Minutes of Investigation Committee (Oral) hearing

Date of hearing: 25 January 2017

Name of doctor: Dr Muhammad Siddiqui

Reference Number: 4282455

Registered qualifications: MB BS 1982 University of Punjab

Committee Members: Mr Ian Kennedy - Chair (Lay)
Dr John Jones - Medical
Mr Geoff Baines - Lay

Legal Assessor: Mr Bernard Phillips

Secretary to the Committee: Mr Declan Leahy

Type of Case: Misconduct

Representation:

GMC:

The General Medical Council was represented by Mr Alex Mills, of Counsel, instructed by GMC Legal.

Doctor:

Dr Siddiqui was present and represented by Mr Tony Haycroft of Counsel instructed by RadcliffeLeBrasseur on your behalf.
Determination

Dr Siddiqui,

1 At today’s hearing the Investigation Committee carefully considered all the material before it including the submissions made by Mr Anthony Haycroft on your behalf, and those made on behalf of the GMC by Mr Alex Mills. It has accepted the advice of the Legal Assessor.

2 The Committee is aware that it must have in mind the GMC’s role of protecting the public, which includes:
   a. Protecting, promoting and maintaining the health, safety and well-being of the public
   b. Promoting and maintaining public confidence in the medical profession, and
   c. Promoting and maintaining proper professional standards and conduct for members of that profession

3 In deciding whether to issue a warning the Committee must apply the principle of proportionality, and balance the interests of the public with those of the practitioner.

Background

4 On 23 September 2014, the GMC was contacted by the Northern Lincolnshire and Goole NHS Foundation Trust who raised concerns about your fitness to practise. The referral related to an incident where a patient required resuscitating.

5 On 16 December 2014 the Northern Lincolnshire and Goole NHS Foundation Trust (‘the Trust’) provided the GMC with the records of their investigation into your clinical management of a patient on 9 September 2014. This report concluded that your ‘intra-operative anaesthetic management of [the patient] was poor (unsafe)’ and that your clinical actions and omissions significantly contributed to the intra-operative morbidity of the patient. Provided alongside the report were statements from colleagues and relevant medical records for the patient.

6 The GMC commissioned an expert report to provide an independent assessment of your actions. A Consultant Anaesthetist, Dr Michael Nathanson, was provided
with the Trust’s investigation, the patient’s medical records and your comments from an IOP hearing transcript, and provided a report dated 4 June 2015. Dr Nathanson’s report concluded that overall, the care you provided to the patient was ‘seriously below the standard [he] would expect of a reasonably competent middle grade anaesthetist.’

7 On 11 August 2015, the GMC wrote to you in accordance with Rule 7 of the GMC Fitness to Practise Rules 2004 informing you of the allegations that you were faced with and the evidence upon which they were based. You were invited to respond to these allegations within 28 days.

8 On 8 September 2015, RadcliffesLeBrasseur wrote to the GMC on your behalf and provided substantive comments in relation to the each of the allegations in turn. They concluded their submissions by stating that you ‘freely admit [you] made a significant error of judgement’ which you sincerely apologise for, and that having ‘reflected very carefully on the case...[you] will never again let a patient into theatre until [you are] satisfied beyond doubt that [they] are in a suitable condition for surgery’.

9 On 17 May 2016, the GMC wrote to you again, in accordance with Rule 7 of the GMC Fitness to Practise Rules 2004 providing you with amended allegations and you were invited to respond to these allegations within 28 days.

10 On 14 June 2016, RadcliffesLeBrasseur wrote to the GMC on your behalf and provided additional comments upon the allegations. They drew the case examiners attention to the supervisor report of Dr Madhaven, dated 12 June 2016, which details that you had been working independently for the last 3 months, that you had not been named in any incidents or complaints during this period and that he had found your ‘anaesthetic plans for high risk patients to be safe’. As a result of the supervisor report and positive testimonials, RadcliffesLeBrasseur concluded that ‘one case of an error of judgement is usually considered an insufficient basis for a finding of impaired fitness to practise’.

11 On 12 August 2016 the GMC wrote to you in accordance with Rules 7 and 11 of the Fitness to Practise Rules 2004, informing you that the Case Examiners, having considered the allegations and supporting information, had decided that this was a case they may conclude with a warning. They invited you to respond to this.

12 On 7 September 2016, RadcliffesLeBrasseur responded to the GMC on your behalf. In this letter they confirmed that, in regards to the events on 9 September 2014 that you accepted the facts of the allegations. The only allegation you did dispute was that you ‘failed to make an adequate and
appropriate entry in [the patient’s] medical records in that he failed to record, in relation to the vasoactive drugs used, the ... (ii) dose given’. They stated that your clinical record ‘clearly states that the dose given was 500mcg phenylephrine.’

13 In this letter RadcliffesLeBrasseur stated that a warning would not be appropriate and would be wholly disproportionate. They stated further that should the Case Examiners decide to issue a warning, you would wish to exercise your right to an Investigation Committee hearing.

14 On 13 December 2016 the GMC wrote to you to inform you that you had been referred to the Investigation Committee for an oral hearing.

GMC Submissions

15 At today’s hearing, on behalf of the GMC, Mr Alex Mills drew the Committee’s attention to the statements from colleagues involved in the incident, which had been compiled as part of the Trust’s investigation. In particular he noted the comments provided by the Operating Department Practitioner (ODP). These comments described how the ODP had raised concerns in regard to the ventilation of the patient, and a potential obstruction and ‘what sounded like a very noisy stridor’. The ODP raised these concerns with you and recalled that you had said you were happy to continue with the interscalene block. After continuing with the procedure, the ODP noted that ‘the patients’ blood pressure and oxygen saturations had dropped out of normal parameters’ and informed you of this. The OPD recalled that you had said you were ‘“okay with this this and the blood pressure would increase soon”’. The ODP continued to describe that upon completion of the block, they informed you that ‘the patient’s new blood pressure reading... had now fallen below 60 systolic’ and that ‘[he] felt that [you were] rather annoyed with [him] for informing [you] of this and [that you] answered that “below a certain range is not to be believed and would be incorrect’’. The ODP’s statement continued to describe them raising concerns in regards to the patient’s condition, in particular that they were hypotensive and hypoxic, and that your responses were to assure him that “this was okay as the patient had good tidal volumes”’ and that you continued to make references to the equipment being faulty. When questioned by the Committee as to whether this could be seen as an error of judgment, Mr Mills submitted that you had acted recklessly in assuming that the equipment was malfunctioning and allowing the surgery to continue, and that you should have reconciled this problem.

16 Mr Mills also drew the Committee attention to the expert report provided by Dr Nathanson. He highlighted the criticisms laid out within the report, namely that you performed an interscalene block on a patient whose chest was tight, where
there was difficulty ventilating him, and where the patient was ‘markedly cardiovascularly unstable’. He drew the Committee’s attention to the criticism that you had asked a healthcare assistant to ventilate the patient, where it was unlikely that they were trained to do so. Mr Mills also directed the Committee to Dr Nathanson’s criticism of you having allowed the surgeon to place the patient in a semi-sitting position when it was inappropriate to do so, and that the overall opinion of Dr Nathanson is that overall ‘[your] care of [the patient] was seriously below the standard’ [he] would expect of a of a reasonably competent middle grade anaesthetist’. He noted that in the responses that you had already provided to the GMC’s investigation you confirmed that there is no factual dispute to the allegations, save that of whether or not you failed to make an accurate record of the dilution of phenylephrine you used. You have already accepted that the care that you provided to the patient was seriously below the standard expected of you.

17 In regard to your actions, Mr Mills submitted that you failed to react to the fall in the patient’s blood pressure and ventilation difficulties in a timely manner, as you incorrectly presumed the monitoring equipment was faulty.

18 Referencing the Guidance on Warnings, Mr Mills submitted that a warning would be appropriate. He submitted that your actions were of sufficient seriousness as to require a formal response from the GMC, and referenced the opinion of the expert report, and stated that you had provided ‘inadequate care that put the patient at risk of life threatening complications’. In reference to the purpose of warnings, Mr Mills submitted that they are appropriate in order to indicate to a doctor that they have departed from the standards expected of them, and that they should not repeat their actions noting that a Warning allows for identification of repeated conduct. He also referenced the need to maintain professional standards and to protect the reputation of the medical profession. Mr Mills highlighted that your conduct was a significant departure from paragraph 15 of Good Medical Practice (2013), which states that ‘you must provide a good standard of practice and care’ to patients.

19 Mr Mills submitted that a Warning would be proportionate, as whilst a Warning is available on the public register for five years, it would not amount to a finding of impaired fitness to practise or affect your registration.

Defence Submissions

20 On your behalf, Mr Anthony Haycroft submitted that the Committee should determine that the matter should not proceed further, under Rule 11 (6)(a) of the General Medical Council’s Fitness to Practice Rules (2004), and that the case should conclude with no further action.
21 In regards to the test for issuing a warning, Mr Haycroft submitted that whilst the criteria was met in this case, as you had made a serious mistake in which significant harm could have occurred, that this test exists as a filter and a gateway, and that it is at the Committee’s discretion as to whether a Warning is to be issued. He further submitted that if a Warning is appropriate, that it must accurately reflect the context of the situation.

22 Mr Haycroft submitted that the context in which the incident took place is of utmost importance. He submitted that you had made a serious error in judgment, but that it was only an error in judgment, and not a case in which you lack basic competence, experience or training. He drew the Committee’s attention to the context of the patient’s history of heavy smoking, that there was inadequate monitoring equipment, and that you had checked the patient the day before, and had agreed your proposed plan with the Consultant Anaesthetist who was due to work with you. He noted that you were relatively unknown at this hospital when the incident occurred, having worked mainly at a neighbouring trust. He stated that once the difficulty had persisted, you noted and addressed the situation properly. Mr Haycroft further stated that, whilst you readily accept that there was a potential harm to the patient, there was no evidence of patient harm in this case.

23 In regard to mitigation, Mr Haycroft stated that a risk of repetition is central to the issuing of a warning and submitted that in your case, there is no real risk of repetition. He drew the Committee’s attention to the fact that this was an isolated single incident, with no previous history across a career of nearly 36 years. He highlighted the supervisory reports provided by clinicians you worked with following the incident. In particular he drew reference to comments by Dr Madhaven which stated that there were no concerns, and that he (the supervisor) had received positive feedback on your performance. Mr Haycroft drew the Committee’s attention to the fact that you have always expressed your regret and made apologies for your actions, and that you had engaged in remedial activities, working on your communication, leadership skills, reflective practice, error management as well as anaesthetic technique. He also highlighted the positive testimonials that have been provided by your colleagues and the positive appraisal you had received in 2016.

24 Mr Haycroft made submissions on the content, proportionality and relevance of the draft warning that had been suggested by the Case Examiners upon conclusion of the case.

Committee Determination

25 In considering this case, the Committee had regard to the overarching objective of the GMC.
26 The Committee notes that you have not contested the allegations in any substance, and that you have apologised for your actions. It also took into account the various factors of mitigation, as highlighted by your representative.

27 In regards to the allegation that you had allowed an untrained healthcare assistant to ventilate the patient, the Committee determined that there was insufficient evidence to substantiate this and no evidence that the HCA who assisted lacked the clinical skills or that this was not usual practice within that Operating Theatre.

28 The Committee found that the allegation that you had failed to make a proper record of the dosage of phenylephrine was not made out.

29 The Committee noted that this was a single clinical incident, but that there were a number of indicators that the patient was unwell, which you missed namely the patient’s blood pressure, oxygen saturation and ventilation, concerns which were expressed by the ODP and ignored by yourself. The Committee accepted that you believed that the equipment was faulty and was giving incorrect readings, but that you realised that this was not so, only when the surgeon drew your attention to the colour of the patient’s blood. However, it notes that you had allowed the operation to continue regardless of the observations noted by the ODP, blaming the various indicators of the patient’s poor condition on the equipment. The ODP is there to assist the surgeon and anaesthetist and is an important member of the team, whose concerns should have been taken seriously.

30 This was a serious error of judgment on your part, which the expert described as ‘putting the patient at a significant risk of a life threatening complication’ and you accept this. The Committee remains unconvinced that there is no risk of repetition if you were to be involved in a similar set of circumstances. You have been subject to close supervision for a prolonged period and have provided satisfactory evidence of your technical skills, both during that period and in your career to date, but the Committee is concerned that in two of the supervisory reports provided by your colleagues, there are references to continued issues with your interpersonal skills. The report by Dr Madhaven on 28 February 2016 stated that ‘[you] may need to improve [your] interpersonal skills to enable [you] to work with all colleagues effectively without any issues’. The Committee is not satisfied that the attitudinal problem which gave rise to this matter has been fully addressed.

31 The Committee also took into account the evidence provided by the expert, Dr Nathanson, as laid out in his report, and accepted his opinion that the standard of care you provided to the patient was seriously below that which is expected of a middle grade anaesthetist.
The Committee determined that there had been a significant departure from Good Medical Practice (2013), in particular Paragraph’s 15 and 35. The Committee determined that in this case, a Warning is both appropriate and proportionate, in order to maintain public confidence in the profession, to act as a deterrent against failing to observe the state of the patient and failing to act upon the warnings from the monitoring systems, even when they were drawn to your attention by the ODP, as well as to mark this conduct as unacceptable to the wider profession. Doctors must listen to those around them who are there to protect their own, and the patient’s interests. Therefore it directs that the following warning to be attached to your registration:

“On 9 September 2014 you were the anaesthetist responsible for a patient who suffered a cardiac arrest on the operating table. The care you provided was inadequate in that you continued to perform an interscalene block despite the fact that the monitors indicated low blood pressure, low oxygen saturations and despite concerns expressed by the ODP. You also allowed surgical positioning to continue without ensuring the blood pressure and oxygen saturation were satisfactory. This placed the patient at significant risk of a life threatening complication.

The required standards are set out in Good Medical Practice (2013), in particular paragraph’s 15 and 35.

This conduct does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good Medical Practice and its associated guidance.

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

This warning will be published on the list of registered medical practitioners (LRMP) for a period of five years and will be disclosed to any person enquiring about your fitness to practise history. After five years, the warning will cease to be published on LRMP; however, it will be kept on record and disclosed to employers on request.’

You will be notified of this decision, in writing, in the next two working days.

That concludes the determination of the Investigation Committee in this case.