Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 13/11/2017 – 24/11/2017
14/05/2018 – 18/05/2018
31/07/2018 – 01/08/2018

Medical Practitioner's name: Dr Pantula SASTRY

GMC reference number: 5193261

Primary medical qualification: MB BS 1989 Berhampur University

Type of case
New - Misconduct

Outcome on impairment
Impaired

Summary of outcome
Erasure

Immediate order imposed

Tribunal:

Lay Tribunal Member (Chair)	Dr Matthew Fiander
Lay Tribunal Member:	Mrs Jillian Alderwick
Medical Tribunal Member:	Professor William Roche

Legal Assessor:	Mrs Julia Oakford
Tribunal Clerk:	Mr Matt O'Reilly

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Ms Sophie Garner, Counsel, instructed by the Medical Defence Shield
GMC Representative:	Ms Susie Kitzing, Counsel

Allegation and Findings of Fact

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

1. On 8 April 2014 your collection of stem cells from Patient A was inappropriate in that the bone marrow would not have had sufficient time to recover from the first stem cell collection on 18 March 2014. **Found Proved**

2. Between April 2014 and June 2014 your recommendation that Patient A undergo high dose chemotherapy with BEAM and autologous stem cell transplantation was inappropriate in that:

    a. Patient A had failed to mobilise an adequate number of CD34 positive cells; and/or
    Found Proved

    b. you did not know the number of CD34 positive cells which Patient A had mobilised.
    Found Not Proved

3. Between 16 and 25 June 2014 you proceeded to high dose chemotherapy with BEAM and autologous stem cell transplantation on Patient A which was inappropriate in that:

    a. an adequate number of CD34 positive cells/kg had not been collected; and/or
    Found Proved

    b. you did not know the number of CD34 positive cells/kg which had been collected.
    Found Not Proved

Attendance of Press / Public

The tribunal agreed, in accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004, that the press and public be excluded from those parts of the hearing where matters under consideration were deemed confidential.

Determination on Facts - 16/05/2018

1. The Allegation in this case relates to events in India. The Tribunal has jurisdiction in this case, albeit the events took place outside the UK, in accordance with Section 35C(3)(a)(i) of the Medical Act 1983.

Application to amend Allegation *– 13 November 2017*

2. At the outset of the hearing Ms Kitzing, Counsel, on behalf of the General Medical Council (GMC), made an application to amend paragraph 3 of the Allegation under Rule 17(6) of the GMC (Fitness to Practise) Rules 2004 ('the Rules'), as follows:

> "3. Between 16 and ~~23~~ 25 June 2014 you proceeded to high dose chemotherapy with BEAM and autologous cell transplantation on Patient A which was inappropriate in that:
>
> …"

3. Ms Kitzing submitted and Ms Garner agreed that there is an error in a date in the Allegation and accepted that, as the relevant date is 24 June 2014, the Allegation should be amended. The Tribunal was satisfied that the amendment could be made without injustice and determined to accede to the application and make the amendment.

Application for video-link *– 14 November 2017*

4. Ms Garner made an application to admit into evidence a letter dated 7 November 2017 and for Professor E to give evidence by video link if required.

5. Ms Kitzing made no objection, provided that Professor E's evidence concentrated solely on the Indian setting. She submitted that the GMC may wish to ask Professor E questions and requested that the GMC's expert witness be allowed to hear Professor E's evidence, then comment upon it.

6. The Tribunal accepted Professor E as a witness of fact and as an expert limited to the context of India only.

7. The Tribunal determined it was fair to hear Professor E's evidence and there was no unfairness to the GMC to hear the evidence in this context.

8. The Tribunal determined that it would require Professor E to give evidence and acceded to the application to allow evidence to be given via video-link.

Application to amend the Allegation *– 16 November 2017*

9. Ms Kitzing, made an application to amend paragraph 2 and 3 of the Allegation under Rule 17(6) of the Rules, by adding sub paragraphs 'a' and 'b' respectively to each of those charges, as follows:

> "2. Between April 2014 and June 2014 your recommendation that Patient A undergo high dose chemotherapy with BEAM and autologous cell transplantation was inappropriate in that:
>
> a. Patient A had failed to mobilise an adequate number of CD34 positive cells;
>
> b. you did not know whether or not Patient A had failed to mobilise an adequate number of CD34 positive cells.
>
> 3. Between 16 and 25 June 2014 you proceeded to high dose chemotherapy with BEAM and autologous cell transplantation on Patient A which was inappropriate in that:
>
> a. at least at least 2 x 10^6 CD34 positive cells/kg had not been collected;
>
> b. you did not know whether or not an adequate number of CD34 positive cells/kg had been collected."

10. In summary, Ms Kitzing submitted that it was appropriate to amend paragraphs 2 and 3 of the Allegation, as the GMC's understanding of the case had developed during the oral evidence of the GMC's expert witness Dr C, and also took into account your supplementary statement. She submitted that this is a complicated case and the detail had not been concisely encapsulated in the charge.

11. Ms Kitzing referred to your Rule 7 response to the GMC and the defence argument that whilst you state that it had not been possible to get the necessary number of CD34 cells, you then proceeded with your treatment of Patient A, stating that it was appropriate to do so.

12. Ms Kitzing referred the Tribunal to your supplementary witness statement, 9 November 2017 in which you state:

> "13. I was left with a difficult decision of either abandoning the procedure or proceeding with an uncertain CD34 result. If the CD34 was 0.05%, then as per my calculations this would be a CD34 count of 0.809 x 10^6. If the CD34 was 0.5%, then as per my calculations this would mean a CD34 count of 4.994 x 10^6/kg."

13. Ms Kitzing submitted that either you believed it was appropriate to proceed based on the CD34 results as set out in your Rule 7 response, or you were uncertain, as stated in your supplementary witness statement.

14. Ms Kitzing submitted that if you did not know the CD34 result, then that is not clearly reflected in the charges. She submitted that the proposed amendments arise out of the same facts and evidence that are already before this Tribunal and that it would be unjust to proceed and leave a lacuna because of the discrepancy. She submitted that the amendment could be made without injustice to you. Ms Kitzing accepted that it was clear that the GMC had not appreciated these factors at an earlier stage in the proceedings. However there was no new evidence of facts to be considered

15. In summary, Ms Garner submitted that the application to amend the charge is unnecessary, unjust, imprecise and unfair. She submitted that the GMC have brought the charge without considering what the evidence is and that the preparation of your defence of this case is based on the way the charge have been put. Therefore, it is unjust to amend the charge.

16. Ms Garner submitted that in the GMC's case examiners' correspondence, dated 23 February 2017, following your Rule 7 letter response, the GMC sets out their reasoning and were fully aware of your position in this matter based on your evidence and had made a decision as to the appropriate Allegation.

17. Ms Garner submitted that the GMC does not have the evidence to prove its case and is therefore moving the goal post. She submitted that this is a case following a complaint by Witness B, the son of Patient A. She submitted that it had not been clear by which standards you are being judged.

18. Ms Garner submitted that the issue in this case is whether your decision to proceed with the cell transplantation was appropriate based on the CD34 results and for that, the Allegation does not need to be amended. Ms Garner submitted that the proposed amendment refers to matters already considered by the case examiners and it is unjust to amend the charge.

19. The Tribunal has considered paragraphs 2 and 3 of the Allegation separately. In doing so it has considered the evidence relevant to this application. It has taken account of Ms Kitzing's submissions on behalf of the GMC and those made by Ms Garner on your behalf.

20. The Tribunal bore in mind Rule 17 (6) of the Rules as set out in Ms Kitzing's submission:

> 6. Where at any time, it appears to the Medical Practitioners Tribunal that -

(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and
(b) the amendment can be made without injustice,

it may, after hearing the parties, amend the allegation in appropriate terms.

Tribunal's Decision

21. In determining this application, the Tribunal had careful regard to the case examiners' analysis of the issues. The Tribunal finds that you were well aware of these issues which the amendment merely seeks to clarify.

22. The Tribunal had regard to the overarching objective as set out in Section 1 (1A) and (1B) of the Medical Act, namely to protect and promote the health, safety and wellbeing of the public; to promote and maintain public confidence in the medical profession; and to promote and maintain proper professional standards and conduct for the members of the profession. It was satisfied that the amendment could be made without injustice and determined to accede to Ms Kitzing's application to amend the Allegation. The Tribunal determined to further amend the Allegation.

23. The Tribunal determined the amended charges to be:

"2. Between April 2014 and June 2014 your recommendation that Patient A undergo high dose chemotherapy with BEAM and autologous cell transplantation was inappropriate in that:

a. Patient A had failed to mobilise an adequate number of CD34 positive cells; and/or

b. you did not know the number of CD34 positive cells which Patient A had mobilised.

3. Between 16 and 25 June 2014 you proceeded to high dose chemotherapy with BEAM and autologous cell transplantation on Patient A which was inappropriate in that:

a. at least 2 x 10^6 CD34 positive cells/kg had not been collected; and/or

b. you did not know the number of CD34 positive cells/kg which had been collected."

24. The parties raised no objection to the Tribunal's suggested amendment as compared to that proposed by the GMC. The Tribunal determined to make this amendment.

Application for telephone evidence – *17 November 2017*

25. Ms Kitzing made an application for telephone evidence to be heard as she requested that Dr C, GMC Expert Witness and Consultant Haemato-Oncologist, be recalled in light of the amendment to the charges. Due to Dr C's work commitments and availability, her attendance in person was not feasible. Ms Garner did not oppose the application, which was for the Tribunal to decide.

26. The Tribunal considered that, in the circumstances, it was in the interests of justice for Dr C to be recalled and to give further evidence on the telephone, and it determined to grant the application.

Tribunal decision to amend the Allegation – *15 May 2018*

27. During its private deliberations on the facts of the case, the Tribunal considered that an amendment to charge 3a of the Allegation may be required.

28. The Tribunal considered that the following amendment to charge 3a of the Allegation would address its concerns.

> "3. Between 16 and 25 June 2014 you proceeded to high dose chemotherapy with BEAM and autologous stem cell transplantation on Patient A which was inappropriate in that:
>
> ~~a. at least 2 x 10^6 CD34 positive cells/kg had not been collected; and/or"~~
>
> a. an adequate number of CD34 positive cells/kg had not been collected; and/or"

The Tribunal invited Ms Kitzing and Ms Garner to make submissions regarding the proposed amendment.

29. Ms Kitzing submitted that the rules do allow the Tribunal to amend the Allegation under Rule 17 if it can be made without injustice to the doctor. She submitted that the Tribunal heard significant evidence in this case about the number of CD34 cells and that if the Tribunal is of opinion the charges need to be amended to meet the evidence in this case then it can do so. Ms Kitzing submitted that the GMC have no objection to the proposed amendment.

30. Ms Garner objected to the proposed amendment. She submitted that the ongoing proceedings in India makes this difficult for you and the wording of the proposed amendment makes it evident which direction the Tribunal is going. She

submitted that the GMC have already had an opportunity to amend the Allegation in the way they are going to prove the case which was presented and if that evidence is insufficient then that should be an end to the matter. Ms Garner submitted that there is an issue of fairness to you as the GMC are having a third 'bite of the cherry' and that it would not be fair to proceed with the amendment.

31. Ms Garner submitted that the timing of this proposed amendment is at an exceptionally late stage in the proceedings. She submitted there is difficulty as evidence has not been aired to the specific issues in the wording of the proposed amendment, although this wording has already been used in relation to paragraph 2a of the Allegation. She concluded by submitting that the amendment seems particularly unfair as it appears to move the goal posts for a third time.

32. The Tribunal considered that the issue regarding adequacy of the CD34 count has been well aired in this hearing and considered that there is no injustice. The amendment reflects the evidence the Tribunal has heard. The Tribunal was satisfied that amending paragraph 3a of the Allegation is necessary to meet the Tribunal's overarching objective. The Tribunal therefore determined to amend paragraph 3a of the Allegation as it had proposed.

Background

33. You qualified with a MB BS from Berhampur University, India in 1989. You trained in Medical Oncology and Bone Marrow Transplant at Tata Memorial Hospital, Mumbai. In particular, from June 1997 – September 1998 you trained at the Royal Marsden Hospital in the UK in the Leukaemia and Myeloma units.

34. In December 2014, you were referred to the GMC by Witness B, who raised a complaint about the care you provided to his late mother, Patient A, in 2014. At the time of the incident you were working as a Consultant Medical Oncologist at Kokilaben Dhirubhai Ambani Hospital, Mumbai. You have been registered with the Maharashtra Medical Council (MMC) Mubai since 1993 and have held full registration with the GMC since 2003.

35. Witness B alleges that Patient A died following negligent treatment by you. Patient A had suffered from lymphoma in 2012 and following chemotherapy had gone into remission. In October 2013, Patient A relapsed. Following this, Patient A came under your care and you recommended R-ICE salvage chemotherapy followed by autologous cell transplant. The R-ICE salvage chemotherapy took place on 2-5 December 2013, 7-10 January 2014 and 3-5 February 2014.

36. Following the R-ICE salvage chemotherapy, cell harvesting took place on the 18 March 2014, 19 March 2014 and 8 April 2014. On 16 June 2014 Patient A was admitted to hospital for high dose chemotherapy with BEAM and autologous cell transplantation. Such high intensity treatment by its nature destroys the patient's own bone marrow and survival is dependent on successful regeneration of the bone

marrow from the patient's own stem cells that are infused after the chemotherapy. Between 17 and 22 June 2014 Patient A was given high dose chemotherapy. On the 24 June 2014 the cells that had been collected were reinfused.

37. Following the transplant Patient A developed a series of complications and her bone marrow and cell production had failed to recover in response to the transplant. Shortly before her death on 10 July 2014, the family of Patient A requested that you take no further part in her care.

Documentary evidence

38. The Tribunal was provided with supporting documentation on behalf of the GMC and yourself including agreed GMC and defence bundles which included expert reports, witness statements and extracts from the patient's case notes.

39. During the hearing, the Tribunal admitted on your behalf documents which included, but are not limited to:

- A defence bundle and supplementary defence bundle;
- A witness statement from you;
- A statement from Professor E;
- Journal articles and reports.

Oral evidence

40. You provided the Tribunal with oral evidence. In addition, the Tribunal heard oral evidence from:

- Witness B, son of Patient A.
- Dr C, GMC Expert Witness and Consultant Haemato-Oncologist. Dr C was subsequently recalled via telephone link.
- Dr D, Defence Expert Witness and Consultant Haematologist.
- Professor E, Consultant in Oncology, via video link.

<u>Witness B</u>

41. The Tribunal found Witness B to be a credible witness. It found his evidence to be consistent with the documentary evidence. He had good recall of the appointments he attended and of Patient A's treatment. It considered that Witness B did not embellish his evidence, acknowledging occasions when he was not present and stating that he was generally satisfied with his mother's care relating to her last admission.

Professor E

42. The Tribunal found that Professor E was neither an independent, nor impartial expert witness.

- Professor E and you had worked together at Tata Hospital and Jaslo Hospital in the 1990's.
- Professor E was the lead author on approximately 20 publications in which you were also an author and, by Professor E's own admission, you had worked closely together on these.
- Professor E had also told the Tribunal that he met you socially at conferences.
- Professor E was not familiar with the requirements of being an expert witness when he wrote his reports/letter.
- Professor E told the Tribunal that he had relied on others in writing his statement, specifically in relation to the CD34 results. He told the Tribunal that these were calculated by Dr F and Dr G.
- Professor E told the Tribunal that Dr F had previously worked at the same hospital and you were close colleagues.

43. The Tribunal was unable to place any reliance on Professor E's evidence as regards the transplantation procedures involved in the treatment of Patient A.

44. The Tribunal did find that Professor E gave clear evidence on the 'Indian context' generally. However, he could not assist the Tribunal with regard to clinical and laboratory procedures at Kokilaben Dhirubhai Ambani Hospital as he did not practise there and in his own unit cell tests were outsourced to external laboratories.

Dr C

45. Dr C has had extensive experience as an expert witness in fitness to practise hearings.

46. The Tribunal received Dr C's reports dated, 6 June 2016 and 16 September 2016, a letter dated 26 March 2017, a report dated 27 July 2017 and a supplementary report dated 14 November 2017.

47. The Tribunal received a joint report with Dr D dated 13 October 2017**.**

48. The Tribunal found Dr C's evidence to be clear, consistent and credible. She was careful to ensure that references to the literature were placed in the context of a GMC registered medical professional. She did not seek to go beyond her experience and expertise.

Dr D

49. Dr D has extensive experience as an expert witness in fitness to practise hearings.

50. The Tribunal received Dr D's reports dated 14 November 2016 and 20 August 2017. It also received her undated supplementary report produced at the hearing.

51. The Tribunal received the joint report with Dr C dated 13 October 2017**.**

52. You had worked in the leukaemia and lymphoma units at the Royal Marsden Hospital in the 1990's, including experience of bone marrow transplants when Dr D was working there as a consultant.

53. Dr D was acquainted with Professor E on a professional level following a voluntary work-based visit to India 23 years ago and then subsequently had met him at conferences.

54. In her evidence Dr D stated that she had changed her opinions since the joint experts' report. She stated she felt she had been pushed into the opinions expressed. The Tribunal considered Dr D to have been inconsistent in her opinions and not to have sustained the requirement to provide objective opinions. It appeared to the Tribunal that she had, to a degree, lost sight of her role as a professional witness in providing consistent and detached analysis.

Your evidence

55. The Tribunal drew no general adverse inference from you not answering direct questions clearly in your oral evidence. It considered that your answers being quite discursive may have been the product of a combination of cultural factors and the fact that your treatment of Patient A has been under scrutiny for some three years.

56. However, the Tribunal found that your evidence was at times evasive. For example, when asked if you had known the result of the third CD34 cell count, you stated that you would have done a further cell harvest. When asked why you would do another harvest, you did not answer.

57. In relation to a clear entry in Patient A's nursing notes 'WBC' which the Tribunal considered stands for white blood cells, you stated that you believed that the letter 'W' in the entry could equally have been the letter 'R' standing for red. The Tribunal determined that your assertion was wholly without foundation, disingenuous and designed to give credence to your assertion that Patient A's engraftment had begun.

58. The Tribunal found your evidence inconsistent and that at times you introduced information that appeared to fit the evidence as it unfolded.

59. When questioned about calculating CD34 cells and whether you used ideal or actual body weight, you made reference in your oral evidence that it was unusual for an Indian woman to be overweight and would therefore use actual body weight. When the Tribunal questioned you further on this you retracted this comment and stated that obesity in Indian women was a 'recent thing'.

60. The Tribunal noted that your explanations of your actions once you had recognised a discrepancy in the reports of the third harvest of CD34 cell harvest evolved as the hearing proceeded. In your explanation in your written statement you stated you were notified of the test results via telephone by a laboratory technician who stated the result was a CD34 cell count of 0.5% and that once you saw the written laboratory result you realised there was a discrepancy you said that you contacted the laboratory technician to investigate but they never responded to you. In your oral evidence you stated that you contacted the consultant who signed off the laboratory report but she avoided giving you a clear explanation. Then, later in your oral evidence, you stated that you went up to the laboratory and saw the laboratory register which stated 0.5%.

61. The Tribunal took the view that your oral evidence was not consistent with the explanations that you had previously provided in writing.

62. The Tribunal found that the way in which your account of events changed to fit the evidence casts doubt on your credibility.

63. The Tribunal considered your actions in relation to the third CD34 cell count laboratory report from the 8 April 2014 cell harvest and the consultation you had with Patient A and her family on 13 June 2014. You submitted in your oral evidence that at the time you were unclear whether the result was 0.5% or 0.05%. However, you told the Tribunal that both the case summary dated 7 July 2014 and the death summary you wrote some weeks later were written and signed by you and that these contained information in relation to the CD34 count which was incorrect. You told the Tribunal that you were under duress from the CEO of Kokilaben Hospital and were instructed to state on the case summary report the CD34 cell count was 0.05% as per the laboratory report. You stated that your presentation of this information in these reports was misleading, that you were of that opinion at the time and nonetheless you still wrote them and signed them.

64. The Tribunal took into account that the brief case summary report was to be used as a hand over document for the continuing care of Patient A.

65. The Tribunal also took into account that the death summary was required by the family to claim insurance.

66. The Tribunal accepted that you are of good character. However, examining the evidence, it has concluded that you at times sought to deliberately mislead the Tribunal. It has taken this into account when assessing the credibility of your evidence.

67. The Tribunal was unable to accept as reliable your evidence when it was contradicted by the evidence of another or was not supported by documentary evidence.

Tribunal's Approach

68. In determining the facts of this case the Tribunal applied the standards applicable to a GMC registered doctor albeit having full regard to the circumstances in which you were working in India.

69. The Tribunal is aware that in respect of the matters set out in the paragraphs of the Allegation the burden of proof rests with the GMC and the standard of proof is that applicable to civil proceedings, namely the balance of probabilities.

Tribunal's Decision

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

Allegation 1

1. On 8 April 2014 your collection of cells from Patient A was inappropriate in that the bone marrow would not have had sufficient time to recover from the first cell collection on 18 March 2014. **Found Proved**

71. The Tribunal placed weight the Joint Experts Report dated 13 October 2017, paragraph 1, which states:

> "[Dr D] was of the opinion that 4 weeks should be left before a further cell collection was attempted. [Dr C] was of the opinion that there should be a gap of 6 weeks between collections. Both were in agreement that a gap of 20 days was insufficient between the first and second cell collections."

72. The Tribunal considered Dr D's assertion in her supplementary report:

> "…Dr Sastry had the problem that, on the balance of probabilities based on her medical history, Patient A would experience disease relapse unless things were progressed rapidly. He was therefore obliged to compromise."

73. Whilst Patient A had relapsed previously and was at high risk for a further relapse, there was no evidence at the time of the third harvest to suggest the need to proceed to it with any such urgency that warranted proceeding outside the guidance period.

74. For these reasons the Tribunal found paragraph 1 of the Allegation proved.

Allegation 2 and 2a

2. Between April 2014 and June 2014 your recommendation that Patient A undergo high dose chemotherapy with BEAM and autologous cell transplantation was inappropriate in that:

    a. Patient A had failed to mobilise an adequate number of CD34 positive cells; **Found Proved**

75. In relation to paragraph 2 of the Allegation, the Tribunal first considered the evidence before it which was that the CD34 cell count at the third harvest was known to you. It was your case that you were aware of conflicting reports of this harvest; specifically 0.5% and 0.05%.

76. The Tribunal examined your medical note of the appointment of 13 June 2014 at Kokilaben Hospital. It is clear from that note that you recommended high dose chemotherapy with BEAM at that appointment.

77. In issue is the CD34 result of the third harvest. The Tribunal considered the screen shot of the laboratory report with a CD34 result of 0.05% in Patient A's medical records. It is stamped 'true copy and attested'. The laboratory report that confirms Patient A's CD34 cell count as 0.05% is signed off by the laboratory consultant.

78. You contended that the laboratory technician telephoned you to tell you that it was 0.5%. This number is recorded by the junior ward doctor on the ward discharge summary for Patient A which was approved by you.

79. However, you told the Tribunal that you did not rely on this result as you say that on the 13 June 2014 you were aware of a discrepancy between what the laboratory technician told you and what the laboratory test report stated. It is your case that having recognised the discrepancy, you ignored entirely the CD34 results and instead proceeded on the basis of the mononuclear cell count.

80. It is your case that you discussed the discrepancy in depth with Patient A and her family on 13 June 2014, and explained fully that your intentions were to use the mononuclear cell counts.

81. This is in contrast to the evidence of Witness B. In his written statement dated 12 May 2017:

> "Before the admission in June 2014 he simply took us through the day to day details i.e. what would be done on each day with regards to the administration of high dose chemotherapy and re-injection of harvested cells as well as where my mother would be staying throughout the hospitalisation. Going ahead with the cell transplant in a case of massively less than sufficient CD34 cells was never ever (during the entire period between February 2014 to June 2014) mentioned or discussed with me or my father or anyone for that matter. If it had been then we would never had gone ahead with this procedure…"

82. The Tribunal accepts Witness B's evidence that you neither explained the risks of proceeding with discrepant CD34 cell counts reports or that you were relying on the mononuclear count. Your contemporaneous note of the meeting makes no mention of this. Witness B is clear that you did not make any mention of this.

83. In your oral evidence you stated that, had you been aware of the low number of CD34 cells mobilised with Plerixafor, you would have performed a fourth harvest to generate the necessary number of cells. If your evidence is true, after the third harvest you were relying on the mononuclear cell count. The Tribunal would have expected to see evidence of a note to this effect and finds it remarkable there is no note.

84. A further issue the Tribunal took into account was that in your disregarding of the CD34 cell count and reverting to an older technology, you also departed from the recommendation of the other doctor's second opinion which was to proceed subject to sufficient numbers of CD34 positive cells. However, there was nothing in your notes to reflect your decision that you state you were relying on the mononuclear cell count contrary to the second opinion.

85. When asked by the Tribunal why the case summary dated 7 July 2014 and the death report written some weeks later both of which you wrote and signed stated the CD34 result as 0.05% you claimed to have deliberately presented misleading CD34 counts under duress from the hospital CEO.

86. The Tribunal considered your account of the creation of these documents very carefully. It found this account wholly implausible because you only introduced the notion of having deliberately included misleading information under questioning from the Tribunal. Further, when probed for details your answers lacked credibility.

87. The Tribunal does not believe your evidence that the laboratory technician told you by telephone that the result was 0.5%. Further it did not accept your claim, belatedly made when questioned by the Tribunal that, between 13 June and 16 June 2014, you visited the laboratory and saw for yourself an entry in the laboratory register stating that the CD34 result was 0.5%.

88. The cell count on which you proceeded to high dose chemotherapy with BEAM on Patient A was very significantly below the contemporaneous European and American guidelines for practice.

89. The Tribunal determined that your recommendation to proceed was inappropriate and it did not accept your account that the mononuclear cell count justified your decision, at the time, to proceed with high dose chemotherapy with BEAM. It considered the literature presented to the Tribunal in your defence which does not support the mononuclear cell count as an alternative measure of adequacy of harvest in circumstances where the CD34 cell count is below recommended guidelines.

90. On the balance of probability, the Tribunal determined that when you recommended high dose chemotherapy with BEAM to Patient A; you believed the CD34 positive cell count from the harvest on 8 April 2014 was 0.05% and that there was no uncertainty as to the CD34 count.

91. Notwithstanding Dr D's inconsistent evidence, the Tribunal placed considerable weight on the Joint Experts Report dated 13 October 2014:

> "Both experts agree that it was inappropriate for Patient A to have undergone high-dose chemotherapy with BEAM and autologous cell transplantation with an inadequate cell count (which was between 0.77 and 0.82x106 CD34 cells/kg)…"

92. Thus there was an issue over the appropriateness of your recommendation to proceed. Had you been aware of a discrepancy at the time the Tribunal is of the view that you would have raised it with Patient A and her family and noted it in the medical record. You would also not have produced misleading case summary and death summary documents.

93. In all circumstances the Tribunal found that there were not adequate CD34 cells mobilised to recommend proceeding with high dose chemotherapy with BEAM.

Allegation 2b

b. you did not know the number of CD34 positive cells which Patient A had mobilised. **Found Not Proved**

94. Given the Tribunal's finding in 2a in respect of your knowledge of the CD34 count following the third harvest, it follows that you did know that Patient A had failed to mobilise an adequate number of CD34 cells.

Allegation 3 and 3a

3. Between 16 and 25 June 2014 you proceeded to high dose chemotherapy with BEAM and autologous cell transplantation on Patient A which was inappropriate in that:

    a. an adequate number of CD34 positive cells/kg had not been collected; **Found Proved**

95. It is common ground between parties that you proceeded to high dose chemotherapy with BEAM and autologous cell transplantation on Patient A on the relevant dates.

96. The Tribunal accepted the evidence of the experts that the established method for assessing the number of available stem cells for transplantation is the number of CD34 positive cells per kilogram of body weight.

97. The Tribunal accepted Dr C's evidence in which she stated that the assessment of CD34 cells was a more accurate method of counting stem cells and that this had replaced the mononuclear cell count which she regarded as no longer relevant.

98. It is your case that you used mononuclear cell count instead of CD34 because you believed the CD34 results unreliable. However, as the Tribunal found in its determination in relation to paragraph 2a of the Allegation, you were aware that the CD34 count of the third harvest was 0.05%. The Tribunal found that at the time you recommended high dose chemotherapy with BEAM there was no uncertainty as to the CD34 count.

99. You claim to have seen the 0.5% in the ward discharge summary and you had viewed this in the laboratory register between the 13 and 16 June 2014. The Tribunal has already rejected your claim that you saw 0.5% in the laboratory register. The Tribunal found that there was no further information available to you which would call into question the CD34 report of 0.05% reported by the laboratory on the certified test results sheet. Therefore, when you proceeded with high dose chemotherapy with BEAM you did so on the same basis as when you recommended it on the 13 June 2014.

100. When asked to explain by the Tribunal about the CD34 stem cell count, you acknowledged the importance of CD34 counts. Indeed, you told the Tribunal that had you known that the result was 0.05% you would have attempted a fourth harvest. When asked for reasons for this, your responses were evasive;

"Q …When it came to the post-plerixafor harvest, am I correct that you said that if you had known that it was low, you would have attempted another harvest?

A Yes, sir, definitely. I would have probably attempted another harvest on 9 April.

Q Why would have attempted another harvest, Doctor?

A I have already stimulated the cells enough with the...

Q I know what you have done. I am asking you very specifically: what would have made you attempt another harvest? What in the reports would have made you decide to attempt another harvest?

A If it was 0.05%, the calculations are leading to a sort of still relatively figure which is lower than the guideline figure, so I would have probably thought of making another attempt on the next day.

Q Why would it have been important to acquire more CD34+ cells?

A By understanding CD34 is a marker for the stem cells...

Q I think we have heard that in great detail, Doctor. I am asking you very specifically: why would you have considered at short notice getting access to the apheresis machine again in order to do another harvest? What was the importance of the CD34 cells that if you had known, you would have done another harvest?

A It would have been considered, sir; because the CD34 has been low, that is why the second attempt was being made, so I would have tried to maximise the benefit of the plerixafor.

Q What would the benefit have been to the patient?

A Sorry, sir?

Q What would the benefit have been to the patient if you had conducted a second harvest?

A The benefit if I had collected a bit more stem cells, CD34 cells, is unquantifiable for me, sir.

> Q I am sorry, Doctor, but I am now confused and it may be my fault. Why would you do this if there was no quantifiable benefit?
>
> A It is just to try to somehow get to a bit more of the CD34. All along, I was very happy with the total cells, with the mononuclear. The CD34 reports seemed unreliable, but then I still thought I will give it another go.
>
> Q I appreciate, Doctor, that you had in mind to give it another go, but I am trying to establish why you had that in mind. What benefit did you see to the patient of taking the apheresis machine for a number of hours again, bringing the patient in again? There must have been some reason to do this and I am trying to establish what, in your mind, was the reason for potentially attempting to harvest more CD34 cells?
>
> A The more CD34 I could have probably collected was based on the general understanding that CD34 stands as a marker for the stem cells."

101. The Tribunal has concluded that when you proceeded to high dose chemotherapy with BEAM not only were you fully aware of the low CD34 cell count of 0.05% but also of its significance in your treatment of Patient A at Kokilaben Dhirubhai Ambani Hospital.

102. Dr C stated in her reports the CD34 per kilogram collected based on the data provided by Witness B was 0.47 $x10^6$/kg.

103. The Tribunal considered carefully the case summary and death summary you produced. It took into account that in these documents you quote the total mononuclear cell count per kilogram body weight and the percentage of CD34 cells as per the combined cell harvests on the 18 and 19 March 2014 and for the cell harvest on the 8 April 2014. The results that you state in your case summary and your death summary corroborate the 0.47 $x10^6$/kg as cited by Dr C in her reports. The Tribunal was satisfied that this was the actual number of cells with which Patient A was treated. Thus, the Tribunal concluded that the true number of CD34 cells/kilogram collected was below the minimum numbers quoted by you and by the experts as being supported by the literature as appropriate for attempting high dose chemotherapy and transplantation. In your statement dated 22 September 2017, you said;

> "115. As the total number of CD34 infused is above 0.75$x10^6$ /kg which is a level at which successful engraftment has been documented in scientific literature and referred to by Dr D in her report dated 14 November 2017, the contention that low CD34 counts have resulted in the patient death is incorrect."

104. It appears that subsequent figures quoted by you and the experts were not based on the patient's actual body weight and therefore did not reflect the calculated number of cells per kilogram that you gave in the care summary and the death summary.

105. For all the reasons above, the Tribunal has found paragraph 3a of the Allegation proved.

Allegation 3b

b. you did not know the number of CD34 positive cells/kg which had been collected. **Found Not Proved**

106. Given the Tribunal's finding in 3a in respect of your knowledge of the CD34 count following the third harvest, it follows that you did know the number of CD34 cells per kilogram which had been collected.

Determination on Impairment - 18/05/2018

1. The Tribunal now has to decide in accordance with Rule 17(2)(k) of the Rules whether, on the basis of the facts which it has found proved, your fitness to practise is impaired by reason of your misconduct.

The Evidence

2. The Tribunal has taken into account all the evidence before it at the facts stage of the hearing, both oral and documentary. Ms Garner on your behalf, provided the Tribunal with a supplementary defence bundle which included:

- A supplementary witness statement from you;
- Evidence of courses and continuous professional development ('CPD') undertaken;
- Testimonials.

GMC Submissions

3. In summary, Ms Kitzing submitted that this Tribunal relied on the expert evidence of Dr C and Dr D in this case in which the experts' opinion was that your conduct fell seriously below that which is expected of a medical professional. She submitted that the facts found amount to misconduct that is serious.

4. Ms Kitzing reminded the Tribunal it should have regard to the overarching objective and submitted that all three limbs are engaged. She submitted that whilst you do not carry out stem cell transplantation work in the UK, there are issues of record keeping and matters of communication with Patient A and her family which

could happen again in the UK. She submitted that a reasonable and well informed member of the public would be dismayed if a finding of impairment was not made and that public confidence in the medical regulator and the maintenance of proper professional standards in the medical profession would be undermined.

5. Ms Kitzing referred the Tribunal to the relevant legal principles and the relevant paragraphs of Good Medical Practice 2013 ('GMP'). She submitted that your fitness to practice is impaired; that you have shown no insight; that there have been no admissions and you have given alternative accounts. She submitted that whilst you have produced a supplementary statement and evidence of some CPD, it does not show appreciation of the factors that are a matter for concern in this case. She submitted that you have brought the medical profession into disrepute and for these reasons your misconduct was serious and your fitness to practise remains impaired.

Submissions on your behalf

6. In summary, Ms Garner submitted that the matters before this Tribunal should be considered in light of the Indian context as they would never have occurred in the UK. She submitted that you are currently working in the UK and the Tribunal has read the letters from your colleagues stating you provide a good level of patient care and that you adhere to all procedures and guidelines. Ms Garner submitted that the matters before this Tribunal were unlikely to be repeated. She submitted that the features in this case are unusual as UK practice differs from the Indian context where there are no national or even hospital guidelines regarding the level of CD34 cell count to be collected to proceed with stem cell transplantation. Ms Garner submitted that you had to act on the best information available and in the absence of any guidelines. She invited the Tribunal to consider all the factors that had been set out in this hearing in relation to the Indian context.

7. Ms Garner submitted that Patient A and her family had copies of the medical reports themselves and that Witness B had stated in his evidence that you had explained the process of treatment throughout. She submitted that the matters before this Tribunal were not something that had been done on purpose and there had been a full discussion with Patient A and her family. She asked the Tribunal to take into account that patient consultations in India are different from those in the UK.

8. Ms Garner submitted that impairment in this case could only relate to those paragraphs of GMP relating to your failure in patient communication and record keeping as already set out by Ms Kitzing. She submitted that there is no risk of repetition or harm to patients in the future. She reminded the Tribunal that you are now practising in the UK, but not in the area of stem cell transplantation. She submitted that you did the best you could with the facilities available and that your decisions did not fall below that which is set out in GMP and can be judged correct with hindsight. Ms Garner submitted that you had not done anything in the UK that would dent the public's confidence in the medical profession.

9. With regards to insight Ms Garner submitted that you appreciate the situation that you are in.

The Tribunal's Approach

10. In making its decision, the Tribunal took into account all the evidence adduced as well as the submissions made on your behalf and those on behalf of the GMC. The Tribunal reminded itself that the decision as to whether your fitness to practise is currently impaired is a matter for this Tribunal alone, exercising its own judgment. In so doing, the Tribunal had particular regard to its statutory overarching objective of protecting the public which includes: protecting and promoting the health, safety, and wellbeing of the public; promoting and maintaining public confidence in the medical profession; and promoting and maintaining proper professional standards and conduct for members of the profession.

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

12. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: firstly, whether the facts as found proved amounted to misconduct, and that the misconduct was serious; and secondly, whether the misconduct could lead to a finding of impairment.

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

The Tribunal's Decision

Misconduct

14. The Tribunal firstly considered whether the facts found proved amounted to misconduct that is serious. In so doing, it considered the relevant legal principles and went on to consider the relevant paragraphs of GMP.

15. The Tribunal considered paragraphs 7 and 14, which state, respectively:

> "7. You must be competent in all aspects of your work, including management, research and teaching."
>
> "14. You must recognise and work within the limits of your competence."

The Tribunal considered the joint experts' report from Dr D and Dr C, dated 13 October 2017 which states:

> "Both experts note that Dr Sastry is a medical oncologist, in the opinion of both experts he has:
>
> 1. Not completed a training scheme in haematology or in medical oncology that would enable him to manage patients who have undergone autologus stem cell transplantation…
>
> 4. Has insufficient training in stem cell transplantation and this has not been part of his work in the UK since 1998 (he spent a year at the Royal Marsden Hospital in 1997/98), and neither was it part of his role in locum roles he undertook in the UK between 2006-2008 and from October 2014 onward…"

Having taken the experts' opinions into account, the Tribunal satisfied itself that your conduct breached paragraphs 7 and 14 of GMP.

16. The Tribunal considered paragraph 16 a, b and c of GMP, which states:

> "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 needs
>
> b. provide effective treatments based on the best available evidence
>
> c. take all possible steps to alleviate pain and distress whether or not a cure may be possible…"

The Tribunal has already determined that the numbers of CD34 cells available were not adequate for proceeding with autologus stem cell transplantation and that you should neither have recommended nor proceeded with high dose chemotherapy with BEAM. The Tribunal satisfied itself that your conduct breached paragraph 16 a, b and c of GMP.

17. The Tribunal considered paragraph 17 of GMP, which states:

> "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."

The Tribunal determined, as it has already set out in its determination on the facts, that you did not fully inform Patient A of the CD34 cell count, or of the full implications of proceeding with your treatment plan without the necessary CD34 cell count. Patient A was therefore unable to provide fully informed consent to your

treatment plan. In this regard, the Tribunal satisfied itself that your conduct breached paragraph 17 of GMP.

18. The Tribunal considered paragraphs 19 and 21 of GMP, which state, respectively:

> "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:
>
> …
>
> b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions
>
> c. the information given to patients…"

The Tribunal bore in mind your evidence regarding the Indian context and different practices when considering paragraphs 19 and 21 of GMP. The Tribunal had particular regard to the medical note, dated 3 March 2014, from the doctor who provided a second opinion for Patient A and her family. The Tribunal considered that this medical note is a record from the doctor giving a second opinion confirming that in his consultation regarding Patient A matters were discussed in detail; he advised that Patient A is a candidate for high dose chemotherapy and autologus stem cell transplantation given the good response to salvage chemotherapy; based on the collection of a sufficient number of CD34 stem cells and then referring Patient A back to you. The Tribunal determined that the doctor who provided the second opinion produced a full and clear note which was in stark contrast to the note you made of the consultation on 13 June 2014. The Tribunal took into account that the second opinion doctor note was made in the Indian context. Furthermore, It considered that the evidence of the medical record from the doctor providing the second opinion referring to a 'sufficient number of cells (CD34)' suggests that in the Indian context sufficient CD34 was a valid concept which refers to standards which are well known and accepted in the Indian context. For these reasons, the Tribunal satisfied itself that your conduct breached paragraphs 19 and 21 of GMP.

19. The Tribunal considered paragraph 32 of GMP, which states:

> "32. You must give patients the information they want or need to know in a way they can understand…"

As the Tribunal has already set out in its determination on the facts; you did not inform Patient A of the implications of proceeding with an insufficient CD34 cell count. It considered that whilst Patient A and her family may have had the medical report with the CD34 cell count result, the Tribunal determined that the

responsibility to fully explain these results and their significance to the patient was yours. For these reasons, the Tribunal satisfied itself that your conduct breached paragraph 32 of GMP.

20. The Tribunal considered paragraph 49 of GMP, which states:

> "49. You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:
>
> a. their condition, its likely progression and the options for treatment, including associated risks and uncertainties
>
> b. the progress of their care, and your role and responsibilities in the team…"

The Tribunal determined, as it has already set out in this determination, that you did not share necessary information with Patient A in order for her to make informed decisions. The Tribunal satisfied itself that your conduct breached paragraph 49 of GMP.

21. The Tribunal considered paragraph 57 of GMP, which states:

> "The investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options…"

The Tribunal considered the experts' opinion from their joint report, dated 3 March 2017, which states:

> "In [Dr D's] opinion, Dr Sastry's care was below the standard of care of a reasonable competent consultant medical oncologist, specialising in stem cell transplantation in proceeding to high dose chemotherapy and autologus stem cell transplantation with a CD34 count between 0.77 and 0.82 x 106 CD34 cells/kg.
>
> In [Dr C's] opinion, Dr Sastry's care was seriously below the standard of care of a reasonable competent consultant medical oncologist, specialising in stem cell transplantation in proceeding to high dose chemotherapy and autologus stem cell transplantation with a CD34 count between 0.77 and 0.82 x 106 CD34 cells/kg.
>
> With such a low stem cell count both experts agree an autologus stem cell transplant, should not have been recommended or offered."

The Tribunal accepted the experts' opinion that the treatment you provided to Patient A should not have been recommended or proceeded with, that your clinical

judgment in knowing the CD34 cell count was not sufficient or in the best interest of Patient A's needs or priorities.

22. The Tribunal accepted the experts' opinion in which both Dr D and Dr C stated that the standard of care you provided to Patient A fell below that of a reasonably competent consultant medical oncologist specialising in stem cell transplantation. Furthermore, it accepted the experts' opinion that the total number of CD34 positive cells in relation to mobilisation and their collection were substantially below the level at which the experts thought it was inappropriate to proceed.

23. The Tribunal determined that your misconduct breached multiple paragraphs of GMP. It rejected the notion, advanced by Ms Garner, that your actions were an isolated incident as your treatment of Patient A spanned two months from the third harvest of CD34 stem cells to progression to high dose chemotherapy with BEAM treatment. The Tribunal considered that this was not a treatment that was so urgent as to require an early third harvest. You had two months during which you were aware of the low CD34 cell count and had time to reflect on this, think about your treatment plan and discuss it with your colleagues in order to make a decision in the best interest of Patient A.

24. For the reasons set out above, it determined that your conduct amounted to serious misconduct.

Impairment

25. The Tribunal reminded itself that you are entitled to challenge the Allegation against you. It did not equate the fact of your challenge with a lack of insight on your part.

26. The Tribunal next considered if your misconduct was remediable. It had regard to the joint experts' report, dated 3 March 2017, in which it was the view of Dr C and Dr D that you did not have the necessary level of training that would enable you to manage patients who have to undergo autologus stem cell transplantation. The Tribunal therefore determined that, in so far as having the necessary knowledge and skills required, your misconduct is potentially remediable.

27. The Tribunal went on to consider if your misconduct had been remediated. It had very serious concerns about your attitude regarding the treatment you provided to Patient A. It bore in mind that you have not demonstrated any recognition regarding the concerns of this Tribunal or acceptance that you did anything wrong in your treatment of Patient A. It determined that this demonstrates very little insight into your failings.

28. Furthermore, the Tribunal considered that you had demonstrated knowledge during these proceedings in that you knew it to be inappropriate to proceed with

autologus stem cell transplantation with a CD34 count lower than 0.75 x 10^6 CD34 cells/kg. Given this position and that you recommended and proceeded with an autologus stem cell transplantation with a CD34 cell count of 0.47 x 10^6 cells per/kg, the Tribunal determined that this further demonstrates your lack of insight into your failings in this case.

29. The Tribunal considered your failure to fully inform Patient A of the importance of the CD34 count, the implications that went with this failure and therefore a failure to obtain fully informed consent for your treatment plan. It determined that these factors and your failings in the management of Patient A's treatment demonstrates a lack of insight. The Tribunal determined that during this hearing you repeatedly sought to mislead it. It determined that this is a further indication that your insight is poorly developed. Whist the Tribunal acknowledged your supplementary statement and CPD undertaken, it was not satisfied that this went far enough to demonstrate insight into your actions or that you had addressed any of the concerns before this Tribunal. For these reasons the Tribunal was not persuaded that you have remediated your misconduct.

30. The Tribunal went on to consider whether there is a risk of repetition of your misconduct. It considered that you are currently working as a locum consultant in the UK in a different area of practice. The Tribunal was satisfied that you would not work in the area of autologous stem cell transplantation in the UK without further training. Whilst the Tribunal heard submissions that the MDT process in the UK could contribute to the prevention of recurrence, it took into account that you were aware of a clear opinion in India regarding the need for sufficient CD34 cells. For reasons that are entirely unclear, you choose to ignore that opinion. The Tribunal was concerned that your attitudes and behaviors evident in this case might not be confined to a particular medical procedure. In the absence of insight, reliance should not be placed on external arrangements for a doctor to avoid repeated misconduct. The Tribunal considered that that similar behavior in your practice as a medical oncologist might occur in future. It bore in mind that you had worked in India providing autologus stem cell transplantation treatment to patients when you were not sufficiently trained to do so. It was not satisfied that you would not again practise elsewhere in this area of practice without first having remedied your failings. It saw no evidence that you had addressed the matters before this Tribunal. The Tribunal therefore determined, in considering all these factors and your lack of insight, that there is a real risk of harm to patients.

31. The Tribunal determined that a reasonable and well informed member of the public would find it unacceptable and disgraceful that a doctor proceeded with high dose chemotherapy with BEAM in the knowledge that there were not sufficient CD34 stem cells available to enable that patient to recover.

32. The Tribunal determined that in all circumstances your serious misconduct undermined the three limbs of the overarching objective.

33. The Tribunal therefore determined that your fitness to practice is currently impaired by reason of your serious misconduct.

Determination on adjournment and Interim order - 18/05/2018

1. The Tribunal has completed stage two and handed down its determination on impairment. There is insufficient time in the scheduled hearing to complete stage three of the case. Therefore, the Tribunal has decided to exercise its powers under Rule 29(2) of the Rules to adjourn the hearing of these proceedings until 31 July 2018 when it will reconvene for 2 days until 1 August 2018, which is a time that has already been identified as convenient by the Tribunal and the parties. The Tribunal therefore asked the parties if they had any further application prior to this hearing adjourning.

Submissions

2. Ms Kitzing made an application for an interim order of suspension under section 41A of the Medical Act 1983 to be imposed as it is necessary for public safety and is otherwise in the public interest. She submitted that this Tribunal has already found that you have a lack of insight into your misconduct and that there is a real risk of repetition.

3. Ms Garner submitted that there is no risk of harm to patients or risk to the public and that nothing would be served by imposing an interim order of suspension on your medical registration at this time and that there have been no incidents or concerns in the 4 years since the matters before this Tribunal occurred. She submitted that you previously had an interim order of conditions imposed on your registration and that they were revoked but that you continue to adhere to them voluntarily.

The Tribunal's Determination

4. The Tribunal first considered whether an order is necessary. It determined that given the Tribunal's specific findings in relation to the risk of harm to patients and the strong public interest considerations in this case, the public would not be adequately protected and the public interest would not be met were an order were not made.

5. The Tribunal next considered what order it should impose. It first considered if an interim order of conditions would be appropriate. It considered that whilst conditions may protect the public, given its findings at the impairment stage, the public interest would not be adequately served by imposing an interim order of conditions on your registration.

6. The Tribunal determined that based on its concerns regarding your serious misconduct; the fact you went ahead with high dose chemotherapy with BEAM in the knowledge that there was not sufficient CD34 cells; its serious concerns about your lack of insight and therefore the real risk of repetition and that a well-informed member of the public would expect that this Tribunal would suspend your registration. The Tribunal determined that public confidence in the medical profession would be undermined if an order of suspension was not imposed on your medical.

7. The Tribunal determined that it is necessary to protect the public and that it is otherwise in the public interest that an interim order of suspension be imposed for a period of 4 months. This will allow time for these matters to be concluded.

8. The order will take effect from today. Notification of this decision will be served upon you in accordance with the Medical Act 1983, as amended.

Determination on Sanction - 01/08/2018

140. Having determined that your fitness to practise is impaired by reason of your misconduct, the Tribunal has now considered what action, if any, it should take with regard to your registration.

141. In so doing, the Tribunal has given careful consideration to all the evidence adduced before it, the submissions by Ms Garner on your behalf and the submissions by Ms Kitzing on behalf of the GMC.

GMC Submissions

142. In summary, Mr Kitzing referred the Tribunal to the relevant paragraphs of the Sanctions Guidance (February 2018) ('SG'). She submitted that the appropriate sanction is a period of suspension. She submitted that the SG states GMP is the benchmark that doctors are expected to meet and that this Tribunal has found you to have breached GMP.

143. Ms Kitzing submitted that taking no action would be wholly inappropriate in this case and that the imposition of conditions would not meet the need to maintain public confidence in the profession.

144. Ms Kitzing submitted that a period of supervision through conditions might protect the public but would not address your current shortcomings or the factors identified by this Tribunal as set out in its determination at Stage 2 of these proceedings.

145. Ms Kitzing submitted that this Tribunal found at Stage 2 that your attitude and behaviour regarding your treatment of Patient A may not be confined to a particular medical procedure. She submitted that this reflects on your lack of insight. She submitted that there are no specific areas identified in your behaviour, but there are more global issues.

146. Ms Kitzing submitted that whilst there is some evidence of Continuing Professional Development, there is a question as to the adequacy of this. She submitted that you have not shown a willingness to accept that the CD34 cell count was not sufficient. Ms Kitzing submitted that all these factors indicate that the imposition of conditions would not be sufficient, appropriate or workable, or meet the need to address the overarching objective in this case.

147. Ms Kitzing submitted that your conduct was not incompatible with continued registration but that you made no admissions. She raised the likelihood of repetition and submitted that you have demonstrated a deficiency in performance, a risk to patient safety and lack of insight.

148. Ms Kitzing submitted that given the findings of this Tribunal, the serious breaches of GMP and your undermining of the overarching objective, that a period of suspension is the appropriate sanction. She stated that while the GMC did not seek erasure, that the Tribunal may consider that sanction. She submitted that suspension would have a deterrent effect.

Submissions on your behalf

149. In summary, Ms Garner submitted that the Tribunal should take into account the facts that you are of good character and have successfully practised in the UK and abroad without complaint regarding any aspect of treatment over many years.

150. Ms Garner submitted that the decisions made by this Tribunal were with regard to the application of GMP for a doctor practicing in India. She submitted that in relation to the facts and impairment stages, there had been little reference to the realities that you were facing.

151. Ms Garner referred the Tribunal to the Indian Medical Council rules. She submitted that you are subject to litigation in India and the proceedings in India are very different to those in the UK. Ms Garner submitted that doctors in India do not have the protection of the Compensation Act and that if you make an expression of apology or regret, it may be viewed differently to how it would be perceived in the UK.

152. Ms Garner submitted that there has been a four year lapse of time since the matters before this Tribunal occurred and that there has been no repeated

behaviour or further concerns raised. She drew the attention of the Tribunal to the letters from your clinical colleagues in the UK.

153. Ms Garner submitted that you have been hampered in the presentation of your case as you have not had access to Kokilaben Dhirubhai Ambani Hospital's resources or records, as you may have had, had these matters occurred in the UK. She submitted that the GMC themselves were denied their request for documentation from the Hospital. She submitted that for this reason you have had to present your case with limitations, a situation in which a doctor would not normally find themselves.

154. Ms Garner submitted that whilst the Tribunal disregarded the conditions under which you were working at Kokilaben Dhirubhai Ambani Hospital, it does not mean those conditions did not exist, or that you did not consider them in your decision making.

155. Ms Garner submitted that you are now fully aware of the deficiencies in your practice the Tribunal has identified, accepting that the remediation undertaken so far had not been exactly as the Tribunal may have wished. Ms Garner submitted that those areas identified are remediable and can be addressed through the imposition of conditions.

156. Ms Garner submitted that you are a practitioner who is well-regarded by his colleagues and invited the Tribunal to review the colleague and patient feedback. She submitted that you are a doctor who is able to think about what factors need to be taken into account when making clinical decisions, listen to others and take advice.

157. Ms Garner submitted that there is a very low risk of harm to patients and the public, and that a period of suspension is not warranted. She submitted that there has been four years of 'future' since these matters occurred during which there has been no repetition. Ms Garner submitted that there had been an interim order of conditions in place that was lifted, but you continued voluntarily to observe the conditions.

158. Ms Garner acknowledged that the Tribunal had found that you have breached GMP, and contended that the Tribunal considers your conduct to be remediable. She reminded the Tribunal that there had been no allegation of dishonesty in this case. She submitted therefore, that should the Tribunal consider a period of suspension, as opposed to conditions to be the appropriate sanction, any period of suspension should be as short as possible.

Tribunal's Approach

159. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgement.

160. In reaching its decision, the Tribunal has taken account of the SG. It has borne in mind that the purpose of sanctions is not to be punitive, but to protect patients and the wider public interest, although sanctions may have a punitive effect.

161. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing your interests with the public interest. It has taken account of the statutory overarching objective, namely to protect and promote the health, safety and wellbeing of the public; to promote and maintain public confidence in the medical profession; and to promote and maintain proper professional standards and conduct for the members of the profession.

162. The Tribunal has already given a detailed determination on impairment and it has taken those matters into account during its deliberations on sanction. The Tribunal was aware of Ms Garner's submission that your defence was hampered by the lack of documentation available to you. However, it was satisfied that it had seen sufficient documentary evidence, taken together with oral testimony, to properly determine the appropriate sanction in this case.

Mitigating Factors

163. The Tribunal found the following mitigating factors:

- There are no previous or subsequent regulatory findings in the UK;
- You have been practicing at an acceptable level since these events;
- There was no MDT structure in Kokilaben Dhirubhai Ambani Hospital, as you would have been used to in the UK. Whilst the Tribunal considered this in mitigation, it noted that you had seen a documented second opinion;
- Palliative care in India is less well developed than in the UK;
- You provided evidence of some non-targeted Continuing Professional Development;
- You provided positive testimonials from recent colleagues.

Aggravating Factors

164. The Tribunal found the following aggravating factors:

- Your actions left Patient A with no realistic chance of survival;
- You were practising in an area outside your specific expertise;
- You made no expression of remorse, regret or apology;
- Whilst the Tribunal accepts that denial is not an aggravating factor, it found that you had attempted repeatedly to mislead it;
- You were not open and honest in your evidence to this Tribunal;
- You demonstrated a complete lack of insight into your failings and their consequences.

No Action

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

166. The Tribunal determined that having found your fitness to practise impaired by reason of your misconduct, your lack of any insight and the risk of repetition, taking no action would not be sufficient to meet the overarching objective. Furthermore, the Tribunal did not consider the Indian context in relation to the clinical procedure to amount to exceptional circumstances that would justify taking no action.

Conditions

167. The Tribunal next considered whether it would be sufficient to impose conditions on your registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

168. The Tribunal bore in mind that you have not demonstrated any insight into your actions regarding the matters before this Tribunal. Furthermore, the Tribunal considered that whilst conditions may address learning and training needs, they cannot address adequately the attitudinal issues it identified at Stage 2, including those which underpinned your attempts to mislead this Tribunal.

169. The Tribunal was mindful of its requirement to impose the least restrictive sanction, consistent with its requirement to meet the overarching objective. Given

the seriousness of your actions, the Tribunal determined that conditions would not protect the public, be in the public interest, and would not maintain public confidence in the medical profession. As such, the Tribunal determined that it would not be sufficient or proportionate to direct the imposition of conditions on your registration.

Suspension

170. Having decided that conditions would be neither sufficient nor proportionate, the Tribunal then went on to consider whether a period of suspension would be an appropriate and proportionate sanction. In so doing it noted paragraphs 92 of the SG which states:

> "92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession)."

171. The Tribunal considered the seriousness of its findings, in particular, that you recommended and knowingly carried out a procedure which would leave Patient A with no realistic chance of survival.

172. The Tribunal considered that once you commenced the course of treatment of high dose chemotherapy with BEAM without adequate CD34 cells, the outcome was inevitable. The Tribunal considered these actions amounted to an extremely serious failure and fell far below the standards expected of a doctor.

173. The Tribunal considered the submission from Ms Garner regarding the reasons that there had been no apology from you, namely, the impact that any apology may have on ongoing proceedings in India. The Tribunal was of the view that at least some attempt could have been made to address your duty under GMP in this regard albeit acknowledging the limitations you may have been under as a consequence of the proceedings elsewhere. In any event, the Tribunal considers that the prime reason that you have made no apology or expression of remorse is that you maintain that you did nothing wrong. The Tribunal found no acceptable justification for your lack of apology or your repeated attempts to mislead it.

174. The Tribunal considered paragraphs 108 and 109 of the SG, which state:

> "108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain

public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.

109 Any of the following factors being present may indicate erasure is appropriate…

a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.

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[…]

…

j Persistent lack of insight into the seriousness of their actions or the consequences."

175. Whilst the Tribunal recognised that this is one episode of misconduct relating to one patient, your behaviour in proceeding to high dose chemotherapy with BEAM, in the particular circumstances of this case represents a blatant disregard for the well-established safeguards for such treatment. Your reasons for disregarding them remain unclear. Furthermore, it found that you were working outside your area of expertise when you treated Patient A. It found that you did not obtain informed consent to proceed with the high dose chemotherapy with BEAM. The Tribunal found that you were not open in your communication with Patient A and her family. It took into account that you say that you provided misleading information in both the handover case summary and in the death summary. The Tribunal considered that you maintained that your judgment was shown to be correct even with the benefit of hindsight and you have not accepted any responsibility for your wrongdoing. Taken as a whole, your misconduct represents a very serious departure from the principles of GMP.

176. The Tribunal has no doubt that your actions placed Patient A at high risk of serious harm. Throughout these proceedings you have demonstrated a persistent lack of insight into the consequences of your misconduct on the patient, her family, the public and the profession.

177. The Tribunal determined that a sanction of suspension would not meet the need to satisfy the overarching objective. It determined that for these reasons a period of suspension would neither be appropriate nor proportionate.

178. The Tribunal has determined that your conduct was so unacceptable, that it is fundamentally incompatible with continued registration. Therefore, the Tribunal has concluded that erasing your name from the Medical Register would be the only proportionate sanction to impose in order to serve the public interest, maintain public confidence in the medical profession and send a message to the medical profession that this behaviour is unacceptable.

179. The effect of this direction is that, unless you exercise your right of appeal, this decision will take effect 28 days from when written notice of this determination is deemed to have been served upon you. A note explaining your right of appeal will be supplied to you.

Determination on an Immediate Order - 01/08/2018

1. Having determined to erase your name from the Medical Register, the Tribunal considered in accordance with Section 38(1) of the Medical Act 1983, as amended, whether to impose an immediate order of suspension on your registration.

2. Ms Kitzing referred the Tribunal to the relevant paragraphs of the SG and submitted that given the Tribunal's findings, it is necessary to protect the public and is otherwise in the public interest to impose an immediate order of suspension.

3. Ms Garner submitted that given that you are currently subject to an order of suspension, she made no opposition to the application.

4. The Tribunal determined that given the seriousness of its findings it is necessary to protect the public and is otherwise in the public interest to impose an immediate order of suspension.

5. The interim order of suspension currently on your registration is revoked.

6. The substantive direction for erasure, as already announced, will take effect 28 days from when written notification is deemed to have been served upon you, unless an appeal is lodged in the interim. This order of immediate suspension takes effect from today. The immediate suspension will remain in force until the substantive sanction takes effect, or until such time as the outcome of any appeal is decided.

7. That concludes this case.

Confirmed
Date 01 August 2018 Dr Matthew Fiander, Chair