PUBLIC RECORD

Dates: 25/03/2024 - 22/04/2024

Medical Practitioner's name:	Dr Thatipalli MAHADEV
GMC reference number:	4567589
Primary medical qualification:	MB BS 1992 Osmania

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

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Tehniat Watson
Lay Tribunal Member:	Mr Geoff Brighton
Medical Tribunal Member:	Dr John Garner

Tribunal Clerk:	Mr Michael Murphy

Attendance and Representation:

Medical Practitioner:	Not present, not represented
GMC Representative:	Ms Jade Bucklow, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 12/04/2024

1. Dr Mahadev qualified in medicine in 1992 with an MBBS from Osmania University, India. Dr Mahadev practised in the NHS since 1996 and underwent General Surgery Specialist Registrar Training, which he completed in 2008. Dr Mahadev also practised as a Consultant Breast Oncoplastic and General Surgeon both in the NHS and privately which included working at NU Cosmetic Clinic, Liverpool and Dolan Park Hospital, Bromsgrove. At the time of the events in the Allegation Dr Mahadev was practising as a Consultant Breast Surgeon at William Harvey Hospital (the Hospital), part of East Kent Hospitals University NHS Foundation Trust (the Trust). Dr Mahadev had been appointed to this role on 24 June 2019. Dr Mahadev is no longer working for the Trust. The Root Cause Analysis Investigation report produced by the Trust was an aggregated investigation into cases involving patients and the outcome of their surgery performed between August 2019 and November 2019 by Consultant A (Dr Mahadev). Dr Mahadev was excluded from work on 9 December 2019, pending further investigation. Dr Mahadev thereafter resigned from the Trust.

2. The events that have led to this hearing include the GMC's allegation that, on 1 June 2019, Dr Mahadev submitted an application for the post of Consultant Breast Surgeon at the Trust and it was alleged he did not declare that he was subject to a fitness to practise investigation by the GMC. The GMC alleged that this was dishonest.

3. The GMC also allege that there were failings in Dr Mahadev's treatment and care of Patients A, B, C, G, H, I, J and K and that Dr Mahadev failed to carry out a number of actions that were required of him relating to his care of the patients.

4. The initial concerns were raised with the GMC further to a local investigation relating to Dr Mahadev's treatment of patients.

The Outcome of Applications Made during the Facts Stage

5. The Tribunal granted the GMC's application, made pursuant to Rule 31 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to proceed in Dr Mahadev's absence. The Tribunal's full decision on the application is included at Annex A.

6. The Tribunal granted the GMC's application, made pursuant to Rule 34(1) of the Rules, to admit additional evidence. The Tribunal's full decision on the application is included at Annex B.

7. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the Rules, to amend the Allegation. The Tribunal's full decision on the application is included at Annex C.

The Allegation and the Doctor's Response

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

    1. On 1 June 2019 you submitted an application for the post of Consultant Breast Surgeon at East Kent Hospitals University NHS Foundation Trust ('the Application') in which you answered 'No' to the question 'Are you currently subject to a fitness to practise investigation and/or proceedings of any nature by a regulatory or licensing body in the UK or any other country?'. To be determined

    2. When submitting the Application, you knew that you were subject to a fitness to practise investigation by the GMC. To be determined

    3. Your actions as set out at paragraph 1 were dishonest by reason of paragraph 2. To be determined

Patient A

    4. On 25 September 2019 Patient A underwent a left mastectomy with axillary lymph node clearance ('the Procedure') and you inappropriately informed Patient A on the morning of the Procedure, in contradiction to the advice and instruction of Mr L (the substantive Consultant Breast Surgeon) that:

a. there would be no drain; To be determined

b. she would be discharged home on the day of the Procedure. To be determined

5. On 25 September 2019 you provided inadequate surgical care to Patient A in that you used:

a. poor surgical design; and/or To be determined

b. poor dissection technique. To be determined

6. On 26 September 2019, when Patient A noted that the Procedure site had started to fill with fluid, produce pain and was swelling, you failed to personally examine and/or review Patient A. To be determined

7. On 26 September 2019 Patient A underwent a pre-discharge assessment by her breast care nurse, when you had overall responsibility for Patient A's care, and this was inappropriate because:

a. it occurred in the lady's toilet as there were no rooms available on the ward; To be determined

b. there was no privacy for Patient A who was required to undress for the assessment. To be determined

Patient B

8. On 12 September 2019 Patient B underwent a right mastectomy and sentinel lymph node biopsy ('the Procedure'), prior to which you failed to obtain fully informed consent as you failed to record having discussed one or more of the significant risks as set out at Schedule 1. To be determined

9. On 12 September 2019 you performed the Procedure on Patient B and you provided inadequate surgical care in that Patient B was left with a tethered scar and excess tissue laterally as a result of poor surgical technique. To be determined

10. You failed to record within your operation note any detail as to the use / administration of:

a. radioisotope and/or; Successful application under Rule 17(6)
To be determined

b. patent blue dye. To be determined

~~11. On 15 November 2019 Patient B's bone densitometry scan was reported and you failed to inform Patient B's General Practitioner ('GP') of the result which identified osteoporosis of the spine and osteopenia of the hip in Patient B.~~ Successful application under Rule 17(6)

12. You~~r~~ failed to advise Patient B's GP that, in light of the results of the bone densitometry scan, Patient B ~~actions at paragraph 11 were inappropriate because Patient B was taking an aromatase inhibitor and~~: Successful application under Rule 17(6)

a. was at risk of developing a vertebral compression fracture; To be determined

b. should be ~~osteoporosis of the hip in a patient taking an aromatase inhibitor requires~~: Successful application under Rule 17(6)

i. commenced on supplemental calcium; Successful application under Rule 17(6)
To be determined

ii. commenced on vitamin D; Successful application under Rule 17(6)
To be determined

iii. considered ~~ation~~ for bisphosphonates. Successful application under Rule 17(6)
To be determined

13. On 2 December 2019 you consulted with Patient B and you failed to arrange further assessment of her complaint of right shoulder pain radiating to her shoulder blade and upper back, to exclude metastatic breast cancer, including:

a. an isotope bone scan; To be determined

b. a repeat computerised tomography scan ('CT') of the chest, abdomen and pelvis. To be determined

14. In your letter to Patient B's GP dated 3 December 2019 you failed to inform Patient B's GP of your clinical examination regarding the state of Patient B's scar and the presence of tenderness and seroma. To be determined

15. You inappropriately requested Patient B's GP to arrange intensive physiotherapy and to consider a referral to an orthopaedic surgeon for Patient B's skeletal pain in the knowledge that Patient B had osteoporosis and had had previous breast cancer. To be determined

Patient C

16. On 1 November 2019 you performed a revision of Patient C's right mastectomy scar ('the Procedure'), prior to which you failed to obtain fully informed consent as:

    a. you failed to discuss with Patient C the potential for:

        i. the persistence of the dog ear scar deformity; To be determined

        ii. the need for further surgery; To be determined

    b. the consent discussion took place in an inappropriate environment; To be determined

    c. Patient C had inadequate time to consider the proposed treatment. To be determined

17. On 1 November 2019 you performed the Procedure on Patient C and you provided inadequate surgical care in that Patient C was left with excess skin, fat and scar tissue as a result of poor surgical technique. To be determined

Patient G

18. On 13 September 2019 you consulted with Patient G in the out-patient breast clinic and you failed to:

    a. write to Patient G's GP following your consultation; To be determined

    b. record a handwritten entry of your clinical encounter with Patient G in the out-patient section of Patient G's medical records. To be determined

19. On 19 September 2019 Patient G underwent a left mastectomy and sentinel lymph node biopsy ('the Procedure'), prior to which you failed to obtain fully informed consent as you failed to discuss with Patient G the potential complications relating to the:

    a. use of patent blue dye; To be determined

    b. sentinel lymph node dissection in the axilla; To be determined

    c. enhanced risk of wound breakdown and infection in view of Patient G's:

        i. previous radiotherapy to the left breast; To be determined

        ii. long-standing heavy smoking habit; To be determined

        iii. intermittent high alcohol intake. To be determined

Patient H

20. On 5 November 2019 Patient H underwent left axillary lymph node clearance ('the Procedure') and you failed to obtain fully informed consent as you failed to record having discussed with Patient H, in view of her past history, one or more of the serious risks set out at Schedule 2. To be determined

21. On 22 November 2019 you undertook a post-operative review of Patient H and you prescribed Augmentin (Co-Amoxiclav) to Patient H which was inappropriate because:

    a. Patient H was allergic to Penicillin; To be determined

    b. Patient H was at significant risk of anaphylactic allergic reaction; To be determined

    c. there was extensive reference in Patient H's medical records to her allergy to Penicillin. To be determined

22. You failed to:

    a. document in your letter dated 22 November 2019 to Dr M, Consultant Oncologist, that after the Procedure:

i. Patient H required serial seroma aspirations; To be determined

ii. Patient H developed a wound infection; To be determined

iii. Patient H required antibiotics; To be determined

iv. you had prescribed Augmentin to Patient H; To be determined

b. record in Patient H's medical records that on 22 November 2019 that:

i. there was a seroma that required aspiration; To be determined

ii. the axillary wound was infected; To be determined

iii. you had prescribed Augmentin. To be determined

Patient I

23. In your letter of 24 September 2019 following a review of Patient I in the breast out-patient clinic on 20 September 2019, you advised Patient I that she reduce the dose of Letrozole 2.5mg to alternate days rather than daily, which was inappropriate because Patient I was placed at increased risk of recurrence of breast cancer for a period of 6-7 months whilst taking the sub-optimal dose. To be determined

Patient J

24. On 19 November 2019 Patient J underwent a right capsulotomy and left capsulectomy with replacement of the original implants ('the Procedure') and you failed to arrange a pre-operative ultrasound scan of Patient J's 12 year old implants ('the Implants'). To be determined

25. Prior to undertaking the Procedure you failed to obtain fully informed consent from Patient J because:

a. Patient J was unaware as to the status of the Implants; To be determined

b. you failed to record having discussed with Patient J one or more of the risks of capsulectomy as set out at Schedule 3. To be determined

26. You failed to correspond with the Clinical Commissioning Group ('CCG') to request ~~secure~~ funding for the replacement implants ~~Procedure~~.. Successful application under

Rule 17(6)
To be determined

27. You failed to adequately record having considered replacing the Implants due to their age and the necessary intra-operative handling, which carries a risk of damage and rupture of one or both the Implants. To be determined

28. On 19 November 2019 during the Procedure you removed and re-inserted the Implants which was inappropriate because:

    a. the Implants were out of date; To be determined

    b. the Implants were at increased risk of developing complications in comparison to new implants; To be determined

    c. removal of the Implants had been recommended by the Department of Endocrinology at St. George's Hospital with the caveat that replacement was currently not funded on the National Health Service ('NHS'); To be determined

    d. the Implants carried a risk of damage and rupture during intra-operative handling, due to their fragility. To be determined

Patient K

29. On 13 September 2019 you consulted with Patient K in the breast out-patient clinic and you:

    a. failed to follow the multidisciplinary team ('MDT') advice on 5 September 2019 to refer Patient K to oncology for their opinion, with regard to adjuvant endocrine treatment; To be determined

    b. prescribed Tamoxifen 10mg daily which was inadequate; To be determined

    c. inappropriately advised Patient K's GP to continue to prescribe Tamoxifen in a sub-optimal dose of 10mg daily; To be determined

    d. failed to provide a valid reason for deviating from the MDT's advice. To be determined

Witness Evidence

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

- Patient A,
- Patient C,
- Patient G,
- Ms N, Deputy Head of People and Culture Services at the Trust;
- Mr O, Investigation Manager at the GMC.

Expert Witness Evidence

10. The Tribunal also received evidence from expert witness, Mr Q, a Consultant General Surgeon with a special interest in breast surgery. Mr Q was called by the GMC and gave oral evidence at this hearing. He provided an expert report, dated 15 July 2021 along with three supplemental expert reports dated 10 December 2021, 29 March 2023 and 23 October 2023. Mr Q's evidence was directed at assisting the Tribunal in understanding the standard of care Dr Mahadev provided to Patients A, B, C, G, H, I, J and K.

11. The Tribunal also received a preliminary report from Professor P, a Consultant Breast Surgeon, dated 7 March 2022. This report was produced at the request of Dr Mahadev's previous legal representatives, who are no longer instructed.

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 medical records;
- Patient B's medical records;
- Patient C's medical records;
- Patient G's medical records;
- Patient H's medical records;
- Patient I's medical records;
- Patient J's medical records;

- Patient K's medical records;
- Application form submitted by Dr Mahadev for the post of Consultant Breast Surgeon at the Trust, dated 1 June 2019 together with notes taken by the interviewers interviewing Dr Mahadev's for this post on 17 June 2019;
- Root Cause Analysis Investigation reports;
- Extract from IOT Transcript, 11 March 2022.

The Tribunal's Approach

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

14. When considering the standard required to prove an allegation, the Tribunal had regard to the case of *Byrne v General Medical Council [2021] EWHC 2237 (Admin) (10 August 2021)* which states:

> *'(1) There is only one civil standard of proof in all civil cases, and that is proof that the fact in issue more probably occurred than not.*
>
> *(2) There is no heightened civil standard of proof in particular classes of case. In particular, it is not correct that the more serious the nature of the allegation made, the higher the standard of proof required.*
>
> *(3) The inherent probability or improbability of an event is a matter which can be taken into account when weighing the probabilities and in deciding whether the event occurred. Where an event is inherently improbable, it may take better evidence to persuade the judge that it has happened. This goes to the quality of evidence.*
>
> *(4) However, it does not follow, as a rule of law, that the more serious the allegation, the less likely it is to have occurred. So whilst the court may take account of inherent probabilities, there is no logical or necessary connection between seriousness and probability. Thus, it is not the case that "the more serious the allegation the more cogent the evidence need to prove it.'*

15. If the Tribunal, having weighed all the evidence in relation to an allegation, considers the case is evenly balanced, then the GMC will not have discharged its burden and will not have proved its case.

16. The Tribunal was advised not to draw any adverse inferences from Dr Mahadev's absence at this hearing.

17. The LQC advised the Tribunal on the approach to take to evidence and referred to the following passage from the case of *Byrne v GMC [2021] EWHC 2237 (Admin)*:

> '*First, the credibility of witnesses must take account of the unreliability of memory and should be considered and tested by reference to objective facts, and in particular as shown in contemporaneous documents. Where possible, factual findings should be based on objective facts as shown by contemporaneous documents*..'

18. The LQC further advised that the Tribunal must consider all of the evidence before it before making findings as to the credibility of any witness and should not rely exclusively on a witness' demeanour when giving evidence.

19. The Tribunal was mindful that Dr Mahadev faces an allegation of dishonesty. It was advised of the test for dishonesty and referred to the case of *Ivey v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] UKSC 67* which states:

> '*When dishonesty is in question the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest*.'

20. The expert reports formed part of the evidence as a whole and the Tribunal was advised to carefully consider those and attach such weight to the conclusions within it as it considered appropriate but to give reasons if it did not accept any aspect of it.

21. The Tribunal was advised that it must reach its decision on the facts based on the evidence before it. It could draw reasonable inferences from what it had heard but it must not speculate. Also, when drawing inferences, the Tribunal must be able to safely exclude, as less than probable, any other possible explanations.

The Tribunal's Analysis of the Evidence and Findings

22. 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.

23. The Tribunal considered what weight to give to the extract from the IOT Transcript of 11 March 2022. It considered that it only received an extract and was not privy to the full representations made on behalf of Dr Mahadev. From the information, the Tribunal could not be certain which allegation or Patient any information related to and was also mindful that the information was from two years ago and the representations were not made with the intention of being used at the substantive hearing. In fairness to both parties, the Tribunal therefore placed no weight on the extract provided to it.

24. The Tribunal also considered what weight to place on Professor P's report. It remained mindful that it was a preliminary opinion and not a substantial report. It noted that Professor P reviewed an expert report by Mr Q, although not all of Mr Q's supplemental reports, as they had not been completed until a date later than Professor P's report of 7 March 2022. It was also mindful that Professor P's preliminary opinion was completed without full disclosure of the documentation which included Professor P not having sight of the medical records relating to the patients. Professor P had also not been a live witness to provide further detail on the contents of their preliminary opinion. The Tribunal therefore decided not to place any weight on this report, in fairness to both parties.

25. The Tribunal bore in mind its previous decision to proceed in the absence of Dr Mahadev. In order to mitigate any risks of coming to improper conclusions in the doctor's absence, it had explored any weaknesses in the GMC's case and scrutinised all the written evidence and sought clarification questions of the witnesses. In evaluating all the evidence before it, it sought to consider reasonable alternatives, without speculation, before coming to its decision.

<u>Paragraph's 1, 2 and 3 of the Allegation</u>

26. The Tribunal considered whether Dr Mahadev submitted the job application and answered no to the question 'Are you currently subject to a fitness to practise investigation..' when he knew that he was subject to an investigation by the GMC and whether this was dishonest.

27. The Tribunal had regard to the application form submitted by Dr Mahadev for the post of Consultant Breast Surgeon at the Trust. It noted that on this form Dr Mahadev had answered 'No' to the question enquiring whether he was subject to a fitness to practise investigation. The application form did not show the date it was completed by Dr Mahadev as the layout had changed when imported from the website, as explained by Ms N. However, the Tribunal noted that the recruitment record relating to Dr Mahadev showed an entry that the application was received on 1 June 2019. It therefore considered it to be more likely than not, that the application was submitted by Dr Mahadev on 1 June 2019.

28. The Tribunal considered if there was an open GMC fitness to practise investigation at the relevant date of 1 June 2019. It noted Mr O's evidence that a fitness to practise investigation had opened on 6 March 2019 and that a letter was sent to Dr Mahadev on 14 March 2019 to advise that he was under investigation. This letter was sent to Dr Mahadev's then registered address in India but returned to the GMC. Thereafter, a pathfinder email was sent by the GMC on 17 May 2019. Dr Mahadev replied to that email on 19 May 2019 and the GMC then followed this by sending the letter with the information regarding the opened investigation.

29. The letter stated:

> '*I hope you understand after reading the information provided that we need to open an investigation to make sure that there are no risks to patients, as our role is to protect the public*.'

30. The letter also attached a guide for doctors reported to the GMC.

31. Dr Mahadev then emailed the GMC on 29 May 2019 to state:

> *'With regards to the complaint received by you, I am awaiting all the details, so that I can formulate the response.'*

32. The Tribunal noted that there was therefore an investigation opened in March 2019. It noted that Dr Mahadev's reply indicated that Dr Mahaedev was aware of the GMC investigation he was subject to. In addition to this, the Tribunal considered an email from Mr O to Dr Mahadev dated 24 July 2019 which provided him with an update on the then open investigation. It stated:

'*The GMC are still in the process of obtaining evidence in relation to the concerns we are investigating*.'

33. The Tribunal therefore noted that the said investigation was still open at the date of the application and the date of Dr Mahadev's interview being the 1 and 17 June 2019 respectively.

34. The Tribunal further noted that the application form was a digital online form. In clicking 'No' to the question in the Allegation, the Tribunal asked itself if Dr Mahadev may have made an inadvertent mistake. However, the Tribunal noted that he had failed to provide any details of the open investigation, as required by the next question on the application form, which Ms N stated would be a free text box. It considered that there was also no evidence of Dr Mahadev taking the opportunity to declare the open investigation within his interview by the Trust prior to his recruitment. It therefore took the view that Dr Mahadev's action in answering 'No' to the said question on the application was not a mistake but was deliberate.

35. Having established that Dr Mahadev knew that he was subject to an open investigation on 1 June 2019, when he answered 'No' to the question whether he was subject to a fitness to practise investigation, the Tribunal applied the standards of ordinary decent people and concluded that they would consider Dr Mahadev's actions to be dishonest.

36. The Tribunal therefore found paragraphs 1, 2 and 3 of the Allegation proved.

Patient A

Paragraph's 4(a) and 4(b) of the Allegation

37. The Tribunal considered if on 25 September 2019 Dr Mahadev inappropriately informed Patient A, who underwent a left mastectomy with axillary lymph node clearance, that there would be no drain and that she would be discharged home on the day of her procedure, in contradiction to the advice and instruction of Mr L, her substantive consultant breast surgeon.

38. The Tribunal had regard to the letter dated 22 August 2019 sent by Mr L to Patient A's GP regarding her clinic attendence on 16 August 2019. In the letter Dr L highlighted that

Patient A was aware of the risks of the procedure which on the face of it also noted the need for a drain and an overnight stay as 'risks'. It further considered Patient A's account, both written and oral, which was clear and consistent. Patient A had come away from the initial consultation with Mr L firmly in the belief that she would be having a drain inserted as part of the procedure explained by Dr L and would be staying in the hospital overnight. Patient A stated that Dr Mahadev had informed her just prior to her surgery that she wouldn't have a drain and that Dr Mahadev 'didn't do drains' and that she would not need to stay in the hospital overnight. Patient A had 'worried' as she had arranged for her daughter to stay with her the night of 26 September 2019 (the day after her surgery), and not the night of the surgery. She confirmed to him that she lived alone and would have been alone that night had she returned home after surgery.

39. In his oral evidence, Mr Q stated it was mandated that a patient who lived alone should stay in hospital for the first night after this type of procedure. In his expert report he stated:

> *'the conflicting information given to Patient A immediately prior to her undergoing major surgery is totally inappropriate and clinically incorrect…*
>
> *…The decision by Mr Mahadev just prior to Patient A undergoing surgery, to counter-instruct Patient A would cause distress and potential harm and risk to Patient A for each of the above, both separately and combined.'*

40. The Tribunal further considered Mr Q's evidence that generally, not inserting a drain would be acceptable practice as some surgeons use drains and some do not. The Tribunal noted that the issue with regard to Patient A was the contradictory advice given to Patient A just before her procedure. It further considered Mr Q's oral evidence. He stated that it was 'absolutely mandatory' for there to be a competent adult present with the patient after a major procedure such as the one that Patient A had, if that patient was to be discharged home the same day as the surgery. The competent adult could then seek urgent medical assistance in case it was needed. He stated that it was *'fundamental error of judgment and a fairly major error to go against the advice….and would have completely disrupted her [Patient A's] arrangements.'*

41. Mr Q further stated in oral evidence that if there was a clash between Dr Mahadev's and Dr L's view as to what was the optimum treatment, then that ought to have been

explained to Patient A and she should have been given the right to decline. There was no evidence that this had taken place.

42. In light of the expert evidence of Mr Q and the clear evidence from Patient A which had caused her to worry, it took the view that it would have been inappropriate for Dr Mahadev to have advised Patient A that there would be no drain and that she would be discharged home on the day of her procedure.

43. The Tribunal therefore found paragraphs 4(a) and 4(b) of the Allegation proved.

Paragraphs 5(a) and 5(b)

44. The Tribunal considered if Dr Mahadev provided inadequate surgical care to Patient A in that he used poor surgical design and/or poor dissection technique.

45. It had regard to Mr Q's supplemental expert report in which he stated:

> *'The appearance of the scar, as stated by Patient A, was "horrendous" with excessive puckering and ridging so that she was unable to wear her prosthesis and would require corrective surgery resulting in a delay in both the administration of radiotherapy and the potential reconstruction which would not take place until after revisional surgery'.*

46. It also had regard to Mr Q's second supplemental expert report in which he stated:

> *'The resulting mastectomy scar was aesthetically unsatisfactory with puckering and ridging. This caused Patient A discomfort, resulted in limitation of her left arm and shoulder movement, delayed her receiving postoperative radiotherapy, resulted in Patient A being unable to wear her prosthesis and required a referral for revisional surgery to a Consultant Plastic and Reconstructive Surgeon. This sequence caused significant physical and psychological distress to Patient A who required counselling.'*

47. In his oral evidence, Mr Q stated that as Consultant Surgeon, the responsibility lay with Dr Mahadev, even if a more junior doctor performed the surgery under his supervision. It would have been for Dr Mahadev to, at any time, take over or rectify any errors and record this accordingly. However, no such record was apparent. The Tribunal had regard to the Operation/Procedure Record which recorded that the Consultant was 'Prof Mahadev' and the surgeon was somebody else.

48. The Tribunal accepted the evidence of Patient A that her scar was *'horrendous',* that she found it uncomfortable and that as a result, a delay was caused to her radiotherapy. Mr L sent a letter, dated 18 August 2020, to a plastic surgeon which stated that Patient A's *'ridging is worse than I have encountered before.*' In his oral evidence, Mr Q stated that this was a very significant adverse comment and that the scarring was a result of poor technique which resulted in Patient A being unable to wear a prosthesis.

49. Based on the evidence received from Patient A and following the opinions of Mr L and Mr Q, the Tribunal was satisfied that Dr Mahadev provided inadequate surgical care regardless of whether Dr Mahadev carried out the surgery or had supervised the surgery.

50. The Tribunal therefore found paragraphs 5(a) and 5(b) of the Allegation proved.

Paragraph 6 of the Allegation

51. The Tribunal considered whether on 26 September 2019, Dr Mahadev failed to personally examine and/or review Patient A when she noted that the Procedure site had started to fill with fluid, produce pain and was swelling.

52. The Tribunal had regard to the oral evidence of Mr Q who stated that it would have been acceptable for Dr Mahadev to delegate the examination to another doctor. In his expert report, he stated, '*clinical assessment on the day of discharge...when Patient A was symptomatic, should have included examination of the operation site by a doctor*.' Mr Q further stated that Dr Mahadev would have overall responsibility and if he was not around or off duty, then he should ensure an adequate handover to others which is essential in ensuring patient safety. Whilst critical of the consultation and lack of examination, Patient A confirmed that she had seen a doctor the next morning as part of the ward round.

53. Based on this evidence, the Tribunal was satisfied that Dr Mahadev's actions did not amount to a failure to personally examine Patient A as he could delegate this and Patient A had been seen by a doctor the morning after her surgery.

54. However, the Tribunal noted that following her operation, Patient A was symptomatic. She had low blood pressure, low oxygen saturation and due to her having had morphine administered had stayed in recovery until late afternoon as opposed to the half an hour that would ordinarily have been required, as explained by Mr Q. It also noted Patient A's

evidence that she had not seen Dr Mahadev at all after the surgery and there were no medical records indicating he had reviewed her post operative care or recovery. It considered Mr Q's evidence that it remained Dr Mahadev's duty to assess the competence of another doctor or subordinate that he would delegate/handover to and to obtain feedback from them. It further accepted Patient A's evidence of the pain and swelling she suffered post operatively and at the time of her discharge. The evidence showed no post operative input by Dr Mahadev on 26 September 2019.

55. The Tribunal took the view that Dr Mahadev was under a duty to review Patient A in light of her symptoms. On balance, after consideration of the evidence, it determined that Dr Mahadev failed to do this.

56. The Tribunal therefore found paragraph 6 of the Allegation proved, only in relation to the review of Patient A.

Paragraphs 7(a) and 7(b) of the Allegation

57. The Tribunal considered the pre-discharge assessment on 26 September 2019 that Patient A underwent by her breast care nurse, when Dr Mahadev had overall responsibility for her care. It considered if this was inappropriate as it occurred in the lady's toilet with no privacy for Patient A who was required to partially undress.

58. Mr Q's evidence to the Tribunal was that an assessment in the toilets would be inappropriate and would carry a higher risk of infection. The Tribunal accepted Patient A's oral evidence, consistent with her written account, that as space was needed to manoeuvre and lift her arm to undress, the assessment could not take place in the toilet cubicle and needed to take place in the public area of the toilet. Patient A stated that she found the assessment embarrassing and that she was in a lot of pain whilst trying to undress, felt distressed and had begun to cry. In respect of this assessment and lack of privacy, it noted and accepted Mr Q's evidence, that it was '*utterly irresponsible'* and '*appalling*'. He stated that as an alternative, the breast nurse ought to have taken Patient A to a room at the outpatient's clinic in the hospital.

59. Further, in his supplemental expert report, Mr Q stated, *'The lack of privacy, when Patient A was assessed at the time of discharge by the breast care nurse F in the ladies' toilet due to there being no available room on the ward, indicates an inadequate standard of clinical care'.*

60. The Tribunal noted that Dr Mahadev did still have overall responsibility for Patient A and would do so until her discharge from hospital. However, it did consider that based on the evidence, it was unlikely that Dr Mahadev would have known about the breast care nurse's decision to examine Patient A in the toilet where there was no privacy, at least, before that assessment occurred.

61. The Tribunal, nevertheless, determined that the pre discharge assessment by Patient A's breast care nurse, when Dr Mahadev had overall responsibility for Patient A's care, was inappropriate by virtue of being in the toilet, and, as there was no privacy for Patient A.

62. The Tribunal therefore found paragraphs 7(a) and 7(b) of the Allegation proved.

Patient B

Paragraph 8 of the Allegation

63. The Tribunal considered if Dr Mahadev had failed to obtain fully informed consent from Patient B, before she underwent a right mastectomy and sentinel lymph node biopsy, as he failed to discuss one or more of the risks set out in Schedule 1 of the Allegation as below:

Schedule 1

- the potential side effects of the patent blue dye administration to identify the sentinel lymph node namely: allergic reaction, faint blue discolouration of the skin, blue discolouration of the urine and persistence of cutaneous pigmentation around the site of injection.
- the potential side effects of the axillary sentinel lymph node procedure, namely: axillary pain, shoulder stiffness, a low incidence of lymphoedema (less than 10%).

64. The Tribunal had regard to the consent form, dated 12 September 2019, signed by Dr Mahadev, and noted that none of the significant risks, as listed in Schedule 1, were included within it.

65. The Tribunal had regard to Mr Q's opinion in his expert report that:

'The consent for Patient B to undergo a right mastectomy and sentinel lymph node biopsy was taken by Mr Mahadev on 12.09.2019 and correctly includes the benefits of removal of the tumour and the lymph node but omits the potential side effects of the patent blue dye in the identification of the sentinel lymph node and also the potential side effects of the sentinel lymph node procedure, namely axillary pain, shoulder stiffness and the low incidence of lymphoedema (less than 10%). This would result in Patient B not being fully informed at the time of consenting…'.

66. The Tribunal further considered the expert opinion of Mr Q that, the person carrying out the consent process is responsible for the discussion, information to be given to Patient B about the procedure and the risks and the recording of that information. He referred to the guidance from the Royal College of Surgeons and stated that consenting a patient is a process and completing the form is merely one part. He stated that the discussion is very important, and that discussion should be noted in the medical records and detailed on the form at the very least. He stated that it is required for the surgeon to do this, so one can be confident that the patient has understood and agreed to the procedure. Mr Q also confirmed that it is not adequate for there to merely be a discussion about the risks and those risks not being recorded in writing. Further, only a small amount of information may be retained by the patient and therefore it is important for the consent form to be adequately completed so that it can be perused by them and the option of changing their mind, following reflection, remains available.

67. The Tribunal considered the summary of the national guidelines collated by Mr Q which included guidance from the GMC publication 'Consent - patient and doctors making decisions together' dated 2008 and also 'Consent: Supported decision making – a guide to good practice' Royal College of Surgeons of England publication dated 2016. The guidelines stipulated the requirement for written consent to be obtained for procedures with higher risk. It further considered the requirement for decision-making records. The guidance provided that in addition to the consent form, the surgeon should maintain written decision making records that contain contemporaneous documentation of the key points of the consent discussion. The Tribunal therefore noted that any verbal discussion of risks without a written record would be outside the national guidelines.

68. The Tribunal did however note a letter from Dr L to Patient B's GP dated 30 August 2019, in respect of Dr L having seen Patient B in a clinic on 28 August 2019. The letter confirms the risks that Dr L discussed with Patient B, those being '*bleeding, infection, pain, scarring, the use of blue dye and radioactivity to localise the sentinel node and the need to switch off the pacemaker prior to surgery and the need for use of bipolar diathermy which will increase the risk of bleeding'.*

69. The Tribunal queried whether such a discussion between Mr L and Patient B at the clinic approximately 2 weeks prior to the surgery, could be considered as fully informed consent being obtained from Patient B. Mr Q's view was that Mr L's letter did list the procedure in detail, but it was incumbent on '*the surgeon who took consent on the day to enumerate the complications then and there'*.

70. The Tribunal considered the guidance from the Royal College of Surgeons, and accepted Mr Q's evidence. It considered that the consent process is more than the discussion of risks in a pre-operative clinic, it needed to be accompanied by a discussion by the surgeon and be recorded in the consent form which is signed by the patient.

71. It further considered that the letter from Mr L to Patient B's GP did document both the use of patent blue due and radioactivity [radioisotopes] to identify the sentinel node, which may have been indicative of his intention to use both. However, the medical note did not record the use of patent blue dye by Dr Mahadev. Therefore, the Tribunal, being unclear as to whether the dye had been used or not, did not consider that Dr Mahadev could have failed to record the risks relating to the use of patent blue dye on the consent form if he had not used it. However, it did consider that the remainder of the risks as per Schedule 1 which were not present as risks on the said consent form, was a failure on part of Dr Mahadev who had a duty to discuss and records those on the consent form.

72. The Tribunal therefore found paragraph 8 of the Allegation proved.

Paragraph 9 of the Allegation

73. The Tribunal considered if Dr Mahadev provided inadequate surgical care on 12 September 2019, in that Patient B was left with a tethered scar and excess tissue laterally as a result of poor surgical technique.

74. The Tribunal had regard to the letter from the Plastic Surgeon, dated 11 March 2020, which stated that Patient B was '*left with a severely tethered scar around the right chest wall and so she feels mutilated by the surgery*'… '*On examination, she does have a very tethered scar from her mastectomy*.'

75. In his oral evidence, Mr Q had criticisms of the outcome of Patient B's surgery as shown in the diagram within her medical notes. It noted *'excess tissue'* and *'ext of breast tissue*

left'. He stated that these were very telling observations and suggested that they were indicative of inadequate surgical care. In explaining the procedure in his oral evidence, Mr Q stated that the excess tissue indicated in the diagram would have been obvious during the operation and not resolving this was inadequate surgical care.

76. In his expert report, Mr Q provided, *'In my opinion, in Patient B, the failure in planning the incision and the dissection technique in fashioning the mastectomy flaps, with the purpose of creating an even, flat scar, avoiding redundant skin and excess subcutaneous fat, actually resulted in Patient B being unable to wear her bra and prosthesis.'*

77. The Tribunal accepted Mr Q's view and was satisfied that Dr Mahadev provided inadequate surgical care and demonstrated poor surgical technique.

78. The Tribunal therefore found paragraph 9 of the Allegation proved.

Paragraph 10 of the Allegation

79. The Tribunal considered if Dr Mahadev failed to record any detail as to the use of radioisotope and/or patent blue dye. In doing so the Tribunal noted that none of these were mentioned in the operating note completed by Dr Mahadev.

80. The Tribunal considered Mr Q's evidence that it is important to record the use and administration of radioisotope/patent blue dye due to the serious potential side effects. He stated that anaesthetists also needed to know what a patient had been given in case of complications. He further stated that there is an expectation that all procedures should be recorded – further that surgeons would not only record what was administered but also its volume and the corresponding manufacturer's number. The Tribunal accepted that there was a duty on Dr Mahadev to accurately record what was used.

81. Mr Q stated that in order to identify a sentinel lymph node a doctor would have to use either radioisotope, patent blue dye or both of these. In the absence of any of these, the doctor would not be performing a sentinel lymph node biopsy but be doing an axillary lymph node sample.

82. It could be seen from the medical records that Dr Mahadev reported removing seven nodes, including the sentinel lymph node, although the pathology report commented

that no blue dye was seen. Mr Q stated that it was possible that it was not used at all as the procedure could be carried out by use of just a radioisotope. The Tribunal noted that the removal of the lymph nodes did show that the biopsy was done which indicated that at least one of the radioisotope or patent blue dye would have been used. In light of there being no recording made as to which one, if not both, the Tribunal determined that Dr Mahadev had failed to record within the operating note, any details as to what was used/administered.

83. The Tribunal therefore found paragraph 10 of the Allegation proved.

Paragraphs 12(a), 12(b)(i), 12(b)(ii) and 12(b)(iii)

84. The Tribunal considered if Dr Mahadev failed to advise Patient B's GP that in light of the results of the bone densitometry scan, she was at risk of developing a vertebral compression fracture, that she should be commenced on supplemental calcium, vitamin D and considered for bisphosphonates.

85. The Tribunal noted that a letter was sent to Dr Mahadev, by Patient B's GP, dated 21 November 2019, which enclosed the scan report for Patient B.

86. In his expert report, Mr Q stated *'In my opinion it would be important to inform Patient B's General Practitioner of the result since osteoporosis requires supplementary calcium, Vitamin D and consideration for bisphosphonates. There is no evidence that this information was provided to Patient B's General Practitioner by Mr Mahadev'*. Further in considering the standard of care provided by Dr Mahadev, Mr Q stated that Patient B *'would be at risk of developing a vertebral compression fracture in view of the osteoporosis.'* In his oral evidence he stated that this information would have been important for the GP to know so he could prescribe appropriate medication to reduce the risk of future problems, particularly the risk of vertebral collapse. Mr Q further confirmed that there was no such communication to the GP by Dr Mahadev.

87. Mr Q further stated in his oral evidence that it was for Dr Mahadev to write back to the GP with a planned action as the GP would not start treatment without permission of the consultant. The Tribunal accepted this and took the view that Dr Mahadev was given the results of Patient B's bone density scan and as such was under a duty to consider these and provide Patient B's GP with his opinion of any risks to Patient B such as osteoporosis of the spine and how that risk could best be managed for example with calcium, vitamin

D or bisphosphonates. There was no evidence of him having done this within Patient B's medical notes.

88. The Tribunal therefore found paragraphs 12(a), 12(b)(i), 12(b)(ii) and 12(b)(iii) of the Allegation proved.

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

89. The Tribunal considered if Dr Mahadev failed to arrange further assessment of Patient B's right shoulder pain to exclude metastatic breast cancer including an isotope bone scan and a repeat computerised tomography scan of the chest, abdomen, and pelvis.

90. In providing his oral evidence to the Tribunal Mr Q stated that as Patient B was suffering from severe shoulder pain radiating to her upper back and shoulder blade, one would be concerned about metastases given her previous lobular carcinoma. He further stated that metastatic disease can cause spinal cord compression which is a '*real emergency and preventing that is of paramount importance.*'

91. In his oral evidence, Mr Q expressed shock at Dr Mahadev's lack of investigation into the cause of her concerns. His expert report also confirmed the view that he provided orally. He stated:

> *'The occurrence of persisting pain in the right shoulder (02.12.2019) should have been further investigated by Mr Mahadev with an isotope bone scan and possibly a repeat of the CT scan of the chest, abdomen and pelvis by Mr Mahadev in order to exclude metastatic breast cancer albeit that the lymph nodes were negative (clinic letter 03.12.2019)'*
>
> *'In a patient with breast cancer with unexplained severe pain, in this case in the right shoulder radiating to the scapula and upper back, in my opinion and that of a responsible body of Consultant Breast Surgeons, it should have been further assessed with an isotope bone scan and possible repeat CT scan of the chest and abdomen which had been previously carried out on 26.06.2019 as preoperative staging'.*

92. Based on the evidence of Mr Q, which the Tribunal accepted, the Tribunal determined that Dr Mahadev did have a duty to arrange further assessment of Patient B's right shoulder pain to exclude metastatic breast cancer including an isotope bone scan. The

Tribunal did not find any evidence indicating that Dr Mahadev had arranged an isotope bone scan and took the view that he failed to discharge his duty in this respect.

93. The Tribunal further noted Mr Q's expert view that Patient B's right shoulder pain diagnosis may have been further assisted by a '*possible*' CT scan. The Tribunal did not consider that *'a possible CT scan'* indicated that a duty had been established for Dr Mahadev to arrange a repeat computersied tomography scan of the chest, abdomen and pelvis. Accordingly, it did not find proved that he had failed in this regard.

94. The Tribunal therefore found paragraphs 13(a) of the Allegation proved and paragraph 13(b) of the Allegation not proved.

Paragraph 14 of the Allegation

95. The Tribunal considered if Dr Mahadev failed to inform Patient B's GP in his letter of 3 December 2019, of his examination regarding the state of her scar and the presence of tenderness and seroma.

96. The Tribunal had regard to the letter sent by Dr Mahadev to Patient B's GP, dated 3 December 2019, which made no reference to the state of Patient B's scar or to the presence of tenderness and seroma.

97. In his oral evidence, Mr Q stated that at each review, the surgeon should always address each symptomatic area. He stated that the pain reported by Patient B could radiate from the scar to her shoulder and also to the axilla. Mr Q questioned if an examination took place or not. If it did, he stated that any clinical information gained was very important and ought to be communicated to the GP. This would be the start of resolving Patient B's problems and the clinical examination would indicate the direction of the investigation. He stated that there was no scar, tenderness or seroma mentioned in the letter and there was no handwritten out-patient entry found.

98. Bearing in mind the evidence received, the Tribunal took the view that Dr Mahadev was under a duty to address each symptomatic area, particularly as Patient B had reported severe shoulder pain as recorded by Dr Mahadev in the letter of 3 December 2019. Dr Mahadev was also under a duty to then provide Patient B's GP with full information from his clinical examination of her on 2 December 2019. The Tribunal noted that there was no mention of the scar, tenderness or seroma mentioned in the letter which it

considered on balance Dr Mahadev would have noted from a clinical examination following Patient B's complaints and therefore he failed to discharge the duty on him in this regard.

99. The Tribunal therefore found paragraph 14 of the Allegation proved.

Paragraph 15 of the Allegation

100. The Tribunal was mindful that it had found that Dr Mahadev had failed to arrange further assessment of Patient B's complaint in respect of pain, on 2 December 2019. It also bore in mind that Dr Mahadev was aware that Patient B had osteoporosis and previous breast cancer. The Tribunal considered if Dr Mahadev had inappropriately requested Patient B's GP to arrange intensive physiotherapy and for them to consider a referral to an orthopaedic surgeon for Patient B's skeletal pain.

101. Mr Q, in his oral evidence, stated that further investigation into Patient B's previous breast cancer was necessary before she undertook any physiotherapy or a referral to an orthopaedic surgeon. He also stated that he was shocked at the lack of investigation and the lack of help Dr Mahadev had provided to Patient B and to her GP, as it would not have been appropriate to arrange intensive physiotherapy without the scan as damage could be caused from strenuous exercise. He stated that to refer to an orthopaedic surgeon without excluding the possibility of metastases disease was '*unthinkable*'.

102. Mr Q further stated that, to refer Patient B for '*intensive physiotherapy'* would delay Patient B in getting the appropriate treatment and could have potentially caused harm.

103. The Tribunal accepted Mr Q's evidence and determined that Dr Mahadev's request to Patient B's GP to arrange intensive physiotherapy and to consider a referral to an orthopaedic surgeon was in the circumstances inappropriate.

104. The Tribunal therefore found paragraph 15 of the Allegation proved.

Patient C

Paragraphs 16, 16(a)(i), 16(a)(ii), 16(b) and 16(c) of the Allegation

105. The Tribunal considered if Dr Mahadev failed to obtain fully informed consent for performing a revision of Patient C's right mastectomy scar. It considered whether Dr Mahadev failed to discuss with Patient C; the potential for the persistence of the dog ear scar deformity; and the potential need for further surgery. The Tribunal also considered if the consent discussion with Patient C took place in an inappropriate environment and if Patient C had inadequate time to consider the proposed treatment.

106. The Tribunal also considered Patient C's written evidence that Dr Mahadev did not discuss any risks and benefits with her and that she was not told that the procedure could result in a lump under her arm. She also stated that the risk of a persistence of the dog ear scar deformity was also not discussed nor was the potential need for further surgery after the procedure.

107. From Patient C's oral evidence, the Tribunal noted that Patient C did not recollect having seen Dr Mahadev in clinic on 4 October 2019, prior to her procedure on 1 November 2019, though documentation in her medical record suggested this outpatient consultation took place. The Tribunal considered that this was reasonable as the incident was over four years ago. It did however note that Patient C clearly and consistently maintained her recollection of seeing Dr Mahadev on the day of the procedure and considered him to be friendly and reported that he had informed her that there was nothing to worry about and that the procedure would be over before she knew it. She was also clear in her oral evidence when recalling the day of the procedure and consistent with her written account that the risks were not discussed with her. She further stated that Dr Mahadev had not informed her of any of the risks. She stated, '*not a thing*'.

108. The Tribunal noted the letter from Dr Mahadev to Patient C's GP, further to the clinic on 4 October 2019. It noted that there was no mention of any risks being discussed with Patient C. It had regard to the consent form, dated 1 November 2018 which mentioned the risks as '*bleeding*' and '*infection*'.

109. In his oral evidence, Mr Q stated that Dr Mahadev had not included additional risks that should have been recorded on the consent form such as the risk of pain, risk of a seroma and the possibility of additional surgery. It was Mr Q's view that fully informed consent should have included notification of these risks. He stated that it was important for Patient C to have known these risks as undertaking further surgery could result in nerve damage and pain.

110. In his expert report Mr Q stated:

> *'The signature is that of Mr Mahadev and the omission of the potential for further surgery and persistence of the "dog ear" deformity does not fully comply with National Guidelines'*

111. The Tribunal considered the consent form which did not record a discussion between Dr Mahadev and Patient C, of the risks relating to further surgery and the persistence of a dog ear deformity. It had regard to the national guidelines which required there to be a written record of any verbal discussion of the risks and benefits by the surgeon, in order for there to be adequate and informed consent.

112. The Tribunal further considered the environment of the consent discussion and whether Patient C had adequate time to consider the proposed treatment. The Tribunal bore in mind Patient C's evidence that she signed the consent form at the door of the operating theatre. She detailed in her oral evidence that Dr Mahadev had collected her from the waiting room and walked with her to the door of the theatre. Here, and standing at a desk, she was asked to sign the consent form. She maintained that Dr Mahadev had not told her about any of the risks. Nonetheless, the Tribunal noted that there was reference to bleeding and infection, recorded as risks to the procedure within the consent form that Patient C had signed.

113. Mr Q, in his oral evidence, stated that obtaining consent at the door of theatre would not have given Patient C enough time to consider the procedure, nor would she be able to have *'retained the information or remember it accurately'*. He stated that when the form is completed, time should be given to the patient to read it. In this case, it was Mr Q's view that Patient C would not have had a full understanding and therefore the consent obtained was flawed and invalid.

114. The Tribunal accepted Patient C's evidence in respect of signing the consent form at the door of the theatre and determined that it was an inappropriate environment for any consent discussion prior to signature and that Patient C would not have had sufficient time to consider the proposed treatment or retain any information given to her.

115. The Tribunal determined that the failure to discuss and record the potential for a persistent dog ear scar deformity and need for further surgery, together with the

inappropriate environment in which the consent form and not giving Patient C adequate time to consider the treatment, cumulated in a failure on part of Dr Mahadev to obtain fully informed consent from Patient C.

116. The Tribunal therefore found paragraphs 16, 16(a)(i), 16(a)(ii), 16(b) and 16(c) of the Allegation proved.

Paragraph 17 of the Allegation

117. The Tribunal considered if Dr Mahadev provided inadequate surgical care in that Patient C was left with excess skin, fat and scar tissue as a result of poor surgical technique.

118. The Tribunal noted that following the revision surgery, Patient C was reviewed by Mr L on 4 December 2019 and reported that she was unhappy about the persistence of the dog ear following surgery. It recorded that Patient C declined the option of further surgery with Dr Mahadev. In a further letter dated 12 February 2020, Mr L reported Patient C's concern regarding her symptoms of pain and discomfort, difficulty wearing a bra and pain at night if she were to roll on to her right side.

119. In his oral evidence, Mr Q stated that the outcome of the procedure Dr Mahadev performed on Patient C was very unsatisfactory, was due to poor surgical technique and that the adverse effects would have been apparent when Patient C was being sewn up.

120. In his expert report, Mr Q stated:

> *'2 months later, 12.02.2020, [Mr L] documented the persistence of pain in that region and that Patient C was still unable to wear her bra and prosthesis.'*

121. In his third supplemental report, Mr Q stated:

> *'the presence and persistence of the lump, and excess skin and subcutaneous fat, which required further corrective surgery, would indicate poor planning and operative dissection'*

122. The Tribunal considered Mr Q's evidence, referring to the photographs of Patient C's chest area where the revision was performed. He stated that Patient C's dog ear scar had got worse after the fishtail incision, undertaken by Dr Mahadev. It was magnified by the

scar contracting and bulging the remaining tissue even more. By reference to the photographs, Mr Q highlighted that the flush and '*nice, flat chest wall scar*' was the result of the second revision surgery by Mr L which the Tribunal considered was in stark contrast to the outcome of the procedure carried out by Dr Mahadev.

123. Having considered the entirety of the evidence, The Tribunal determined that Dr Mahadev had provided inadequate surgical care to Patient C, had left her with excess skin, fat and scar tissue. It therefore found paragraph 17 of the Allegation proved.

Patient G

Paragraphs 18(a) and 18(b) of the Allegation

124. The Tribunal considered if following Dr Mahadev's consultation with Patient G on 13 September 2019, he failed to write to Patient G's GP and to record a handwritten entry of his clinical encounter with Patient G in the out-patient section of Patient G's medical records.

125. Based on the evidence received, the Tribunal was satisfied that Dr Mahadev had a duty to write to Patient G's GP. This was to provide updated clinical information and to record the findings of the consultation in Patient G's medical records for accuracy and to assist colleagues in having the clinical information at any future point. However, the Tribunal noted that there was no evidence of a letter to the GP or a handwritten note of the consultation within Patient G's medical records.

126. In his expert report, Mr Q stated:

> *'On 13.09.2019 Patient G attended the outpatient clinic but there was no handwritten entry in the outpatient section and only the named CNS, breast care nurse R is noted. There was no corresponding correspondence found.'*

127. In his oral evidence, Mr Q maintained that there was no record of the consultation in Patient G's medical records nor was there a letter to her GP.

128. The Tribunal could also not find any handwritten entry relating to the consultation on 13 September 2019 but did note an entry entitled EPR, which it considered was an abbreviation for Electronic Patient Records. This entry referred to '*SB Professor Dev…*'.

The Tribunal inferred that SB was an abbreviation for 'seen by' and noted that the entry referred to Dr Mahadev in the third person. The entry was signed '*R*', which the Tribunal inferred was a record made by the breast nurse with those initials. The Tribunal considered that this entry corroborated that a consultation on 13 September 2019 had taken place. It did not see any copy letter from Dr Mahadev to Patient G's GP nor did it find a corresponding hand written entry by him in the outpatients section of Patient G's medical records.

129. The Tribunal therefore found paragraphs 18(a) and 18(b) of the Allegation proved.

Paragraphs 19(a), 19(b), 19(c)(i), 19(c)(ii) and 19(c)(iii) of the Allegation

130. The Tribunal considered if Dr Mahadev failed to obtain fully informed consent from Patient G on 9 September 2019 when she underwent a left mastectomy and sentinel lymph node biopsy. It considered whether Dr Mahadev had failed to discuss with Patient G, the potential complications relating to the use of patent blue dye and sentinel lymph node dissection in the axilla. It also considered whether there was a failure to discuss the potential complications relating to the enhanced risk of wound breakdown and infection in view of Patient G's previous radiotherapy to the left breast, long-standing heavy smoking habit and intermittent high alcohol intake.

131. The Tribunal had regard to the consent form dated 19 September 2019. It noted that the consent form did not make any reference to the use of patent blue dye or any potential complications relating to the sentinel lymph node dissection in the axilla or the impact of Patient G's previous radiotherapy, smoking habit or alcohol intake. The consent form documented the risks as, '*bleeding, infection, scar and further surgery*'.

132. The Tribunal noted Patient G's evidence. She had stated that '*I don't recall specifically though I believe I would have told them not to tell me the particular details of the Procedure, as I normally do not like to know what could go wrong. However, I do know that we did not discuss the use of blue dye in the Procedure nor the possibility of infection.*'

133. In her oral evidence, Patient G maintained her stance that if she is told gory details, she tends to '*brew*' and does not want to know what could go wrong. She further stated that she could not recall any risks being mentioned in any consultation. Patient G was asked to recall whether she was informed of the enhanced risk of wound breakdown or an

infection, as specific risks and complications emanating from her previous radiotherapy, long-standing and heavy smoking habit and alcohol intake. Patient G maintained that those had not been mentioned to her and if she knew about the potential complications then she would have considered alternatives to surgery as she was '*half hearted*' about the procedure in any event.

134. Mr Q opined that '*one cannot omit serious risks off the consent form*' and that the consent process needed to take place in full. He stated that the risks could be explained with sensitivity and stated in normal English without use of any '*gory details*' to avoid frightening the patient. He stated that if the risk factors were not adequately explained to Patient G, then the consent gained was inadequate as it was incomplete. He stated that the consent process needed the potential risks and problems of the wound not healing to be highlighted and documented, which could lead to a decrease in quality of life.

135. The Tribunal had regard to the GMC Guidance entitled *'Consent: patients and doctors making decisions together'.* This guidance stated:

> *'35. If a patient does not want to know about the possible risks of a proposed investigation or treatment, you must follow the guidance in paragraphs 13 –17…*
>
> *…Reasons for not sharing information with patients*
>
> *13. No one else can make a decision on behalf of an adult who has capacity. If a patient asks you to make decisions on their behalf or wants to leave decisions to a relative, partner, friend, carer or another person close to them, you should explain that it is still important that they understand the options open to them, and what the treatment will involve. If they do not want this information, you should try to find out why.*
>
> *14. If, after discussion, a patient still does not want to know in detail about their condition or the treatment, you should respect their wishes, as far as possible. But you must still give them the information they need in order to give their consent to a proposed investigation or treatment. This is likely to include what the investigation or treatment aims to achieve and what it will involve, for example: whether the procedure is invasive; what level of pain or discomfort they might experience, and*

what can be done to minimise it; anything they should do to prepare for the investigation or treatment; and if it involves any serious risks.

15. If a patient insists that they do not want even this basic information, you must explain the potential consequences of them not having it, particularly if it might mean that their consent is not valid. You must record the fact that the patient has declined this information. You must also make it clear that they can change their mind and have more information at any time.

16. You should not withhold information necessary for making decisions for any other reason, including when a relative, partner, friend or carer asks you to, unless you believe that giving it would cause the patient serious harm. In this context 'serious harm' means more than that the patient might become upset or decide to refuse treatment.

17. If you withhold information from the patient you must record your reason for doing so in the patient's medical records, and you must be prepared to explain and justify your decision. You should regularly review your decision, and consider whether you could give information to the patient later, without causing them serious harm.'

136. The Tribunal took the view that despite any hesitation on Patient G's part to know about the details of the procedure and the risks involved, it was incumbent on Dr Mahadev to explain the potential consequences and complications of the procedure to Patient G.

137. The Tribunal considered all the evidence before it. It noted Patient G's evidence that she was not informed of the potential complications of the procedure. It further noted no reference to those risks in any consultation letter or the consent form. It also reminded itself of the national guidance on the consent process and determined that the consent form demonstrated inadequate recording of the risks at the very least. The Tribunal accepted Patient G's account that she was not told the specific complications which would have led to her to consider alternatives to the surgery.

138. The Tribunal therefore was satisfied that Dr Mahadev failed to obtain fully informed consent from Patient G.

139. The Tribunal therefore found paragraphs 19(a), 19(b), 19(c)(i), 19(c)(ii) and 19(c)(iii) of the Allegation proved.

Patient H

Paragraph 20 of the Allegation

140. The Tribunal considered if Dr Mahadev failed to obtain fully informed consent from Patient H on 5 November 2019, when she underwent a left axillary lymph node clearance. It considered if Dr Mahadev failed to record having discussed with Patient H, one or more of the serious risks set out at Schedule 2 as follows:

Schedule 2

- chest wall pain;
- seroma / haematoma formation;
- numbness in the axilla and upper arm;
- significant shoulder stiffness;
- an increased risk of damage to structures including: the axillary vein, the latissimus dorsi pedicle, the nerve to the serratus anterior resulting in a winged scapula;
- lymphoedema of the upper limb.

141. The Tribunal had regard to the consent form, dated 5 November 2019 which listed '*bleeding*' and '*infection*' as the risks.

142. It was Mr Q's opinion that the procedure Patient H underwent, a left axillary lymph node clearance, was a fairly substantial operation with a risk of various side effects such as chest wall pain, seroma/haematoma formation, numbness in the axilla and upper arm, significant shoulder stiffness, an increased risk of damage to structures including the axillary vein, the latissimus dorsi pedicle, the nerve to the serratus anterior resulting in a winged scapula and lymphoedema of the upper limb. None of these risks were noted on the consent form. Mr Q opined that Patient H's consent process was therefore incomplete and inadequate.

143. In his oral evidence, Mr Q further stated that the procedure Patient H underwent would require the incision being reopened so the risk of infection would be considerable and could result in permanent changes. Mr Q stated that a left axillary lymph node clearance is a very intrusive procedure and would always be discussed at a multidisciplinary team meeting. He went on to state that the risks and benefits of the procedure should be

made entirely clear to the patient who should always be given the time and opportunity for a secondary discussion with a breast care nurse.

144. The Tribunal accepted the opinion of Mr Q. It considered the consent guidance from the Royal college of Surgeons which required there to be an explanation of the risks and benefits of treatment options, together with the likelihood of success of the various options and the impact the treatment would have on the patient's life. There was a requirement for the patient to understand the information and sufficient time allowed for the patient to deliberate and consider the treatment. It reminded itself that a verbal discussion without any written record of the consent discussion would also not be adequate consent.

145. Based on the evidence received, the Tribunal took the view that the consent process for Patient H ought to have taken place/commenced in advance of her procedure on 5 November 2019, so she had ample time and opportunity to consider the risks and benefits and make an informed decision. It noted the letter dated 5 September 2019, from Dr L recording risks discussed with Patient H on 3 September 2019 in respect of the 'biopsy' procedure which took place on 26 September 2019 and predated the 'clearance' procedure. It could not find any evidence of the consent process having been started in clinic for Patient H in advance of the 'clearance' procedure which took place on 5 November 2019. It considered that at the very least, there was a duty on Dr Mahadev to discuss and record the relevant risks within the consent form that the patient would sign. It determined that Dr Mahadev failed to discharge this duty.

146. The Tribunal therefore found paragraph 20 of the Allegation proved.

Paragraphs 21(a), 21(b) and 21(c) of the Allegation

147. The Tribunal considered the allegation that on 22 November 2019, Dr Mahadev undertook a post-operative review of Patient H and prescribed Augmentin (Co-Amoxiclav) to her which was inappropriate because she was allergic to Penicillin, she was at significant risk of anaphylactic allergic reaction and because of there being extensive reference in Patient H's medical records to her allergy to Penicillin.

148. The Tribunal had regard to the letter from Mr L to Patient H's GP, dated 5 September 2019, which stated *'She is allergic to Penicillin'.*

149. In addition, the Adult Surgery Care Pathway noted:

> *'Allergies or drug reactions*
> *Penicillin – anaphylaxis'.*

150. The Tribunal also noted that the pre-operative assessment form completed by the anaesthetist stated:

> *'ALLERGIES*
> *Penicillin – Anaphylactic shock'*
>
> Also, Patient H's medication chart showed:
>
> *'ALLERGIES OR SENSITIVITY*
>
> *Penicillin'*

151. The Tribunal took the view that Dr Mahadev should have taken note of these records which were readily available to him, both in the handwritten and electronic medical notes, highlighting that Patient H was allergic to penicillin. There was also a clear reference in Patient H's medical records of her having previously suffered from anaphylactic shock. Mr Q opined that when a surgeon is assessing a patient, they would obtain information from their colleagues letter/s and other information within the medical records.

152. In his oral evidence, Mr Q said that the intensity of a patients reaction can escalate with continued exposure to the drug prescribed in this instance.

153. The Tribunal acknowledged that as per the entry in the electronic patient notes, Dr Mahadev had apologised to Patient H for his prescribing error on 6 December 2019 when he reviewed her. Even so, the Tribunal concluded that it was inappropriate for Dr Mahadev to have prescribed Augmentin (Co-Amoxiclav) to Patient H on 22 November 2019 in a post-operative review when there had been extensive reference to her having a penicillin allergy and having suffered an anaphylactic shock in the past.

154. The Tribunal therefore found paragraphs 21(a), 21(b) and 21(c) of the Allegation proved.

Paragraphs 22(a)(i), 22(a)(ii), 22(a)(iii) and 22(a)(iv) of the Allegation

155. The Tribunal considered if Dr Mahadev failed to document in his letter dated 22 November 2019, to Dr M Consultant Oncologist, that after the procedure, Patient H required serial seroma aspirations, developed a wound infection, and required antibiotics.

156. The Tribunal had regard to Patient H's electronic patient notes which showed the following entry relating to 22 November 2019:

> '*Seen in clinic with Professor Mahadev for post op results. He advised that 2/6 nodes were involved for the ANC and therefore a total of 2/7. He suggested that she sees the oncologist for a discussion of chemotherapy, radiotherapy and hormone tablets. Patient H was feeling unwell and it appears that she has a wound infection to her axilla as red and warm too. Augmentin prescribed and for review next week. Approx. 250 mls seroma drained from site. CT requested. VP*'

157. The Tribunal also had regard to the letter from Dr Mahadev to Patient H's GP dated 22 November 2019. It noted that it did not refer to the recorded information from the same date, regarding Patient H requiring serial seroma aspirations, nor that she had developed a wound infection or that she required antibiotics which were prescribed.

158. The Tribunal had regard to Mr Q's opinion. He stated that the letter of 22 November 2019 lacked clinical information for the consultant oncologist. He stated that an infected axillary wound would not only lead to permanent side effects but could delay adjuvant treatment and that would have an adverse effect on the prognosis of the patient. He stated that the oncologist would need to be appraised of this information as they would give advice regarding the specialist adjuvant treatment, dose and timescales of chemotherapy and whether radiotherapy should follow. Mr Q also stated that the oncologist would also need to know the agents prescribed.

159. The Tribunal took the view that there was a duty on Dr Mahadev to provide Patient H's consultant oncologist with this information. This would allow them to make an informed decision about the future treatment of Patient H and that it would be important for them to be aware of these elements in order to advise the patient about the most appropriate next steps.

160. Based on the evidence received, the Tribunal concluded that Dr Mahadev failed to document in the letter to Patient H's oncologist that Patient H required serial seroma aspirations, that she had developed a wound infection and had required antibiotics for which Augmentin was prescribed.

161. The Tribunal therefore found paragraphs 22(a)(i), 22(a)(ii), 22(a)(iii) and 22(a)(iv) of the Allegation proved.

Paragraphs 22(b)(i), 22(b)(ii) and 22(b)(iii) of the Allegation

162. The Tribunal considered if Dr Mahadev failed to record in Patient H's medical records that there was a seroma that required aspiration, that the axillary wound was infected and that he had prescribed Augmentin.

163. In his oral evidence, Mr Q confirmed that Dr Mahadev should have made notes in Patient H's medical records to correspond with the consultation on 22 November 2019. He stated that he could not find any corresponding clinical entry in the medical notes. He stated that this was a significant post operative consultation and examination which noted a complication of an infection in Patient H's wound. He went on to state that an infected axilla wound following lymph node surgery would not only lead to permanent side effects but would also delay the adjuvant treatment. He stated that a clinical record of this was important and vital for other hospital clinicians to have in case the patient was readmitted or attended the Accident and Emergency department of the hospital. Further, that a lack of essential clinical details had the potential to affect the future care of Patient H.

164. The Tribunal took the view that the three elements were significant events in Patient H's medical history and an accurate medical record would have been needed for other clinicians if Patient H was re-admitted and essential for her future care. It determined that Dr Mahadev had therefore failed to record in Patient H's medical records on 22 November 2019, that there was a seroma that required aspiration, that the auxiliary wound was infected and that he had prescribed Augmentin.

165. The Tribunal found paragraphs 22(b)(i), 22(b)(ii) and 22(b)(iii) of the Allegation proved.

Patient I

Paragraph 23 of the Allegation

166. The Tribunal considered if Dr Mahadev's advice to Patient I, documented within the letter of 24 September 2019, that she reduce the dose of Letrozole 2.5mg to alternate days rather than daily, was inappropriate because Patient I was placed at increased risk of recurrence of breast cancer for a period of 6-7 months whilst taking the sub-optimal dose.

167. The Tribunal had regard to the clinical information summary drug list which stated *'Letrozole 2.5mg tablets'* and *'One To Be Taken Each Day For a Minimum of 5yrs'*. It also had regard to the letter by Dr Mahadev, dated 24 September 2019, which stated *'I did impress upon her that she needs to stay on this because of her breast cancer. As a compromise, we decided that she take this every other day that allows her to be on the medication as well as hopefully having less side effects.'*

168. The letter from the breast care nurse, dated 5 May 2020, stated *'At a consultation in September 2019 Patient I was advised due to the side effects to take the Letrozole on alternate days. However on discussion with Mr S in [Mr L's] absence we have suggested a switch of hormone manipulation rather than reduced dose'*.

169. In his oral evidence, Mr Q said that Letrozole is the most effective hormone inhibitor and 2.5 mg is the standard and optimal dose. He stated that he had never heard of this medication being taken every other day and that this would make it ineffective, unlikely to reduce any side effects and that this was unacceptable. He said that Patient I would lose the intended benefits of the medication and that following 6 to 7 months of taking a sub optimal dose Patient I would have permanently lost the benefit and suffered reduced protection from a recurrence of breast cancer. Mr Q stated that this was significant as protection from Letrozole was highest in the first two years of treatment. He went on to state that any risks would have longevity and that Patient I's prognosis would go down.

170. The Tribunal noted that due to the compromise made by Dr Mahadev for Patient I, a Datix report was later produced by another doctor. Mr Q explained this report was to report an incident where a patient may have been placed at risk of harm and it was also used as a learning tool to prevent a recurrence.

171. Having considered the evidence before it, the Tribunal took the view that advising Patient I to take Letrozole dose of 2.5 mg every other day and effectively reducing her dose was inappropriate. It placed her at an increased risk of recurrence of breast cancer for the period of 6-7 months whilst taking the sub-optimal dose.

172. The Tribunal therefore found paragraph 23 of the Allegation proved.

Patient J

Paragraph 24 of the Allegation

173. The Tribunal considered if Dr Mahadev failed to arrange a pre-operative ultrasound scan of Patient J's 12-year-old breast implants.

174. The Tribunal had regard to the letter from Patient J's endocrinologist, dated 5 July 2019, and noted that an ultrasound scan of the breast had been advised. It stated:

> '*She had breast implants back in the day, now need to be changed, as they are out of date..*'
>
> '*Breast examination revealed hardness with nodularity particularly on the Left side. She will require investigations into both conditions locally. I would be grateful if she is referred to have an ultrasound scan of the abdomen to look for gallstones. In addition US scan of the breast and a referral to the local breast services*.'

175. The Tribunal noted that despite the indication that the implants were out of date and that hardness with nodularity required investigation, there was no evidence that Dr Mahadev had ordered an ultrasound before Patient J's surgery. Dr Mahadev consulted with Patient J on 17 September 2019, some months before the surgery took place and this would have been an opportunity to have arranged an ultrasound of the implants.

176. In his oral evidence, Mr Q stated that in his opinion an ultrasound would have been essential to give Patient J the information needed to make an informed decision about proceeding to surgery. The Tribunal further noted Mr Q's evidence that there were no contraindications for an ultrasound and that it was advised by the endocrinologist and would have been mandatory.

177. In his expert report, Mr Q stated, *'In my opinion, an ultrasound should have been carried out to assess the state of the implants prior to surgery in order to exclude or confirm silicone leakage'*. He further explained that any leakage would lead to an inflammatory reaction in the patient and cause increasing pain and discomfort. He stated that the cosmetic appearance would also be lost and in addition that surgery would become difficult once there was leakage.

178. Based on the evidence received, the Tribunal was satisfied that there was a duty on Dr Mahadev to arrange a pre-operative ultrasound scan of Patient J's 12-year-old implants and he failed to do so.

179. The Tribunal therefore found paragraph 24 of the Allegation proved.

Paragraph 25(a) and 25(b) of the Allegation

180. The Tribunal considered if Dr Mahadev failed to obtain fully informed consent from Patient J because she was unaware of the status of the implants and because he had failed to record discussing with Patient J one or more of the risks listed in Schedule 3 as follows:

Schedule 3

- implant rupture intra-operatively;
- haematoma / seroma formation;
- persistent pain;
- recurrence of the capsule.

181. The Tribunal bore in mind the evidence of Mr Q and its earlier determination that Dr Mahadev had failed to arrange a pre-operative ultrasound scan of Patient J's implants. Full information as to the status of the implants, whether they had leaked and whether the pectoral muscle has been infiltrated by the seeping gel, or whether there were adhesions between the capsules and the implants, had not therefore been established without an ultrasound having been carried out. The Tribunal noted that it was from the clinical examination that a grade 3 capsule in the left breast and a grade 2 capsule in the right breast was indicated together with both breasts being tender to touch and the patient complaining of pain and discomfort.

182. The Tribunal noted the letter from Dr Mahadev dated 18 September 2019 in which he outlined the various options he had given to Patient J. *'..firstly doing nothing and the second option either capsulotomy or capsulectomy with replacement of the same implants and the last option being removal of the implants totally. She would like to go through the second option of further capsulotomy or capsulectomy with replacement of the same implants. I shall put her on the waiting list.'*

183. The Tribunal considered Mr Q's evidence that adhesions between the capsules and the implants would make it more difficult to remove the implants and increased the risk of damaging them such that ultimately they could not be safely re-inserted. He stated that there is no indication that Patient J knew this when consenting to the option she chose which was replacement of the same implants.

184. Further, the Tribunal had regard to the consent form dated 19 November 2019 which noted the risks as '*bleeding/infection/scar*.' The form referred to the procedure being a '*bilateral breast capsulotomy*…'. It noted the risks as '*bleeding*' and '*infection*'. The Tribunal noted that Patient J underwent a right capsulotomy and a left capsulectomy. It noted that the risks relating to a capsulectomy, within Schedule 3, were not present on the consent form.

185. The Tribunal had regard to Mr Q's evidence. He stated that Patient J had a grade 3 capsule in the left breast for which a capsulotomy would not be sufficient. As such, the Tribunal noted that Patient J did have a capsulectomy in the left breast which was a more invasive procedure when compared to the capsulotomy as per the expert evidence. Mr Q stated that it was not clear why capsulectomy had not been included on the form. He detailed that a capsulectomy involves a more prolonged recovery period and the incision made is greater. He stated that there was a risk of haematoma and seroma formation and an increased risk of bleeding and persistent pain. Mr Q stated that the implant could rupture intraoperatively and a risk of recurrence of the capsule should also be explained to the patient for them to have a realistic expectation of the procedure. He stated that the consent form did not reflect the procedure offered. Further that it was '*absolutely not acceptable'* for Dr Mahadev to have carried out a capsulectomy without having explained it prior to the procedure. Mr Q also stated that written consent for the risks would be mandatory and that it may be acceptable for consent to have been obtained for the major procedure, that of capsulectomy, with the minor procedure of capsulotomy being performed but not the other way around.

186. The Tribunal accepted Mr Q's evidence in this regard and reminded itself of the guidance on the process of consenting that it had previously considered. It considered that firstly, the absence of an ultrasound scan would have prevented full information being known about the implants which would have an impact on the options offered to Patient J; and secondly, the consent form did not reflect any of the risks for the more invasive procedure of a capsulectomy which Patient J underwent in addition to the capsulotomy. It therefore determined that Dr Mahadev had failed to obtain fully informed consent from Patient J.

187. The Tribunal therefore found paragraphs 25(a) and 25(b) of the Allegation proved.

Paragraph 26 of the Allegation

188. The Tribunal considered if Dr Mahadev failed to correspond with the CCG to request funding for Patient J's replacement implants.

189. The Tribunal noted the endocrinologist's indication that '*implants could be removed on the NHS with no replacement…. If there are significant problems*.'

190. Mr Q opined that a replacement is not typically funded by the Trust. He stated that the replacement would not be a cosmetic procedure for Patient J as she was a transgender patient and the issue ought to have been raised with the CCG in respect of allocation of funding. Mr Q stated that the loss of potential implants would likely have a negative impact on Patient J's wellbeing and could have put her at a risk of harm. Mr Q also stated that not writing to the CCG for funding for the replacement implants would have prevented full information being given to Patient J in respect of the options available to her. He went on to state that some clinical commissioning groups would have considered funding for the implants in these circumstances.

191. The Tribunal considered the evidence and Mr Q's opinion. It took the view that writing to the CCG, and informing Patient J of this, would have added to the options available to her, further to which Patient J may have also opted to self fund the new implants, should there have been a refusal to fund from the CCG. The Tribunal accepted the evidence of Mr Q that there was a duty on Dr Mahadev to have corresponded with the CCG, particularly due to the procedure not being urgent, which would have allowed time for the CCG to have considered the request and reply.

192. Based on the evidence received, the Tribunal was satisfied that Dr Mahadev ought to have but failed to correspond with the CCG to request funding for Patient J's replacement implants.

193. The Tribunal therefore found paragraph 26 of the Allegation proved.

Paragraph 27 of the Allegation

194. The Tribunal considered if Dr Mahadev failed to adequately record having considered replacing the implants due to their age and the necessary intra-operative handling, which carried a risk of damage and rupture of one or both the implants.

195. The Tribunal noted from the outset that to fail to adequately record having considered replacing the implants with new implants, would necessitate an inference to be drawn that Dr Mahadev had in fact considered replacing the implants, after which he could have recorded that consideration. The Tribunal considered the evidence.

196. The Tribunal had regard to the referral letter to Mr L by Patient J's GP dated 6 August 2019, which stated that Patient J's *'breast implants are out of date and should be removed to prevent complications'.* It reminded itself that the letter from the endocrinologist also indicated that the implants were out of date and needed to be changed. The letter also highlighted that the implants could be removed on the NHS but funding was not available for the replacement of new implants.

197. The Tribunal reminded itself of its earlier finding that Dr Mahadev had failed to correspond with the CCG to request funding for the new implants. From his letter to Patient J's GP dated 18 September 2019, the Tribunal noted that Dr Mahadev had confirmed his communication with Patient J, which was to advise her that '*currently in the NHS we can only remove the implants, but not replace them*.' Replacement of the existing implants also did not feature as one of the three options Dr Mahadev presented to Patient J, as per this letter. On the contrary, re-insertion of the same implants was presented as an option, which was chosen by Patient J.

198. It considered that in line with Dr Mahadev's experience, he ought to have knowledge of the risks associated with intraoperative handling and reinsertion of the out-of-date implants. However, it could find no evidence from which it could safely infer that even with his knowledge and experience, Dr Mahadev would have considered replacing the

existing implants with new implants in light of the risks associated with the intraoperative handling of the existing implants. Consequently, the Tribunal could not progress to consider if Dr Mahadev failed to adequately record having considered replacing the implants, as it did not know if he had in fact considered it.

199. The Tribunal therefore found paragraph 27 of the Allegation not proved.

Paragraphs 28(a), 28(b), 28(c) and 28(d) of the Allegation

200. The Tribunal considered if it was inappropriate for Dr Mahadev to remove and re-insert Patient J's implants because they were out of date and were at increased risk of developing complications in comparison to new implants. Further, if the removal and reinsertion was inappropriate because the removal of them had been recommended by the Department of Endocrinology at St. George's Hospital with the caveat that replacement was currently not funded on the NHS.

201. The Tribunal again had regard to the endocrinologist's letter, dated 5 July 2019, which stated that the implants *'now need to be changed as they are out of date'* and highlighted that implants can be removed by NHS with no replacement. It also reconsidered the referral letter to Mr L, from Patient J's GP dated 6 August 2019, which also stated that the implants were out of date and should be removed to prevent complications.

202. The Tribunal considered the evidence of Mr Q in relation to the risks of rupture and damage if removing and reinserting the implants.

203. In his oral evidence, Mr Q stated that there were more chances of complications with implants the older they are, and that Patient J's implants should have been removed. In his expert report, Mr Q stated:

> *'It is accepted that the life of implants is not predictable, but removal of outdated implants had been recommended to Patient J by the Department of Endocrinology at St George's Hospital. On 19.11.2019, Mr Mahadev consented Patient J for capsulotomy and reinsertion of implants +/- their removal. In view of the age of the implants and the necessary intra-operative handling, there was a risk of damage or rupture of one or both implants'.*

204. Mr Q had stated that when the implants are manipulated and removed, there is a real risk of trauma and weakness of the membrane which may break or split it. He stated that in line with the endocrinologist's advice, and to reduce future risks of complications, replacement was strongly contraindicated on medical grounds.

205. As such, the Tribunal took the view that it was inappropriate for Dr Mahadev to have removed and re-inserted Patient J's implants as they were out of date, were at increased risk of developing complications due to their fragility and the removal of them had been recommended.

206. The Tribunal therefore found paragraph 28(a) of the Allegation proved.

Patient K

Paragraph 29(a) and 29(d) of the Allegation

207. The Tribunal considered that on 13 September 2019, Dr Mahadev consulted Patient K in the breast out-patient clinic and if Dr Mahadev failed to follow the MDT advice to refer Patient K to oncology for their opinion, with regard to adjuvant hormone treatment.

208. The Tribunal had regard to the MDT minutes from 5 September 2019, which recorded the outcome as:

> *'Today's MDM* [MDT] *Outcome: Prof.G.Mahadev to refer to Oncology team for Hormones. outpatient review to be booked'*

209. The Tribunal noted that Dr Mahadev was recorded as being in attendance at the MDT meeting alongside the oncology team. It had regard to Mr Q's evidence that it was important to note that a separate referral to the oncology team was needed regardless of their recorded attendance at the MDT. He explained that Patient K had a 93mm high grade DCIS that necessitated adjuvant hormone treatment. The oncology team would be able to discuss the risks and benefits with the patient including the side effects and which hormone was needed and for how long. He said that Patient K was young and premenopausal and a discussion with the patient as to any side effects of the hormone prescribed, which may pose health dangers, was needed.

210. The Tribunal noted from the letter dated 16 September 2019, that Dr Mahadev however prescribed Tamoxifen to Patient K instead of making a referral to oncology; the latter would have been in line with the advice of the MDT. There was no indication from the notes that a referral to oncology was offered and had been declined by the patient. There was also no indication from the notes that Dr Mahadev had disagreed with the advice and actions prescribed by the MDT.

211. In light of the evidence, the Tribunal therefore determined that there was a duty on Dr Mahadev to follow the MDT's advice to refer patient K to oncology for their opinion with regard to adjuvant hormone treatment which he failed to do. Further, it could find no explanation or reason for Dr Mahadev not to follow the advice of the MDT and took the view that he did fail to provide a valid reason for deviating from the MDT's advice.

212. The Tribunal therefore found paragraph 29(a) and 29(d) of the Allegation proved.

Paragraphs 29(b) and 29(c) of the Allegation

213. The Tribunal considered that on 13 September 2019, Dr Mahadev consulted Patient K in the breast out-patient clinic prescribed Tamoxifen 10mg daily, which was inadequate. It also considered if he inappropriately advised Patient K's GP to continue to prescribe Tamoxifen in a sub-optimal dose of 10mg daily.

214. The Tribunal had regard to the letter dated 16 September 2019, following the clinic out-patients appointment, sent by Dr Mahadev to Patient K's GP which stated: *'Following discussion in the MDT, we feel that she would benefit from hormone treatment and I have therefore given her Tamoxifen 10mg once daily and I would be grateful if you could continue her on this'.*

215. Mr Q stated that Tamoxifen is particularly appropriate for pre-menopausal and peri-menopausal ladies however the dose of 10mg Tamoxifen daily was a sub optimal dose. He stated that a dosage of 10mg amounted to a small dose that would only be suitable for a young male with gynecomastia.

216. The Tribunal noted that it was not until 8 June 2020 when Patient K called to query the 10mg dosage, as she had realised that her dose was different from others in her support group. This was almost 9 months after Dr Mahadev had initially prescribed it. Mr Q said that during this period Patient K was put at increased risk as she was not getting

adequate coverage from the suboptimal dosage and the correct dosage of Tamoxifen would have been 20mg. He stated that as a clinician, even if a patient is having serious side effects, one would encourage the patient to complete two years on the optimal dose of Tamoxifen to obtain the full benefit of it, with the first year being the most beneficial. He stated that in this case Patient K would have lost 75% of the benefit.

217. The Tribunal noted that further to the call by Patient K, the consultant oncologist advised the breast care nurse that the standard dose was 20mg daily and to inform Patient K's GP.

218. The Tribunal accepted the opinion of Mr Q. In light of the evidence before it, it determined that the 10mg dose of Tamoxifen prescribed was sub-optimal and inadequate. Further that the advice to the GP by Dr Mahadev, to continue to prescribe the sub-optimal dose was inappropriate.

219. The Tribunal therefore found paragraphs 29(b) and 29(c) of the Allegation proved.

The Tribunal's Overall Determination on the Facts

The Tribunal has determined the facts as follows:

1. On 1 June 2019 you submitted an application for the post of Consultant Breast Surgeon at East Kent Hospitals University NHS Foundation Trust ('the Application') in which you answered 'No' to the question 'Are you currently subject to a fitness to practise investigation and/or proceedings of any nature by a regulatory or licensing body in the UK or any other country?'. **Determined and found proved**

2. When submitting the Application, you knew that you were subject to a fitness to practise investigation by the GMC. **Determined and found proved**

3. Your actions as set out at paragraph 1 were dishonest by reason of paragraph 2. **Determined and found proved**

<u>Patient A</u>

4. On 25 September 2019 Patient A underwent a left mastectomy with axillary lymph node clearance ('the Procedure') and you inappropriately informed Patient A on the

morning of the Procedure, in contradiction to the advice and instruction of Mr L (the substantive Consultant Breast Surgeon) that:

a. there would be no drain; **Determined and found proved**

b. she would be discharged home on the day of the Procedure. **Determined and found proved**

5. On 25 September 2019 you provided inadequate surgical care to Patient A in that you used:

a. poor surgical design; and/or **Determined and found proved**

b. poor dissection technique. **Determined and found proved**

6. On 26 September 2019, when Patient A noted that the Procedure site had started to fill with fluid, produce pain and was swelling, you failed to personally examine and/or review Patient A. **Determined and found proved in relation to the failure to review.**

7. On 26 September 2019 Patient A underwent a pre-discharge assessment by her breast care nurse, when you had overall responsibility for Patient A's care, and this was inappropriate because:

a. it occurred in the lady's toilet as there were no rooms available on the ward; **Determined and found proved**

b. there was no privacy for Patient A who was required to undress for the assessment. **Determined and found proved**

Patient B

8. On 12 September 2019 Patient B underwent a right mastectomy and sentinel lymph node biopsy ('the Procedure'), prior to which you failed to obtain fully informed consent as you failed to record having discussed one or more of the significant risks as set out at Schedule 1. **Determined and found proved**

9. On 12 September 2019 you performed the Procedure on Patient B and you provided inadequate surgical care in that Patient B was left with a tethered scar and excess tissue laterally as a result of poor surgical technique. **Determined and found proved**

10. You failed to record within your operation note any detail as to the use / administration of:

    a. radioisotope and/or; **Successful application under Rule 17(6) Determined and found proved**

    b. patent blue dye. **Determined and found proved**

~~11. On 15 November 2019 Patient B's bone densitometry scan was reported and you failed to inform Patient B's General Practitioner ('GP') of the result which identified osteoporosis of the spine and osteopenia of the hip in Patient B.~~ **Successful application under Rule 17(6)**

12. You~~r~~ failed to advise Patient B's GP that, in light of the results of the bone densitometry scan, Patient B ~~actions at paragraph 11 were inappropriate because Patient B was taking an aromatase inhibitor and~~: **Successful application under Rule 17(6)**

    a. was at risk of developing a vertebral compression fracture; **Determined and found proved**

    b. should be ~~osteoporosis of the hip in a patient taking an aromatase inhibitor requires~~: **Successful application under Rule 17(6)**

        i. commenced on supplemental calcium; **Successful application under Rule 17(6)**
        Determined and found proved

        ii. commenced on vitamin D; **Successful application under Rule 17(6)**
        Determined and found proved

        iii. considered ~~ation~~ for bisphosphonates. **Successful application under Rule 17(6)**
        Determined and found proved

13. On 2 December 2019 you consulted with Patient B and you failed to arrange further assessment of her complaint of right shoulder pain radiating to her shoulder blade and upper back, to exclude metastatic breast cancer, including:

a. an isotope bone scan; **Determined and found proved**

b. a repeat computerised tomography scan ('CT') of the chest, abdomen and pelvis. **Not proved**

14. In your letter to Patient B's GP dated 3 December 2019 you failed to inform Patient B's GP of your clinical examination regarding the state of Patient B's scar and the presence of tenderness and seroma. **Determined and found proved**

15. You inappropriately requested Patient B's GP to arrange intensive physiotherapy and to consider a referral to an orthopaedic surgeon for Patient B's skeletal pain in the knowledge that Patient B had osteoporosis and had had previous breast cancer. **Determined and found proved**

Patient C

16. On 1 November 2019 you performed a revision of Patient C's right mastectomy scar ('the Procedure'), prior to which you failed to obtain fully informed consent as:

    a. you failed to discuss with Patient C the potential for:

        i. the persistence of the dog ear scar deformity; **Determined and found proved**

        ii. the need for further surgery; **Determined and found proved**

    b. the consent discussion took place in an inappropriate environment; **Determined and found proved**

    c. Patient C had inadequate time to consider the proposed treatment. **Determined and found proved**

17. On 1 November 2019 you performed the Procedure on Patient C and you provided inadequate surgical care in that Patient C was left with excess skin, fat and scar tissue as a result of poor surgical technique. **Determined and found proved**

Patient G

18. On 13 September 2019 you consulted with Patient G in the out-patient breast clinic and you failed to:

    a. write to Patient G's GP following your consultation; **Determined and found proved**

    b. record a handwritten entry of your clinical encounter with Patient G in the out-patient section of Patient G's medical records. **Determined and found proved**

19. On 19 September 2019 Patient G underwent a left mastectomy and sentinel lymph node biopsy ('the Procedure'), prior to which you failed to obtain fully informed consent as you failed to discuss with Patient G the potential complications relating to the:

    a. use of patent blue dye; **Determined and found proved**

    b. sentinel lymph node dissection in the axilla; **Determined and found proved**

    c. enhanced risk of wound breakdown and infection in view of Patient G's:

        i. previous radiotherapy to the left breast; **Determined and found proved**

        ii. long-standing heavy smoking habit; **Determined and found proved**

        iii. intermittent high alcohol intake. **Determined and found proved**

<u>Patient H</u>

20. On 5 November 2019 Patient H underwent left axillary lymph node clearance ('the Procedure') and you failed to obtain fully informed consent as you failed to record having discussed with Patient H, in view of her past history, one or more of the serious risks set out at Schedule 2. **Determined and found proved**

21. On 22 November 2019 you undertook a post-operative review of Patient H and you prescribed Augmentin (Co-Amoxiclav) to Patient H which was inappropriate because:

    a. Patient H was allergic to Penicillin; **Determined and found proved**

    b. Patient H was at significant risk of anaphylactic allergic reaction; **Determined and found proved**

c. there was extensive reference in Patient H's medical records to her allergy to Penicillin. **Determined and found proved**

22. You failed to:

a. document in your letter dated 22 November 2019 to Dr M, Consultant Oncologist, that after the Procedure:

i. Patient H required serial seroma aspirations; **Determined and found proved**

ii. Patient H developed a wound infection; **Determined and found proved**

iii. Patient H required antibiotics; **Determined and found proved**

iv. you had prescribed Augmentin to Patient H; **Determined and found proved**

b. record in Patient H's medical records that on 22 November 2019 that:

i. there was a seroma that required aspiration; **Determined and found proved**

ii. the axillary wound was infected; **Determined and found proved**

iii. you had prescribed Augmentin. **Determined and found proved**

Patient I

23. In your letter of 24 September 2019 following a review of Patient I in the breast out-patient clinic on 20 September 2019, you advised Patient I that she reduce the dose of Letrozole 2.5mg to alternate days rather than daily, which was inappropriate because Patient I was placed at increased risk of recurrence of breast cancer for a period of 6-7 months whilst taking the sub-optimal dose. **Determined and found proved**

Patient J

24. On 19 November 2019 Patient J underwent a right capsulotomy and left capsulectomy with replacement of the original implants ('the Procedure') and you

failed to arrange a pre-operative ultrasound scan of Patient J's 12 year old implants ('the Implants'). **Determined and found proved**

25. Prior to undertaking the Procedure you failed to obtain fully informed consent from Patient J because:

    a. Patient J was unaware as to the status of the Implants; **Determined and found proved**

    b. you failed to record having discussed with Patient J one or more of the risks of capsulectomy as set out at Schedule 3. **Determined and found proved**

26. You failed to correspond with the Clinical Commissioning Group ('CCG') to request ~~secure~~ funding for the replacement implants ~~Procedure~~.. **Successful application under Rule 17(6)**
    Determined and found proved

27. You failed to adequately record having considered replacing the Implants due to their age and the necessary intra-operative handling, which carries a risk of damage and rupture of one or both the Implants. **Not proved**

28. On 19 November 2019 during the Procedure you removed and re-inserted the Implants which was inappropriate because:

    a. the Implants were out of date; **Determined and found proved**

    b. the Implants were at increased risk of developing complications in comparison to new implants; **Determined and found proved**

    c. removal of the Implants had been recommended by the Department of Endocrinology at St. George's Hospital with the caveat that replacement was currently not funded on the National Health Service ('NHS'); **Determined and found proved**

    d. the Implants carried a risk of damage and rupture during intra-operative handling, due to their fragility. **Determined and found proved**

Patient K

29. On 13 September 2019 you consulted with Patient K in the breast out-patient clinic and you:

    a. failed to follow the multidisciplinary team ('MDT') advice on 5 September 2019 to refer Patient K to oncology for their opinion, with regard to adjuvant endocrine treatment; **Determined and found proved**

    b. prescribed Tamoxifen 10mg daily which was inadequate; **Determined and found proved**

    c. inappropriately advised Patient K's GP to continue to prescribe Tamoxifen in a sub-optimal dose of 10mg daily; **Determined and found proved**

    d. failed to provide a valid reason for deviating from the MDT's advice. **Determined and found proved**

Determination on Impairment - 18/04/2024

1. The Tribunal now has to decide in accordance with the Rules whether, on the basis of the facts which it has found proved, Dr Mahadev's fitness to practise is impaired by reason of misconduct.

2. At the outset of the impairment stage, Ms Bucklow, on behalf of the GMC, informed the Tribunal that Dr Mahadev was currently subject to an unexpired sanction. That sanction, of twelve months' conditions, was imposed by a Medical Practitioners Tribunal (MPT) in March 2023, following its determination that Dr Mahadev's fitness to practise was impaired by reason of misconduct. The 2023 Tribunal had also directed a review hearing to take place shortly before the end of the period of conditional registration. Ms Bucklow invited the Tribunal to conduct a review of this matter under Rule 22 of the Rules. Hence the Tribunal also has to decide whether Dr Mahadev's fitness to practise remains impaired.

The Outcome of Applications Made during the Impairment Stage

3. The Tribunal granted the GMC's application, made pursuant to Rule 31 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to proceed in

Dr Mahadev's absence. The Tribunal's full decision on the application is included at Annex D.

4. The Tribunal refused the GMC's application, made pursuant to Rule 34(1) of the Rules, to admit additional evidence. The Tribunal's full decision on the application is included at Annex E.

The Evidence

5. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. It was also provided with additional documentation relating to Dr Mahadev's review matter. This evidence included the following:

- Record of determination for MPT Hearing that concluded on 21 March 2023;
- GMC emails to Dr Mahadev, dated 5 April 2023 and 13 December 2023.

Submissions

6. On behalf of the GMC, Ms Bucklow submitted that the paragraphs of the Allegation found proved by this Tribunal were serious and that they engaged with all three limbs of the overarching objective. She stated that Dr Mahadev's dishonesty was directly related to his medical practice and that patient safety is a concern in this case.

7. Ms Bucklow highlighted the clinical concerns raised and that they related to Dr Mahadev's dangerous prescribing, failures to obtain informed consent, inadequate communication with patients and colleagues and also to the surgical and clinical care he provided to patients. She reminded the Tribunal of Mr Q's opinions that Dr Mahadev's conduct fell seriously below the standard expected. Ms Bucklow stated that paragraphs 16, 17, 21, 35 and 44 of Good Medical Practice (2013) (GMP) were engaged in this case.

8. Ms Bucklow stated that there was a serious risk to patient safety in this case and that Dr Mahadev's failings were not isolated to one area but encompassed a broad spectrum of failings which took place over a short period of time.

9. Ms Bucklow reminded this Tribunal of the 2023 Tribunals findings that Dr Mahadev's insight was incomplete, that there was no evidence of remediation and that there was a risk of repetition. She said that Dr Mahadev has stopped engaging with the GMC and submitted that nothing had changed since the last hearing in 2023. Ms Bucklow submitted that therefore, the risk of repetition still remained.

10. Ms Bucklow further submitted that public confidence in the medical profession would be undermined if a finding of impairment was not made in this case. She also submitted that a finding of impairment was necessary in order to send a clear signal to other members of the medical profession that conduct of this nature is not acceptable.

11. Ms Bucklow submitted that Dr Mahadev's fitness to practise remains impaired with respect to the review case and is also impaired with respect to the new case.

The Relevant Legal Principles

12. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone. In respect of the review matter, there was a persuasive burden on Dr Mahadev to show that he is no longer impaired.

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

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

15. In its deliberations, the Tribunal had regard to the questions posed by Dame Janet Smith in the Fifth Shipman Report, as referred to in the case of *CHRE v NMC and Grant [2011] EWHC 927 (Admin), as follows:*

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

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession

d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The Tribunal's Determination on Impairment

Misconduct

16. The Tribunal had regard to the nature and seriousness of the facts found proved.

Paragraphs 1, 2 and 3 of the Allegation

17. It first considered if Dr Mahadev's dishonesty, in not declaring he was subject to an investigation by the GMC on a job application, amounted to misconduct. It took the view that Dr Mahadev's dishonesty engaged the following paragraphs of GMP:

'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, are honest and trustworthy, and act with integrity and within the law.

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

71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

a You must take reasonable steps to check the information is correct.

b You must not deliberately leave out relevant information.'

18. The Tribunal had regard to its finding that Dr Mahadev's actions in answering 'No' to the question on the application form, was deliberate. It bore in mind that honesty is a fundamental tenet of the medical profession and took the view that Dr Mahadev undermined this.

19. The Tribunal also took the view that Dr Mahadev's dishonesty put patients at a potential risk of harm. It misled the Trust, who became his employer and did not allow them the opportunity to assess if action was needed for patient safety, in light of the fitness to practise investigation that Dr Mahadev was subject to. The Tribunal determined that Dr Mahadev's dishonest conduct was a serious departure from the principles set out in GMP as above and amounted to misconduct.

Patient A

Paragraph 4 of the Allegation

20. The Tribunal considered if Dr Mahadev's treatment and care of Patient A amounted to misconduct. It took the view that Dr Mahadev's conduct, in inappropriately informing Patient A, on the morning of the procedure, that there would be no drain and that she would be discharged home on the day of her procedure in contradiction to the advice and instruction of Mr L, engaged the following paragraphs of GMP:

> *'11 You must be familiar with guidelines and developments that affect your work*
>
> *31 You must listen to patients, take account of their views, and respond honestly to their questions.*
>
> *35 You must work collaboratively with colleagues, respecting their skills and contributions'*

21. Mr Q had confirmed in oral evidence that hospital guidance required a patient who lived alone not to be discharged home the same day as their major surgery, unless accompanied by a competent adult at home. The Tribunal reminded itself that the conflicting information, given to Patient A, who did live alone, just before her surgery had caused her to 'worry'. In respect of Dr Mahadev's actions, Mr Q took the view that the standard of care fell seriously below that expected of a reasonably competent

consultant breast surgeon. The Tribunal concluded that Dr Mahadev's contradictory advice was also a serious departure from the principles of GMP set out above and amounted to misconduct.

Paragraph 5 of the Allegation

22. The Tribunal considered if Dr Mahadev's conduct, in providing inadequate surgical care to Patient A in that he used poor surgical design and/or poor dissection technique, amounted to misconduct. It considered the following paragraphs of GMP to be engaged:

> *'7 You must be competent in all aspects of your work, including management, research and teaching'.*
>
> *15 You must provide a good standard of practice and care.'*

23. The Tribunal also considered Mr Q's opinions. In his expert report, he stated:

> *'The standard of care delivered to Patient A in respect of the operation – left mastectomy, axillary lymph node clearance and outcome – falls seriously below that expected of a reasonably competent Consultant Breast Surgeon due to the poor cosmetic outcome which prevented Patient A being able to wear her post mastectomy breast prosthesis'.*

24. In his third supplemental expert report, Mr Q stated:

> *'The resultant standard of care, in my opinion, fell seriously below that expected of a reasonably competent Consultant Breast Surgeon with Patient A suffering both physical and psychological harm'.*

25. The Tribunal bore in mind that after her surgery, Patient A was in pain and was unable to wear a prosthesis. It accepted Mr Q's opinion. As such, the Tribunal was satisfied that Dr Mahadev's poor surgical design and/or poor dissection technique, were a serious departure from the GMP principles set out above and amounted to misconduct.

Paragraph 6 of the Allegation

26. The Tribunal considered if Dr Mahadev's conduct, in failing to review Patient A on 26 September 2019, before her discharge from hospital, when she noted that the

procedure site had started to fill with fluid, produce pain and was swelling, amounted to misconduct. It took the view that the following paragraphs of GMP were engaged:

> *'15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> *a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
>
> *b promptly provide or arrange suitable advice, investigations or treatment where necessary'.*

27. The Tribunal took the view that Dr Mahadev's failure to review Patient A following her surgery was a serious ommission in light of her being symptomatic, having spent a prolonged period in recovery and having stayed in hospital overnight.

28. Mr Q opined that Dr Mahadev's conduct fell seriously below the standard expected and the Tribunal agreed with this. It also considered Dr Mahadev's failure to review Patient A, to be a serious departure from the GMP principles set out above. It took the view that this failure amounted to misconduct.

Paragraph 7 of the Allegation

29. The Tribunal considered if the inappropriate pre-discharge assessment Patient A underwent with her breast care nurse amounted to misconduct.

30. The Tribunal reminded itself that it considered that Dr Mahadev did still have overall responsibility for Patient A and would do so until her discharge from hospital. However, on the evidence presented, it thought it unlikely that Dr Mahadev would have known about the breast care nurse's decision to examine Patient A in the toilet where there was no privacy, at least, before that assessment occurred. As such, the Tribunal could not attribute the inappropriate pre-discharge assessment as misconduct on part of Dr Mahadev.

Patient B

Paragraph 8 of the Allegation

31. The Tribunal considered if Dr Mahadev's failure to obtain fully informed consent from Patient B amounted to misconduct. It considered paragraph 17 of GMP to be engaged:

> *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.'*

32. It also noted that Mr Q, in his second supplemental expert report stated:

> *'Omission of significant risks, as outlined in 7.3.3 of my original report dated 15.07.2021, would indicate that fully informed consent was not obtained from Patient B and the consent therefore was not valid. Verbal discussion of risks without written record of that discussion would be outside national guidelines. The standard of care in terms of obtaining informed consent and appropriate documentation in Patient B's medical records would each independently fall seriously below that expected of a reasonably competent Consultant Breast Surgeon'.*

33. The Tribunal accepted Mr Q's opinion. As such, the Tribunal was satisfied that Dr Mahadev's failure to obtain fully informed consent from Patient B was a serious departure from paragraph 17 of GMP and outside the national guidance on the consenting process, and amounted to misconduct.

Paragraph 9 of the Allegation

34. The Tribunal considered if Dr Mahadev's failure to provide adequate surgical care to Patient B, in that she was left with a tethered scar and excess tissue laterally as a result of poor surgical technique, amounted to misconduct.

35. It had regard to Mr Q's expert report in which he referred to Patient B's poor cosmetic outcome which resulted in a referral to a plastic surgeon, and Patient B's inability to wear a prosthesis. He stated that the standard of care provided by Dr Mahadev to Patient B was seriously below the standard expected of a consultant breast surgeon.

36. The Tribunal reminded itself of the letter from the plastic surgeon in which it was reported that Patient B had felt '*mutilated by the surgery*'. It also considered that Dr Mahadev's actions were a serious departure from the principles within paragraphs 7 and

15 of GMP, noted above. The Tribunal was satisfied that Dr Mahadev's failure to provide adequate surgical care to Patient B amounted to misconduct.

Paragraph 10 of the Allegation

37. The Tribunal considered if Dr Mahadev's failure to record any detail as to the use of radioisotope and/or patent blue dye amounted to misconduct. It noted that neither of these were referenced within Patient B's operating note. However, the Tribunal had found that at least one of those would have been used.

38. The Tribunal considered paragraphs 19 and 21d of GMP to be engaged.

> *'19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
>
> *21 Clinical records should include:*
>
> *…d any drugs prescribed or other investigation or treatment'*

39. The Tribunal had regard to Mr Q's evidence that it was important to record the use/administration of radioisotope/patent blue dye due to the potential serious side effects. He stated that anaesthetists needed to know what a patient had been given in case of complications. He further stated that there is an expectation that all procedures should be recorded. The Tribunal accepted Mr Q's evidence and considered that Dr Mahadev's omission to accurately record the use of either radioisotope and/or patent blue dye was serious. It was not in keeping with the principles within paragraphs 19 and 21d of GMP and amounted to misconduct.

40. The Tribunal took the view that Dr Mahadev's failure to record his use/administration of either the radioisotope or patent blue dye, in the operation note, to an otherwise successful operation was poor practice. However, it considered that by itself, it was not sufficiently serious as to amount to misconduct.

Paragraph 12 of the Allegation

41. The Tribunal considered if Dr Mahadev's failure to advise Patient B's GP that she was at risk of developing a vertebral compression fracture, that she should be commenced on supplemental calcium, vitamin D and considered for bisphosphonates amounted to misconduct. It considered the following paragraphs of GMP to be engaged:

'44. You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

a. share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers.'

42. The Tribunal also noted Mr Q's oral evidence that Patient B *'would be at risk of developing a vertebral compression fracture in view of the osteoporosis.'* Further that this information would have been important for the GP to know so he could prescribe appropriate medication to reduce the risk of future problems, particularly the risk of vertebral collapse. Further, that it was for Dr Mahadev to write back to the GP with a planned action as the GP would not start treatment without permission of the consultant.

43. The Tribunal accepted Mr Q's opinion and considered that failing to advise Patient B's GP in these terms was a serious omission, and a serious departure from the principles within paragraph 44 a of GMP and amounted to misconduct.

Paragraph 13 of the Allegation

44. The Tribunal considered if Dr Mahadev's failure to arrange further assessment of Patient B's right shoulder pain, to exclude metastatic breast cancer including an isotope bone scan amounted to misconduct. It considered paragraph 16b of GMP to be engaged:

'16. In providing clinical care you must:

b. provide effective treatments based on the best available evidence.'

45. The Tribunal noted Mr Q's opinion in his expert report, that:

'The occurrence of persisting pain in the right shoulder (02.12.2019) should have been further investigated by Mr Mahadev with an isotope bone scan and possibly a repeat of the CT scan of the chest, abdomen and pelvis by Mr Mahadev in order to exclude metastatic breast cancer albeit that the lymph nodes were negative (clinic letter 03.12.2019). As this placed Patient B at risk, the standard of care delivered to Patient B by Mr Mahadev in this respect falls seriously below that expected of a reasonably competent Consultant Breast Surgeon.'

46. The Tribunal took the view that Patient B's right shoulder pain was not adequately assessed to enable effective treatment and placed her at risk. It reminded itself of Mr Q's oral evidence, in which he stated that he was shocked at the lack of investigation into patient B's pain. As such, the Tribunal was satisfied that Dr Mahadev's failure to arrange further assessment of Patient B's right shoulder pain was a serious departure from the principle within paragraph 16b of GMP and amounted to misconduct.

Paragraph 14 of the Allegation

47. The Tribunal considered if Dr Mahadev's failure to inform Patient B's GP of his examination regarding the state of her scar and the presence of tenderness and seroma amounted to misconduct. It considered paragraphs 21 and 44a (the latter is quoted above, in respect of safe transfer of patients and sharing relevant information with colleagues) of GMP to be engaged:

21. Clinical records should include:

a. relevant clinical findings

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c. the information given to patients

d. any drugs prescribed or other investigation or treatment

e. who is making the record and when

48. The Tribunal reminded itself of Mr Q's oral evidence that any clinical information gained was very important and ought to be communicated to the GP. He stated that this would be the start of resolving Patient B's problems and the clinical examination would indicate

the direction of the investigation. As such, the Tribunal took the view that Dr Mahadev's failure to inform Patient B's GP of his clinical examination may have impacted her ongoing treatment and care. It was a serious departure from the GMP principles set out above and amounted to misconduct.

Paragraph 15 of the Allegation

49. The Tribunal considered if Dr Mahadev's actions in inappropriately requesting Patient B's GP to arrange intensive physiotherapy and for them to consider a referral to an orthopaedic surgeon for Patient B's skeletal pain amounted to misconduct. It considered pargraph 15 and 16a of GMP to be engaged:

> *'15 You must provide a good standard of practice and care.*
>
> *16. In providing clinical care you must:*
>
> *a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's need'.*

50. The Tribunal reminded itself of Mr Q's evidence in which he stated that he was shocked at the lack of investigation and that it would not have been appropriate to arrange intensive physiotherapy without the scan as damage could be caused from strenuous exercises. Further that to refer to an orthopaedic surgeon without excluding the possibility of metastases disease was '*unthinkable*' and that, to refer Patient B for '*intensive physiotherapy*' would delay Patient B in getting the appropriate treatment and could have potentially caused harm.

51. In his third supplemental expert report, Mr Q stated that:

> *'In my opinion and that of a responsible body of Consultant Breast Surgeons, the above omission and inappropriate advice indicate a standard of care falling seriously below that expected of a reasonably competent Consultant Breast Surgeon, due to Patient B potentially suffering significant harm.'*

52. The Tribunal accepted Mr Q's evidence. It was therefore satisfied that Dr Mahadev's actions in this respect placed Patient B at risk of harm and were a serious departure from the GMP principles set out above and amounted to misconduct.

Patient C

Paragraph 16 of the Allegation

53. The Tribunal reminded itself that it had found the entirety of paragraph 16 of the Allegation proved. It considered if Dr Mahadev's failure to obtain fully informed consent from Patient C amounted to misconduct. It considered paragraph 17 of GMP in respect of valid consent and authority (quoted above) to be engaged and also had regard to the second supplemental expert report of Mr Q in which he stated:

> *'If the Medical Practitioners Tribunal accept the account of Patient C, then the standard of care falls seriously below that expected of a reasonably competent Consultant Breast Surgeon in respect of the process of obtaining informed consent including an adequate discussion of the risks and benefits. The lack of full information given to Patient C, the inappropriate environment for the consent discussion and process, and inadequate time for Patient C to consider the proposed treatment, its benefits and relevant risks fall outside national guidelines.'*

54. The Tribunal accepted Mr Q's opinion. It considered Dr Mahadev's failure to obtain fully informed consent, by failing to discuss the risk of the persistence of a dog ear scar and the potential need for further surgery was a significant omission. It also considered that the consenting discussion took place at the door of the operating theatre which would not have given Patient C the necessary privacy nor provide adequate time to consider the treatment. It considered this to be a serious departure from the principles within paragraph 17 of GMP and the national guidance on the consenting process. It determined that the failure to obtain fully informed consent amounted to misconduct.

Paragraph 17 of the Allegation

55. The Tribunal considered if Dr Mahadev providing inadequate surgical care to Patient C, in that she was left with excess skin, fat and scar tissue as a result of poor surgical technique, amounted to misconduct. It considered that paragraphs 7 and 15 of GMP were engaged:

> *'7 You must be competent in all aspects of your work, including management, research and teaching.'*
>
> *'15 you must provide a good standard of practice and care.'*

56. In his expert report, Mr Q stated:

> *'The revisional surgery by Mr Mahadev, removal of the "dog ear" utilising a fishtail incision, had an unsatisfactory outcome with persistent discomfort and, in particular, the inability for Patient C to wear her bra. This indicates a standard of care falling seriously below that expected of a reasonably competent Consultant Breast Surgeon since Patient C experienced discomfort, inability to wear her bra and had to undergo further revisional surgery.'*

57. The Tribunal agreed with Mr Q's view and considered Dr Mahadev's inadequate surgical care to Patient C impacted her adversely as it caused her pain and discomfort, and she was unable to wear a prosthesis. It considered it to be a serious departure from the GMP principles noted above. The Tribunal determined that it amounted to misconduct.

Patient G

Paragraph 18 of the Allegation

58. The Tribunal considered Dr Mahadev's failure to write to Patient G's GP, and his failure to record a handwritten entry of his clinical encounter on 13 September 2019 with Patient G in the out-patient section of Patient G's medical record. It considered whether these amounted to misconduct.

59. In respect of the failure to write to the GP, the Tribunal considered paragraph 44a of GMP, as quoted above, to be engaged. It noted Mr Q's statement, within his email dated 24 January 2024, that:

> *'My comment is that the standard of care in respect of communication would fall seriously below that expected of a reasonably competent Consultant Breast Surgeon since the letter to the GP and the entry in the medical records should have included the diagnosis, the results of investigations (isotope bone scan and CT), and the planned procedure with benefits and risks. Failure of communication would potentially place Patient G at risk of harm in each of the above circumstances.'*

60. The Tribunal was satisfied that Dr Mahadev's failure to write to Patient G's GP was serious as updated clinical information would not have been provided to her GP, thereby placing her at potential risk of harm. This was a departure from the GMP principles within paragraph 44a and amounted to misconduct.

61. However, the Tribunal had regard to an electronic patient record entry relating to Patient G in respect of the consultation on 13 September 2019. Having been directed to this, Mr Q changed his initial view and stated that in light of the electronic entry, the standard of care in respect of Dr Mahadev's failure to make a handwritten entry within Patient G's medical notes, was '*below that expected of a reasonably competent consultant breast surgeon'* as opposed to seriously below. The Tribunal accepted this and in light of the existence of the electronic entry recording the clinical encounter of that day, it took the view that the failure to make a hand written entry by Dr Mahadev did not amount to misconduct.

Paragraph 19 of the Allegation

62. The Tribunal considered if Dr Mahadev's failure to obtain fully informed consent from Patient G, when she underwent a left mastectomy and sentinel lymph node biopsy, amounted to misconduct.

63. The Tribunal considered paragraph 17 of GMP to be engaged. It noted that in his expert report Mr Q stated:

> *'The consent form is completed and signed by Mr Mahadev but omits the complications relating to the use of patent blue dye: allergic reaction, blue discolouration of the urine (transient), and of the breast skin at the site of the injection, which may persist for months, and the sentinel lymph node dissection in the axilla: numbness of the skin and pain in the axilla, a stiff shoulder, and a low incidence of lymphoedema (less than 10%). This therefore results in Patient G not being fully informed. In addition, the enhanced risk of infection is not emphasised to Patient G on the consent form, and overall, this falls seriously below the standard of care expected of a reasonably competent Consultant Breast Surgeon'.*

64. The Tribunal took the view that Dr Mahadev's failure to obtain fully informed consent which included a failure on his part to discuss with Patient G, complications as a result of her particular history, was a serious breach of his duty and departure from paragraph 17 of GMP and the national guidance on the consenting process. It considered that there was a duty on Dr Mahadev to communicate the risks to Patient G in a sensitive way using plain english, and in keeping with guidance from the GMC publication '*Consent - patient and doctors making decisions together' (2008*). It considered Dr Mahadev's failure to obtain fully informed consent amounted to misconduct.

Patient H

Paragraph 20 of the Allegation

65. The Tribunal considered if Dr Mahadev's failure to obtain fully informed consent, in that he failed to record having discussed the serious risks with Patient H, amounted to misconduct. It considered paragraph 17 of GMP to be engaged.

66. The Tribunal considered Mr Q's expert report in which he referred to the risks of the procedure and stated:

> *'These are significant and their omission constitutes a standard of care falling seriously below that expected of a reasonably competent Consultant Breast Surgeon since Patient H would not be in a position of agreeing to surgery in the full knowledge of the risks and benefits.'*

67. The Tribunal was satisfied that Dr Mahadev's failure to obtain fully informed consent from Patient H was a serious omission as Patient H may not have fully appreciated the risks before the procedure took place. It was a serious departure from paragraph 17 of GMP and also the national guidances on the consenting process and amounted to misconduct.

Paragraph 21 of the Allegation

68. The Tribunal considered if Dr Mahadev's action in prescribing Augmentin to Patient H, which was inappropriate, amounted to misconduct.

69. It considered paragraphs 15, in respect of providing a good standard of practice and care, and paragraph 16b of GMP were engaged:

> *'16. In providing clinical care you must:*
>
> *a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's need.*

70. It noted and accepted Mr Q's opinion in his expert report that:

'As the prescribing of Augmentin placed Patient H at significant serious risk, since she was already documented as having anaphylactic allergic reaction to Penicillins[sic] and had the potential for this very serious adverse reaction to be repeated, the standard of care delivered to Patient H by Mr Mahadev inappropriately prescribing the Penicillin, Augmentin, indicates a standard of care falling seriously below that expected of a reasonably competent Consultant Breast Surgeon.'

71. The Tribunal accepted Mr Q's evidence. It bore in mind the potential for the very serious adverse reaction that Patient H may have had. It took the view that Dr Mahadev's actions in inappropriately prescribing Augmentin to Patient H was a serious departure from the GMP principles noted above and amounted to misconduct.

Paragraph 22 of the Allegation

72. The Tribunal firstly considered if Dr Mahadev's failure to document in his letter to Dr M, consultant oncologist, that (i) Patient H required serial seroma aspirations, (ii) developed a wound infection, (iii) required antibiotics and that (iv) he had prescribed Augmentin, amounted to misconduct.

73. It had regard to Mr Q's view in his expert report that the following amounted to falling seriously below the standard expected:

'Failure to inform Dr M, Consultant Oncologist, that after axillary lymph node clearance, Patient H required antibiotics, serial seroma aspiration and developed a wound infection, potentially impacting adversely on adjuvant therapy.'

74. It also had regard to Mr Q's oral evidence that the oncologist would need to be appraised of this information as they would give advice regarding the specialist adjuvant treatment, dose and timescales of chemotherapy and whether radiotherapy should follow and would also need to know the agents prescribed. The Tribunal had regard to Mr Q's view and considered that the information within paragraph 22(a)(i), (ii), and (iii) of the Allegation would be required by the oncologist. The failure to provide it was serious and a breach of paragraph 44a of GMP and amounted to misconduct. However, the Tribunal further considered that a failure to inform the oncologist as to which particular agent was prescribed as per 22(a)(iv) of the Allegation would not be sufficiently serious to amount to misconduct, if the letter to the oncologist had stated that antibiotics had been prescribed.

75. The Tribunal further considered paragraph 22(b) of the Allegation which was Dr Mahadev's failure to record the clinical information in Patient H's medical records. It noted that whilst there was a duty on Dr Mahadev to record the three elements as they were significant events in Patient H's medical history, there was a comprehensive electronic patient record entry made by a breast nurse in her medical records which recorded the three elements identified on 22 November 2019. It considered that the clinical information would therefore be available for other clinicians treating patient H and therefore did not consider this failure to be sufficiently serious to amount to misconduct.

Patient I

Paragraph 23 of the Allegation

76. The Tribunal considered if Dr Mahadev's inappropriate advice to Patient I, that she reduce the dose of Letrozole, amounted to misconduct. It had regard to Mr Q's expert report in which he stated:

> *'Due to placing Patient I at an increase of recurrence of breast cancer, with 6 months' treatment of suboptimal adjuvant endocrine treatment (aromatase inhibitor), the standard of care delivered to Patient I by Mr Mahadev fell seriously below that expected of a reasonably competent Consultant Breast Surgeon'.*

77. The Tribunal considered this to be a departure from paragraph 16a of GMP (as quoted above) and was satisfied that Dr Mahadev's inappropriate advice to Patient I was significant as it placed her at an increased risk of recurrence of breast cancer and amounted to misconduct.

Patient J

Pargraph 24 of the Allegeation

78. The Tribunal considered if Dr Mahadev's failure to arrange a pre-operative ultrasound scan of Patient J's 12-year-old breast implants amounted to misconduct.

79. The Tribunal considered paragraphs 15a and 15b and 35 of GMP were engaged:

'15 you must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a Adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient.

b Promptly provide or arrange suitable advice, investigations or treatment where necessary.'

'35 you must work collaboratively with colleagues, respecting their skills and contributions.'

80. It noted Mr Q's opinion in his report, '*The failure to carry out an ultrasound scan of both implants prior to any surgical procedure as recommended by the Endocrinologists, placed Patient J at serious risk in respect of the procedure that she had consented, namely bilateral capsulotomy/ capsulectomy and re-insertion of the original implants which could have been found to be either leaking or ruptured during the procedure of explanation. As Patient J lacked very significant information that would be essential to her decision making, the standard of care delivered to her by Mr Mahadev fell seriously below that expected of a reasonably competent Consultant Breast Surgeon*.'

81. The Tribunal accepted Mr Q's evidence and also noted that the letter from the endocrinologist had highlighted the need for an ultrasound scan which Dr Mahadev did not follow. It was satisfied that Dr Mahadev's failure was a significant omission. It was also a serious departure from paragraphs 15a, 15b, 35 of GMP and in the Tribunal's view amounted to misconduct.

<u>Pargraph 25 of the Allegeation</u>

82. The Tribunal considered if Dr Mahadev's failure to obtain fully informed consent from Patient J amounted to misconduct.

83. It considered that paragraph 17 of GMP was engaged. It also had regard to Mr Q's evidence that the absence of an ultrasound scan would have prevented full information being known about the status of the implants which would have an impact on the options offered to Patient J; and secondly, the consent form did not reflect any of the risks for the more invasive procedure of a capsulectomy which Patient J underwent in

addition to the capsulotomy. Patient J therefore did not know the status of her implants and whether there was silicone leakage. Mr Q stated:

> '*The occurrence of silicone leakage would have significant implications for Patient J regarding the surgical procedure and she should have had the knowledge of the state of the implants prior to consenting in order to make an informed decision regarding her treatment. Failure placed her at risk from a surgical procedure where the implants could have been damaged or found to be leaking and thus required explanation without replacement*.'

84. It further noted Mr Q's evidence that a capsulectomy was more invasive than a capsulotomy, involved a more prolonged recovery period and the incision made was greater. He stated that there was a risk of haematoma and seroma formation and an increased risk of bleeding and persistent pain. Mr Q stated that the implant could rupture intraoperatively and a risk of recurrence of the capsule should also be explained to the patient for them to have a realistic expectation of the procedure. He stated that the consent form did not reflect the procedure offered. Further that it was '*absolutely not acceptable'* for Dr Mahadev to have carried out a capsulectomy without having explained it prior to the procedure.

85. The Tribunal had regard to Mr Q's expert report in which he stated:

> *'The lack of information in the consenting process by Mr Mahadev indicated a standard of care falling seriously below that expected of a reasonably competent Consultant Breast Surgeon exposing Patient J to risks'.*

86. In light of this evidence which the Tribunal accepted, it took the view that in failing to obtain fully informed consent, Dr Mahadev placed Patient J at a risk of harm. It considered this to be significant and also a serious departure from paragraph 17 of GMP alongside the national guidelines on consent. The Tribunal determined that Dr Mahadev's failure to obtain fully informed consent amounted to misconduct.

<u>Pargraph 26 of the Allegeation</u>

87. The Tribunal considered if Dr Mahadev's failure to correspond with the CCG to request funding for Patient J's replacement implants amounted to misconduct.

88. It considered that pargraphs 15a and 16d of GMP were engaged:

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

a Adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values, where necessary, examine the patient'

'*16 In providing clinical care you must:*

d consult colleagues where appropriate'

89. In failing to correspond with the CCG to request funding for replacement implants, Dr Mahadev departed from the principle in paragraph 15a as he did not appear to take account Patient J's history, namely that she was a transgender patient. As such, in Mr Q's view, CCG funding may have been available for her as providing new implants may not be classed as a cosmetic procedure, but rather one that would sustain her holistic treatment. Mr Q also stated that not writing to the CCG for funding for the replacement implants would have prevented full information being given to Patient J in respect of the options available to her. He stated if as a result of any correspondence with the CCG, there was a refusal to fund the replacements, Patient J may then have opted to fund the replacements herself.

90. As such, the Tribunal was satisfied that Dr Mahadev's failure to request funding for Patient J's replacement implants, limited Patient J's options. His failure was also a departure from the principles within paragraphs 15a and 16d of GMP and amounted to misconduct.

Pargraph 28 of the Allegeation

91. The Tribunal considered if Dr Mahadev's actions in inappropriately removing and re-inserting Patient J's implants amounted to misconduct.

92. It had regard to Mr Q's opinion within his expert report:

'The removal and re-insertion of 12 year old implants carries a risk of damage and rupture during the intra-operative handling and placed Patient J at risk since, with

time, the original implants would become more fragile and intra- operative damage would have made re-insertion impossible. The standard of care therefore falls seriously below that expected of a reasonably competent Consultant Breast Surgeon.'

93. The Tribunal accepted Mr Q's view. In light of the risk of complications developing due to the fragility of the implants, it considered Dr Mahadev's actions in inappropriately removing and replacing the same implants placed Patient J at risk. It considered that Dr Mahadev's actions were a serious departure from the principle within paragraph 15 of GMP which states '*You must provide a good standard of practice and care*.' As such, the Tribunal was satisfied that this amounted to misconduct.

Patient K

Paragraph 29 of the Allegation

94. The Tribunal considered if Dr Mahadev's failure to follow the MDT advice to refer Patient K to oncology without a valid reason to deviate from that advice, amounted to misconduct. It also considered if Dr Mahadev's actions in inappropriately advising Patient K's GP to continue to prescribe Tamoxifen in an inadequate and suboptimal dose amounted to misconduct.

95. The Tribunal considered paragraphs 16a and 35 of GMP to be engaged:

'16 In providing clinical care you must:

a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's need.

35 You must work collaboratively with colleagues, respecting their skills and contributions.'

96. The Tribunal had regard to Mr Q's expert report, in which he stated:

'Patient K received a sub-optimal dose of Tamoxifen 10mgm daily for 9 months whereas the standard dose was 20mgm daily. This placed Patient K at risk due to lack of protection of the contra-lateral breast from developing breast cancer in situ or invasive and thereby the standard of care falls seriously below that expected of a

reasonably competent Consultant Breast Surgeon. Moreover, Mr Mahadev did not follow the MDT advice to refer Patient K to Medical Oncology for their opinion with regard to hormone treatment but instead he prescribed a sub-optimal dose of Tamoxifen. This falls seriously below the standard of care expected of a reasonably competent Consultant Breast Surgeon in the absence of Mr Mahadev providing a valid reason for deviating from the MDT advice.'

97. The Tribunal accepted Mr Q's view and considered that Dr Mahadev's actions in not following the advice of MDT and not having referred Patient K to oncology, deprived her of the opportunity to discuss the risks, side effects and benefits of hormone treatment with the oncology team. Further Dr Mahadev's actions in advising Patient K's GP to continue with the inadequate and sub-optimal dose of Tamoxifen placed her at risk due to the lack of protection from developing breast cancer. As such, the Tribunal was satisfied that in addition to seriously departing from the paragraphs of GMP quoted above, these actions and failures amounted to misconduct.

98. To summarise, the Tribunal was satisfied that Dr Mahadev's conduct fell so far short of that expected of a consultant breast surgeon to amount to misconduct.

Impairment by reason of Misconduct

99. Having found misconduct, The Tribunal went on to consider if Dr Mahadev's fitness to practise is currently impaired.

100. The Tribunal took the view that Dr Mahadev's misconduct engaged all three limbs of the overarching objective. It referred to the approach in *CHRE v NMC and Grant [2011] EWHC 927 (Admin) and considered that all four limbs, (a), (b), (c) and (d) were engaged.* It agreed with the GMC's submission that Dr Mahadev's failings encompassed a broad spectrum of failings which took place over a short period of time.

101. The Tribunal considered if any of Dr Mahadev's misconduct was remediable. It was mindful that dishonesty was conduct that was not easily remediable. It was of the view, that whilst difficult, remediation was not impossible in this case. It considered that it would also be possible for Dr Mahadev to remediate his failures in respect of inadequate and inappropriate prescribing, failures to obtain informed consent, inadequate communication with patients and colleagues and also the surgical and clinical care he provided to patients.

102. The Tribunal noted that in respect of prescribing Augmentin to Patient H, Dr Mahadev had apologised to Patient H for his error when he saw her next in clinic for a review appointment. However, the Tribunal had no other evidence in respect of any remediation or reflection on part of Dr Mahadev. Despite his non-attendance at this hearing, there had been no evidence submitted by him to demonstrate that he had remediated or that he had insight in respect of his personal failures. Dr Mahadev had ceased all engagement with the regulatory process since March 2023. Without any knowledge of Dr Mahadev's remediation or insight, the Tribunal considered that a risk of repetition of misconduct on Dr Mahadev's part was present.

103. The Tribunal was not aware of Dr Mahadev having undertaken any medical practice since the index events. It also had no information in respect of Dr Mahadev keeping his clinical knowledge and skills up-to-date.

104. In the circumstances, the Tribunal concluded that a finding of impairment was necessary to promote and maintain the health, safety and wellbeing of the public, promote and maintain public confidence in the medical profession and to promote and maintain proper professional standards and conduct for members of the profession. It therefore determined that Dr Mahadev's fitness to practise is impaired by reason of misconduct.

Review of Impairment by reason of misconduct

The Review Background

105. Dr Mahadev's case was originally considered by an MPT which concluded in March 2023. At this hearing, the 2023 Tribunal found that two parts of the allegation amounted to serious misconduct: that Dr Mahadev had not corrected the divarication of Patient A's recti muscles during her surgery, and that he had failed to examine Patient A post-operatively prior to her discharge. It considered whether Dr Mahadev was currently impaired by reason of his serious misconduct.

106. The 2023 Tribunal noted that Dr Mahadev had accepted the findings of the 2023 Tribunal at the facts stage and the Tribunal gave him credit for this.

107. However, the 2023 Tribunal noted that there were some aspects of Dr Mahadev's submissions which indicated that his insight was not complete. The 2023 determination of the Tribunal stated that Dr Mahadev indicated that he had learned his lesson regarding the need to review his patients post-operatively. However, that Tribunal noted

that Dr Mahadev '*still seemed focussed on the fact that Patient A had not required his presence the day after her surgery rather than accepting that he should either have attended on her or put in place proper arrangements to ensure that someone else could step into that role'*.

108. The 2023 Tribunal was concerned that Dr Mahadev had not provided any evidence which demonstrated that he fully understood what was required of him in terms of discharging a patient in a private hospital setting, and how he would bring his skills up to date, in order to remediate his deficiencies. That Tribunal also noted that it had not seen any practical evidence of Dr Mahadev's plans for training '*to address the deficiencies revealed by his misconduct'.*

109. The 2023 Tribunal had also noted that Dr Mahadev had made submissions with regard to the apologies he had made in respect of Patient A. It also stated that it had '*noted that Dr Mahadev's response to the GMC, dated 15 August 2019, stated:*

- *Firstly, I also wish to apologise to [Patient A] that she felt that she did not receive the right treatment from me'*.

110. That Tribunal had considered that at that stage, it was '*only a limited apology or demonstration of remorse in that this initial apology did not acknowledge any failing on his part*.'

111. The 2023 Tribunal had continued to state within its determination, that Dr Mahadev expressed deep remorse and sadness for his actions that had hurt Patient A's feelings. Further that he had stated that not a day passed when he did not feel remorseful. The Tribunal stated that '*this apology still did not entirely acknowledge the extent of the impact of his serious misconduct on Patient A but was considered by the Tribunal to be evidence of his developing insight'*.

112. The 2023 Tribunal considered that Dr Mahadev had not fully understood that the misconduct identified was of wider applicability than simply performing an abdominoplasty. Although the misconduct identified was in the opinion of the 2023 Tribunal remediable, it stated that there was no evidence of any steps Dr Mahadev had taken towards remediation.

113. The 2023 Tribunal were of the opinion that until Dr Mahadev had fully developed his insight into his failings and the way in which they may be remedied, there remained a

risk of repetition.

114. The 2023 Tribunal, in their assessment, were satisfied that all three limbs of the overarching objective were engaged. It stated that '*given Dr Mahadev's limited insight and remediation, and the seriousness of his actions, it determined that his fitness to practise was impaired by reason of misconduct*'.

115. The 2023 Tribunal also stated that it may assist a future reviewing Tribunal if Dr Mahadev provided:

- A reflective statement;
- Evidence of any courses undertaken;
- Evidence that he has kept his knowledge and skills up to date

<u>This 2024 Tribunal's determination in respect of the Review</u>

116. In considering whether Dr Mahadev's fitness to practise remained impaired by reason of misconduct, it bore in mind that there was a persuasive burden on Dr Mahadev to demonstrate that he was no longer impaired.

117. It had regard to the previous determination, made by the 2023 Tribunal, and noted the conditions imposed on Dr Mahadev's registration. It was mindful that the 2023 Tribunal had listed what information and evidence Dr Mahadev could provide to assist a reviewing Tribunal.

118. This Tribunal however did not have any information or evidence before it to demonstrate if Dr Mahadev had further reflected or remediated the misconduct found proved by the previous Tribunal. It could therefore not assess whether Dr Mahadev had appreciated the nature, gravity and impact of his past misconduct and had developed further insight. As such, there was no material change in the circumstances since the 2023 Tribunal's determination. This Tribunal therefore considered that the risk of repetition remained.

119. This Tribunal was also mindful of potential attrition of Dr Mahadev's clinical skills and knowledge as there was no evidence of Dr Mahadev continuing clinical practice or having completed Continuing Professional development (CPD) /training courses.

120. In the circumstances, the Tribunal could not be satisfied that Dr Mahadev could safely practice without restriction and therefore determined that Dr Mahadev's fitness to practise remains impaired by reason of misconduct.

Determination on Sanction - 22/04/2024

1. Having determined that Dr Mahadev's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 22(1)(h) of the Rules its decision on whether to direct any sanction.

The Evidence

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

Submissions

3. On behalf of the GMC, Ms Bucklow submitted that there were no mitigating factors in this case. She went on to submit that there were many aggravating factors in this case such as the nature of Dr Mahadev's misconduct which put patient safety at risk. Ms Bucklow stated that probity is a fundamental tenet of the medical profession and reminded the Tribunal that it has already found dishonesty which related to Dr Mahadev's profession.

4. Ms Bucklow stated that Dr Mahadev's actions caused harm to patients and that his dishonesty prevented the Trust from considering any steps to protect patient safety. She went on to state that Dr Mahadev had not provided any evidence of insight, remediation or that he understood the gravity of the Allegation made against him. She submitted that Dr Mahadev displayed a broad spectrum of failings across his clinical practice.

5. Ms Bucklow submitted that a sanction of conditions would no longer be sufficient to protect the public or to maintain public confidence in the medical profession due to the concerns raised and Dr Mahadev's lack of engagement. She stated that conditions would require Dr Mahadev to have insight and demonstrate an intention of regaining his fitness to practise.

6. Ms Bucklow went on to submit that the imposition of a suspension would also not be sufficient to address the concerns in this case. She stated that there had been no acknowledgment of fault from Dr Mahadev with regard to the new Allegation and that he had not submitted any evidence of remediation. Ms Bucklow reminded the Tribunal that Dr Mahadev indicated an intention to remediate to the 2023 Tribunal, although no plans for that were submitted and since then, there is no evidence to suggest that he undertook any remediation. Additionally, in referring to the facts and impairment found by this Tribunal, Ms Bucklow submitted that there had been a repeat of similar misconduct as found by the 2023 Tribunal.

7. Ms Bucklow submitted that there had been no accountability from Dr Mahadev, no expression of remorse or insight and no attempts to address the failings identified. Ms Bucklow submitted that the public would be concerned if Dr Mahadev was able to maintain his medical registration in these circumstances.

8. Accordingly, Ms Bucklow submitted that a sanction of erasure was necessary in this case. She stated that erasure would protect patient safety due to the clinical concerns raised. Further, that following Dr Mahadev's dishonesty, in the course of his employment with the Trust, he caused significant harm to patients before '*disappearing*' and showing disregard for the regulatory process. Ms Bucklow stated that in light of this, being allowed to remain on the medical register, would undermine public confidence. She stated that erasure was necessary in order to maintain proper professional standards and that it would send a clear message to other medical professionals about the importance of probity and unacceptable clinical practice.

The Tribunal's Determination on Sanction

9. The decision as to the appropriate sanction to impose, if any, is a matter for this Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken account of the Sanctions Guidance (2024) (SG) and GMP. It has borne in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it may have a punitive effect.

10. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Mahadev's interests with the public interest. It has already given a detailed

determination on impairment and has taken those matters into account during its deliberations on sanction.

Aggravating and Mitigating factors

11. The Tribunal considered the aggravating factors in this case to be Dr Mahadev's dishonesty which was related to his medical profession. It took the view that Dr Mahadev's dishonesty put patients at potential risk of harm. It misled the Trust, who became his employer and did not allow them the opportunity to assess if action was needed to safeguard patient safety. It considered this to be an aggravating feature of this case. It further considered that in not engaging within the regulatory process, Dr Mahadev showed a lack of insight into the concerns in respect of his probity and clinical practice. His insight was considered to be incomplete by the previous Tribunal and Dr Mahadev had not demonstrated taking any steps to remediate or develop insight.

12. The Tribunal sought to balance these against any mitigating features of this case. It accepted that Dr Mahadev had apologised to Patient H in respect of prescribing her with Augmentin when she was allergic to penicillin. It was not able to identify any other mitigating features. Whilst the Tribunal acknowledged the apology, it could only place little weight on it due to the impact of Dr Mahadev's actions on this patient's safety.

13. The Tribunal was of the view that the aggravating features in this case relating to probity and lack of insight were serious and impacted patient safety and thus outweighed the mitigating feature identified.

No action

14. In reaching its decision as to the appropriate sanction, if any, to impose in this case, the Tribunal first considered whether to conclude the case by taking no action.

15. The Tribunal noted that there were no exceptional circumstances to justify taking such a course. It determined that, due to the seriousness of the concerns raised in this case, it would not be sufficient, proportionate or in the public interest to conclude the case by taking no action.

Conditions

16. The Tribunal next considered whether it would be appropriate to retain and /or impose further conditions on Dr Mahadev's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable.

17. It had regard to the following paragraphs of the SG:

'82 Conditions are likely to be workable where:

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

84 Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:

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

18. The Tribunal determined that in light of its findings, the imposition of conditions on Dr Mahadev's registration would be unworkable given the doctor's lack of complete insight, non-engagement and the finding of dishonesty.

19. The Tribunal further considered that the imposition of conditions on Dr Mahadev's registration would also be inappropriate as it would not send a sufficiently robust message to the public or the profession as to the seriousness of his misconduct. In the circumstances, the Tribunal determined that a period of conditional registration would neither be appropriate nor meet the public interest.

Suspension

20. The Tribunal then went on to consider whether imposing a period of suspension on Dr Mahadev's registration would be appropriate and proportionate. In doing so it had regard to the following paragraphs 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.

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

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

a A serious 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'

21. The Tribunal bore in mind that in addition to dishonesty, this case concerned a broad spectrum of clinical failings in respect of eight patients. The 2023 Tribunal had also found misconduct by Dr Mahadev in respect of one patient. It took the view that there had not been an acknowledgement of fault from Dr Mahadev in respect of his clinical failings relating to the eight patients. Due to a lack of engagement by Dr Mahadev, the Tribunal had no evidence to demonstrate remediation, any development of insight or contrition and it therefore did not have a proper basis to conclude that Dr Mahadev's actions would not be repeated.

22. The Tribunal was mindful that Dr Mahadev had shown a comprehensive lack of adherence to GMP in multiple areas such as communication, clinical skills and probity. It considered that since the findings of misconduct relating to incidents in 2017, there had

been a repeat of similar behaviour as demonstrated by the findings relating to incidents in 2019.

Erasure

23. The Tribunal considered the following paragraphs of the SG:

'109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.

b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.

c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients

d Abuse of position/trust

h Dishonesty, especially where persistent and/or covered up

124 Although it may not result in direct harm to patients, dishonesty related to matters outside the doctor's clinical responsibility (eg 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

129 Cases in this category are those where a doctor has not acted in a patient's best interests and has failed to provide an adequate level of care, falling well below expected professional standards. This is particularly where there is a deliberate or reckless disregard for patient safety or a breach of the fundamental duty of doctors to 'Make the care of [your] patients [your] first concern' (Good medical practice,

page 7). A particularly important consideration in these cases is whether a doctor has developed, or has the potential to develop, insight into these failures. Where insight is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.

132 However, there are some cases where a doctor's failings are difficult to remediate. This is because they are so serious that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients, and should have taken steps earlier to prevent this

136 Doctors are expected to work collaboratively with colleagues to maintain or improve patient care'

24. The Tribunal had regard to these paragraphs of the guidance. It took the view that Dr Mahadev had shown a deliberate disregard for the principles set out in GMP due to his dishonesty and a reckless disregard in respect of the failings in his clinical care which resulted in harm to patients. It took the view that the false statement Dr Mahadev made in his application form was serious and would undermine public trust in the medical profession. His failure to work collaboratively with his colleagues and in going against the advice of the MDT without providing a valid reason, impacted negatively on patient safety. Against this background, the Tribunal reminded itself of its earlier findings that it did not have any information or evidence before it to demonstrate if Dr Mahadev had further reflected or remediated the misconduct found proved by the previous Tribunal. It could therefore not assess whether Dr Mahadev had appreciated the nature, gravity and impact of his past misconduct or had developed further insight. It had considered that there was no material change in the circumstances since the 2023 Tribunal's determination and had also determined that the risk of repetition remained.

25. The Tribunal took the view that whilst a period of suspension would have a deterrent effect, Dr Mahadev's misconduct was fundamentally incompatible with continued medical registration. It weighed in the balance Dr Mahadev's interest in not being able to practise as a doctor. However it considered that to protect the safety of the public, maintain public confidence in the profession and to maintain proper professional standards in the profession was more important. In all the circumstances, it concluded that erasure was the only appropriate and proportionate sanction in this case.

26. The Tribunal therefore determined to erase Dr Mahadev's name from the Medical Register.

Determination on Immediate Order - 22/04/2024

366. Having determined to erase Dr Mahadev's name from the medical register, the Tribunal has considered whether his registration should be subject to an immediate order.

Submissions

367. On behalf of the GMC, Ms Bucklow submitted that an immediate order is sought in this case as the Tribunal has already found that conditions would not be sufficient to protect the public. She stated that an example scenario of concern could be that if Dr Mahadev was to start working, in a medical capacity, during any appeal period. In this scenario conditions would be in place on Dr Mahadev's registration which would be unsatisfactory and potentially unsafe.

The Tribunal's Determination

368. The Tribunal had regard to paragraphs 172 – 178 of the SG. In its deliberations, it had particular regard to paragraph 173 of the SG which states:

> *'An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession'*

369. The Tribunal considered that it would be in the interest of patient safety, and in the public interest, to impose an immediate order.

370. The Tribunal therefore determined to impose an immediate order of suspension.

371. This means that Dr Mahadev's registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, 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.

372.That concludes the case.

ANNEX A – 25/03/2024

Determination on service and proceeding

1. Dr Mahadev is neither present nor represented at these proceedings. The Tribunal has considered whether notice of this hearing has been properly served upon Dr Mahadev in accordance with Rules 15 and 40 of the General Medical Council (Fitness to Practise) Rules 2004 (as amended)(the Rules) and Schedule 4, Paragraph 8 of the Medical Act 1983 (as amended). In so doing, it has taken into account all the information placed before it, together with the submissions made on behalf of the GMC.

2. In its deliberations, the Tribunal bore in mind that it is Dr Mahadev's responsibility to keep his registered address and contact details up to date. It has been provided with a service bundle, containing a copy of the Notice of Allegation, dated 29 January 2024, which was sent to Dr Mahadev's registered address. The tracker information for this stated *'Private address problem: Consignee moved'* and *'Return arrived at Norsk Hub'* on 7 February 2024. The Notice of Allegation, dated 29 January 2024, was re-sent on 5 February 2024. The tracker information for this stated '*Consignee has moved from the address provided'* and that it was *'Returned to shipper'* on 13 February 2024.

3. The service bundle also contained a copy of the Notice of Hearing, dated 31 January 2024, which was sent to Dr Mahadev's registered address. The tracker information stated *'Delivery attempted but no response at Consignee address'* and that it was *'Returned to shipper'* on 9 February 2024. The Notice of Hearing was re-sent on 6 February 2024. The Tribunal noted that the notice of hearing was sent to Dr Mahadev within 28 days of this hearing, informing him of his right to attend the hearing and informing him of the power of the Medical Practitioners Tribunal to proceed in his absence under rule 31. This was sent by first class airmail and no signature was required. The Tribunal also noted that the GMC had contacted Dr Mahadev's registered email address and two other email addresses all previously used by him. No responses had been received to these emails.

4. Having considered all the information, including the additional efforts made to send pathfinder emails and the telephone calls made to Dr Mahadev to make contact with him, the Tribunal was satisfied that all reasonable efforts had been made to properly serve notice of this hearing upon Dr Mahadev.

5. Accordingly, the Tribunal went on to consider whether to proceed with the case in Dr Mahadev's absence in accordance with Rule 31 of the Rules. In doing so, it bore in mind the legal advice given by the Legally Qualified Chair. The Tribunal noted that it had a discretion to proceed with the case in Dr Mahadev's absence, though this discretion must be exercised with caution with the overall fairness of the proceedings in mind. In doing so, the Tribunal took into account the cases of *Adeogba v GMC [2014] EWHC 3872* and *R v Jones [2003] 1AC.* It had regard to all the circumstances including the following:

- The nature and circumstances of the doctor's behaviour in absenting himself, in particular, whether the behaviour was voluntary and therefore waived the right to be present;
- Whether an adjournment would resolve the matter;
- The likely length of any such adjournment;
- The extent of any disadvantage to the doctor in not being able to present his account of events;
- The public interest that a hearing should take place within a reasonable time;
- The effect of any delay on the memories of witnesses.

6. The Tribunal bore in mind that its discretion to proceed in Dr Mahadev's absence must be exercised with caution and with regard to the overall fairness of the proceedings. The Tribunal has balanced the interests of the practitioner, including fairness to him and the public interest, including the need to protect patients.

7. The Tribunal has noted Dr Mahadev was previously legally represented and that the GMC had sent a witness statement and a supplemental expert report from Mr Q to them. It noted that Dr Mahadev's solicitors came off the record as acting for him in April 2023 and provided email addresses for him. Dr Mahadev's last email correspondence with the GMC was dated 23 March 2023. It noted that since then numerous emails had been sent to him however he had not acknowedged receipt or responded to any emails since then.

8. On the basis of the information provided the Tribunal was satisfied that Dr Mahadev had voluntarily waived his right to be present and represented at this hearing. The Tribunal considered that there was no evidence that Dr Mahadev would attend a future hearing, were it to adjourn today. It bore in mind that the witnesses had been warned and were scheduled to attend today. Further that any delay in the proceedings may impact their memories. The nature of the allegations was such that there was a strong public interest

in the matter being heard without delay. It also considered that it was in Dr Mahadev's interest for there to be finality of these proceedings. The Tribunal also bore in mind that expeditious and efficient disposal of allegations was of real importance. Overall, it considered that Dr Mahadev had voluntarily absented himself and appeared to have disengaged with the process. The Tribunal therefore determined that it was in the public interest and also in Dr Mahadev's interests to exercise its discretion and proceed with the case in his absence.

ANNEX B – 04/04/2024

Application to adduce further evidence

381. On behalf of the GMC, Ms Bucklow made an application pursuant to Rule 34(1) of the Rules to adduce additional evidence.

Submissions

382. Ms Bucklow submitted that the additional evidence was an email from the GMC to Dr Mahadev, dated 24 July 2019, and that this relates to paragraphs 1 and 2 of the Allegation. She informed the Tribunal that the email serves to answer a valid question of the Tribunal as to whether a GMC investigation was open on 1 June 2019. Ms Bucklow submitted that the email is plainly of relevance and does not give away other details of the previous investigation and therefore no inferences can be made from it being shared and it was being adduced to assist the Tribunal. She stated that it was therefore not prejudicial to Dr Mahadev nor was it unfair to admit.

The Tribunal's decision

383. The Tribunal took the view that the email did in fact answer a question it raised within the hearing. Its contents were relevant to the allegation and as the email did not provide any other information other than its open status, it could be admitted without unfairness or prejudice to Dr Mahadev. Additionally, this email was sent to Dr Mahadev as part of an ongoing dialogue concerning the GMC's previous investigation. It concluded that it would be in the interests of fairness for the email to be admitted into evidence.

4. The Tribunal therefore determined to grant the GMC's application.

ANNEX C – 04/04/2024

Application to amend Allegation

384. On behalf of the GMC, Ms Bucklow made an application pursuant to Rule 17(6) of the Rules to amend the Allegation.

Submissions

385. Ms Bucklow applied to withdraw paragraph 11 of the Allegation and to amend paragraphs 10, 12 and 26 as follows:

10. You failed to record within your operation note any detail as to the use / administration of:

a. radioisotope and/or;

b. patent blue dye.

12. You~~r~~ failed to advise Patient B's GP that, in light of the results of the bone densitometry scan, Patient B ~~actions at paragraph 11 were inappropriate because Patient B was taking an aromatase inhibitor and~~:

a. was at risk of developing a vertebral compression fracture;

b. should be ~~osteoporosis of the hip in a patient taking an aromatase inhibitor requires~~:

i. commenced on supplemental calcium;

ii. commenced on vitamin D;

iii. considered ~~ation~~ for bisphosphonates.

26. You failed to correspond with the Clinical Commissioning Group ('CCG') to request ~~secure~~ funding for the replacement implants ~~Procedure~~.

386. Ms Bucklow submitted that paragraph 11 of the Allegation was no longer sustainable as it was identified that the letter sent in November 2019 had been sent to Dr Mahadev by the GP. Ms Bucklow submitted that a failure to inform cannot arise if the GP had sent the scan to Dr Mahadev. Ms Bucklow further submitted that paragraph 12 of the Allegation is worded in a way which follows on from paragraph 11 so if paragraph 11 was withdrawn then paragraph 12 would not make sense without amendment. She stated that the proposed amendment would make paragraph 12 clear and independent of paragraph 11. She submitted that it was important for there to be clarity regarding what is alleged and further that the proposed amendment did not change the nature of the allegation or its seriousness.

387. Ms Bucklow submitted that the amendment to paragraph 10 of the Allegation would be appropriate in light of Mr Q confirming that there would have been no requirement for Dr Mahadev to have used both; a radioisotope as well as patent blue dye. Therefore, the insertion of 'and/or' would make the allegation clear.

388. With regard to paragraph 26 of the Allegation, Ms Bucklow informed the Tribunal of Mr Q's evidence which provided clarity that the correspondence with the CCG would be to request funding for the replacement implants of Patient J as opposed to secure funding for the procedure as a whole. Ms Bucklow submitted that the proposed amendment was more specific and address the alleged mischief.

The Tribunal's decision

389. In its deliberations, the Tribunal took the view that the proposed amendment to paragraph 10 would make the allegation clearer and easier to read. It agreed with the GMC that paragraph 11 could not stand, based on the information given in the letter dated 21 November 2019, and that this could be withdrawn without any injustice to Dr Mahadev.

390. Due to the withdrawal of paragraph 11, the Tribunal took the view that the proposed amendment to paragraph 12 made the allegation more specific and focused on the alleged failure. As such, it concluded that this amendment could be made with no injustice to Dr Mahadev.

391. In relation to the proposed amendment to paragraph 26, the Tribunal noted that this puts the nature of the allegation into the proper context and that it could be amended in fairness to Dr Mahadev and without any injustice to him.

392. The Tribunal therefore determined to grant the GMC's application.

ANNEX D – 15/04/2024

Determination on service and proceeding

1. Dr Mahadev is neither present nor represented at these proceedings. The Tribunal considered whether the notice of the hearing in respect of the review matter was properly served upon Dr Mahadev in accordance with Rules 20 and 40 of the General Medical Council (Fitness to Practise) Rules 2004 (as amended)(the Rules) and Schedule 4, Paragraph 8 of the Medical Act 1983. In so doing, it has taken into account all the information placed before it, together with the submissions made on behalf of the GMC.

2. In its deliberations, the Tribunal again bore in mind that it is Dr Mahadev's responsibility to keep his registered address and contact details up to date. The Tribunal has been provided with a service bundle, containing a copy of the GMC letter, dated 29 January 2024 informing Dr Mahadev about the date of the review hearing. This letter was sent via courier to Dr Mahadev's registered address. The tracker information for this stated *'Private address problem: Consignee moved'* and *'Return arrived at Norsk Hub'* on 8 February 2024. The GMC Information Letter, dated 29 January 2024, was re-sent on 5 February 2024, by courier but also returned to the hub on 15 February 2024.

3. Another letter dated 31 January 2024, with the notice of the review hearing was sent by the MPTS to Dr Mahadev's registered address via airmail on 6 February 2024. The Tribunal noted that the notice of hearing was sent to Dr Mahadev within 28 days of this hearing, informing him of his right to attend the hearing and informing him of the power of the Medical Practitioners Tribunal to proceed in his absence under Rule 31.

4. In addition, the Tribunal had regard to the conclusion of the 2023 hearing in which the previous Tribunal directed a review of Dr Mahadev's case. Dr Mahadev sent an email on 22 March 2023 in response to the outcome of the 2023 hearing so would have been aware that a review had been directed. The Tribunal also noted that the GMC had tried to contact Dr Mahadev by emailing his registered email address and two other email

addresses all previously used by him. No responses had been received to these emails since March 2023.

5. Having considered all the information before it, the Tribunal was satisfied that all reasonable efforts had been made to properly serve notice of the review hearing upon Dr Mahadev at his registered address.

6. Accordingly, the Tribunal went on to consider whether to proceed with the review in Dr Mahadev's absence in accordance with Rule 31 of the Rules. In doing so, it bore in mind the legal advice given by the Legally Qualified Chair. The Tribunal noted that it had a discretion to proceed with the case in Dr Mahadev's absence, though this discretion must be exercised with caution with the overall fairness of the proceedings in mind. In doing so, the Tribunal took into account the cases of *Adeogba v GMC [2014] EWHC 3872* and *R v Jones [2003] 1AC.* It had regard to all the circumstances including the following:

- The nature and circumstances of the doctor's behaviour in absenting himself, in particular, whether the behaviour was voluntary and therefore waived the right to be present;
- Whether an adjournment would resolve the matter;
- The likely length of any such adjournment;
- The extent of any disadvantage to the doctor in not being able to present his account of events;
- The public interest that a hearing should take place within a reasonable time.

7. The Tribunal bore in mind that its discretion to proceed in Dr Mahadev's absence must be exercised with caution and with regard to the overall fairness of the proceedings. The Tribunal balanced the interests of Dr Mahadev, including fairness to him and the public interest, including the need to protect patients. It also bore in mind that Dr Mahadev's last email correspondence with the GMC was dated 23 March 2023 and since then he has ceased all contact.

8. On the basis of the information provided the Tribunal was satisfied that Dr Mahadev had voluntarily waived his right to be present and represented at this hearing. It considered that there was no evidence to suggest that Dr Mahadev would attend a future hearing, were the Tribunal were to adjourn the review.

9. The Tribunal was also satisfied that Dr Mahadev had voluntarily absented himself and that he had disengaged from the regulatory process. It therefore determined that it was in the public interest, and in Dr Mahadev's interests, to exercise its discretion and proceed with the review hearing in his absence.

ANNEX E – 15/04/2024

Application to adduce further evidence

1. On behalf of the GMC, Ms Bucklow made an application pursuant to Rule 34(1) of the Rules to adduce additional evidence.

Submissions

2. Ms Bucklow informed the Tribunal that the additional evidence was an email from Dr Mahadev to the GMC dated 22 March 2023. She submitted that this email should be admitted into evidence as the Tribunal may consider it relevant to Dr Mahadev's insight. Ms Bucklow submitted that the Tribunal may also consider that it summarises Dr Mahadev's intentions in respect of compliance with the regulator and his response to the sanction imposed by the 2023 Tribunal.

3. Ms Bucklow submitted that it would be fair to admit the email as it is an email Dr Mahadev wrote and therefore, he would have seen it and would know of its existence.

The Tribunal's decision

4. The Tribunal noted that the email was sent by Dr Mahadev over a year ago and appears to be in response to having just been sent the determination of the 2023 Tribunal. It considered that Dr Mahadev was self-representing at that point and may not have known that any such correspondence and statements by him could be considered by a future Tribunal as evidence. It considered that the email began with Dr Mahadev referring to the submissions he made to the previous Tribunal (the day before the email was written). This Tribunal was not privy to those submissions. The Tribunal therefore considered it unsafe to place reliance on statements made, without knowledge of the full context and without those statements being tested due to Dr Mahadev's absence.

5. Accordingly, the Tribunal concluded that it would not be fair to admit Dr Mahadev's email to the GMC, dated 22 March 2023.

6. The Tribunal therefore determined to refuse the GMC's application.

Schedule 1

- the potential side effects of the patent blue dye administration to identify the sentinel lymph node namely: allergic reaction, faint blue discolouration of the skin, blue discolouration of the urine and persistence of cutaneous pigmentation around the site of injection.
- the potential side effects of the axillary sentinel lymph node procedure, namely: axillary pain, shoulder stiffness, a low incidence of lymphoedema (less than 10%).

Schedule 2

- chest wall pain;
- seroma / haematoma formation;
- numbness in the axilla and upper arm;
- significant shoulder stiffness;
- an increased risk of damage to structures including: the axillary vein, the latissimus dorsi pedicle, the nerve to the serratus anterior resulting in a winged scapula;
- lymphoedema of the upper limb.

Schedule 3

- implant rupture intra-operatively;
- haematoma / seroma formation;
- persistent pain;
- recurrence of the capsule.