre-printed consent form which included a clause which indicated that she had been informed of the risks of the procedure, and it was asked to consider instances when that form had not been no signed.

34. The Tribunal took into account that Mr D in his report stated:

> *'The quality of the consent form for the filler treatment was poor and did not mention the aims of the treatment, for example to increase the lip volume or turn up and out the appearance of the lip or a list of common or serious complications such as lumpiness, unevenness, bruising, redness at the injection site, asymmetry, skin necrosis and or blindness and there is no evidence that other information about the products that have been used has been shared with Patient A, or that alternative treatments have been discussed'*

35. The Tribunal considered that it is essential that patients have the relevant information regarding their treatment and any issues that may arise. Dr Akhtar's failure to record relevant discussions with Patient A is serious. Had this documentation existed, it would have provided objective evidence that the discussions occurred. Having taken into account what Mr D has said about the extent to which this behaviour falls below the standards required, and GMP, it does, in the Tribunal's view, amount to misconduct.

<u>Banking materials</u>

36. The Tribunal took into consideration the opinion of Mr D who indicated that banking products was a practice that fell seriously below the standards required and that a patient was entitled to expect. He accepted that there was evidence that the banking of products was done by other practitioners at the time, but that its prevalence did not make it good practice. He indicated that many patients may not require an entire syringe of filler but may require a retouch or intermittent augmentation after some time. There were those, who at the relevant time, stored the remaining material in a suitably specific environment for reuse

by the same patient. The Tribunal noted that Mr D explained in evidence that there could be an adverse reaction to banked products, and that it could cause unnecessary risk in enabling the introduction of a bacterial infection. In his report he quoted an extract from a journal that he had been provided with:

> *'Journal of Dermatological Surgery 2017 Jul;43(7):967-970), which concludes That "although it is a commonly practiced, the storage of HA fillers after initial patient injection carries a real but small risk of contamination."*

37. The Tribunal noted Dr Akhtar had set time limits and put precautions in place to prevent the product from being contaminated. His practice was usually to reuse the filler within two weeks, or at the most within six weeks. However, in his oral evidence Dr Akhtar, conceded that he now realises this practice was wrong, and under cross-examination admitted that in relation to Patient A, the gaps between using the banked product had not followed his own self-declared intended practice, given that a six-month gap between treatments and the use of a banked product had occurred.

38. The Tribunal noted that Mr D indicated that economies of scale apply to fillers in the same way that they do to other products, meaning that the larger the volume of a purchased product, the more economical its price. Lower volume vials were available to Dr Akhtar to purchase which would not have necessitated banking. When asked Dr Akhtar indicated that the amount of filler that he would use would be patient specific, with new patients having smaller amounts injected and previously treated patients' larger amounts injected at once generally. He said that a lower amount of filler would be less likely to cause an adverse reaction or outcome, or risk an immune-response from over-filling. He did not indicate why he did not purchase smaller vials, but said that any savings he obtained from purchasing larger vials, he passed onto the patient.

39. The Tribunal noted that on reflection Dr Akhtar acknowledged that the reuse of banked products amounts to misconduct. Dr Akhtar indicates that he would not do this in his surgical work and recognises that doing so introduces an unnecessary risk of infection for a patient.

Current Impairment

40. The Tribunal went on to examine whether there were grounds for finding Dr Akhtar's fitness to practise to be currently impaired. It considered whether Dr Akhtar presents a risk to patients or to the public; whether a finding of impairment was required to maintain public confidence in the medical profession; and whether a finding of impairment was required to

promote and maintain proper professional standards and conduct for members of the profession.

41. The Tribunal carefully considered Dr Akhtar's level of insight. The Tribunal acknowledges that Dr Akhtar made admissions in relation to his actions from the outset of the hearing and now appears to recognise the seriousness of his actions. He has reflected on his actions and in particular he has undertaken a lot of learning regarding consent procedures and has gained more experience as a doctor since the incident.

42. Dr Akhtar admitted he was naïve in the running of his practise. Dr Akhtar explained that he wanted an extra income stream during his training and that participating in fine needle work counterbalanced his orthopaedic practice. He further explained that his primary purpose was in providing a useful service that helped patients and improved his skills, but on being asked why he did not obtain this within his NHS Orthopaedic setting, or in one of the private aesthetic clinics he had referenced, he acknowledged that the secondary income stream, and his desire to start a business, was very much a secondary aim. Dr Akhtar now understands that his practice fell below the standards required of him, due to his poor practices at the time that he ran his business.

43. The Tribunal noted Dr Akhtar has taken steps to remediate his misconduct and works in a different setting where he is not responsible for managing a business or putting in place practices and procedures which underpin and govern the clinical work undertaken. He now works as a consultant in a highly supported environment. He has learned and now values the importance of keeping good records through his training and as a surgeon he is fully aware of how infections contribute to patient safety.

44. The Tribunal noted that the feedback and testimonials point towards Dr Akhtar being a conscientious and excellent surgeon. The Tribunal considered that since Patient A complained, Dr Akhtar has been on the path towards remedying his behaviour and has now demonstrated appropriate insight into his misconduct. He has admitted his failings and that his practice fell below standards. The Tribunal considered that the Allegation concerned a single patient, which, although serious, appears unlikely to be repeated.

45. The Tribunal then went on to consider whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment was not made.

46. In considering this aspect the Tribunal took into account that during these proceedings it found that Dr Akhtar's actions amounted to misconduct. In the Tribunal's view,

this reflected the serious nature of Dr Akhtar's failings and was sufficient to uphold proper professional standards.

47. The Tribunal considered a member of the profession or member of the public would be reassured by Dr Akhtar's comprehensive remediation and reflection, and the evidence about the changes he has made to his practice. A finding of impairment was not necessary in these circumstances.

48. The Tribunal determined that Dr Akhtar's fitness to practise is not impaired by reason of his misconduct, pursuant to Section 35C(2)(a) of The Medical Act 1983 as amended.

Determination on Warning - 05/03/2021

49. As the Tribunal determined that Dr Akhtar's fitness to practise was not impaired, it considered whether in accordance with Section 35D(3) of the Medical Act 1983 and under Rule 17(2)(m) of the Rules, a warning was required.

The Evidence

50. The Tribunal had regard to all of the evidence adduced during the course of these proceedings.

Submissions

51. The following is a summary of submissions made at the warning stage:

Submissions on behalf of the GMC

52. Ms Johnson submitted that a warning would be appropriate in this case based on the Tribunal's finding that Dr Akhtar's conduct did amount to misconduct. Mr Johnson directed the Tribunal's attention to the relevant paragraphs of the Sanctions Guidance (November 2020 edition) ('the SG') and the GMC's Guidance on warnings (February 2018) ('the Guidance').

Submissions on Dr Akhtar's behalf

53. Ms Stock submitted that there is no justification for the Tribunal to issue a warning on Dr Akhtar's registration. She submitted that it would not be a proportionate response to issue a warning in light of the Tribunal's finding of no impairment. She submitted that the

misconduct found relates to an incident involving a single patient and that the finding of misconduct, in conjunction with Dr Akhtar's insight and the substantial, targeted remediation he has undertaken addresses the concerns of the Tribunal. She said the Tribunal found that the risk of repetition is low, therefore, the issuance of a warning would be disproportionate and in effect, punitive, in light of the circumstances of the case.

The Tribunal's Determination on a Warning

54. The decision 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 had regard to the GMC's Guidance on warnings (February 2018) ('the Guidance'), and in particular, it had regard to paragraphs 13 and 33 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.'
>
> 33 'However, 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 aggravating or mitigating factors to determine whether a warning is appropriate. These might include:
>
> the level of insight into the failings.
>
> a. A genuine expression of regret/apology.
>
> b. Previous good history
>
> c. Whether the incident was isolated or whether there has been any repetition.
>
> d. Any indicators as to the likelihood of the concerns being repeated.
>
> e. Any rehabilitative/corrective steps taken.
>
> f. Relevant and appropriate references and testimonials.'

55. 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.

56. The Tribunal considered that whilst it found that Dr Akhtar's fitness to practise is not currently impaired, this finding was due to the level of insight demonstrated and the low risk of repetition, which does not diminish the seriousness of his failures in respect of Patient A.

57. The Tribunal determined that a warning would be appropriate and proportionate in this case and that such a warning would mark the seriousness of the departures from GMP to both the public and fellow members of the profession, as well as serving as a reminder to Dr Akhtar. This would maintain and uphold proper standards of the profession and protect public confidence. It concluded that to issue a warning was justified in light of the circumstances of the case.

58. The Tribunal therefore determined to impose the following Warning on Dr Akhtar's registration:

> 'Dr Akhtar
>
> Between October 2014 and July 2016 Dr Akhtar carried out Botox and filler injections on Patient A. He failed to complete a written consent form on each occasion, failed to document the discussion about treatments, possible complications, what products were being used and the reason for their selection. Further, that he inappropriately injected residual amounts of filler from an opened vial, which he had banked in a fridge, from a treatment for Patient A six months previously.
>
> Doctor Akhtar admitted the entirely of the factual particulars of the Allegation, and gave evidence about how a school friend and he had set up a business dealing with aesthetic and cosmetic treatments which ran for 10 years from 2010-2020. He acknowledged the short courses he attended in preparation for this were inadequate in terms of being able to run a business. He was frank that the processes and procedures which should support clinical practice were not in place, and as a result of Patient A's complaint changed his practice.
>
> This conduct does not meet the standards required of a doctor. It risks undermining public confidence and professional standards in the profession and it must not be repeated. The required standards are set out in Good Medical Practice and associated guidance. In this case, paragraphs 19, 20 and 21(c) of Good Medical Practice are particularly relevant. These paragraphs state:

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards

20 You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.

21 Clinical records should include:

…….

(c) the information given to patients

Although this Warning does not place any restriction on your registration by the way of finding your fitness to practise impaired, it is both necessary and proportionate to issue this formal warning.'

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

60. That concludes this case.

Confirmed
Date 05 March 2021 Ms Melissa Coutino, Chair