PRIVATE RECORD

Dates: 03/04/2024 - 12/04/2024
15/08/2024 - 20/08/2024

Medical Practitioner's name: Dr Sohail KHAN

GMC reference number: 7091157

Primary medical qualification: MB BS 1996 Karnatak

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	Mr Kenneth Hamer
Lay Tribunal Member:	Mrs Ann Bishop
Medical Tribunal Member:	Dr Alan Shepherd

Tribunal Clerk:	Mr Josh Dayco

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Ghazan Mahmood, Counsel, instructed by Medical Protection Society
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 - 12/04/2024

Background

1. Dr Khan qualified in 1996 from Kamatak University in Dharwad, India. Prior to the events which are the subject of the hearing Dr Khan held various medical posts in India and Saudi Arabia before commencing work in the UK as a locum Consultant Radiologist in January 2011. Since March 2023 Dr Khan has been employed as a Locum Consultant Radiologist at Antrim Area Hospital in Northern Ireland.

2. At the time of the events Dr Khan was practising as a Consultant Radiologist and was a director of, and the Medical Director at, BestCare Diagnostic Limited ('BestCare'), a company registered with the Care Quality Commission providing diagnostics and screening non obstetric ultrasounds.

3. The allegation that has led to Dr Khan's hearing can be summarised as follows. It is alleged that between 2018 and December 2019, as the Medical Director of BestCare, Dr Khan failed to monitor and review the service that BestCare was providing. As a result of this failure, it is alleged that he was unable to provide the West Sussex NHS Clinical Commissioning Group/Coastal West Sussex Clinical Commissioning Group (CCG) with accurate information in a timely manner to assist with their Clinical Harm Review (CHR), which commenced in June 2020. It is alleged that 64 of the patients assessed by the CCG during the CHR were found to have suffered physical and/or psychological harm, of which 29 had experienced moderate to severe harm.

4. It is also alleged that during Dr Khan's time as Medical Director, he only instigated four Serious Incident reports ('SIs'). The SIs in respect of which Dr Khan had overall responsibility were SI 2019/4021, SI 2019/12016 and SI 2019/1203. Dr Khan accepted that the SIs concerned incidents of basic imaging errors of interpretation and were not completed in a timely manner. However, it is alleged that the SIs BestCare instigated

provided limited information, lacked clarity and were not investigated appropriately, and that Dr Khan did not discharge his role regarding his duty of candour. It is also alleged that the SIs BestCare instigated should have prompted Dr Khan to invoke a clinical review to assess the overall performance of BestCare, but he did not do so.

The Outcome of Applications Made during the Facts Stage

5. On 9 April 2024, Ms Goring, Counsel, on behalf of the GMC, made an application pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to withdraw paragraph 4(g)(i) of the Allegation.

> *4. The SIs BestCare instigated, as set out at paragraph 3, over which you had overall responsibility:*
>
> *…*
>
> *g) did not discharge your role regarding your duty of candour, in that:*
>
> *i) in respect of SI 2019/12016, you failed to ensure that BestCare spoke to the patient to whom harm had been caused;*

6. Ms Goring submitted that there is no evidence to support this paragraph of the Allegation. She said that the patient regarding this SI had passed away at the time the SI was notified to BestCare and it would not have been possible for BestCare to speak to the patient. Mr Mahmood, on behalf of Dr Khan, did not oppose the application.

7. The Tribunal considered the deletion of paragraph 4(g)(i) within the Allegation. It noted that the patient had passed away before the SI was notified to BestCare. Therefore, a communication between the patient and BestCare would not have been possible. However, the Tribunal noted that there was evidence of a telephone conversation, in accordance with the duty of candour, with the patient's husband after she died and prior to the duty of candour letter being sent to the patient's husband. Accordingly, paragraph 4(g)(i) was unlikely to be found proved.

8. The Tribunal was, therefore, satisfied that the proposed deletion of paragraph 4(g)(i) of the Allegation was appropriate and could be made without causing injustice to Dr Khan. Therefore, the Tribunal granted the application made pursuant to Rule 17(6) of the Rules.

The Allegation and the Doctor's Response

9. The Allegation made against Dr Khan is as follows:

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

1. Between 2018 and December 2019, you:

a) were the Medical Director at BestCare Diagnostics Limited ('BestCare');
Admitted and found proved

b) failed to monitor and review the service that BestCare was providing, in that you did not:

i) have a system in place that accurately recorded:

(1) which sonographer had performed the scans;
To be determined

(2) when the scans were performed;
To be determined

(3) where the scans were performed;
To be determined

(4) what examinations were undertaken;
To be determined

ii) monitor the performance levels of the sonographers carrying out work for BestCare.
To be determined

2. As a result of the failure as set out at paragraph 1(b):

a) you were unable to provide the West Sussex NHS Clinical Commissioning Group/Coastal West Sussex Clinical Commissioning Group ('CCG') with accurate information in a timely manner to assist with their Clinical Harm Review ('CHR');
To be determined

b) 64 of the patients assessed by the CCG during the CHR were found to have suffered physical and/or psychological harm, of which 29 had experienced moderate to severe harm.
To be determined

3. During your time as Medical Director, despite the CCG's conclusion as set out at paragraph 2(b), you only instigated four Serious Incident reports ('SIs').
Admitted and found proved

4. The SIs BestCare instigated, as set out at paragraph 3, over which you had overall responsibility:

a) were:

i) SI 2019/4021;
Admitted and found proved

ii) SI 2019/12016;
Admitted and found proved

iii) SI 2019/12023;
Admitted and found proved

b) concerned incidents involving basic imaging errors of interpretation;
Admitted and found proved

c) provided limited information;
To be determined

d) lacked clarity;
To be determined

e) were not investigated appropriately, in that no attempt was made to:

i) assess training competence and performance levels of the sonographers involved;
To be determined

ii) instruct a third party to assess the quality of the imaging that BestCare was providing;
To be determined

iii) assess the language capability of the sonographer in respect of SI 2019/12016;
To be determined

iv) ensure a thorough Root Cause Analysis was carried out;
To be determined

f) were not completed in a timely manner;
Admitted and found proved

g) did not discharge your role regarding your duty of candour, in that:

~~i) in respect of SI 2019/12016, you failed to ensure that BestCare spoke to the patient to whom harm had been caused;~~
Deleted under Rule 17(6)

ii) in respect of SI 2019/4021, you failed to:

(1) ensure that attempts were made to contact the family regarding this incident;
To be determined

(2) in the alternative to paragraphs 4(g)(ii)(1), record having undertaken the action as set out at paragraphs 4(g)(ii)(1);
To be determined

iii) in respect of SI 2019/12023, you failed to ensure that there was an adequately detailed record of the verbal apology given to the patient over the telephone, in that there was no detail as to:

(1) whom the call was with;
To be determined

(2) who made the call;
To be determined

(3) the date of the call;
To be determined

(4) what was discussed in the call;
To be determined

h) should have prompted you to invoke a clinical review to assess the overall performance of BestCare, but you did not do so.
To be determined

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

10. At the outset of these proceedings, through his counsel, Mr Mahmood, Dr Khan made admissions to some paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (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

11. Dr Khan provided his own witness statements dated 13 March 2024 and 2 April 2024. He also gave oral evidence at the hearing.

Expert Witness Evidence

12. The Tribunal also received evidence from one expert witness, Professor A, instructed on behalf of the GMC. He provided an expert report dated 26 July 2022. He also provided two supplemental reports dated 19 February 2023 and 26 March 2024. Professor A gave oral evidence to the Tribunal on 4 and 5 April 2024.

Documentary Evidence

13. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:
    - Clinical harm review outcome report dated 14 January 2021;
    - West Sussex CCG report to the GMC dated 20 August 2021;
    - Various serious incident reports;
    - Various correspondences between Dr Khan and Coastal West Sussex CCG;
    - Letter from Professor A to the GMC dated 9 February 2023;
    - Various exhibits provided by Dr Khan relating to his witness statement.

The Tribunal's Approach

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

15. The Tribunal had regard to the advice of the Legally Qualified Chair (LQC) which included, but was not limited to, advice on the burden and standard of proof and Dr Khan's good character; separate treatment; the wording of the Allegation; and approach to the evidence.

16. After the Tribunal had begun to deliberate on the facts, the LQC gave further legal advice, namely, that the duty of candour provisions in the Health and Social Care Act 2008 (Regulatory Activities) Regulations 2014 (the Regulations) applied to BestCare as it was at the material time registered with the CQC and was carrying on a regulated activity of diagnostic and screening procedures.

The Tribunal's Analysis of the Evidence and Findings

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

18. The Tribunal established the facts surrounding the Allegation. It noted that as the Medical Director of BestCare, Dr Khan had overall responsibility to monitor and review the service that BestCare was providing and overall responsibility for the SIs. Dr Khan accepted in evidence that he had a lack of any prior experience of being a Medical Director, had not familiarised himself beforehand with the role and that he lacked experience of writing SIs, with no prior experience of writing SIs whether in the NHS or the private sector. He accepted that he could have written the three SIs in this case to a higher standard, and that he was responsible for the SIs as Medical Director and for monitoring and reviewing the services that BestCare provided. The Tribunal noted that Dr Khan only worked 1.5 days a week at BestCare. He largely left the duty of day-to-day operation of BestCare to others.

19. Professor A is a consultant radiologist and has been both Deputy Medical Director and Interim Medical Director at University Hospitals Bristol and Weston. He explained that the role of a Medical Director is vital for patient safety. It entails a duty to oversee the process and sign off SI reports on behalf of the CEO. Professor A has been involved with commissioning and signing off some 150 SIs and, while he conceded he had no experience as a Medical Director running a diagnostic imaging company, he said that the role is the same as in the NHS and that the Medical Director's main responsibility is to ensure patient safety.

Paragraph 1(b) of the Allegation

20. The Tribunal considered whether, between 2018 and December 2019, Dr Khan failed to monitor and review the service that BestCare was providing, in that he did not have a system in place that accurately recorded: which sonographer had performed the scans;

when the scans were performed; where the scans were performed; and what examinations were undertaken.

21. The Tribunal considered the evidence of Professor A. Professor A was not an expert on information technology systems, and he was giving evidence about the role of a Medical Director rather than an expert on information systems. Nevertheless, in his report he said:

> *'modern PACS systems are very good at documenting who performed the scans, when, where and what examinations have been performed'*

22. Within his witness statement, Dr Khan said that from the inception of BestCare's services in April 2017, until September 2018 (when its contract with West Sussex CCG was suspended), the company used the APT Vision Patient Portal which was upgraded to EMIS Web. Dr Khan said that APT Vision recorded information about each patient, including the clinic where the patient was scanned, the scheduled date, the area scanned and the report date and time approved. In other words the matters covered in paragraphs (1) to (4) of allegation 1(b)(i). Later BestCare used the Radiology Information System (RIS) and Picture Archiving and Communication Systems (PACS).

23. In his witness statement, Dr Khan said:

> *'Throughout its period of operations, BestCare had information systems across the full patient pathway covering: referral acceptance by the administration team; contacting the patient; preparing and assigning the patient to an ultrasound clinic; registering the patient on the day; confirming patient attendance, examining the patient; reporting the scan images; urgent onward referral and/or routine reporting procedures; transmission of images and finalised reports to our dedicated Radiology Information System (RIS) and Picture Archiving and Communication systems (PACS); raising alerts for urgent reports, and registering any patients who had not attended their appointments.*
>
> *Data was monitored in-house and shared with the CCG monthly.'*

24. The Tribunal noted that it was probable that there was a system in place that adequately recorded the matters in paragraph 1(b)(i), given that BestCare only received payment from West Sussex CCG on production of relevant data during the period April 2017 to September 2018.

25. The Tribunal considered that it had insufficient evidence to justifiably infer that there was no system in place after September 2018 until December 2019 (the remaining period covered by the charge). It noted that, during this period, BestCare continued to provide services to Manchester and Leeds CCGs.

26. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 1(b) of the Allegation not proved.

Paragraph 1(b)(ii)

27. The Tribunal considered whether, between 2018 and December 2019, Dr Khan failed to monitor and review the service that BestCare was providing, in that he did not monitor the performance levels of the sonographers carrying out work for BestCare.

28. In his evidence Professor A noted that the same sonographer was involved in the three serious incidents in this case. He said that there was nothing to assure him that the individual who performed the scans involved in these SIs was monitored or assessed.

29. The Tribunal considered the evidence of Dr Khan about what system was in place to monitor the performance levels of the sonographers carrying out work for BestCare. Within his witness statement, he stated the following:

> *'Although I was only working as Medical Director of [BestCare] 1.5 days per week, I met with Ms B and Mr C in person every Friday to discuss our compliance with policies and procedures, and to ascertain whether there were any complaints or difficulties in respect of the service. I also spoke with Ms B and Mr C regularly by telephone, usually about an hour each day.'*
>
> *On reflection I recognise with hindsight that I ought to have spent more time with the company on a day to day basis and I should not have delegated its management to other members of staff; as a director I accept that responsibility for running [BestCare] ultimately lay with me. I am truly sorry that I delegated such responsibilities but at the time I had good intentions and placed complete reliance and trust in managers that I thought were well qualified to do the job.*

30. The Tribunal noted that, although Dr Khan said he met with the Quality Manager and the IT Manager every Friday "to discuss our compliance with policies and procedures" and

was in regular communication by telephone, the Tribunal was not satisfied that monitoring the performance levels of the sonographers was specifically discussed, or was reviewed.

31. The Tribunal then considered the monthly governance meetings. It noted that there were 15 sets of minutes of governance meetings, together with two sonographer meetings, that took place from 31 July 2017 to 15 July 2019.

32. The Tribunal was concerned to note that the minutes of the two sonographer meetings which took place on 17 February 2019 and 1 July 2019, were an exact duplication of each other. These feature a discussion relating to performance levels of the sonographers, but given that the minutes are a complete duplication of each other, the Tribunal did not feel able to rely on the minutes for either meeting.

33. The Tribunal further noted that references to HR sick leave and HR exit interviews on at least five occasions are repeated, and that the minutes of the governance meeting supposedly held at 16 June 2018 contained references to a discussion about the SIs received from CCG, which were only received in 2019.

34. The Tribunal then considered the audits provided by Dr Khan. It noted that it only had the April to September 2019 audits. The Tribunal recognised that BestCare ceased trading in December 2019 and went into liquidation in January 2020 and as a result Dr Khan may have faced difficulty in obtaining records. Nevertheless, the audits provided do not show that Dr Khan was monitoring the performance levels of the sonographers during those months. The Tribunal noted that there is a 'Comments' column within the audits provided. However, the comments made did not demonstrate to the Tribunal how Dr Khan monitored the performance levels of the sonographers.

35. The Tribunal considered that within Dr Khan's witness statement, he stated the following:

> *'Audit was also an important aspect of our governance processes. Each sonographer reporting for BestCare was regularly audited in accordance with our Clinical Governance and Audit Policy... and using the British Medical Ultrasound Society ('BMUS') peer review audit tool. Each month, a random selection comprising 5% percent of each sonographer's reports, was audited by the Senior Sonographer, Mr D.*

In addition to the colour coding described above, the auditing sonographer would incorporate commentary upon each report categorised as yellow or red. This information was then fed back immediately to each sonographer, and also discussed monthly in the clinical governance meetings.'

36. The Tribunal noted that there was nothing in Dr Khan's witness statement that he as Medical Director took any part personally in monitoring the performance levels of the sonographers. It appears that any auditing was delegated to Mr D, senior sonographer. The Tribunal was not satisfied that Dr Khan received any feedback from Mr D, or reviewed Mr D's work.

37. Bringing these matters together, the Tribunal was satisfied that the GMC had proved its case on the balance of probabilities in relation to paragraph 1(b)(ii). Accordingly, the Tribunal determined and found paragraph 1(b)(ii) of the Allegation proved.

Paragraph 2(a) of the Allegation

38. The Tribunal considered whether, as a result of the failure as set out at paragraph 1(b), Dr Khan was unable to provide the CCG with accurate information in a timely manner to assist with their CHR.

39. The GMC's case under paragraph 2(a) concerns the lack of accurate information provided in a timely manner about the number of patients scanned, not how many scans were undertaken but the number of patients involved. This information was plainly important information for the CCG to assist with their Clinical Harm Review.

40. The Tribunal noted the email correspondence between Dr Khan and the CCG on this issue. It noted that on 20 June 2019, at the start of the CHR, the CCG was working on a figure of 1,845 patients, which presumably had come from Dr Khan or information he had supplied to the CCG. On 26 June 2019 Dr Khan wrote to the CCG saying that the amount of data for the patients to be transferred would reasonably take approximately two weeks. A month later, in an email sent on 31 July 2019 by Dr Khan, he said that the total number of patients scanned was 2,400. Then, in an email dated 7 August 2019, Dr Khan corrected this figure to 2,274 patients scanned.

41. The Tribunal noted the CCG's report to the GMC regarding concerns with Dr Khan. Within the section entitled 'Poor engagement, delays and inaccuracies', it stated:

'Their communication with the CCG was poor; [BestCare] did not keep the CCG informed of their progress or stick to the agreed extended schedule.

[BestCare] informed the CCG of the increased numbers 5 days before the transfer deadline. It is unclear why they could not confirm the total number earlier and this fed into the concerns about their organisation in general. The original figure given was short by 429 scans. There were extensive delays in receiving the information.'

42. The Tribunal appreciated it had not heard any evidence from the CCG, a point made more than once by Mr Mahmood on behalf of Dr Khan. All the same, the Tribunal considered that any well maintained IT system ought to have been capable of providing accurate information about the number of patients scanned and that this information would be readily available in a much shorter space than the 6 weeks it took Dr Khan.

43. In Dr Khan's evidence, he admitted that the failure to provide accurate figures may have contributed to the delay in starting the CHR.

44. The Tribunal considered that a reasonable inference to be drawn from the fact that the figures for the number of patients scanned increased and decreased in such a short time scale, and by such large proportions, must have been due to a failure to monitor and review the service that BestCare was providing. The service that BestCare was providing included monitoring the performance levels of the sonographers who were scanning the patients concerned.

45. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 2(a) of the Allegation proved.

<u>Paragraph 2(b) of the Allegation</u>

46. The Tribunal considered whether, as a result of the failure as set out at paragraph 1(b), 64 of the patients assessed by the CCG during the CHR were found to have suffered physical and/or psychological harm, of which 29 had experienced moderate to severe harm.

47. The Tribunal considered the CCG's Clinical Harm Review Outcome Report. It stated:

It is worth noting that by Stage two all patients on the agreed CHR lists had been written to, to make them aware of the Clinical Harm Review process and any clinical

follow up required at this stage of the process. A total of 876 cases were reviewed for harm and these are summarised in the table three below:

Table Three

Cases Reviewed for Harm

Level of Harm	*Number of Cases*
No harm	*812 [93%]*
Low harm	*35 [4%]*
Moderate harm	*20 [2%]*
Severe harm	*9 [1%]*
Total	*876*

48. The Tribunal noted that the figures in this table for patients suffering harm were compiled by the CCG, rather than based on information provided by Dr Khan to the CCG. Their report would appear to indicate that as a result of the Stage 2 process undertaken by the CCG 64 patients were found to have suffered physical and/or psychological harm, of which 29 had experienced moderate to severe harm.

49. The Tribunal did not receive any evidence from the CCG to show on what basis these figures were compiled. Doubtless, they were based on an analysis of information obtained by the CCG albeit linked in part to information provided by BestCare or contained in GP records or provided by patients themselves. Professor A said that the number of patients in each of the categories listed of no harm, low harm, moderate harm and severe harm might also change as a result of further information being obtained.

50. These proceedings are directed solely to the issue of Dr Khan's professional conduct, and they are not private law proceedings in tort or for breach of contract. Nevertheless, the Tribunal considered it could not be satisfied that the figures of patient harm, coming as they were from information compiled by the CCG rather than from Dr Khan, were capable of being linked to any failure by Dr Khan to monitor and review the service that BestCare was providing.

51. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 2(b) of the Allegation not proved.

<u>Paragraph 4 of the Allegation</u>

52. The Tribunal noted that in relation to paragraph 4 of the Allegation, the GMC's case rested on the evidence of Professor A. The Tribunal recognised that Professor A's experience as a radiologist and medical director is in the NHS rather than the private sector. Nevertheless, Professor A emphasised throughout his evidence that the role of a Medical Director ultimately is one of patient safety, wherever the Medical Director may be working.

53. The Tribunal took account of the submissions of Mr Mahmood and recognised that Professor A's evidence was based on his experience of compiling SI reports, rather than what a reasonable body of Medical Directors would consider the requirements of an appropriate SI report.

54. The Tribunal was of the view that Professor A had the necessary knowledge and experience to give skilled expert evidence on SI reports and the role of a Medical Director, and to render his opinions of value to the Tribunal; see *Kennedy v. Cordia (Services) Ltd* [2016] UKSC 6, [2016] 1 WLR 597. Moreover, he was impartial and willing to readily concede points in favour of Dr Khan.

55. The Tribunal noted from the CHR Outcome Report that two out of four SIs submitted by BestCare were closed by the CCG. The CCG's report to the GMC indicates that one of those closed was SI 2019/12016 in January 2020. The two remaining SIs were not concluded before BestCare went in liquidation.

56. The Tribunal recognised that the fact at least one of the SIs in this case was closed by the CCG might undermine Professor A's evidence. However, the Tribunal is ultimately concerned with Dr Khan's professional responsibilities as the Medical Director of BestCare in overseeing the SI report process, rather than decisions taken by the CCG.

57. During the hearing and during its deliberation of the facts the GMC confirmed which of the various versions of the SIs before the Tribunal were the final reports provided to it by the CCG. The Tribunal's determination is based on these final reports provided to the GMC by the CCG, and which were covered by Professor A's evidence.

58. In approaching paragraph 4 of the Allegation, the Tribunal considered Dr Khan's case that, while he did not have prior experience of drafting SIs, he employed a suitably qualified Quality Manager to produce the SIs, with assistance and input from Dr Khan's wife, the Chief Executive Officer of BestCare. Additionally, BestCare relied on their IT

manager and retained outside third party assistance and also enlisted support from the CCG.

59. Whilst bearing these points in mind, the Tribunal nevertheless noted that each of the three SIs state that the Medical Director (i.e. Dr Khan) contributed to the reports. And within the CCG's report to the GMC, there is an extract from an email which records the Quality Manager expressing that she felt 'overwhelmed' by the process. When asked by the CCG if she was getting enough support from Dr Khan, she said that she was but mentioned that Dr Khan was not familiar with the process. The writer of that email interpreted this to mean 'limited support'.

Paragraph 4(c) and (d) of the Allegation

60. The Tribunal considered whether the SIs referred to in paragraph 4(a) of the Allegation that BestCare instigated, over which Dr Khan had overall responsibility, provided limited information and lacked clarity.

61. The Tribunal considered Professor A's supplemental expert report dated 19 February 2023. In relation to SI 2019/4021, he stated the following:

'The incident was reported on the 8th February 2019 and the serious incident report was submitted for closure on the 28th March 2019.

Again in essence, this is a fundamental basic error of interpretation.

On the initial scan of the 24th May 2018, a lesion within the uterus measured 2.4 x 2.3 cm and was misdiagnosed as a fibroid rather than a potential endometrial cancer.

The cancer was diagnosed on the 11th January 2019.

The original SI report is of very poor quality with no assessment of the individual ultra sonographers performance. In fact, there is very little information provided about the individual and their background
training.

The serious incident report is more than just a summary of the facts, but there is no attempt made to find the degree of error or assess the experience of the sonographer.

There is no comment that even a third party has reviewed the imaging to assess whether the quality of the imaging provided was up to standard.

The SI report is of an extremely poor quality with a very limited investigation undertaken.'

62. Later in his written report, after considering each of the SIs separately, Professor A said:

In the 3 of the 4 SI reports I have reviewed, all represent basic errors of interpretation in the missed diagnosis of cancer.

The pattern of these SI reports should have suggested to the Medical Director, Dr Khan, that there were major concerns around the performance of the sonographers concerned and as such he should have invoked a review to identify any further missed cancers.

The SI report are short, lack detail and do not show a proficient RCA in each case.

Failure to provide this information when reviewing a serious incident, is a failure to provide information which would have allowed Dr Khan to undertake or commission this review.

The interpretative errors are basic in all 3 cases and as such the SI reports are below the quality that I would expect any service to provide.

Given Dr Khan is responsible for the production of the SI Reports as Medical Director. The timeliness of the reports represents a failure seriously below the standard expected.'

63. In his oral evidence, Professor A noted that while SI 2019/4021 states on its front sheet that it was submitted for closure on 28 March 2019, the body of the report says that the author was Ms B, Governance Lead, and the Report date is given as 14 May 2019.

64. The Tribunal noted that in Dr Khan's oral evidence, during cross-examination, Dr Khan agreed that SI 2019/4021 should have been more elaborated.

65. In light of Professor A's expert evidence in relation to the SI reports, which did not materially change in cross-examination, and the absence of any expert evidence on

behalf of Dr Khan, the Tribunal found paragraphs 4(c) and (d) of the Allegation proved on the balance of probabilities in relation to SI 2019/4021.

66. In relation to SI 2019/12016, the Tribunal considered Professor A's supplemental expert report dated 19 February 2023. He stated the following:

'This is a short SI report.

Without being able to review the imaging I would state that dilatation of the intra hepatic ductal system in this context is always pathological. It is likely that this was caused by an obstructive lesion within this region, which is either a small cholangiocarcinoma or another malignant lesion within the liver. The language of the report is poor and there is no evidence that either of these diagnoses had been considered. Neither of these issues have been further investigated.

There is a brief summary of the incident, but there is no evidence of a thorough Root Cause Analysis (RCA).

From this SI, it is suggested that the person performing the examination was a qualified radiologist from abroad and suggests that the individual is a medical practitioner. There is no evidence that the practitioner has undergone any sort of assessment of their English language ability, and presumably they are operating in the context of a sonographer rather than a radiologist.

This is a basic ultrasound error and should have initiated alarm bells when it occurred and was reported as in SI. This type of error would raise serious concerns about the overall performance of this individual. There is no clarity, within this investigation, on what assessment was undertaken regarding the practice of this potential medical practitioner operating in a sonographer capacity.

There is no documentation or formal assessment of their command of the English language was undertaken in order to allow appropriate and well written examination reports to have been provided. The examination report provided by this individual is misleading and confusing. None of these issues have been investigated or addressed.

In the lessons learned, BestCare suggested a discrepancy in training meeting but there is no record of these meetings and who attends these meetings. There is no definition

of what the CPD program is in place and no recognition that this was a basic error of interpretation.'

67. The author of the SI report was again Ms B, Governance Lead, and the report date is 21 August 2019.

68. In his oral evidence, Professor A said that he would question why the SI report was signed off. He had a clinical concern, and it was likely to be cancer. Professor A said that the SI report did not put the emphasis as he would put it. He said that he still had major concerns about this SI report.

69. In light of Professor A's expert evidence, the Tribunal found paragraphs 4(c) and (d) of the Allegation proved on the balance of probabilities in relation to SI 2019/12016.

70. In relation to SI 2019/12023, the Tribunal considered Professor A's expert supplemental report dated 19 February 2023. He stated the following:

'This is an SI report which investigates the missed diagnosis of a ureteric carcinoma which has led to a right hydronephrosis.

Again, the whole report lacks quality.

There is only a brief summary of the incident with no evidence of a RCA or what investigation had been undertaken as the problem was the report was delayed and the GP practice never received a copy of what was marked as urgent report. There are some outcome points in this SI report in that there are learning points identified by the sonographer, the company and the actions laid out.

Again, there is no reflection on the quality, qualifications or background of the individual sonographer providing the examinations.

A large hydronephrosis is a basic ultrasound miss, and by the ultra sonographers own omission this was quantified as a non-urgent report.

Each of the 3 SI reports I have reviewed should have raised major concerns regarding the individual's performance as each represented a potential basic error of interpretation'

71. Given the evidence of Professor A, the Tribunal found on the balance of probabilities paragraphs 4(c) and (d) of the Allegation proved in relation to SI 2019/12023.

72. Accordingly, paragraphs 4(c) and (d) of the Allegation were proved in relation to SI 2019/4021, 2019/12016 and 2019/12023.

Paragraph 4(e)(i) of the Allegation

73. The Tribunal considered whether the SIs referred to in paragraph 4(a) of the Allegation that BestCare instigated, over which Dr Khan had overall responsibility, were not investigated appropriately at the time in that no attempt was made (i) to assess training competence and performance levels of the sonographers involved.

74. The Tribunal noted that whilst paragraph 4(e)(i) refers to sonographers in the plural, the same sonographer, referred to in these proceedings as Mr E, was involved in each of the scans.

75. The Tribunal considered the information relating to each of the SIs, as follows:

SI number	*Date of scan/incident*	*Date notified to BestCare*	*Date of the report*
2019/4021	*24 May 2018*	*8 February 2019*	*14 May 2019*
2019/12016	*3 April 2018*	*23 May 2019*	*21 August 2019*
2019/12023	*24 April 2018*	*2 May 2019*	*23 August 2019*

76. The Tribunal noted that there is no reference in the SI reports to any attempt being made to assess the competence and performance levels of Mr E, the sonographer of the SIs above.

77. However, the Tribunal had audits relating to Mr E seemingly carried out during the dates of the SIs, in particular in April and May 2019.

78. The Tribunal was of the view that, although the audits were of limited value, nonetheless an attempt was made at the time to assess training and competence and performance levels of the sonographer.

79. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 4(e)(i) of the Allegation not proved.

Paragraph 4(e)(ii) of the Allegation

80. The Tribunal considered whether the SIs referred to in paragraph 4(a) of the Allegation that BestCare instigated, over which Dr Khan had overall responsibility, were not investigated appropriately at the time in that no attempt was made (ii) to instruct a third party to assess the quality of the imaging that BestCare was providing.

81. The Tribunal noted that in his oral evidence, Dr Khan accepted that he did not instruct a third party to assess the quality of the imaging that BestCare was providing.

82. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 4(e)(ii) of the Allegation proved.

Paragraph 4(e)(iii) of the Allegation

83. The Tribunal considered whether the SIs referred to in paragraph 4(a) of the Allegation that BestCare instigated, over which Dr Khan had overall responsibility, were not investigated appropriately at the time in that no attempt was made (iii) to assess the language capability of the sonographer in respect of SI 2019/12016.

84. The Tribunal noted that whilst paragraph 4(e)(iii) refers to the sonographer in respect of SI 2019/12016, Mr E was involved in each of the scans in paragraph 4(a) of the Allegation.

85. The Tribunal considered Professor A's expert supplemental report dated 19 February 2023. He stated:

> *'From this SI, it is suggested that the person performing the examination was a qualified radiologist from abroad and suggests that the individual is a medical practitioner. There is no evidence that the practitioner has undergone any sort of assessment of their English language ability, and presumably they are operating in the context of a sonographer rather than a radiologist.'*

86. However, the Tribunal noted that an International English Language Testing System ('IELTS') certificate was provided in respect of Mr E which indicated that Mr E passed the IELTS test on 16 August 2017.

87. In his oral evidence, Professor A, having sight of the IELTS certificate, withdrew his criticism of Mr E's English language ability.

88. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 4(e)(iii) of the Allegation not proved.

Paragraph 4(e)(iv) of the Allegation

89. The Tribunal considered whether the SIs referred to in paragraph 4(a) of the Allegation that BestCare instigated, over which Dr Khan had overall responsibility, were not investigated appropriately at the time in that no attempt was made (iv) to ensure a thorough Root Cause Analysis ('RCA') was carried out.

90. The Tribunal noted that, in his oral evidence, Professor A said that if there had been a thorough RCA, it would have become apparent that the common denominator between the SIs was Mr E. This would have raised an alarm for him (Professor A). He also said that the methodology for carrying out an RCA is advocated by NHS England and is based on who, what, why and when. He said that an SI report is not just about what was the root cause, but it is also about patient safety. Further, he said that third party involvement is important and necessary when undertaking an RCA to see what other issues may arise, such as issues relating to equipment, etc.

91. The Tribunal noted that in his oral evidence, Dr Khan accepted that in the case of each of the three SIs the RCAs were not investigated thoroughly, and he said that in hindsight the SIs should have been more detailed.

92. The Tribunal noted that the details of the RCAs in SI 2019/4021 and SI 2019/12023 are very limited. Whilst the Tribunal accepted that the RCA for SI 2019/12016 was more detailed, Dr Khan agreed that it was not thorough.

93. The Tribunal considered that Dr Khan did attempt an RCA in the case of each SI report, however, he did not ensure that a thorough RCA was carried out in each case.

94. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 4(e)(iv) of the Allegation proved.

Paragraph 4(g) of the Allegation

95. The Tribunal considered paragraph 4(g) of the Allegation and whether in relation to the SIs in paragraph 4(a), over which Dr Khan had overall responsibility, Dr Khan had a duty of candour.

96. Dr Khan previously admitted paragraph 4(b) of the Allegation, that the SIs concerned incidents involving basic imaging errors of interpretation. It was not suggested that these were other than notifiable safety incidents covered by the Regulations.

97. In his witness statement Dr Khan said that he initially applied for CQC registration in approximately 2016. In order to do this, he sought the help of a consultancy firm called QMADS Limited in order to fulfil all the CQC registration requirements. They helped him to draft the initial policies and procedures, and provided guidance upon the steps required to obtain CQC registration. The policies and procedures included one entitled 'Duty of Candour Policy'. In his witness statement Dr Khan says that BestCare applied for and were granted CQC registration on 14 October 2016, following which he was eligible to apply for tenders.

98. The Tribunal noted that the Duty of Candour Policy document produced in evidence by Dr Khan is dated October 2017, is signed by Dr Khan and states that Dr Khan is the author and the 'person responsible'.

99. In light of the LQC's further legal advice and having considered the Duty of Candour Policy document the Tribunal was satisfied that Dr Khan had a duty of candour. The Tribunal also noted that in his oral evidence Dr Khan accepted that he had a duty of candour on behalf of BestCare, and that his role was to ensure that the duty candour was complied with.

Paragraph 4(g)(ii)(1) of the Allegation

100. The Tribunal considered the case against and for Dr Khan and to what extent he did not discharge his role regarding his duty of candour in respect of SI 2019/4021 in that he failed to ensure that attempts were made to contact the family regarding the incident.

101. The Tribunal noted that SI 2019/4021 under the heading 'Duty of candour' states 'The patient and relatives were supported by the Consultant Gynaecologist'.

102. The Tribunal considered Dr Khan's witness statement. At paragraph 114 under *SI 2019/4021* he said that it was his understanding that attempts were made to contact the patient's relatives. At paragraph 162 of his witness statement, Dr Khan says that he instructed the Quality Manager to contact the family regarding the incident and comply with the duty of candour.

103. The Tribunal noted that there is no documentary record of any attempt to contact the patient's family or letter of notification as required by regulation 20(3) – (6) of the Regulations. There is no duty of candour letter produced for this SI, compared to SI 2019/12016 and SI 2019/12023. The Tribunal think it unlikely that with the passage of time Dr Khan would be able accurately to recall any conversation with the Quality Manager.

104. Moreover, the Tribunal noted that SI 2019/4021 states that 'The patient and relatives were supported by the Consultant' which implies that the duty of candour was left to the hospital.

105. On the balance of probabilities, the Tribunal was satisfied that the GMC had proved paragraph 4(g)(ii)(1) of the Allegation.

Paragraph 4(g)(ii)(2) of the Allegation

106. Paragraph 4(g)(ii)(2) of the Allegation is in the alternative to paragraph 4(g)(ii)(1). Given the Tribunal's findings above, this paragraph falls away.

107. The Tribunal therefore made no determination in respect of paragraph 4(g)(ii)(2) of the Allegation.

Paragraph 4(g)(iii)

108. The Tribunal considered the case against and for Dr Khan and to what extent he did not discharge his role regarding his duty of candour in respect of SI 2019/12023 in that he failed to ensure that there was an adequately detailed record of the verbal apology given to the patient over the telephone, in that there was no detail as to: whom the call was with; who made the call; the date of the call; and what was discussed in the call.

109. The Tribunal noted that SI 2019/12023 states '*BestCare sent a Duty of Candour letter on the 27/05/2019. This was followed up by a verbal apology on the telephone'.*

110. The Tribunal considered Dr Khan's witness statement. He stated:

> *'I am aware that Ms B [the Quality Manager] had a telephone conversation with the patient's husband and verbally apologised on 26 May 2019. The patient's husband indicated that he would be going to Australia shortly. The duty of candour letter was sent on 27 May 2019, but it was returned undelivered. I do not know whether further attempts were made to contact the patient concerned in respect of SI 2019/12023. I wish to apologise for this omission.'*

111. The Tribunal noted that within the records produced for this SI report there is a copy of a duty of candour letter dated 27 May 2019 and a document entitled 'Notes relating to SI 2019 – 12023'. The notes appear to be an *aide memoir* or record of events. The notes states:

> *'Duty of Candour letter sent: But it was returned (BCD QM immediately after posting the DOC , BestCare Quality manager had a telephonic conversation with patients husband and verbally apologised her. Patients husband said that he is going to Australia shortly, DOC was a registered letter hence it was returned back.'*

112. The Tribunal considered that there was an inconsistency between Dr Khan's witness statement and the notes. In his witness statement, Dr Khan says that the telephone conversation took place on 26 May 2019, followed by the duty of candour letter sent on 27 May 2019. The notes and the SI report itself make clear that the letter was sent first and was followed by the verbal apology on the telephone. Moreover, the duty of candour letter makes no reference to an earlier telephone conversation, unlike the duty of candour letter in respect of SI 2019/12016 where the writer refers to a telephone conversation taking place. Both duty of candour letters were sent by the Quality Manager and it would be reasonable to infer that if a telephone conversation took place with the patient's husband on 26 May 2019 it would have been mentioned in the letter of 27 May 2019.

113. The typed note with the SI records is undated and the Tribunal has not heard any evidence about how it was compiled, by whom or when.

114. In all the circumstances, the Tribunal was satisfied that the GMC had proved its case in relation to this head of charge to the requisite standard of proof.

115. Therefore, the Tribunal determined and found paragraph 4(g)(iii) of the Allegation proved.

Paragraph 4(h) of the Allegation

116. The Tribunal considered paragraph 4(h) of the Allegation and whether the SIs in paragraph 4(a), over which Dr Khan had overall responsibility, should have prompted Dr Khan to invoke a clinical review to assess the overall performance of BestCare, but he did not do so.

117. The Tribunal noted that in his oral evidence, Dr Khan accepted that having been notified by the CCG on 2 May 2019 of the need for a second SI report alarm bells were raised in his head.

118. The Tribunal noted that in his supplementary expert report dated 19 February 2023, Professor A said:

> *'On receipt of these multiple SIs Dr Khan should have invoked a clinical review to assess the overall performance of his service.'*

119. It is important here to understand the distinction between a clinical review and a clinical harm review which the CCG decided to carry out in relation to BestCare. As explained in the CCG's Clinical Harm Review Outcome Report, the CHR was concerned with BestCare's clinical competence and its contract with BestCare, which had been suspended in September 2018. The CHR was in two stages. Stage One confirmed and reviewed all the patients who were seen by the sonographers and involved gathering a great deal of evidence including scans, patient records and so forth. Stage Two was concerned with assessing the level of harm, if any, that the patients experienced.

120. Paragraph 4(h) of the Allegation is directed to a different situation, namely that the SIs should have prompted Dr Khan, as the Medical Director of BestCare, to invoke a clinical review to assess the overall performance of BestCare.

121. The Tribunal noted that Dr Khan started to do audits relating to Mr E from April 2019. The notification of a second SI in early May 2019 should have prompted him to

investigate more thoroughly the overall performance of BestCare, particularly as he freely admitted in evidence alarm bells were ringing. The Tribunal considered that BestCare's Quality Manager and IT Manager ought to have been able to pull any data easily together at this point, which Dr Khan might have wanted for the purposes of invoking a clinical review.

122. The Tribunal recognised that Professor A said there would be no need for a simultaneous review by CCG and BestCare. However, the clinical harm review did not begin until 20 June 2019 and Dr Khan had ample time between 2 May 2019 to 20 June 2019 to at least invoke a clinical review. The Tribunal was satisfied that the notification of the second SI on 2 May 2019 ought to have provoked Dr Khan to invoke a clinical review.

123. Therefore, the Tribunal determined and found paragraph 4(h) of the Allegation proved.

The Tribunal's Overall Determination on the Facts

124. The Tribunal has determined the facts as follows:

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

1. Between 2018 and December 2019, you:

a) were the Medical Director at BestCare Diagnostics Limited ('BestCare');
Admitted and found proved

b) failed to monitor and review the service that BestCare was providing, in that you did not:

i) have a system in place that accurately recorded:

(1) which sonographer had performed the scans;
Not proved

(2) when the scans were performed;
Not proved

(3) where the scans were performed;
Not proved

(4) what examinations were undertaken;
Not proved

ii) monitor the performance levels of the sonographers carrying out work for BestCare.
Determined and found proved

2. As a result of the failure as set out at paragraph 1(b):

a) you were unable to provide the West Sussex NHS Clinical Commissioning Group/Coastal West Sussex Clinical Commissioning Group ('CCG') with accurate information in a timely manner to assist with their Clinical Harm Review ('CHR');
Determined and found proved

b) 64 of the patients assessed by the CCG during the CHR were found to have suffered physical and/or psychological harm, of which 29 had experienced moderate to severe harm.
Not proved

3. During your time as Medical Director, despite the CCG's conclusion as set out at paragraph 2(b), you only instigated four Serious Incident reports ('SIs').
Admitted and found proved

4. The SIs BestCare instigated, as set out at paragraph 3, over which you had overall responsibility:

a) were:

i) SI 2019/4021;
Admitted and found proved

ii) SI 2019/12016;
Admitted and found proved

iii) SI 2019/12023;
Admitted and found proved

b) concerned incidents involving basic imaging errors of interpretation;
Admitted and found proved

c) provided limited information;
Determined and found proved

d) lacked clarity;
Determined and found proved

e) were not investigated appropriately, in that no attempt was made to:

i) assess training competence and performance levels of the sonographers involved;
Not proved

ii) instruct a third party to assess the quality of the imaging that BestCare was providing;
Determined and found proved

iii) assess the language capability of the sonographer in respect of SI 2019/12016;
Not proved

iv) ensure a thorough Root Cause Analysis was carried out;
Determined and found proved

f) were not completed in a timely manner;
Admitted and found proved

g) did not discharge your role regarding your duty of candour, in that:

~~i) in respect of SI 2019/12016, you failed to ensure that BestCare spoke to the patient to whom harm had been caused;~~
Deleted under Rule 17(6)d

ii) in respect of SI 2019/4021, you failed to:

(1) ensure that attempts were made to contact the family regarding this incident;
Determined and found proved

(2) in the alternative to paragraphs 4(g)(ii)(1), record having undertaken the action as set out at paragraphs 4(g)(ii)(1);
No determination

iii) in respect of SI 2019/12023, you failed to ensure that there was an adequately detailed record of the verbal apology given to the patient over the telephone, in that there was no detail as to:

(1) whom the call was with;
Determined and found proved

(2) who made the call;
Determined and found proved

(3) the date of the call;
Determined and found proved

(4) what was discussed in the call;
Determined and found proved

h) should have prompted you to invoke a clinical review to assess the overall performance of BestCare, but you did not do so.
Determined 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**

Determination on Impairment - 20/08/2024

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

The Evidence

126. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

127. Dr Khan provided a witness statement in relation to impairment dated 13 August 2024.

128. In addition, the Tribunal received further evidence as follows:

- Various relevant CPD certificates;
- Various feedbacks from Dr Khan's colleagues and patients;
- Various reflections by Dr Khan;
- Various testimonials from Dr Khan's professional colleagues.

Submissions

<u>On behalf of the GMC</u>

129. Ms Goring submitted that Dr Khan's fitness to practise is currently impaired by reason of misconduct. She referred the Tribunal to relevant paragraphs of Good Medical Practice (2013 edition) (GMP) and the relevant case law. She summarised the allegations found proved and said that Dr Khan had multiple and serious failings when he acted as the Medical Director of BestCare, which took place over a period of more than a year. She

said that these failings were varied and wide ranging in nature, so it could not be said that this was an isolated incident. Ms Goring submitted that, collectively and individually, the facts found proved in this case amount to serious misconduct.

130. In relation to impairment, Ms Goring referred to the admissions made by Dr Khan at the outset of the hearing and the evidence he had provided. She also referred the Tribunal to Dr Khan's expressions of remorse and Dr Khan's statement that he has full insight. Ms Goring submitted that Dr Khan's observations do not go further than that statement itself. She said that his statements were of limited assistance on insight and that beyond making the statement that he has insight he has not been cross-examined to establish the depth and level of his insight.

131. Ms Goring referred the Tribunal to the courses undertaken by Dr Khan and submitted that it is a matter for the Tribunal whether this is sufficient remediation and whether those courses really address the issues in this case. Ms Goring submitted that there is limited insight in this case and that when considering the public interest, the GMC would invite the Tribunal to find that there is current impairment in this case.

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

132. Mr Mahmood submitted that Dr Khan's fitness to practise is not impaired by reason of misconduct. He referred the Tribunal to relevant case law and said that he agrees with Ms Goring that paragraphs of GMP were engaged in this case. Mr Mahmood referred the Tribunal to its findings on facts. He submitted that this Tribunal is essentially dealing with a doctor who admittedly displayed incompetence in managing a company approximately five years ago. Mr Mahmood said that there is no evidence of any malice or deliberate intent on Dr Khan's part and there is evidence that Dr Khan acted in good faith and tried to do his best. He said that there is evidence that he relied on others but there is also evidence that he failed to achieve proper set standards, resulting in the failure of the company.

133. Mr Mahmood submitted that Dr Khan had made a number of admissions at the outset and has always accepted that these matters are serious. He said that the Tribunal may not be faced with difficulty in finding that misconduct is established on the facts of this case.

134. In relation to impairment, Mr Mahmood referred to the documents provided by Dr Khan, specifically his witness statements, his reflections and relevant courses undertaken. Mr

Mahmood submitted that Dr Khan accepted from the beginning that there was fault on his part and that since 2021 Dr Khan has engaged in developing his insight, undertaken relevant courses and reflected on his actions. Mr Mahmood urged the Tribunal to consider the evidence provided by Dr Khan from December 2021, which demonstrates his insight, remorse and remediation. Mr Mahmood submitted that there is no evidence to suggest that Dr Khan lacks insight; or may in the future put patients at risk of unwarranted harm; or breach a fundamental tenet of the profession; or bring the profession into disrepute. Mr Mahmood submitted that there is zero evidence, in this case, of a risk of repetition going into the future.

135. Mr Mahmood submitted that there is no suggestion that Dr Khan has engaged in this kind of behaviour before or since the incidents occurred. He said that this is a case which revolves around the public interest and public confidence. Mr Mahmood submitted that a finding of impairment is not necessary, looking at this case as an informed observer, when Dr Khan has candidly admitted his mistakes at the outset and sought to remedy those mistakes extensively over the course of five years.

The Relevant Legal Principles

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

137. In approaching this decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amount to misconduct, and then whether that finding of misconduct, which was serious, could lead to a finding of impairment.

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

The Tribunal's Determination on Impairment

Misconduct

139.In determining whether Dr Khan's fitness to practise is currently impaired, the Tribunal first considered whether the facts found proved amounted to misconduct.

140.As advised by the Legally Qualified Chair (LQC) the word misconduct in section 35C of the Medical Act 1983 is not defined in the legislation. However, it is described in the case of *Roylance v. GMC (No 2)* [2000] 1 AC 311 as: *'a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* In that case, the Privy Council went on to say that *'The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances'.*

141.The word serious has been judicially said to mean conduct which would be regarded as deplorable by fellow practitioners.

142.The Tribunal considered its previous determination on the facts. During Dr Khan's period as the Medical Director of BestCare between 2018 and December 2019, the Tribunal found proved the following facts:

- Dr Khan failed to monitor the performance levels of the sonographers carrying out work for BestCare.
- That as a result of that failure, Dr Khan was unable to provide the Clinical Commissioning Group with accurate information in a timely manner to assist with their Clinical Harm Review.
- Dr Khan only instigated four Serious Incident Reports (SIs) during the period between 2018 and December 2019.
- The SIs that Dr Khan instigated concerned incidents involving basic imaging errors of interpretation, provided limited information, lacked clarity, were not completed in a timely manner, and were not investigated properly in that no attempt was made to instruct a third party to assess the quality of the imaging and ensure that a thorough Root Cause Analysis was carried out.
- Dr Khan did not discharge his role regarding his duty of candour in respect of two of the SIs instigated, over which he had overall responsibility. In respect of SI 2019/4021, contrary to the Health and Social Care Act 2008 (Regulatory Activities) Regulations 2014, he failed to ensure that attempts were made to contact the family regarding the incident. In respect of SI 2019/12023, he failed to ensure that there was an adequately detailed record of the verbal apology given to the patient over the telephone.
- These concerns should have prompted Dr Khan to invoke a clinical review to assess the overall performance of BestCare, but he did not do so.

143.The Tribunal considered that the following paragraphs of GMP are engaged in this case.

> *7 You must be competent in all aspects of your work, including management, research and teaching.*
>
> *12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*
>
> *14 You must recognise and work within the limits of your competence.*
>
> *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*

144.Professor A emphasised that a Medical Director is primarily concerned with patient safety and that the role entails a duty to oversee the process and signing off of SI reports. Whilst the Tribunal did not find that any patients suffered harm as a result of Dr Khan's failings, the Tribunal considered that nonetheless given the matters found proved, and that Dr Khan breached the above paragraphs of GMP, his actions both individually and collectively as the Medical Director of BestCare amounted to misconduct.

145.The Tribunal determined that Dr Khan's conduct fell significantly below the standards expected of a Medical Director and thereby amounted to serious misconduct. It was also a significant breach of GMP.

Impairment

146.Having found that the facts found proved amounted to misconduct, the Tribunal went on to consider whether, as a result of that conduct, Dr Khan's fitness to practise is currently impaired.

147.The Tribunal had regard to paragraph 76 of the judgment in the case of *CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin)*, in which Mrs Justice Cox set out the helpful and comprehensive approach of Dame Janet Smith in her 5th Shipman Report when determining issues of impairment. At paragraph 25.67 of the Shipman Report, Dame Janet identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise.

> *'Do our findings of fact in respect of the doctor's misconduct…show that his/her fitness to practise is impaired in the sense that s/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.'

148. In relation to limb (a), the Tribunal considered there was the *potential* of unwarranted risk of harm to patients and to that extent the Tribunal considered that this limb is engaged in this case. In relation to limbs (b) and (c), the Tribunal considered that in light of its findings on misconduct both of these limbs are engaged. It is a fundamental tenet of the medical profession that a doctor should continue to develop and maintain their professional knowledge, skills and performance and that a failure to do so may damage the public's trust in the medical profession. Limb (d) does not arise in this case.

149. The Tribunal has borne in mind the GMC's over-arching statutory objective in Section 1 of the Medical Act 1983, as amended, which states:

'(1A) The over-arching objective of the General Medical Council in exercising their functions is the protection of the public.
(1B) The pursuit by the General Medical Council of their over-arching objective involves the pursuit of the following objectives –

(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.'

150. In determining whether a finding of current impairment of fitness to practise is required in this case, the Tribunal considered the nature and seriousness of Dr Khan's misconduct, his level of insight and remediation, his reflective statements, the testimonial evidence that speaks of his fitness to practise, and the risk of his misconduct being repeated.

151.The tribunal balanced these factors against the important matters highlighted in the case of *Grant* where the judge said:

> *'71. However, it is essential, when deciding whether the fitness to practise is impaired, not to lose sight of the fundamental consideration emphasised at the outset of this section of his judgment at paragraph 62, namely the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.*
>
> *74... 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.'*

152.In relation to insight and remediation, the Tribunal considered the following extracts from the evidence provided by Dr Khan.

Dr Khan's reflective statement – December 2021

> *'With reflection, review of the concerns raised and study of the GMC guidance on leadership and management I now realise that I was underprepared for the complexities of managing staff and services remotely and over such wide geographies e.g. Coast West Sussex CCG.*
>
> *As of 2019, I closed the company and am no longer in a management position. I have decided that I will not take on any role of this nature in the future unless I have had sufficient training and feel confident that I have the necessary skills, time and competence to undertake the role effectively. Further, I have no intention of seeking or taking a similar role in the near to medium future.*
>
> *…There are things that could have been done better. I have therefore spent a lot of time since the concerns were raised on reviewing my actions and managerial practice through the period, and have come to the following conclusions:*
>
> *a) The complexities of creating a new business in a clinical setting required more investment in time and at the development and planning stage than I expected, and I realise now that I required more hours than I had to setup Bestcare Ltd during the first year to ensure all of the quality systems which were put in place*

were embedded and working correctly so that the team had the skills and tools to monitor the audit and quality systems which had been introduced.

b) *Again with hindsight, I hadn't realised that my management skills and experience were lacking to take on such a new and complex role, and I should have attended managerial and management courses before starting the company. …'*

Dr Khan's reflective statement dated 18 May 2023

This highlights Dr Khan's reflections on the GMC's document Good Medical Practice and Dr Khan's reflections on various courses he attended between December 2021 and May 2023. The courses attended included a Leadership and Management Course, a Serious Incident Investigation Course, a Root Cause Analysis Intensive Masterclass, and a Duty of Candour in Health and Social Care Course.

Dr Khan's witness statement dated 13 March 2024

'2. At the outset I would like to convey my apologies to the GMC and the wider public for the shortcomings in my management of Bestcare Diagnostics Ltd. When I started the enterprise in 2016, my intentions were to provide a better, faster ultrasound service for NHS patients, closer to their homes. I had become aware of significant waiting times and travel times for ultrasound patients.

3. Although I entered into the venture in good faith, and with good intentions, I have since appreciated that I did not have sufficient experience in clinical governance and management to ensure the safety of all patients. Additionally, although I employed a Quality Manager, with hindsight I believe I overestimated her level of experience, and I did not devote enough of my time to the organisation. I should have appreciated these things much sooner, for which I also apologise.

…

5. I am extremely sorry for what has happened; I am particularly sorry for any harm suffered by patients and the impact this has had on the public and the CCG. I am truly devastated by what has happened, the impact of this on patients, and the fact that a company I developed in good faith, with the best of intentions, has been found to have caused harm. I can categorically assure the Tribunal that I recognise and accept my failings, my lack of managerial acumen, and I truly regret ever placing trust in others to run the company whilst I remained employed in the NHS.'

Dr Khan's witness statement dated 13 August 2024, and additional reflective statement

In his witness statement Dr Khan says:
'I wish to stress that:

- *I am deeply and truly sorry for everything that has happened. The Tribunal will recall that I repeatedly expressed genuine remorse for my actions at stage 1, during cross-examination, and I have previously apologised too. I remain contrite. I am devastated by what has happened, the impact on this on patients and the fact that a company, which I formed with the best of intentions and in good faith, has been found by the CCG to have been the cause of so much harm and concerns. I recognise the adverse impact this has likely had on the reputation of the profession and the wider public interest. I cannot apologise enough.*
- *….*
- *The events in question took place between 2018 and 2019. I have had over 5 years to reflect on matters. I have full insight into my failings and I can assure the Tribunal that there is no chance of repetition. I remain employed in the NHS on a full time basis, and I have absolutely no intention of running my own business ever again, or seeing (sic) appointment as MD of any organisation.'*

Dr Khan's witness statement and his most recent reflective statement attached to his witness statement refer to the substantial number of courses he has attended since 2019, and his reflections on the findings of the Tribunal at stage 1. In his witness statement, Dr Khan says that he fully understands and accepts his failings and that his reflections have enabled him to develop and learn from those failings, so that there is "no chance of repetition whatsoever".

In his reflective statement, Dr Khan says:

> *'I have read and fully understood the Determination on Facts produced by the Tribunal. I fully respect the Tribunal's findings. I have reflected deeply on all issues, both before and since the Determination. I have set out my learnings and reflections in previous documents, and I have set out below my additional reflections since the Determination.'*

Dr Khan sets out in some detail his learnings and reflections on matters such as leadership and management; failure to properly monitor and supervise staff;

inaccurate data supplied to the CCG; delegating work; serious incident reporting, root cause analysis; accurate reporting; duty of candour; and clinical review and audits.

Under the heading Summary, Dr Khan says:

> *'I accept that the responsibilities laid on me regarding Bestcare were more than I expected, and I fell short of what was required to run the company and its governance, and I should have committed more time, and not delegated as much to the team. I should have supervised and properly monitored the performance of staff and the use of systems. I should have had more effective processes for supervision. I should have personally undertaken robust audits to check and cross check the day to day activities in the company rather than relying on the staff to know what to tell me or what is important or raise concerns. These led to failings of service and potentially impacted on patient safety for which I am again deeply sorry.'*

153. The Tribunal noted that prior to the substantive hearing commencing in April 2024, Dr Khan had already demonstrated a level of insight into his actions when he made his reflective statement in December 2021, updated in May 2023. Dr Khan's insight into his actions has developed over the course of time as demonstrated by his witness statement of March 2024, and his most recent witness statement and reflective statement in August 2024.

154. The Tribunal also noted Dr Khan's acceptance of the Tribunal's findings in relation to the facts found proved and how Dr Khan has tried to address and reflect on the Tribunal's findings. Dr Khan was entitled to deny various heads of charge and the Tribunal has in no sense held it against him that he did so.

155. The Tribunal is satisfied that Dr Khan has developed good insight since an early stage in the disciplinary process and that the risk of repetition in this case is negligible.

156. The Tribunal has borne in mind the GMC's over-arching statutory objectives in section 1(1A) and 1(1B) of the Medical Act 1983, and the specific need highlighted in *Grant* and other cases not to lose sight of these principles.

157. The Tribunal agrees with Ms Goring and Mr Mahmood that essentially this is a case about the public interest which centres around sub-paragraphs (b) and (c) of section 1(1A) of the 1983 Act. The Tribunal does not consider Dr Khan to present a current risk

to members of the public. The key question for the Tribunal, emphasised by Mrs Justice Cox at paragraph 74 of her judgment in the case of *Grant,* is 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'.*

158. Dr Khan's misconduct is confined to his role as the Medical Director of BestCare between 2018 and December 2019. The Tribunal recognises that the facts found proved occurred over a period of up to two years and that individually and cumulatively they amount to serious misconduct. However, the Tribunal was mindful of the extent of Dr Khan's insight and the remedial steps he has undertaken. There has been no repetition of any similar incident for over five years and by all accounts Dr Khan is a competent doctor who presents no material danger to the public and can provide considerable useful future service to society.

159. Standing back, and looking at the case overall, the Tribunal is not satisfied that public confidence and the need to uphold proper professional standards would be undermined if a finding of impairment was not made in the particular circumstances of this case. It is very much a case on its own facts. Accordingly, the Tribunal did not consider that a finding of impairment is warranted in this case.

160. Therefore, the Tribunal found that Dr Khan's fitness to practise is not currently impaired.

161. In accordance with section 35D (3) of the Medical Act 1983, and Rule 17(2)(m) of the GMC (Fitness to Practice) Rules 2004, the Tribunal will nevertheless consider whether a warning should be imposed.

Determination on Warning - 20/08/2024

162. As the Tribunal determined that Dr Khan's fitness to practise was not impaired it considered whether in accordance with s35D(3) of the 1983 Act, a warning was required.

Submissions

On behalf of the GMC

163. Ms Goring submitted that the GMC would invite the Tribunal to issue a warning in this case. She referred to paragraphs 20 and 21 of the Tribunal's determination on impairment and that Professor A emphasised that a Medical Director is primarily

concerned with patient safety and that the role entails a duty to oversee the process and signing off Serious Incident reports. Ms Goring referred the Tribunal to relevant paragraphs of the Guidance on Warnings (April 2024) ('the Guidance'). Ms Goring submitted that the Tribunal found that Dr Khan's conduct fell significantly below the standards expected and had significantly breached paragraphs of Good Medical Practice. On that basis, she said that the test for issuing a warning is satisfied in this case. Ms Goring also submitted that, given the Tribunal's findings in relation to serious misconduct, a warning is appropriate in this case.

On behalf of Dr Khan

164. Mr Mahmood submitted that a warning is not necessary in this case. He also referred the Tribunal to the relevant paragraphs of the Guidance and its determination on misconduct and impairment. He then referred the Tribunal to the relevant factors on whether a warning is necessary. Mr Mahmood said that Dr Khan has a good level of insight, he is a doctor of previous good history, it was an isolated incident, there has been no evidence of repetition, he has tried to remediate and reflect, has expressed his apology and the risk of repetition in this case is negligible. Mr Mahmood submitted that Dr Khan is a competent doctor who does not represent a danger to the public. Mr Mahmood said that given that there is no risk of repetition in this case, there is no need for a formal warning and that no deterrent is needed here. He submitted that a warning would simply be disproportionate given the circumstances in this case.

The Tribunal's Determination on Warning

165. The Tribunal took account of the specific circumstances of this case and had regard to the submissions of parties.

166. The decision whether or not to issue a warning is a matter for the Tribunal alone, exercising its own judgement. The Tribunal was mindful of the overarching objective in s1(1A) and (1B) of the Medical Act 1983, and in particular the need to promote and maintain public confidence in the medical profession, and the need to promote and maintain proper professional standards and conduct for members of that profession.

167. The Tribunal also had regard to all relevant parts of the Guidance including the test at paragraph 16:

> *'**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…'*

168.The Tribunal also considered paragraph 20 of the Guidance which states:

'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).'

169.When approaching its decision on whether to issue Dr Khan with a warning, the Tribunal had regard to its findings within its previous determinations as to the facts and impairment. The Tribunal noted that Dr Khan's misconduct is confined to his role as a Medical Director, there has been no repetition of anything similar since and by all accounts Dr Khan is a competent doctor who presents no material danger to the public. It also noted that Dr Khan has developed good insight, has taken remedial steps and that

the risk of repetition in this case is negligible. Thus, Dr Khan's fitness to practise was found not to be currently impaired.

170. However, the Tribunal considered its findings on misconduct and the seriousness of Dr Khan's actions. It was of the view that Dr Khan's actions fell significantly below the standards expected of a Medical Director, had breached paragraphs of Good Medical Practice and had breached a fundamental tenet of the profession. It noted that a Medical Director is primarily concerned with patient safety and Dr Khan's conduct had the potential to put patients at risk of harm, albeit no such finding was made in this case.

171. The Tribunal took into account the public interest and balanced this with the evidence produced by, and the interests of, Dr Khan. The Tribunal was mindful of the factors in paragraph 32 of the Guidance when deciding if a warning is appropriate, but nevertheless the Tribunal determined that a warning would be appropriate and proportionate. It considered that a warning was necessary in the public interest and to mark the seriousness of Dr Khan's conduct as a Medical Director and his significant departure from GMP. A warning would also send a signal to both the public and fellow members of the profession, as well as to Dr Khan, that the conduct in this case is unacceptable.

172. Therefore, the Tribunal determined that it was necessary to impose a warning on Dr Khan's registration. The following warning will therefore appear on Dr Khan's registration:

'Dr Sohail Khan

Between 2018 and December 2019, as the Medical Director of BestCare Diagnostics Limited, you failed to monitor the performance levels of the sonographers carrying out work for BestCare. As a result, you were unable to provide accurate information in a timely manner to assist with a Clinical Harm Review. You only instigated four Serious Incident Reports during the time you were the Medical Director. Three of these concerned basic imaging errors of interpretation, provided limited information, lacked clarity, were not completed in a timely manner, and were not investigated properly in that no attempt was made to instruct a third party to assess the quality of the imaging and ensure that a thorough Root Cause Analysis was carried out. You did not discharge your role regarding your duty of candour in respect of two of the Serious Incident Reports instigated. These concerns should have prompted you to

invoke a clinical review to assess the overall performance of BestCare, but you did not do so.

There was a significant departure of Good Medical Practice and fell significantly below the standards expected of a Medical Director.

This conduct does not meet with the standards required of a doctor carrying out the role of a Medical Director. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good Medical Practice and associated guidance. In this case, paragraphs 7, 12, 14 and 65 of Good Medical Practice are particularly relevant, which states:

> *7 You must be competent in all aspects of your work, including management, research and teaching.*
>
> *12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*
>
> *14 You must recognise and work within the limits of your competence.*
>
> *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*

Whilst this failing in itself is not so serious as to require any restriction on your registration, it is necessary in response to issue this formal warning.

This warning will be published on the medical register in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy.'

173.There is no interim order to revoke.

174.That concludes the case.