PUBLIC RECORD

Dates: 07/10/2024 - 21/10/2024

Medical Practitioner's name:	Dr Sohier EL-NEIL
GMC reference number:	4157384
Primary medical qualification:	MB ChB 1987 University of Zimbabwe

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

Summary of outcome

Suspension, 9 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Ms Louise Sweet, KC
Lay Tribunal Member:	Dr Caroline Friendship
Medical Tribunal Member:	Dr Gabrielle Downey

Tribunal Clerks:	Mr John Poole

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Ranald Davidson, Counsel, instructed by Gordons Partnership
GMC Representative:	Ms Katie Nowell, 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 - 15/10/2024

Background

1. Dr El-Neil qualified as a doctor in 1987 from the University of Zimbabwe and went on to specialise in obstetrics and gynaecology. She moved to the UK in 1990 and became a member of the Royal College of Obstetricians and Gynaecologists in 1994. Following completion of her training, she took up a post as a Consultant Gynaecologist specialising in Urogynaecology and Uro-neurology in 2004 at University College Hospital and the National Hospital for Neurology and Neurosurgery, where she remains at present.

2. The Allegation that has led to Dr El-Neil's hearing can be summarised that, on 23 October 2017 and 13 December 2017, Dr El-Neil, failed to obtain informed consent from Patient A and was dishonest in her communication with Patient A in respect of the procedure undertaken. It is further alleged that, on 28 March 2018, Dr El-Neil provided information she knew to be dishonest to NHS Highland, in respect of the procedure.

3. The initial concerns were raised by Patient A with the GMC via an online complaint form dated 22 March 2021.

4. Patient A complained about the treatment she received from Dr El-Neil regarding the removal of an implanted Gynecare TVT Obturator System ('the Mesh'). In summary, Patient A complained that Dr El-Neil had led her to believe that all the Mesh could be removed in one operation. She complained that at her post operative review she was informed by Dr El-Neil that all the Mesh had in fact been removed. In contrast, she learned several months later that further surgery would be required to remove all the Mesh.

5. By way of further background, Patient A's TVT-O Mesh was inserted in 2010 to assist with stress urinary incontinence and was attached by anchoring it to the obturator muscles at the tops of both legs. From 2014, she started to experience chronic pain in her pelvis, as well as frequent urinary tract infections. In 2016, she was diagnosed as likely suffering a reaction to the Mesh. She was offered a partial removal in Glasgow but, after doing a lot of research herself, she came across Dr El-Neil who was a leading consultant in the field, whom she believed had the skills and experience to remove the Mesh in one surgery. She had been counselled about the dangers of complications caused by scarring as a result of multiple surgeries. Her own surgeon and two other surgeons in Scotland had stated that they could not safely achieve full removal of the Mesh. Patient A asserted that the reason she pushed

for funding from NHS Highland was for full removal of the Mesh in London by Dr El-Neil in only one surgery.

The Allegation and the Doctor's Response

6. The Allegation made against Dr El-Neil is as follows:

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

1. On 23 October 2017 you consulted with Patient A about symptoms related to an implanted Gynecare TVT Obturator System ('the Mesh'), and you failed to obtain informed consent from Patient A for removal of the Mesh ('the Mesh Removal Procedure') in that you:

    a. knew that Patient A did not want:

        i. a partial removal of the Mesh;
        Admitted and found proved

        ii. more than one procedure to fully remove the Mesh;
        To be determined

    b. told Patient A you could fully remove the Mesh, or words to that effect;
    To be determined

    c. failed to explain to Patient A that only part of the Mesh was likely to be removed during the Mesh Removal Procedure.
    To be determined

2. On 13 December 2017 you were part of the surgical team performing the Mesh Removal Procedure, and following completion, when asked by Patient A '*did you get all of my Mesh?*' or words to that effect you responded by:

    a. putting two thumbs up;
    To be determined

    b. saying '*yes*' or words to that effect.
    To be determined

3. On 28 March 2018 you wrote to NHS Highland regarding the Mesh Removal Procedure and you stated that *'we were able to remove the mesh in its entirety. It was quite firmly embedded into the obturator fascia'*.
Admitted and found proved

4. When you acted in the manner described at paragraph 2 and/ or paragraph 3, you:

a. knew or ought to have known that not all of the Mesh had been removed;
Admitted and found proved

~~b. in the alternate to paragraph 4.a. above, did not know if all of the Mesh had been removed.~~
Alternative allegation, falls away following admission to paragraph 4a

5. Your conduct:

a. as described at:

i. paragraph 2.a.; and/or
To be determined

ii. paragraph 2.b; and/or
To be determined

iii. paragraph 3;
To be determined

b. was dishonest by reason of:

i. paragraph 4.a; and/or
To be determined

~~ii. paragraph 4.b.~~
Alternative allegation, falls away following admission to paragraph 4a

The Admitted Facts

7. At the outset of these proceedings, through her counsel, Mr Ranald Davidson, Dr El-Neil made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). 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.

The Facts to be Determined

8. In light of Dr El-Neil's response to the Allegation made against her, the Tribunal is required to determine the remaining paragraphs of the Allegation.

Witness Evidence

9. The Tribunal received evidence on behalf of the GMC from the following witnesses:

- Patient A provided a witness statement, dated 10 November 2021 and gave oral evidence to the Tribunal in person.

- Mr B, provided a witness statement, dated 18 March 2024 and gave oral evidence to the Tribunal in person.

10. Dr El-Neil provided her own witness statement, dated 6 September 2024 and also gave oral evidence at the hearing.

Expert Witness Evidence

11. The Tribunal also received expert evidence from Dr C, Consultant Obstetrician Gynaecologist. Dr C was instructed by the GMC to consider the standard of care provided by Dr El-Neil to Patent A. Dr C, provided an expert report dated 13 October 2021. He also provided a supplemental report dated 14 November 2022 and gave oral evidence.

Documentary Evidence

12. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to Patient A's complaint to the GMC, relevant medical records and Dr El-Neil's witness statement.

The Tribunal's Approach

13. In reaching its decision on 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 El-Neil does not need to prove anything. The standard of proof is that applicable to civil proceedings, the balance of probabilities, namely whether it is more likely than not that the events occurred.

14. The Tribunal was reminded that it did not have to resolve every fact but only those matters which, in its view, were relevant to the issues in the case, for example, those matters that impinge on reliability of the key witnesses.

15. The LQC highlighted the passage of time since the allegations which date back to 2017 and observed that Dr El-Neil's last contact with Patient A and Mr B was in 2021. The LQC advised the Tribunal that, when assessing the accurateness or reliability of evidence given, especially when assessing more recent accounts and oral evidence, it must allow for

the fact that the passage of time may have an adverse impact on the memory. Whether there has been such an adverse impact is a matter for the Tribunal's judgment.

16. The LQC reminded the Tribunal to bear in mind that the demeanour of witnesses is of less relevance than that of the contemporaneous documents and the accounts given by each witness. Any sympathy, for either side, must be put to one side and determinations reached on the facts alone.

17. With regards to those paragraphs which allege dishonesty, the LQC referred the Tribunal to the two-stage test laid down by the Supreme Court in *Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67 ('Ivey')*.

a. The Tribunal must first ascertain (subjectively) the state of the individual's knowledge or belief as to the facts.

   The reasonableness of the belief is a matter of evidence going to whether she genuinely held the belief but it is not a requirement that the belief must be reasonable; and

b. The Tribunal must then consider whether that conduct was dishonest by the (objective) standards of ordinary decent people.

   As a matter of law there is no requirement that the individual must appreciate that what they have done was, by those standards, dishonest.

18. When considering the expert evidence received from Dr C, the LQC advised that, as with any other witness, it is the Tribunal's task to weigh up the evidence of the expert, which includes any evidence of opinion expressed and to decide what it accepts and does not accept.

The Tribunal's Analysis of the Evidence and Findings

19. 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.

Paragraph 1

20. Paragraph 1 of the Allegation relates to the consultation with Patient A on 23 October 2017 where it is alleged that Dr El-Neil failed to obtain informed consent from Patient A for removal of the Mesh.

21. The Tribunal first considered the evidence which would have informed Dr El-Neil's knowledge regarding whether or not Patient A wanted full removal of the Mesh rather than partial.

22. The Tribunal had regard to the Twitter messages between Patient A and Dr El-Neil in April 2017. It was mindful at that this point in time, Patient A was not yet under Dr El-Neil's care.

Patient A: *Im so praying that my health board here in Scotland will fund* ***my full removal operation*** *with you!*
Only the best will do and thats you !
29/04/17, 23:50

Dr El Neil: *That's very kind and I sincerely hope the same. Will do my best to help in any way*
30/04/17, 5:12…'

23. The Tribunal had regard to the letter from Patient A's GP, Dr D to Dr El-Neil, dated 3 August 2017. Dr D wrote:

'It has been partially good news for us with our battle with funding for my Patient A. Please find this letter which was delivered to my email from NHS Highland. They were happy for me to refer my patient to you for initial assessment. The NHS Highland has agreed to funding for an assessment at this stage, therefore I am referring Patient A for an assessment.

As you can see, they are querying ***whether you would be able to take all three parts of the mesh*** *and I hope you will be able to provide that service, so we will be able to press for extra funding for my patient…'*

24. The Tribunal had regard to the letter from NHS Highland to Dr D, dated 20 July 2017, which was attached to Dr D's letter to Dr El-Neil. NHS Highland relayed that the Clinical Advisory Group (CAG) had discussed Patient A's request for funding for TVT-O Mesh removal on 18 July 2017. It relayed that:

'the CAG have agreed to an assessment only at this stage. The reason for only approving an assessment is that we need to fully understand what any planned treatment or surgery will entail as this will require further funding approval. ***The CAG is curious to understand how the London surgeon claims to be able to remove all of the mesh, when 3 Scottish consultants have advised that this would be unlikely****…'*

25. The Tribunal noted Dr El-Neil accepted she had received Dr D's letter of 3 August 2017 which had the NHS Highland letter attached to it.

26. The Tribunal had regard to Mr B's email to Dr D on 24 October 2017 which was sent the day after Patient A's consultation with Dr El-Neil on 23 October 2017. Mr B wrote:

'Patient A had her apt yesterday at UCLH and met Dr E and Miss Suzie Elneil.

The appt lasted approx. an hour and Miss Elneil confirmed that the mesh should be removed.

Patient A is being sent to Croydon next month for a transvaginal scan to show the exact position of the mesh and is being put on Miss Elneils list for a removal before or just after Christmas.

This really is very good news for her.

But, we must keep up pressure on NHS Highland to allow the funding to continue for this operation, and there is not much time. ***Suzie Elneil has twice successfully removed 100% tvt-o just this last ten days and is the only, qualified through experience, person fit and able****…*

… I copied Mss Elneil to this email.. just to ask her refer back to you for details of Patient A's case, and why in her opinion she is the best qualified person for full removal… We really must persuade NHS Highland that this is Patient A's best and only hope of a full removal…'

27. The Tribunal noted the consent form completed and then signed on 23 October 2017 by Patient A when, as a new referral, she had her first consultation at UCLH. This form stated '**complete removal of TVT-O**'. In addition, the Tribunal considered the written note of this consultation contained in the patient record, which used the words 'Mesh removal'.

28. In Patient A's complaint to the GMC, sent by email on 20 March 2021 she stated that she believed she would be receiving full Mesh removal and complained that *'At no time ever in my pre op meetings was it made clear that my full mesh removal would be over multiple operations'.*

29. Patient A provided additional information in relation to her complaint in an email to the GMC on 12 April 2021. She wrote that:

'I do feel aggrieved that I fought so hard to obtain funding from NHS Highland, for a full mesh removal with Dr El-Neil, on the grounds that there was no other surgeon able to perform this procedure, certainly in scotland and one of just two or three in England. NHS Highland wrote to Dr El-Neil to clarify her position on mesh removal and after a long hard fight funding was agree. This finding [sic] was for a full mesh removal.

There is no doubt that Dr El-Neil was aware of my wish for a full removal…
Had it been Dr El-Neils intention to perform this surgery in several operations, then it should have been made clear to me, and the increased risks noted on my consent form, and also to NHS Highland, who ultimately did not get what they paid for…'

30. The Tribunal had regard to the clinic letter from Dr F, Consultant Gynaecologist and Obstetrician, dated 5 October 2016. This was addressed to Dr G at Patient A's GP Surgery. Dr F wrote:

> '*The question is whether we advise an attempt of complete removal of the TVT-O tape… I understand her condition had already been discussed at Glasgow Continence MDT and the team advice was not to remove the tape. However, Patient A was not happy with the team decision and would like to consider an attempt at complete removal surgery… I explained to Patient A the technical difficulty and the high risk associated with* ***an attempt of complete removal****…'*

31. The Tribunal considered Dr F's letter clearly indicated that Patient A had wanted full removal of the Mesh.

32. The Tribunal considered whether Dr El-Neil had sight of this letter.

33. The Tribunal noted from Patient A's medical records, that on 29 June 2017, Dr F sent an email to Dr El-Neil with a copy of the clinic letter he had written to Patient A's GP surgery on 5 October 2016 (referred to above), summarising Patient A's condition. Dr F wrote:

> *"…following a full consultation at NHS Lothian with regards to the benefits and risks of a complete mesh tape removal procedure. Further to my previous letters, since August last year, and Dr G's letter of the results of the video urodynamics in February this year, I confirm that Patient A's shared decision with us is an attempt at complete removal of TVT-O tape'*

34. The Tribunal considered that on the balance of probabilities, it was more likely than not that Dr El-Neil saw Dr F's letter of 5 October 2016, given that a copy of it was attached to an email sent to her.

35. The Tribunal also bore in mind Dr El-Neil's admission at paragraph 1ai of the Allegation and acceptance that she knew Patient A wanted full removal rather than partial removal of the Mesh.

Paragraph 1aii

36. The Tribunal considered the evidence regarding whether Dr El-Neil knew that Patient A did not want more than one procedure for full removal of the Mesh.

37. The Tribunal considered the Twitter message from Patient A to Dr El-Neil on 29 April 2017 and noted that Patient A referred to an operation in the singular:

> *'Im so praying that my health board here in Scotland will fund my full removal operation with you!'*

38. The Tribunal had regard to the letter from NHS Highland to Dr D, dated 20 July 2017, noting the comment; *'The CAG is curious to understand how the London surgeon claims to be able to remove all of the mesh, when 3 Scottish consultants have advised that this would be unlikely…'*.

39. The Tribunal considered that there were no explicit references in this letter or any of the documentation it was provided with regarding the number of procedures which might be required for full Mesh removal.

40. The Tribunal considered, therefore, that it could not be safely inferred that Dr El-Neil knew, from the correspondence, that Patient A did not want more than one procedure to fully remove the Mesh.

41. The Tribunal noted that Patient A met Dr El-Neil at Westminster in April 2017. Patient A had gone there with others to raise awareness of the potential adverse effects of Mesh surgery. Patient A's evidence did not suggest that the number of procedures was discussed but she stated that: *'we discussed at Westminster and she said she can do full removal of mesh'*.

42. The Tribunal noted the Twitter message from Patient A to Dr El-Neil in which Patient A talked about an operation in the singular. At this time Patient A was not yet Dr El-Neil's patient. As stated, the subsequent documentary evidence did not explicitly state how many procedures would be required. The Tribunal considered that there was insufficient evidence that Dr El-Neil knew that Patient A wanted only one procedure to remove the Mesh.

43. The Tribunal were not satisfied that Dr El-Neil knew Patient A did not want more than one procedure to fully remove the Mesh.

44. Accordingly, the Tribunal found paragraph 1aii not proved.

Paragraph 1b and 1c

45. The Tribunal considered whether Dr El-Neil told Patient A she could fully remove all three parts of the Mesh, namely the vaginal portion and the two obturator arms ('Mesh arms') or words to the effect (parapgraph1b) and failed to explain to Patient A that only part of the Mesh was likely to be removed during the Mesh removal procedure.

46. The Tribunal took 1b and 1c together as it considered if Dr El-Neil told Patient A she could fully remove the Mesh, it was likely to logically follow that she failed to explain that only part of the Mesh was likely to be removed in the operation to follow.

47. The Tribunal noted that the consent form stated complete removal of TVT-O. It did not say that a second procedure would be necessary to remove any other parts of the Mesh (the Mesh arms) that would be left following removal of the vaginal part.

48. The Tribunal considered that the consent form 23 October 2017 provided little evidence of the counselling said to have been given by either Dr El-Neil or Dr E which states complete removal. There was also no further evidence of any counselling given to Patient A for the procedure in the medical records.

49. Mr B's email sent to Patient A's GP, the day after the consultation with Dr El-Neil, referred to 100% removal of the Mesh. This was sent when the consultation was fresh in his mind and was likely to reflect the information given at the consultation to both him and Patient A who were both present throughout.

50. Dr El-Neil's evidence was that she had left obtaining informed consent to Dr E. She stated that, if she had been obtaining consent from Patient A, she would have clarified that she would be removing the vaginal portion of the Mesh only and that there may be a second procedure required to remove remnant Mesh.

51. The Tribunal considered that it was incumbent on Dr El-Neil and/or Dr E to explain what was being removed, it was not incumbent on Patient A to know the procedure would not mean completely removal of the Mesh.

52. The Tribunal noted that in the letter from Dr E to Dr F, dated 7 November 2017, regarding the consultation on 23 October 2017, he relayed that Patient A was consented for *'an EUA, cystoscopy, vaginal removal of the mesh tape and urethroplasty…'*

53. On the consent from signed by Patient A, it referred to as *'complete removal of TVT-O'*. The Tribunal considered it was reasonable for Patient A to assume this meant that there would be full Mesh removal. It was evidently not clarified to her that this would be only vaginal removal of the Mesh, which was only one of the three parts of the Mesh.

54. In Patient A's witness statement, she said that at the consultation in October 2017:

> *'I had been very clear when speaking with Dr El-Neil that I did not want a partial removal of TVT-O mesh and I did not want multiple procedures to achieve the full removal. Prior to the procedure, Dr El-Neil reassured me directly that she could fully remove the TVT-O mesh. She also never stated that it would require multiple procedures to fully remove the TVT-O mesh…'*

55. The Tribunal considered what documentation, if any, supported Patient A's contention that Dr El-Neil had reassured her directly that she could fully remove the Mesh in one procedure.

56. The Tribunal noted the letter from Nurse H, Clinical nurse, dated 2 February 2018 in which she relayed Patient A's recovery since the surgery on 13 December 2017 and stated Patient A *'of course was keen to know if all the tape was completely removed…'*

57. The Tribunal noted Dr El-Neil's letter to Mr I, NHS Highland, dated 28 March 2018, in which she wrote that:

> *'Following a cystoscopy to rule out the possibility of mesh in the urethra or in the bladder, we proceeded with surgery whereby we hydrodissected the area with Bupivacaine and Adrenaline and then mobilised the anterior vaginal wall with an inverted Y incision. We were able to then remove the mesh in its entirety. It was quite firmly embedded into the obturator facsia…'*

The Tribunal considered that both of these letters lent support to the assertion that Dr El-Neil told Patient A she was able to remove all the Mesh.

58. The Tribunal considered that there was a duty on Dr El-Neil to have a full conversation about the operation and its limitations with Patient A. In Dr El-Neil's evidence she described it as a 'Stage 1' of two operations that would be required, as such she was offering only partial removal of the Mesh as there was likely to be remnant Mesh in the vagina and two parts of the Mesh remaining. Patient A, however, was clear that she wanted full removal of the Mesh.

59. The Tribunal bore in the mind the high regard in which Dr El-Neil was seen by Patient A and Mr B. Dr El-Neil was considered a leader in the field of Mesh removal and Patient A had specifically requested to be referred to her, sought funding from NHS Highlands for the operation and travelled down to London for the consultation.

60. Patient A had told Dr El-Neil in a Twitter message that *'Only the best will do and thats you!'* and Mr B, the day after the consultation, emailed Patient A's GP, Dr D, relaying that they had both met with Dr E and Dr El-Neil for approximately an hour, and emphasised that Dr El-Neil had 'twice successfully removed *100% tvt-o just this last ten days and is the only, qualified through experience, person fit and able…'*

61. The Tribunal considered that if Dr El-Neil had been absent for any considerable portion of the consultation this would have caused Patient A and Mr B concern. Moreover, following the consultation both Patient A and Mr B had the impression that it would be Dr El-Neil carrying out the procedure. Whilst Patient A and Mr B accepted Dr El-Neil popped in and out of the consultation, the Tribunal considered it was reasonable to infer she was present for sufficient time to have reassured Patient A that she could fully remove the Mesh.

62. Dr El-Neil's evidence was that she likely popped in to say hello, and that she had appropriately delegated the taking of informed consent and counselling of Patient A to Dr E.

63. In Dr C's expert report, dated 13 October 2021, he opined that:

> *'Given the highly specialised nature of Dr El-Neil's practice and her national profile as a doctor specialising in mesh complications, and due to the complex nature of Patient A's condition, in my opinion Dr El-Neil should have been personally involved in the decision as to the nature and extent of any proposed surgical treatment. As part of*

that decision making, I would expect Dr El-Neil to have reviewed the referral documentation and obtained a briefing from Dr E as to his clinical findings. If it is the case that Dr El-Neil did not receive a briefing on Patient A's history and the findings on physical examination, I would expect her to make a personal assessment of Patient A before deciding to offer surgical treatment. If it is the case that Dr El-Neil was not informed by Dr E about the details of Patient A's condition and if she did not personally assess Patient A and the relevant documentation before recommending surgical intervention, then in my opinion her assessment and examination of would fall below the standard expected of a reasonably competent Consultant in Obstetrics and Gynaecology..'

64. The Tribunal considered that it was likely that Dr El-Neil was present in the consultation as described by Patient A and Mr B, she therefore knew Patient A wanted full removal of the Mesh and she had told Patient A she could fully remove the Mesh but that there may have been a breakdown in communication in what this meant. Dr El-Neil told Patient A she could fully remove the Mesh but did not clarify that this was the vaginal part only and therefore failed to explain that only part of the Mesh would be removed.

65. The Tribunal considered that, even if Dr El-Neil had delegated the taking of consent to Dr E, she remained responsible for ensuring that Patient A was fully informed about the planned procedure that was going to be undertaken and she was responsible for ensuring that Patient A understood the procedure would only be partial removal of the Mesh.

66. The Tribunal had regard to the GMC Guidance on consent: 'Consent: patients and doctors making decisions together, 2008' ('the Consent Guidance') and considered the following paragraphs to be applicable in this case:

'2 Whatever the context in which medical decisions are made, you must work in partnership with your patients to ensure good care. In so doing, you must:

a) listen to patients and respect their views about their health
b) discuss with patients what their diagnosis, prognosis, treatment and care involve
c) share with patients the information they want or need in order to make decisions
d) maximise patients' opportunities, and their ability, to make decisions for themselves

5 If patients have capacity to make decisions for themselves, a basic model applies:

b) The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.

c) The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one. They also have the right to accept or refuse an option for a reason that may seem irrational to the doctor, or for no reason at all.

d) If the patient asks for a treatment that the doctor considers would not be of overall benefit to them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, they do not have to provide the treatment. But they should explain their reasons to the patient, and explain any other options that are available, including the option to seek a second opinion.

7 The exchange of information between doctor and patient is central to good decision-making. How much information you share with patients will vary, depending on their individual circumstances. You should tailor your approach to discussions with patients according to:

a) their needs, wishes and priorities
…
d) the complexity of the treatment
…

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

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

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

67. Dr El-Neil relied on the fact that Dr E was a consultant in his native country. The Tribunal received no evidence in relation to standards of consent in this country. Dr El-Neil also relied upon the fact that he was working independently at the time of the consultation with Patient A.

68. The Tribunal was mindful that Dr E had been in a trainee subspecialty role (Mesh removal) for a period of approximately ten weeks at the time of consultation on 23 October 2017, having started in August 2017. The Tribunal had regard to the Mesh Removal Surgery Training Log for Dr E and noted that, according to the audit trail, his exposure to patients with this type of Mesh was limited to single figures. Given this lack of experience, the Tribunal was satisfied that it remained incumbent on Dr El-Neil to ensure that he had properly counselled and obtained informed consented from Patient A.

69. In cross examination, when asked whether she checked to ensure Dr E was following procedures properly, Dr El-Neil said that *''I would have felt it wouldn't be appropriate because it would be undermining his position in that situation.''* The Tribunal take the view that this is not a good reason to fail to ensure informed consent had been properly given.

70. In all the circumstances, the Tribunal was satisfied that Dr El-Neil should not have been delegating the responsibility of obtaining informed consent without her ensuring that Patient A had all the necessary information. Even if she had delegated the responsibly, it was still incumbent on her to ensure that Patient A had been given all the information she needed to give informed consent.

71. The Tribunal therefore found paragraph 1b and 1c proved.

Paragraph 2a and 2b

72. The Tribunal considered whether on 13 December 2017 Dr El-Neil was part of the surgical team performing the Mesh Removal Procedure and following completion, when asked by Patient A *'did you get all of my Mesh?'* or words to that effect, responded by a) putting two thumbs ups, and b) saying 'yes' or words to that effect.

73. It is agreed that Dr El-Neil was part of surgical team performing the Mesh Removal Procedure on 13 December 2017 although Dr El-Neil could not recall what active a part, if any, she took in the surgery. It is agreed that she conducted a post operative review in the recovery room. The nature of the consultation is disputed.

74. In Patient A's witness statement, she stated:

> *'I recall that after the procedure, when I was in the recovery room at UCLH, I saw Dr El-Neil standing at the door when I woke up. I remember very clearly that the first thing I said to her was 'Did you get all my mesh?' to which Dr El-Neil responded with two thumbs up and said 'yes!'…'*

75. In Mr B's witness statement dated 18 March 2024, he stated that:

> *'After Patient A came out of surgery on 13 December 2017, I went up to visit her in the recovery room. On the way to the recovery room, I crossed paths with Dr El-Neil in the corridor. I was heading down the corridor and Dr El-Neil was heading towards the lift.*

Dr El-Neil looked at me and said 'It was fine. It was difficult. I got it all.' I specifically remember this as she gave me the thumbs up. My impression from this was that Dr El-Neil had removed all the mesh..'

76. The Tribunal was mindful that Patient A was seen by Dr El-Neil around 25 minutes after operation and still in the early stages of recovery.

77. The Tribunal noted the evidence of the expert Dr C, who stated that patients were likely to remain drowsy after an operation. He stated, whilst it was perfectly possible to have a conversation with a patient in that sort of time scale after a procedure, a patient's ability to recall what was said is likely to be impaired.

78. Dr El-Neil had no recollection of this interaction with Patient A but did not accept that she would have responded to Patient A by putting two thumbs up as it was not a natural gesture she relied upon or part of her character or style of communication with patients. She had stated in her witness statement that she thought it was Dr E who had put his thumbs up. This memory proved to be inaccurate as the records showed that she had undertaken the review with a different doctor. Dr El-Neil also stated she would not have confirmed to Patient A that all of her Mesh had been removed as this was not correct. In her witness statement, Dr El-Neil explained that:

'In 2017, all Mesh removal surgery was done using the two-stage approach, and during the second surgery we would check for remnant visible Mesh. I therefore we would not have confirmed that all of the Mesh had been completely removed as there was a possibility that remnant visible Mesh would be identified during the further procedure to treat recurrence of urinary stress incontinence and, in relation to removal of Mesh arms embedded in the obturator, we had been advised that this surgery should only be discussed where following initial removal the patient continued to experience significant symptoms or infection.

My usual practice at the time would have been to confirm that all of the ***vaginal Mesh*** *(her emphasis) had been removed and I would not have confirmed removal of Mesh without this qualification..'*

79. In reaching its decision, the Tribunal was mindful of the passage of time since 13 December 2017 and the potential effect this can have on a witnesses' memory. The Tribunal considered that there was the possibility of 'innocent contamination' between the accounts given by Patient A and Mr B in respect of the Dr El-Neil putting her thumbs up.

80. The Tribunal was not satisfied on the balance of probabilities that, if thumbs were raised, it was Dr El-Neil who had put her thumbs up in response to Patient A's question.

81. The Tribunal therefore found paragraph 2a not proved.

82. However, the Tribunal noted that this review took place in the recovery room and so a place of privacy. The Tribunal considered it would have been a normal and natural reaction to affirm that the operation was successful, albeit Patient A and Dr El-Neil may have had a different understanding of what was meant by 'all of the Mesh' with Dr El-Neil, at that time, working on the basis that it meant of all the vaginal Mesh.

83. In relation to paragraph 2b, therefore, the Tribunal considered that it was more likely than not that Dr El-Neil said *'yes'* or words to the effect, when asked by Patient A *'did you get all of my Mesh?'.*

84. The Tribunal therefore found paragraph 2b proved.

Paragraph 5

85. The Tribunal went on to consider whether any of Dr El-Neil's conduct was dishonest.

86. Given that the Tribunal found it was not satisfied on the balance of probabilities that Dr El-Neil put two thumbs up in response of Patient A asking her if she had got out all her Mesh, the allegation of dishonesty, as it relates to paragraph 5ai, did not need to be considered.

Post Operation

87. The Tribunal considered whether Dr El-Neil's actions on 13 December 2017 in saying 'yes', or words to the effect, in response to Patient A asking her if she had got out all of her Mesh, was dishonest by reason of Dr El-Neil having known, or ought to have known, that not all of the Mesh had been removed.

88. The Tribunal reminded itself of the two-stage test for dishonesty at set out in *Ivey.*

89. The Tribunal first considered Dr El-Neil's state of knowledge or belief as to the facts on 23 October 2017.

90. The Tribunal bore in mind that Dr El-Neil had failed to obtain informed consent from Patient A for the removal of the Mesh. She knew that Patient A did not want a partial removal of the Mesh. She told Patient A that she could fully remove the Mesh and failed to explain to Patient A that only part of the Mesh was likely to be removed during the operation.

91. As a result of this failure to obtain informed consent, the Tribunal could not rule out that there had been a breakdown in communication between Dr E-Neil and Patient A. It may reasonably be inferred that Dr El-Neil equated, at that time, 'all of the Mesh' to 'all of the vaginal Mesh.' Whilst at the same time Patient A was referring to the complete Mesh, no matter where located.

92. Dr El-Neil could and should have clarified she was referring to the vaginal part of the Mesh or that there could technically have been approximately 20% of the Mesh remaining in the vaginal space. However, in the circumstances of reassuring Patient A in the recovery room post-surgery that the procedure had been successful, the Tribunal considered that Dr El-Neil was not subjectively dishonest. The Tribunal were of the view that it would not be considered dishonest by the objective standards of ordinary decent people, if her response may have been made as a result of a breakdown of communication.

93. Accordingly, the Tribunal found paragraph 5bi in respect of paragraph 5ii, not proved, that is it found that Dr El-Neil's response was not dishonest.

NHS Highland

94. The Tribunal considered whether Dr El-Neil's actions on 28 March 2018, when she wrote to NHS Highland regarding the Mesh Removal Procedure and stated *'we were able to remove the mesh in its entirety. It was quite firmly embedded into the obturator fascia.'*, was dishonest by reason of Dr El-Neil having known, or having ought to have known, that not all of the Mesh had been removed.

95. The Tribunal reminded itself of the two-stage test for dishonesty at set out in *Ivey.*

96. The Tribunal first considered Dr El-Neil's state of knowledge or belief as to the facts at the time she responded to NHS Highland on 28 March 2018.

97. The Tribunal had regard to the letter that Dr El-Neil was responding to, namely an email of 8 November 2017 from Mr I, Service Planning Manager on behalf of the CAG, NHS Highland.

98. Mr I wrote that Patient A:

> *'…has seen numerous gynaecologists in Scotland offering a chance of total removal in the high 90 percentile. It is reported that you have a higher success rate and wonder if you can confirm whether you think it is possible to remove* ***all of this lady's mesh****, in order to help improve her health and wellbeing? If you can share your treatment plan or outpatient letter with us that will be very helpful in securing funding for any planned procedure…'*

99. The Tribunal considered that it was quite clear that Mr I's November letter was asking how Dr El-Neil could do better than the numerous gynaecologists Patient A had seen in Scotland. It considered that it was clear he was enquiring if she could remove all the Mesh.

100. The Tribunal noted that at the time Dr El-Neil wrote the letter of 28 March 2018, it was now three months post the operation. She would have known the limitations of the operation. In addition, she would have seen the letter from Nurse H dated 2 February 2018, that Patient A was *'keen to know if all the tape was completely removed…'*

101. Dr El-Neil had taken some time to respond to Mr I's email. Her response is dated 28 March 2018, she stated in it that:

> *'… Patient A was admitted to us here at University College Hospital on 13th December 2017.*
>
> *She had an examination under anaesthesia, cystoscopy, removal of vaginal mesh, urethroplasty, vaginal reconstruction and Mirena change.*
>
> *The TVT-O could be palpated above the middle to distal third of the urethra and although there was no erosion into the vagina the position of the TVT-O was clearly not in the right side.*
>
> *There was also some thinness to the skin and it was fairly tight.*
>
> *Following a cystoscopy to rule out the possibility of mesh in the urethra or in the bladder, we proceeded with surgery whereby we hydrodissected the area with Bupivacaine and Adrenaline and then mobilised the anterior vaginal wall with an inverted Y incision.* ***We were able to then remove the mesh in its entirety. It was quite firmly embedded into the obturator fascia…'***

102. The Tribunal noted that there was no mention in Dr El-Neil's reply of a two-stage approach and that a second procedure would be necessary to ensure the TVT-O was completely removed. Whilst early on in the letter she referred "removal of vaginal mesh", the Tribunal considered that the subsequent statement ***'We were able to then remove the mesh in its entirety. It was quite firmly embedded into the obturator fascia',*** without any further qualification, was likely to mislead the reader.

103. The Tribunal considered that there had been little ambiguity as to what Patient A had wanted when she sought funding for her operation in London with Dr El-Neil. NHS Highland initially agreed to her going to London for an assessment and wanted an understanding as to how Dr El-Neil could remove all three parts of the Mesh when the surgeons in Scotland had been loath to remove the two parts in the obturator fascia because of the risks involved. The Tribunal considered that it was a reasonable inference that NHS Highland had been willing to fund the surgery only on the basis of Patient A having all the Mesh removed. If this key fact had been misunderstood by Dr El-Neil when the operation happened in December 2017, it cannot reasonably have been so when she responded to Mr I.

104. The Tribunal determined that Dr El-Neil stated *'We were able to remove the mesh in its entirety. It was quite firmly embedded into the obturator fascia'.* These words were evidently misleading because the actual operation performed, on Dr El-Neil's own evidence to the Tribunal, was never intended to remove all of the Mesh. She knew that there were likely to be remnants of the Mesh in the vaginal part and that two other parts of the Mesh remained. Dr El-Neil did not make that clear in her response to Mr I's letter.

105. In Dr El-Neil's GMC witness statement she acknowledged that there was a lack of clarity in her statement on 28 March 2018. She conceded that the letter had been inadvertently misleading but denied she was dishonest. She stated:

> *'In this letter I set out in the third paragraph that Patient A had undergone "an examination under anaesthesia, cystoscopy, removal of vaginal mesh, urethroplasty, vaginal reconstruction and Mirena change." No reference was made throughout this letter to separate Mesh removal from the obturator muscles. The obturator fascia overlies the deep-set obturator muscles.*
>
> *Where I have referred in the first instance to the removal of vaginal Mesh earlier in this letter, any subsequent reference to the removal of such Mesh in its entirety refers solely to vaginal Mesh. I also would have understood that removal of the entirety of the vaginal Mesh would have related to the removal using the two-step approach. I would accept that in hindsight it would have been better to make clear that not all the Mesh had been removed, just that from the vagina as confirmed by follow up scans and I apologise for the lack of clarity in terminology and phraseology used in this letter.*
>
> *Removal of any Mesh beyond the obturator foramina would require paralabial (groin) dissection and careful liaison with orthopaedic colleagues, who had advised at the time to only remove Mesh from this region if there was infection present due to the high risk of nerve and vascular injury. Given this advice, this aspect of Mesh removal was not considered to be part of the intended operation or standard initial treatment to be provided to patients and was only to be pursued with orthopaedic input where symptoms continued and specifically required groin dissection…'*

106. The Tribunal bore in mind that Mr I was not a specialist in this field and had been clear in his enquiries. It considered that it must have clear to Dr El-Neil that Mr I was asking about all of the Mesh, not just the vaginal Mesh.

107. Furthermore, Dr El-Neil gave evidence that that she had no memory of active participation in the operation of 13 December 2017 at all. Her addition of the description of the Mesh being '*quite firmly embedded into the obturator fascia'* is not a description that appears in the operation note of the same date. The Tribunal considered that this description is therefore surprising to see in her reply. It was unlikely that she would recall such a detail if she did not take part or had no memory of taking part in the operation. The description would have added to the false impression given by her letter that the Mesh had been removed in its entirety.

108. The Tribunal considered, looking at the letter as a whole, that it was more likely that Dr El-Neil had carefully chosen her words to give this impression rather than there been an inadvertent lack of clarity on her part.

109. Given her state of knowledge at the time, the Tribunal determined that Dr El-Neil was subjectively dishonest. It also determined that this would be considered dishonest by the objective standards or ordinary decent people.

110. Accordingly, the Tribunal found paragraph 5bi in respect of paragraph 3, proved, that is it found that Dr El-Neil's response to NHS Highland was dishonest.

The Tribunal's Overall Determination on the Facts

111. The Tribunal has determined the facts as follows:
That being registered under the Medical Act 1983 (as amended):

1. On 23 October 2017 you consulted with Patient A about symptoms related to an implanted Gynecare TVT Obturator System ('the Mesh'), and you failed to obtain informed consent from Patient A for removal of the Mesh ('the Mesh Removal Procedure') in that you:

    a. knew that Patient A did not want:

        i. a partial removal of the Mesh; Admitted and found proved

        ii. more than one procedure to fully remove the Mesh; Not proved

    b. told Patient A you could fully remove the Mesh, or words to that effect; Determined and found proved

    c. failed to explain to Patient A that only part of the Mesh was likely to be removed during the Mesh Removal Procedure. Determined and found proved

2. On 13 December 2017 you were part of the surgical team performing the Mesh Removal Procedure, and following completion, when asked by Patient A '*did you get all of my Mesh?*' or words to that effect you responded by:

    a. putting two thumbs up; Not proved

    b. saying '*yes*' or words to that effect. Determined and found proved

3. On 28 March 2018 you wrote to NHS Highland regarding the Mesh Removal Procedure and you stated that *'we were able to remove the mesh in its entirety. It was quite firmly embedded into the obturator fascia'*. Admitted and found proved

4. When you acted in the manner described at paragraph 2 and/ or paragraph 3, you:

a. knew or ought to have known that not all of the Mesh had been removed; Admitted and found proved

~~b. in the alternate to paragraph 4.a. above, did not know if all of the Mesh had been removed.~~
Alternative allegation, falls away following admission to paragraph 4a

5. Your conduct:

a. as described at:

~~i. paragraph 2.a.; and/or~~

ii. paragraph 2.b; and/or

iii. paragraph 3;

b. was dishonest by reason of:

~~i.~~ paragraph 4.a; ~~and/or~~
Falls away in relation to paragraph 2.a
Not proved in relation to paragraph 2.b
Determined and found proved in relation to paragraph 3

~~ii. paragraph 4.b.~~
Alternative allegation, falls away following admission to paragraph 4a

Determination on Impairment - 17/10/2024

112. 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 El-Neil's fitness to practise is impaired by reason of misconduct.

The Outcome of Applications Made during the Impairment Stage

113. The Tribunal granted Mr Davidson's application, on behalf of Dr El-Neil, to admit additional evidence, in accordance with Rule 34(1) of the Rules. The Tribunal's full decision on the application is included at Annex A.

The Evidence

114. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence on behalf of Dr El-Neil. This included but was not limited to:

- A letter from Professor J, Professor of Urology/ Medical Director at UCLH, dated 25 August 2021
- Dr El-Neil's reflective statement, dated 15 October 2024
- Numerous Patient Information Leaflets, information regarding improvements to the London Complex Mesh Centre Pathways and documents produced by NHS England and NICE
- Dr El-Neil's Continuing Professional Development (CPD) portfolio of the Royal College of Obstetrics and Gynaecology.

Submissions

GMC submissions

115. Ms Nowell submitted that Dr El-Neil's fitness to practice is impaired by reason of misconduct by both her dishonesty and her failure to obtain informed consent. She submitted that in terms of, at least the dishonesty, Dr El-Neil has shown no remorse, insight or remediation upon which the Tribunal can properly conclude that the conduct would not be repeated.

116. She submitted that all limbs of the overarching objective are engaged and relied particularly on (b) and (c) and submitted that the doctor's conduct and in particular her dishonesty was serious and bound, if discovered, to lead to the individual patient's and the general public's loss of confidence in the medical profession. A finding of impairment is also necessary to promote and maintain the standards of the profession.

117. With regards to consent she submitted that if you do not have informed consent, then it is essentially an assault on the patient as you are operating on an individual without them having consented to that particular surgery. She submitted that honesty is one of the main tenets of the medical profession. Consent is an important part of any doctor's practice. Not only does it form part of good medical practice, the Tribunal have also found that Patient A did not give consent to the operation that was ultimately performed on her.

118. She submitted that insight, remorse and remediation, are the three factors that the Tribunal have to take into account when looking at whether or not the doctor remains currently impaired.

119. First of all, in terms of lack of consent she submitted that the emails the Tribunal were provided with this morning may be relevant as to when Mr B understood the nature of the

operation performed. There are questions that remain unanswered when we see that e-mail exchange. She submitted that the Tribunal do not know where Mr B got his information from, but there is certainly no evidence that it came from Dr El-Neil. There is no evidence Dr E-Neil intervened to enlighten Mr B or Patient A at this time.

120. With regard to the need for informed consent, the GMC accepts that there has been some remorse and insight, certainly within the doctor's recent stage two statement, but also in her stage one statement, she apologized to Patient A. However, she submitted it does not go far enough. She said that Dr El-Neil did not "put her hands up" and say the lack of consent was down to her but at all times blamed another colleague for this failure. This has precluded any ability to demonstrate insight and remediation personally for the misconduct.

121. She submitted the CPD that is listed does not include any learning in respect of consent. She also said that there is CPD that involves audits and discussions with patients, but there seems to be no learning or CPD directly on informed consent and what it ought to involve.

122. Moving on to the allegation of dishonesty, she submitted that is extremely difficult to demonstrate remorse, insight and indeed remediation. In respect of the allegation of dishonesty, she submitted that there has been no evidence of insight, rendering remediation extremely difficult to demonstrate. In addition, once more the GMC relies on the lack of CPD or any potential other form of remediation in respect of the allegation. In the circumstances the GMC contends that Dr El-Neil has provided no evidence upon which the Tribunal could properly consider that her misconduct will not be repeated in the future.

<u>On behalf of Dr El-Neil</u>

123. Mr Davidson noted the Tribunal have found the doctor was dishonest in relation to correspondence to NHS Highland. The doctor acknowledges that a finding of misconduct will be established. She recognises that honesty and integrity is a core tenet of good medical practice.

124. Turning to the issue of impairment, he submitted that the findings at stage 1 extend beyond the finding of dishonesty as it relates to the communication with NHS Highland and also extends to the Tribunal's views relating to the breakdown of communication and the failure to obtain properly informed consent from Patient A both prior to but also with the continuation of any breakdown of communication in the period immediately after the surgery.

125. With regards to insight, he submitted that Dr El-Neil recognises the importance of communication between patients and the treatment that must be provided to them. The concern of breakdown of communication was acknowledged by Dr El-Neil in her communications and in her witness statement. He submitted that Dr El-Neil extended an apology to Patient A within her witness statement, an apology which was repeated to the Patient A at the outset of the cross examination.

126. He submitted that within the doctor's witness statement, there is an expression of regret and an apology extended to NHS Highland for the lack of clarity in the correspondence as to the circumstances in which these failings took place.

127. He submitted that he wished to emphasise the significant pressures under which Dr El-Neil and her team were working at the time of the events.

128. He further submitted that the pressure on the services and upon Dr El-Neil is also evidenced by the fact that her operating time in 2019 had to be discontinued for a period due to the reconfiguration of the service.

129. Mr Davidson highlighted the remediation and the efforts that have been made by Dr El-Neil to reconfigure, update and improve the service since that time.

130. He submitted that Dr El-Neil has made changes in her individual practice. He emphasised much of the restructuring of the Mesh removal service has taken place as a result of the efforts made by the doctor herself to drive through change in order to provide a better service for patients and avoid some or all of the problems which this case is based on.

131. He submitted that in the period that has elapsed, other centres have been developed and so not only has there been an expansion of the service at UCLH, but that the pressure has also been relieved by the development of these other services and their ability to take on some of the numbers of patients that are seeking Mesh removal.

132. He submitted that evidence to support further improvement in patients and management information is also to be seen in the patient information leaflets that have been provided to the Tribunal. He submitted that the Tribunal have been provided with updated documents relating to the removal of the Mesh which goes a considerable way to safeguarding patients from the miscommunication, which is evidence in this case with Patient A.

133. He submitted that patients are being asked for their feedback. He further submitted that once these forms have been reviewed, there will be then a review of the patient information leaflet and supporting documentation.

134. Mr Davidson referred the Tribunal to the recent layout of the patient pathway, he submitted that there has been a complete recasting of the patient pathway since 2017/ 2018 driven through by Dr El-Neil and creating a situation where it would be highly unlikely that Patient A or any equivalent patient would be left in any doubt whatsoever as to what surgery was being proposed and what risks or benefits was being offered. He informed the Tribunal that this process is being rolled out at the other Mesh centres based upon the UCLH model.

135. He said that there is now a Mesh query e-mail address supported by an administration team dedicated to Mesh removal patients, allowing another portal by which

patients can communicate with the Mesh removal service to highlight their concerns and to receive appropriate advice, guidance and reassurance in appropriate cases.

136. Turning to the finding of dishonesty he submitted that there was no finding of dishonesty made by the Tribunal in relation to her interactions with Patient A. He submitted that the dishonesty was clearly not for any personal benefit on the part of Dr El-Neil, whether that be financial or reputational. Indeed, it remains difficult to see what motive or benefit Dr El-Neil might have gained from her dishonesty.

137. He submitted that the Tribunal have not been provided with testimonials but there is evidence about Dr El-Neil's clinical abilities and the plaudits that she has gained over the years, not only from colleagues but from patient groups arising out of her work in the fields of urogynaecology.

138. Mr Davidson accepted that there is no specific reference to courses on consent, however there are a significant number of learning credits and learning events dedicated to patient's partnership and communication on the doctors CPD log. He submitted that consent has been a natural feature of each of those training episodes and dealing with patients and communication consent has borne part of the reflections and further training undertaken by Dr El-Neil.

139. When turning finally to the doctor's reflective statement, Mr Davidson suggested that it supported many of the points which he has made in his submissions. He further submitted that the evidence in this case would not support a finding of impairment of current fitness to practice.

The Relevant Legal Principles

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

141. 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.

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

The Tribunal's Determination on Impairment

Misconduct

143. The Tribunal considered whether the facts found proved fell so far short of the standards reasonably to be expected of a doctor so as to amount to misconduct.

144. The Tribunal's findings on facts relate to two parts. The first related to the failure of Dr El-Neil to obtain informed consent for the surgical intervention from Patient A. The second related to Dr El-Neil's dishonest representation to NHS Highland as to the nature of the surgery that had been performed.

Failure to obtain informed consent

145. The Tribunal considered whether Dr El-Neil's failure to obtain informed consent from Patient A on 23 October 2017 amounted to misconduct.

146. The Tribunal considered that the obtaining informed consent is essential for any intervention undertaken by a doctor and is especially important when surgical intervention is being considered.

147. The Tribunal considered the following paragraphs of GMP (2013 version) to be engaged in this case:

> *16 In providing clinical care you must:*
>
> > *b) provide effective treatments based on the best available evidence*
>
> *17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research*
>
> *18 You must make good use of the resources available to you*
>
> *45 When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient*
>
> *49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:*
>
> > *a) their condition, its likely progression and the options for treatment, including associated risks and uncertainties*

148. The Tribunal also considered that the following paragraphs of the Consent Guidance 2008 were engaged in this case:

> *5 If patients have capacity to make decisions for themselves, a basic model applies:*

b) The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.

c The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one. They also have the right to accept or refuse an option for a reason that may seem irrational to the doctor, or for no reason at all.

d If the patient asks for a treatment that the doctor considers would not be of overall benefit to them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, they do not have to provide the treatment. But they should explain their reasons to the patient, and explain any other options that are available, including the option to seek a second opinion

149. The Tribunal bore in mind that Patient A had been the subject of a surgical intervention as a result of the implantation of a TVT-O Mesh in a different service. As a consequence of this procedure, she suffered from symptoms for which she sought resolution via Dr El-Neil. Her symptoms included but were not limited to, chronic pain, frequent urinary tract infections ('UTIs') and a severe impact on her mobility, lifestyle and mental health. As a result, Patient A wanted full removal of her Mesh and had deliberately sought out Dr El-Neil due to her high standing within the Mesh removal community and her expertise. She asked to be referred from her health authority in Scotland to England and sought NHS Highland funding to be treated by Dr El-Neil in London.

150. The planned surgery was to be an invasive and intimate intervention. The operation was complex. Full Mesh removal was associated with high risks, which included damage to important structures such as blood vessels, nerves, scarring and chronic pain. There were limitations to its success and had the potential to make the clinical situation worse. Very few surgeons were offering full Mesh removal at the time of these events.

151. The Tribunal considered that it was incumbent on Dr El-Neil to ensure she dealt with Patient A's expectations, explain the nature of the procedure that she was providing, its risks and limitations. There could and should have been every opportunity in the consenting process for there to have been mutual agreement between Dr El-Neil and Patient A for the procedure that was undertaken in December 2017. Patient A believed she had consented to a different surgical procedure, i.e. full removal of her Mesh. Dr El-Neil was offering and only carried out a partial removal of the Mesh.

152. The Tribunal also considered the following parts of Dr C's report to be particularly relevant:

> *'While delegating the assessment of Patient A to Dr E, Dr El-Neil remained responsible for ensuring that Patient A was adequately informed as to the nature of her condition and the proposed treatment plan in accordance with paragraph 32 of 'Good Medical Practice' which states:*
>
> > *"...You must give patients the information they want or need to know in a way they can understand".*
>
> *The GMC states that the information that patients will need to make decisions about their care in paragraph 49a of 'Good Medical Practice" should include:*
>
> > *"...their condition, its likely progression and the options for treatment, including associated risks and uncertainties".*
>
> *If it is the case that Dr El-Neil did not explain to Patient A on 23rd October 2017 that it was her invariable practice to remove only the central vaginal portion of the TVT-O mesh, and if it is the case that Patient A would not have agreed to undergo surgery for a partial removal of the mesh, then in my opinion Dr El-Neil's omission fell seriously below the standard expected of a reasonably competent Consultant in Obstetrics and Gynaecology.*
>
> *…*
>
> *If it is the case the Dr El-Neil failed to indicate that the procedure would be limited to a partial removal of the vagina portion of the mesh, and in so doing failed to obtain valid informed consent from on or prior to 13th December 2017, then in my opinion her actions fell seriously below the standard expected of a reasonably competent Consultant in Obstetrics and Gynaecology. I would consider this to fall seriously below the standard expected as to operate on a patient without valid informed consent would be to fail to treat them as individuals and to respect their dignity.*
> *…*
>
> *If it is the case that Dr El-Neil operated on without obtaining valid informed consent for the procedure, then in my opinion the overall standard of care was seriously below the standard expected of a reasonably competent Consultant in Obstetrics and Gynaecology. I reach this conclusion in the light of the GMC document 'Decision making and consent' which states that:*
>
> > *"All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able".*

> *"Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action".*

> *In my opinion it was unambiguously the case that Patient A had a particular and legitimate interest in having all of the surgical mesh explanted from her pelvis, and that she sought out the help of Dr El-Neil with that goal in mind. If Dr El-Neil did not try to find out what mattered to Patient A and by admitting [sic] (omitting) to do so caused her to undergo an unwanted procedure, then in my opinion Dr El-Neil failed to treat* Patient A *as an autonomous competent individual…'*

153. The Tribunal noted the serious impact on Patient A's trust in Dr El-Neil and in the medical profession more widely, when she realised that not all the Mesh had been removed.

154. In Patient A's witness statement she stated:

> *'On 19 June 2021 I received a surprise telephone call from Dr El-Neil. This phone call, which Dr El-Neil told me was a standard check-up call, came completely out of the blue. Mr B was also on the call with me. I recall being very direct and frank in this telephone conversation and I expressed how I had lost faith and trust in her…'*

155. The Tribunal bore in mind that Dr El-Neil acknowledged that Patient A had lost trust in her in her correspondence following this consultation. Dr El-Neil recorded, following the review with Patient A on 19 June 2021, that Patient A *'had lost trust in our service, and I told her I was saddened to hear this. I informed her that NHS England has now set up multiple complex mesh centres throughout the UK. She asked which one she could be referred to and then stated she was not sure which service she could trust…'*

156. Taking everything into account, the Tribunal was satisfied that Dr El-Neil's failure to obtain informed consent fell so far short of the standards expected so as to amount to misconduct which was serious.

Dr El-Neil's dishonest representation to NHS Highland

157. The Tribunal found that Dr El-Neil had been dishonest when she wrote to NHS Highland on 28 March 2018 and stated '*we were able to remove the mesh in its entirety. It was quite firmly embedded into the obturator fascia.*'

158. The Tribunal considered the following paragraphs of the GMP to be engaged:

> *'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues,1 are honest and trustworthy, and act with integrity…*

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'

159. The Tribunal also noted Dr C's opinion that:

'…if it is the case that Dr El-Neil claimed in a letter to NHS Highland that the mesh had been completely removed while knowing that this was unlikely to be true, then her actions fell seriously below the standard expected of a reasonably competent Consultant in Obstetrics and Gynaecology. I would consider this to fall seriously below the standard expected since the failure to be honest and open and act with integrity impairs the necessary trust between patients and their doctor.'

160. The Tribunal was satisfied that Dr El-Neil's dishonest conduct fell so far short of the standards to be expected of a doctor so as to amount to serious misconduct.

Impairment

161. The Tribunal having found that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Dr El-Neil's fitness to practise is currently impaired.

162. They first considered Dr El-Neil's insight and remediation into her failure to obtain informed consent from Patient A. The Tribunal was mindful that this failure related to one patient and that there has been no evidence of repetition.

163. In Dr El-Neil's reflective statement, she stated:

'I recognize that the care provided was not as holistic, supportive, or effective as it should have been. I have expressed my sincere apologies to the patient for this. Many patients, including Patient A, needed not just physical treatment but also emotional support and the reassurance that they were being truly heard and understood. Unfortunately, the limitations of our resources meant that I could not offer individualized attention to every patient, and delegating responsibilities to the team did not consistently achieve the desired standard of care.

There were specific issues, such as a misalignment of expectations: Patient A believed her surgery would be a one-stage procedure, while our policy at the time required a multi-stage approach. In hindsight it would have been better for me to have communicated this myself, rather than leaving it to a colleague. Additionally, there were gaps in our follow-up processes, and I did not always ensure that notes, consent forms, and care arrangements were thoroughly reviewed by me. I now realize that I should have detected these shortcomings much sooner.

During this period, we were also working to enhance our governance structures, including conducting research audits, developing patient information leaflets, and

formalizing multidisciplinary team (MDT) meetings. These improvements took time to implement, and during the transition, we fell short of delivering the comprehensive care our patients needed, which I regret and apologize for.

…

I acknowledge the challenges Patient A faced caused distress, anxiety, and a sense of being overlooked. Patient A's experience highlighted to me the need to address not only physical health issues but also to support the psychological and social aspects of care. The delays in communication may well have exacerbated feelings of helplessness and frustration, ultimately affecting the patient's recovery and trust in the healthcare system. I remain deeply sorry about this…'

164. The Tribunal considered that Dr El-Neil has shown a good degree of insight into the need for sharing information with patients with a view to them making more informed decisions in general terms. However, as Dr El-Neil sought to blame Dr E for the failure to take informed consent at this hearing, this has restricted her ability to show personal insight and apply remediation to her own practice going forward and demonstrate how her own failure has impacted on Patient A and public trust in the medical profession as a whole. Insight into her own misconduct, therefore, has not been demonstrated.

165. The Tribunal accepted that the Mesh removal surgery was an emerging service at the time. The Tribunal accepted that since mid-2018 Dr El-Neil has made systematic changes to the Mesh removal service, which she has outlined in her reflective statement, for example, in the Patient Information leaflets she provided. These system changes will reduce the likelihood of repetition within the field of Mesh removal.

166. The Tribunal accept that these regulatory proceedings may also reduce the likelihood of any risk of repetition by Dr El-Neil. Dr El-Neil's CPD portfolio is extensive but there is no evidence of learning specifically targeted at informed consent. Therefore, whilst the risk may be low it is not possible to quantify it at present.

167. With regards to the dishonest representation to NHS Highland the Tribunal noted that dishonesty is a breach of a fundamental tenet of the medical profession. The Tribunal reminded itself that dishonesty is difficult but not impossible to remediate.

168. The misrepresentation to NHS Highland was made as a result of an inquiry by NHS Highland as to whether they should fund the treatment of Patient A in London at all, given the advice that had been received from consultants working in the same field in Scotland about the complexities of the operation. They had been cautious to fund only an initial assessment in the first instance. Other clinicians, including Patient A's GP, had also sought reassurance from Dr El-Neil directly, that it was full Mesh removal that Dr El-Neil was providing.

169. It was against this background and, having already carried out only partial Mesh removal, that Dr El-Neil made the misrepresentation that there had been removal of the Mesh "in its entirety". The operation requested by Patient A and by NHS Highland on her behalf, was not the one that was performed. Dr El-Neil's reply to NHS Highland was deliberately misleading.

170. The Tribunal acknowledged that this was a single incident of dishonesty. It was apparent that Dr El-Neil was under a great deal of pressure in this emerging service and the Tribunal accepted that she was not properly supported within the department. The Tribunal noted that Dr El-Neil has apologised for not being clear to Patient A, Mr B and NHS Highland in her witness statement and at this hearing.

171. The Tribunal also bore in mind that Dr El-Neil has not had time to reflect on the Tribunal's findings.

172. The Tribunal determined that Dr El-Neil's fitness to practise is impaired by reason of all of her misconduct. It determined that a finding of impairment was necessary 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 Sanction - 21/10/2024

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

The Evidence

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

175. The Tribunal received further evidence on behalf of Dr El-Neil including three emails and oral evidence from Mr K, Consultant Colorectal Surgeon at UCLH and was involved with the London Complex Mesh Centre ('LCMC').

Submissions

176. Both parties provided detailed written submissions which they added to with oral submissions.

GMC submissions

177. In summary, Ms Nowell submitted that the appropriate sanction was suspension.

178. Throughout her submissions, Mr Nowell referred the Tribunal to the relevant paragraphs of the Sanctions Guidance (February 2024) (the 'SG').

179. Ms Nowell reminded the Tribunal of the purpose of imposing sanctions, which is to uphold the overarching objective. She submitted that the Tribunal must impose the sanction necessary to protect the public even if this may lead to difficultues for Dr El-Neil. She reminded the Tribunal that it must first consider the least restrictive sanction before moving onto consider the more restrictive sanctions.

180. Ms Nowell submitted that it was necessary to consider any aggravating and mitigating factors before moving on to determine the appropriate sanction.

181. Ms Nowell said that the GMC acknowledges that there are some mitigating factors in respect of the failure to obtain consent, these might be considered to include:

a) There is evidence that Dr El-Neil understands the problems and has some insight;
b) She has also apologised to Patient A;
c) Dr El-Neil has no previous fitness to practice history;
d) The Tribunal has accepted that her workload at the time was significant and that there have been changes made to the Mesh practice since, in order to reduce that load and
e) The misconduct occurred over 6 years ago.

182. Ms Nowell submitted, however, that it was difficult to point to similar or any mitigating factors in respect of the finding of dishonesty.

183. As for aggravating factors, Ms Nowell submitted that the following factors apply in respect of Dr El-Neil's dishonesty:

a) Dr El-Neil has not provided any evidence of insight, remorse or remediation.
b) Paragraph 56a of the SG advises that Tribunals are likely to take more serious action where there are issues relating to probity - 'i.e. being honest and trustworthy and acting with integrity...'

184. With regards to dishonesty Ms Nowell drew the Tribunal's attention to the following paragraphs of the SG which provide advice in relation to cases involving dishonesty:

> 120 *Good medical practice states that registered doctors must be honest and trustworthy, they must make sure that their conduct justifies their patients trust in them and the public's trust in the profession*.
>
> 124 *Although it may not result in direct harm to patients, dishonesty related matters outside of the doctors clinical responsibility (e.g. providing false statements or fraudulent claims for monies) is particularly serious. This is because*

it can undermine the trust the public place in the medical profession. Health authorities should be able to trust the integrity of doctors, and where a doctor undermines that trust there is a risk to public confidence in the profession. Evidence of clinical competence cannot mitigate serious and/or persistent dishonesty.

125 *Examples of dishonesty in professional practice could include:*

(a) defrauding an employer,
(b) falsify or improperly amending patient records,
(c) submitting or providing false references,
(d) inaccurate or misleading information on a CV,
e) failing to take reasonable steps to make sure that statements made in formal documents are accurate".

185. Ms Nowell went on to address each sanction and its appropriateness or otherwise. She submitted that there were no special or exceptional circumstances in this case to justify taking no action.

186. Ms Nowell submitted that the paragraphs in the SG which advise where conditions might be appropriate, were not relevant to Dr El-Neil's case and the nature of the misconduct found. She submitted that the lack of any insight in respect of dishonesty and the lack of remediation to date, militate against the imposition of conditions.

187. With regards to her principal submission, Ms Nowell referred the Tribunal to the paragraphs of the SG advising where suspension may be appropriate, in particular, she highlighted paragraphs 91, 92, 97a and 97e.

188. Ms Nowell submitted that Dr El-Neil had failed to obtain informed consent and then had been dishonest about the nature of the operation. She said that dishonesty by itself warrants a severe sanction. She acknowledged, however, that this was a single instance of dishonesty and that there was no personal financial gain. She submitted that the misconduct was not fundamentally incompatible with continued registration, therefore, the appropriate sanction is one of suspension.

189. Ms Nowell added that a review should be directed so that Dr El-Neil will have the opportunity to reflect on and remediate her dishonesty, as well as allowing her to further develop her insight and remediation in respect of her own failure to ensure informed consent was obtained.

190. As per the length of the suspension, Ms Nowell submitted that the Tribunal should impose a period towards the upper end of the 12-month maximum given the seriousness of the misconduct.

<u>On behalf of Dr El-Neil</u>

191. On behalf of Dr El-Neil, Mr Davidson reminded the Tribunal of the general approach to take at the Sanctions stage.

192. Mr Davidson agreed that there were no exceptional circumstances to warrant taking no action in this case and that neither the agreement of undertakings or the imposition of conditions would be appropriate, proportionate, workable and measurable.

193. Mr Davidson invited the Tribunal to have regard to the following mitigating factors when determining not only which sanction to impose but also for how long to impose it:

a) the demands / pressures being placed on the Mesh removal service in general and on Dr El-Neil in particular in 2017/ 2018;
b) Changes to the service which have occurred in the period since 2017/2018 including the development of the LCMC, production of updated (improved) patient information leaflets and a more comprehensive patient pathway with more opportunities to discuss, counsel, consent, advise and reassure;
c) Changes in the funding pathway which meant communications were now managed within the administration service;
d) The "*good degrees of insight*" shown by Dr El-Neil into the need to share information with patients so as to allow them the opportunity to make more informed decisions (albeit, showing insight only in general terms);
e) The fact this was a single act of dishonesty found proved in relation to the communication with NHS Highland;
f) The fact that there is no suggestion that either the failure to obtain informed consent from Patient A, or the dishonest correspondence with NHS Highland was driven by any financial or reputational gain for Dr El-Neil;
g) The apologies and expressions of regret and remorse contained in Dr El-Neil's witness statement and provided directly to Patient A at the start of the hearing.

194. Mr Davidson invited the Tribunal, when balancing the interests of the public with those of Dr El-Neil, to have regard to various personal and professional matters.

195. With regard to personal matters, Mr Davidson submitted that Dr El-Neil has been entirely financially self-sufficient since March 2021. He submitted that, in the event of suspension, her income from private practice would stop immediately. He added that it was unclear whether she would retain her employment and/or continue to be paid by UCLH. He also submitted that the financial hardship which would follow any significant period of suspension would extend to various family members who were also dependent upon her income.

196. With regards to professional matters, Mr Davidson reiterated the evidence provided by Mr K as to the impact on the LCMC. Dr El-Neil was a specialist surgeon that Mr K relied upon to conduct specialist and complex surgery. These specific operations are currently not being performed at this centre.

197. Mr Davidson submitted that as a result of Dr El-Neil voluntarily stepping down from her role within LCMC, it has been unable to continue with a large proportion of the continence Mesh service. Without Dr El-Neil's input the number of women waiting for surgery has increased threefold since July 2023 and the current waiting list for all surgery at the LCMC is now quoted as being two years for women in the Mesh-related chronic pain group requiring surgery. Other procedures have continued albeit at a much lower rate (in part because some patients are insistent on seeing Dr El-Neil.)

198. Mr Davidson submitted that the inability of the LCMC to meet this service demand will inevitably continue for the period of any suspension, adversely affecting patient welfare and potentially threatening the future of the Mesh removal service at UCLH. Moreover, during any period of any suspension, Dr El-Neil is likely to have to stand down from roles within various charities and humanitarian missions thereby depriving them of her advice and support.

The Tribunal's Determination on Sanction

199. The Tribunal reminded itself that the decision as to the appropriate sanction to impose, if any, was a matter for it alone, exercising its own judgement. In reaching its decision on sanction, the Tribunal had regard to the SG, its findings on the facts, its determination on misconduct and impairment and the submissions made by Ms Nowell and Mr Davidson.

200. The Tribunal bore in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it recognised that any sanction imposed may have a punitive effect. It reminded itself that in deciding what sanction, if any, to impose, it should start with the least restrictive.

201. The Tribunal reminded itself that an appropriate sanction was necessary on the facts of this case to maintain public confidence in the profession and to maintain proper professional standards.

Aggravating and Mitigating Factors

202. The Tribunal considered and balanced the aggravating and mitigating factors in this case.

203. The Tribunal has already set out its decision on the facts and impairment which it considered during its deliberations on sanction. Before deciding what action, if any, to take in respect of Dr El-Neil's registration, the Tribunal took into account and balanced the aggravating and mitigating factors in this case.

<u>Aggravating factors</u>

204. As has been noted, the misconduct can be divided into two parts; Dr El-Neil's failure to obtain informed consent from Patient A and Dr El-Neil's dishonesty in relation to her representation to NHS Highland as to the exact nature of the procedure undertaken.

205. The Tribunal considered the obtaining of informed consent to be a cornerstone of the patient-doctor relationship. The Tribunal found that Dr El-Neil's failure to obtain informed consent breached paragraphs 16b, 17, 18, 45 and 49a of GMP 2013, as well as paragraphs 5b, 5c and 5d of the Consent Guidance 2008.

206. Dr El-Neil's subsequent dishonesty was linked to her failure to take informed consent. She knew that only partial Mesh removal had been undertaken and that, at the time of writing to NHS Highland, she appreciated that this was not what Patient A wanted. She had the opportunity to be clear about this failure in March 2018, instead her reply to NHS Highland was dishonest.

207. Her dishonesty was a breach of a fundamental tenet of the profession. She breached paragraphs 1 and 65 of GMP 2013.

208. The Tribunal also considered Dr El-Neil's insight. It considered that her insight and personal reflection regarding the failure to take informed consent was good in relation to the need to ensure that patients in the Mesh service were fully informed. The Tribunal, however, had determined that her insight into her own personal failure was limited, in part because she had sought to put the responsibility on Dr E rather than accepting her own professional responsibility for it. Nevertheless, the Tribunal considered that system changes she had introduced were extensive, had contributed to remediating the misconduct and have significantly reduced the risk of repetition.

209. With regards to the dishonesty, the Tribunal noted that Dr El-Neil has not yet had the opportunity take full responsibility. The Tribunal noted that Dr El-Neil in her statement to the GMC did accept that her reply to NHS Highland could have been clearer. The Tribunal was mindful that dishonesty is difficult to remediate but it considered that it was remediable in this case. The Tribunal also considered that the dishonesty was not at the higher end of the spectrum of dishonesty. This was a single incident over six years ago. There have been no other concerns raised regarding Dr El-Neil's honesty and integrity before or since.

Mitigating factors

210. The Tribunal considered the mitigating factors.

211. The Tribunal bore in the mind that the two incidents of misconduct were closely linked. The Tribunal accepted that Dr El-Neil was under a great deal of professional pressure at the time, was working in an emerging field and was not properly supported.

212. The Tribunal considered that there was evidence that Dr El-Neil understands that there was a failure to take informed consent and has insight into the consequences of the

failure to do so on Patient A and more widely. This is evidenced by her drive to introduce system changes in the Mesh Centre to avoid repetition. Dr El-Neil has also apologised to Patient A and NHS Highland.

213. The Tribunal accepted that the misconduct occurred over six years ago and there has been no repetition. There are no other fitness to practice concerns. It also took into account Dr El-Neil's personal circumstances.

214. The Tribunal had regard to the services Dr El-Neil has provided to the NHS and patients by raising awareness of the complications of Mesh surgery and being instrumental in setting up a surgical programme to assist women with these complications.

215. The Tribunal also noted the evidence provided by Mr K that Dr El-Neil was a skilled surgeon that he relied upon to conduct surgery in a very specialist sub-set of Mesh removal. This service was not currently being provided to patients at UCLH. There were no other testimonials or references provided on behalf of Dr El-Neil.

No action

216. The Tribunal first considered whether to conclude the case by taking no action. It accepted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

217. The Tribunal determined that there are no exceptional circumstances in this case and that, given the seriousness of its findings, it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

218. The Tribunal next considered whether to impose conditions on Dr El-Neil's registration.

219. The Tribunal noted that conditions can be appropriate in cases where there is insight, evidence of shortcomings in a specific area and where supervision could be an appropriate way of addressing this. However, the Tribunal noted that given the specialist nature of Dr El-Neil's role, there would be no one available to supervise her work within the service at UCLH.

220. In any event, given the serious nature of the misconduct, particularly the finding of dishonesty, the Tribunal determined that conditions would not be appropriate as the imposition of conditions would not sufficiently mark the seriousness of Dr El-Neil's misconduct.

Suspension

221. The Tribunal considered whether a period of suspension would be the appropriate sanction.

222. The Tribunal had regard to paragraphs 91 - 93 of the SG:

> 91 *Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> 92 *Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*
>
> *93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated…*

223. The Tribunal also considered the following factors outlined at paragraph 97 of the SG to be engaged on the facts of this case:

> 97 *Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> *a) A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.*
> *…*
> e) *No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage…*
>
> *f) No evidence of repetition of similar behaviour since incident.*
>
> *g) The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.*

224. The Tribunal considered that all of the above paragraphs of the SG indicated that suspension was the appropriate sanction in this case.

225. Whilst there had been a serious departure from GMP, Dr El-Neil has engaged with the regulator and shown a willingness to engage with remediation for her failure to obtain informed consent. The Tribunal, as previously stated, considered that the dishonesty was remediable in this case. It was a single incidence of dishonesty over six years ago and occurred in circumstances where she was under a lot of pressure and not adequately supported in her department.

226. The Tribunal also had regard to the paragraphs of the SG which advise where erasure may be the appropriate sanction. The Tribunal reminded itself that dishonesty was a breach of a fundamental tenet of the medical profession and any dishonesty was likely to seriously erode public confidence in both Dr El-Neil and in the medical profession as a whole.

227. However, the Tribunal has accepted this was a single instance, not persistent and not covered up. The Tribunal was of the view it could be remediated. Dr El-Neil was providing a valuable service to the public within Mesh removal and other services. She was a highly skilled surgeon who was in great demand. Her erasure would not be a proportionate response to the misconduct.

228. The Tribunal, therefore, concluded that Dr El-Neil's misconduct was not fundamentally incompatible with continued registration and that erasure would not be the only means of protecting the public and that it would be disproportionate in this case.

229. Accordingly, the Tribunal concluded that the appropriate sanction was one of suspension.

Length of suspension

230. In considering the length of the suspension, the Tribunal was of the view given the seriousness of the misconduct found, a suspension towards the upper end of the 12-month maximum was appropriate.

231. There were two episodes of misconduct one of which was dishonesty. Both would adversely impact patient confidence in Dr El-Neil and the medical profession. The Tribunal considered that a lengthy suspension was necessary to maintain confidence and standards.

232. However, by way of counterbalance, the Tribunal considered that the two episodes of misconduct were close in time and interlinked. Both occurred when Dr El-Neil was working in a stressful working environment and not adequately supported.

233. The Tribunal also bore in mind that there was a competing public interest in Dr El-Neil being able to work and serve her patients. The Tribunal noted the contributions she has made introducing a Mesh removal service and highlighting the issues with Mesh nationally. It also noted that other services have adopted her templates, in particular a patient decision making matrix which is integral to involving a patient in deciding what is the right treatment

option for them. It also bore in mind the effect her absence from the LCMC has had on its ability to serve its patients.

234. The Tribunal determined that a period of 9-months suspension would sufficiently mark the seriousness of the misconduct found in this case and uphold the over-arching objective specifically to maintain public confidence in the profession and uphold proper professional standards.

Review

235. The Tribunal determined that a review hearing was also necessary. It considered that the period of nine months, in addition to marking the seriousness of the misconduct found, would also provide Dr El-Neil the opportunity to further develop her insight and remediation. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr El-Neil to demonstrate how she has developed insight into the impact her misconduct had on public confidence in the profession and that she has maintained her knowledge and skills.

Determination on Immediate Order - 21/10/2024

236. Having determined to suspend Dr El-Neil's registration for a period of nine months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr El-Neil's registration should be subject to an immediate order.

Submissions

237. On behalf of the GMC, Ms Nowell submitted that an immediate order of suspension was necessary on public interest grounds. She referred the Tribunal to paragraph 172 and 173 of the SG which provide that:

> *172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor….*
>
> *173 An immediate order might be particularly appropriate in cases where... immediate action must be taken to protect public confidence in the medical profession.'*

238. In summary, Ms Nowell submitted that given the seriousness of the matters in this case, that there have been no attempts to remediate and little insight demonstrated, if any, in respect of the dishonesty, an immediate order is necessary to uphold the standards of doctors and also in the public interest generally.

239. On behalf of Dr El-Neil, Mr Davidson submitted that an immediate order

was not necessary in this case.

240. Mr Davidson submitted that paragraph 173 of the SG emphasises that an immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. He submitted that there was no such risk in this case.

241. Mr Davidson also submitted that an immediate order was not necessary in the public interest. He emphasised that the misconduct related to a short period of time, occurred six years ago and Dr El-Neil has been in practice since that time and had not been subject to an interim order.

242. Mr Davidson submitted that the substantive order will also deprive patients of Dr El-Neil's services. Moreover, by making an immediate order, there would be a detrimental effect to the Mesh service, who would need to adjust to Dr El-Neil's absence. He submitted that there was a public interest in allowing the service the opportunity to put in place contingency arrangements.

The Tribunal's Determination

243. The decision as to whether to impose an immediate was for the Tribunal's discretion alone.

244. In arriving at is decision, the Tribunal had regard to paragraphs 172 – 178 of the SG and bore in mind the seriousness of the matters it had found.

245. The Tribunal considered that, whilst no risk to patient safety had been found, an immediate order was necessary to uphold public confidence given the seriousness of its findings.

246. The Tribunal noted Mr Davidson's submission that an immediate order could be detrimental to Dr El-Neil's ability to put in place contingency plans. However, the Tribunal rejected this having had regard to paragraph 174-176 of the SG which provided:

> *174 Doctors and their representatives sometimes argue that no immediate order should be made as the doctor needs time to make arrangements for the care of their patients before the substantive order for suspension or erasure takes effect.*
>
> *175 In considering this argument, the tribunal will need to bear in mind that any doctor whose case is considered by a medical practitioners tribunal will have been aware of the date of the hearing for some time and consequently of the risk of an order being imposed. The doctor will therefore have had time to make arrangements for the care of patients before the hearing, should the need arise.*
>
> *176 In any event, the GMC also notifies the doctor's employers or, in the case of general practitioners, the relevant body, of the date of the hearing. They have a duty*

to make sure that appropriate arrangements are in place for the care of the doctor's patients should an immediate order be imposed.

247. The Tribunal determined that whilst there is no direct patient risk, an immediate order was necessary to protect the public, uphold standards and in the public interest.

248. This means that Dr El-Neil's registration will be suspended from today. The substantive direction will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

249. This concludes the case.

ANNEX A – 21/10/2024

Application to admit further evidence

Submissions

On behalf of Dr El-Neil

250. At the start of stage 2 of the proceedings on 16 October 2024, Mr Davidson made an application to admit into evidence an e-mail exchange sent between Mr B and NHS Highland dated August to September 2018. Mr Davidson said that the documents had come to his attention overnight.

251. Mr Davidson informed the Tribunal that he had asked Dr El-Neil for any information relevant to the issue as to how long NHS Highland was under any misunderstanding regarding the procedure undertaken in 2017. This request prompted her to review the bundle and any other sources of information that might illustrate feedback from NHS Highland in response to her communication in March 2018. He said that Dr El-Neil was able to access a server which incorporated a different body of records and had found the emails sought to be admitted.

252. Mr Davidson submitted that the email exchange would illustrate the state of knowledge as to the procedure that had been performed in December 2017 for both Patient A and Mr B, as well as NHS Highland. He submitted that this correspondence was relevant to the length of time there had been any miscommunication, which he said was relevant to Stage 2.

GMC submissions

253. Ms Nowell submitted that the email exchange was not relevant to impairment. She said that the duration of any misunderstanding was not one of the tests in terms of impairment.

254. Ms Nowell stressed that the author of the first email was Mr B. Ms Nowell stated that it was extremely unfortunate that it was not raised at an earlier stage. She submitted at the facts stage Mr B could have given his input as to what those emails say, why he wrote what he did and what information he had obtained by that stage and from whom.

255. Ms Nowell emphasised that the email exchange did not go to Dr El-Neil's remorse, insight or remediation at all. In summary, she submitted that the questions the email exchange raises are all factual ones. She reiterated that the Tribunal was now at the impairment stage and submitted that the GMC object to it being put into evidence at this stage.

256. Ms Nowell submitted that the Tribunal should make its decision regarding whether to admit the email correspondence without having sight of it lest it cause any prejudice.

However, she did not object to the Tribunal having sight of the correspondence if it considered it necessary in order to determine its relevance and whether it was fair to admit it into evidence.

The Tribunal decision

257. The Tribunal had regard to Rule 34(1) which states that:

> *'…a Tribunal may admit any such evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'*

258. The Tribunal first considered whether it required sight of the email correspondence in order to consider its admissibility.

259. The Tribunal accepted there may be good reason for the emails coming to light at this late stage given the server problems highlighted.

260. The Tribunal bore in mind that the email correspondence post-dated Dr El-Neil's response to NHS Highland on 28 March 2018. It considered therefore they were unlikely to impact the Tribunal's findings on the facts for Stage 1. It considered, however, that the emails might provide some evidence of when Patient A and Mr B realised Patient A had not received full surgical removal of the Mesh and if Dr El-Neil had in any way contributed to them knowing this.

261. The Tribunal were of the view that the length of any deception might impact the seriousness or otherwise of the dishonest misconduct, the emails might, therefore, help the Tribunal at Stage 2.

262. The Tribunal considered that it was unable to make a judgement as to whether the material was relevant without seeing it. In the first instance, therefore, it determined that it needed to see it.

263. The Tribunal had regard to the email exchange. It noted that the first email of 23 August 2018 was sent by Mr B to Mr I of NHS Highland, as well as to Dr El-Neil, Dr D and Patient A. Mr B wrote:

> *'…Patient A was admitted on 13 December 2017 and was discharged the 18th December.*
>
> *Our understanding of Ms Elneils statement saying the mesh was removed in its entirety was concerning the mesh that was removed vaginally. The mesh that remains is the mesh in both the left and right obturator which is a significantly more invasive operation behind the pubic bone.*

The mesh when inserted is a piece of plastic some 18cm long. The mesh that Ms Elneil removed was about one quarter this length. It is not a procedure that one undergoes without considerable thought and is not something that either my wife, or myself relish, but to ensure a proper and as best possible recovery it must me [sic] *done.*

This is likely preceded by a translabial scan which shows the extent and location of the remaining mesh to allow the team to extract from both sides through the top..as i understand things to be.

We are counting on NHS Scotland to pull the stops out and allow the further complete removal of Patient A's mesh…'

264. The Tribunal noted that Mr I responded on 31 August 2018 and advised that NHS Highland would support the funding for the continued treatment as part of Dr El-Neil's surgical plan. The final email of the chain, from a Ms Kirby at NHS Highland, provided details to enable the funding for the surgery.

265. The Tribunal considered that the email exchange illustrated that Patient A, Mr B and NHS Highland knew by August 2018 that there had not been full surgical removal of the Mesh. However, there was no evidence as to when they became aware of this, or by whom.

266. The Tribunal considered that the email exchange could be of potential relevance and that it was fair to admit it into evidence. It considered that what weight, if any, to be attached to the emails would be subject to any further evidence received at Stage 2. Accordingly, the Tribunal granted Mr Davidson's application.