PUBLIC RECORD

Dates: 18/05/2026 - 02/06/2026
26/07/2026
27/07-2026 – 31/07/20260
02/08/2026

Doctor:	Dr Desmond MCCANN
GMC reference number:	2337937
Primary medical qualification:	MB ChB 1978 University of Glasgow

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

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Miss Shamaila Qureshi
Lay Tribunal Member:	Mrs Hannah De Merode
Registrant Tribunal Member:	Dr Pavan Rao

Tribunal Clerk:	Ms Fiona Johnston 18/05/2026 - 02/06/2026, 26/07/2026, 02/08/2026 Mr Alex Currie 27/07-2026 – 31/07/20260

Attendance and Representation:

Doctor:	Not present, not represented
GMC Representative:	Ms Elizabeth Dudley Jones, Counsel

Attendance of Press / Public

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

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 02/06/2026

1. The Tribunal exercised its powers under Rule 41 of the General Medical Council ('GMC') Fitness to Practise Rules 2004, as amended ('the Rules'), to sit in private when the matters under consideration were confidential. This determination will be handed down in private.

Background

2. Dr Desmond Francis McCann qualified from the University of Glasgow in 1978. Dr McCann worked as a locum GP at various surgeries under the Willow Group via the Winlight Recruitment agency. He started working at the Brune Medical Centre on 3 December 2018 and this ended on 31 May 2019. Dr McCann was also employed as a locum at XXX Health Centre between May 2019 and he left in October 2019.

3. The Tribunal will inquire into the allegation that, during the period March 2019 to May 2020, Dr McCann failed to provide good clinical care to seven patients. It is also alleged that, in June 2019 and April 2020, Dr McCann behaved in a sexually motivated manner towards Ms A and Ms B respectively.

4. It is further alleged that in March 2020, Dr McCann was dishonest when completing his NHS appraisal form in that he failed to declare that he was subject to a GMC investigation. In addition, it is alleged that Dr McCann failed to complete and return a Working Details Form sent to him by the GMC on four occasions between September 2019 and July 2020. It is also

alleged that that Dr McCann self-prescribed medications on 2 April and 19 May 2020 when it was not necessary to do so. XXX

The Outcome of Applications made during the Facts Stage

5. The Tribunal granted the GMC's application, made pursuant to Rules 20 and 40 of the Rules, that notice of this hearing had been properly served on Dr McCann, and granted its application, made pursuant to Rule 31 of the Rules, that this hearing should proceed in his absence. The Tribunal's full decision on this application is included in Annex A.

6. On behalf of the GMC, Ms Elizabeth Dudley-Jones, Counsel made an application pursuant to Rule 17(2)(c), to amend paragraph 10a and 13b of the allegation. The Tribunal granted the application.

7. Ms Dudley-Jones, Counsel made a third application pursuant to Rule 35(4) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules') for both the complainants Ms A and Ms B to be granted anonymity throughout these proceedings to protect their privacy as alleged victims in sexually motivated allegations. She also submitted that Patients C– H should be granted anonymity due to the clinical nature of the allegations and requested for the patients not to have their initials in the public domain.

8. The Legally Qualified Chair (LQC) drew the Tribunal's attention to relevant legal principles, and Rule 35(4) of the Rules which states:

> *"35(4) The Committee or Tribunal may, upon the application of a party, agree that the identity of a witness should not be revealed in public"*

9. The Tribunal accepted the submission made by the GMC. It determined that it was appropriate and in the interests of justice that Ms A and Ms B and patients C-H be afforded anonymity throughout these proceedings in order to mitigate any further negative impact on them and to preserve their dignity. It determined that they should be referred to as Ms A and Ms B during the course of these proceedings.

The Allegation and the Doctor's Response

The Allegation made against Dr McCann is as follows:

XXX Medical Centre

1. You engaged in unwanted conduct towards Ms A (a XXX colleague) in that:

a. in June 2019, whilst Ms A was kneeling on the floor to perform a dressing change on a male patient's lower leg, you said to the patient words to the effect:
   i. 'what's it like having a pretty young XXX on her knees in front of you'; To be determined
   ii. 'I bet it's a long time since you've had a young girl bending on her knees in front of you'; To be determined
   iii. I hope so', when the patient said 'she'll be on her knees in front of you in a few minutes'; To be determined

   or words to that effect;

b. On or around 17 June 2019, you slapped Ms A on her upper arm with your hand, after she told you that she could not act as a chaperone for you; To be determined Amended

c. on 25 June 2019, whilst Ms A was in the stock room searching for a scalpel for you, you came and stood behind her, took out a non-medical knife with the blade pointing upwards and said:
   i. 'Do you think this will do?'; To be determined
   ii. 'Do you think this is big enough to do the job?'; To be determined

   or words to that effect.

2. Your actions as set out at paragraph(s) 1ai, 1aii and 1aiii were sexually motivated. To be determined

XXX Practice

3. You engaged in unwanted conduct towards Ms B, a colleague who XXX, in that:
   a. on 15 April 2020 you:
      i. looked at her chest area; To be determined
      ii. said 'why do you cover yourself, it would be nice to see what's underneath', or words to that effect; To be determined
   b. on or around 27 May 2020 you approached Ms B from behind and:
      i. hit Ms B's bottom with your knee or another part of your body; To be determined
      ii. said 'you've been hit by a doctor', or words to that effect and laughed. To be determined

4. Your actions as set out at paragraph(s):
   a. 3ai, 3aii, 3bi and 3bii were sexually motivated; To be determined
   b. 3bi were carried out without Ms B's consent. To be determined

Appraisal

5. On 16 March 2020, you submitted a NHS appraisal form ('the Form') in which you selected *'I have nothing to declare',* in response to the probity statement, '*In relation to suspensions, restrictions on practice or being subject to an investigation of any kind since my last appraisal',* which was untrue. To be determined

6. You knew that your probity declaration was untrue, in that you had been the subject of a GMC investigation since September 2019. To be determined

7. Your action as set out at paragraph 5 was dishonest by reason of paragraph 6. To be determined

Self-prescribing

8. On 2 April and 19 May 2020 you prescribed yourself medication as set out in Schedule 1 when it was not necessary for you to obtain these items urgently. To be determined

Patient C

9. Between 12 February and 22 April 2020 you issued prescriptions for lorazepam and zolpidem to Patient C as set out in Schedule 2 which was inappropriate in that you prescribed these medications:
   a. in excessive quantities and/or at excessive frequency; To be determined
   b. despite relevant information within Patient C's background history which indicated a pattern of drug-seeking behaviour; To be determined
   c. without agreeing a process of stabilisation and reduction to Patient C's prescribed dose of these medication(s). To be determined

Patient D

10. On 12 March 2020, your consultation with Patient D was inadequate in that you:
    a. failed to obtain ~~a~~ an history of: Amended under Rule 17(6)
       i. Patient D's presenting complaint; To be determined
       ii. the frequency of Patient D's migraines; To be determined
       iii. the severity of Patient D's migraines; To be determined
       iv. whether Patient D had taken any treatment that day; To be determined
    b. failed to give advice that:
       i. Patient D should stop taking topiramate when starting gabapentin; To be determined

ii. gabapentin was not recommended for prophylaxis of episodic migraine; To be determined

c. failed to provide appropriate treatment as you:
   i. prescribed gabapentin which was not recommended for the prophylaxis of episodic migraine; To be determined
   ii. added gabapentin 300mg, use as directed, 100 capsules, to the repeat prescribing system without arranging to review Patient D to assess the efficacy and tolerability of this medication; To be determined

d. failed to record:
   i. in the alternative to paragraphs 10a, an adequate history; To be determined
   ii. in the alternative to paragraph 10b, your advice to Patient D; To be determined
   iii. your reasons for prescribing gabapentin. To be determined

Patient E

11. On 19 March 2020 you failed to arrange adequate treatment or follow up of Patient E who presented with elevated cardiovascular risk, in that you did not:
   a. begin treatment with atorvastatin and then arrange to monitor Patient E's response to the drug; To be determined
   b. refer Patient E to a specialist nephrology clinic; To be determined
   c. seek advice from a diabetes specialist on diabetic treatment; To be determined
   d. arrange a follow up appointment with Patient E within seven to fourteen days. To be determined

Patient F

12. On 28 March 2019, your consultation with Patient F (who presented with a history of abnormal labia) was inadequate in that you:
   a. failed to assess the psychological and/or physical issues leading to Patient F's presentation; To be determined
   b. inappropriately performed an internal vaginal examination which was not clinically indicated; To be determined
   c. failed to discuss:
      i. alternative treatments to labial surgery; To be determined
      ii. benefits and risk of labial surgery; To be determined
   d. failed to ensure that labial surgery was appropriate prior to offering to perform labial surgery on Patient F; To be determined

e. failed to record an adequate:
   i. history; To be determined
   ii. diagnosis; To be determined
   iii. management plan; To be determined
f. booked Patient F for labial surgery at the GP Practice, which was inappropriate:
   i. as a GP minor surgery room is not a suitable clinical setting for such a surgery; To be determined
   ii. in that you intended to perform the labial surgery yourself; To be determined
g. failed to contact the local CCG to ascertain whether an NHS referral was possible; To be determined
h. failed to refer Patient F to an appropriate specialist for an opinion on possible surgical options. To be determined

Patient G

13. On 8 April 2019, following your consultation with Patient G who presented with post-menopausal bleeding ('PMB') you failed to make:
    a. an urgent suspicion of cancer referral to the PMB clinic in accordance with NICE Guidelines; To be determined
    b. a referral until the 30 April ~~2020~~ 2019 To be determined Amended under Rule 17(6)

Patient H

14. On 5 May 2020 you prescribed 56 tablets of diazepam (5mg) to Patient H, which was excessive given that you had already prescribed 28 tablets of diazepam (5mg) on 29 April 2020. To be determined

15. Your actions set out in paragraph 14 exposed Patient H to:
    a. the risk of harm from tolerance and/or dependency; To be determined
    b. adverse effects of diazepam; To be determined
    c. the risk of drug interactions with Patient H's other medications including opioids and gabapentin. To be determined

Patient I

16. On 7 May 2020 you prescribed Patient I, who was already taking psychoactive medication for bipolar disorder ('medications'), with:

a. 45 tablets of diazepam (5mg); To be determined
b. 28 tablets of zopiclone (7.5mg); To be determined

which was inappropriate in that you changed Patient I's medications without psychiatry advice/discussion;

c. a combination of both diazepam and zopiclone which was inappropriate because it exposed Patient I to an increased risk of adverse effects. To be determined

17. Having changed Patient I's medications as set out in paragraph 16a your prescribing: was in appropriate as it:
    a. was excessive in quantity; To be determined
    b. was excessive in dosage; To be determined
    c. exposed Patient I to:
        i. the risk of adverse effects; To be determined
        ii. overuse; To be determined
        iii. tolerance and/or dependency; To be determined

18. Having changed Patient I's medication as set out in paragraph 16 b your prescribing was inappropriate in that it:
    a. it was excessive in quantity; To be determined
    b. it exposed Patient I to the risk of tolerance and/or dependency. To be determined

19. On 20 May 2020, you prescribed Patient I with 28 tablets of zopiclone 7.5mg which was inappropriate in that:
    a. Patient I was already being treated for night sedation with quetiapine by a psychiatrist; To be determined
    b. you prescribed an additional supply of quetiapine 25mg (28 tablets) and advised Patient I to take up to 4 tablets at night; To be determined
    c. you changed Patient I's medications without seeking psychiatry advice/discussion; To be determined
    d. it exposed Patient I to:
        i. over-sedation from:
            A. your additional supply of 28 tablets of quetiapine 25mg (28 tablets) on the same date and 28 tablets of zopiclone on 7 May 2020; To be determined
            B. a repeat prescription of quetiapine 25mg (30 tablets) issued on the same date; To be determined
        ii. drug interactions with her existing medication(s). To be determined

WDF

20. You failed to complete and return the Working Details Form which the GMC sent to you by email on 30 September 2019, 30 October 2019, 9 December 2019 and 1 July 2020. To be determined

XXX

21. XXX

22. XXX

And that by reason of the matters set out above your fitness to practise is impaired because of your:

a. misconduct in respect of paragraphs 1 to 20; To be determined
b. XXX

GMC Witness Evidence

10. The Tribunal received oral evidence on behalf of the GMC from expert witness Dr L, GP. Dr L also provided two expert reports dated 23 November 2022 and 20 December 2023. He also provided an additional supplemental report dated 26 May 2024.

Documentary Evidence

11. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to, witness statements, emails, medical records, telephone notes, letters of complaint, investigations notes and outcome letters, Dr McCann's appraisal form, XXX and testimonials.

The Tribunal's Approach

12. The LQC gave legal advice which was adopted by the Tribunal. It can be summarised as follows:

13. The Tribunal is reminded that the GMC brings this Allegation and the burden of proving each paragraph is on the GMC. There is no burden on Dr McCann to prove anything.

14. To reach a decision, the Tribunal must apply the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged.

15. The Tribunal should approach fact finding by firstly identifying the agreed facts and evidence. The Tribunal should then consider what conclusions and inferences can be drawn from the documentary evidence.

16. The LQC advised the Tribunal that the applicable standard of proof is the balance of probabilities. She referred the Tribunal to the authorities of *Re D* and *Re B*, in which Lord Hoffmann confirmed that there is a single civil standard of proof. She further referred to *IPCC v Hayman and Bannister*, noting that when considering whether something is more likely than not to have occurred, the Tribunal should bear in mind that the more serious the allegation, the less likely it is inherently to have occurred. She advised that this relates to inherent probability and does not create a higher standard of proof. She reminded the Tribunal that not every peripheral fact needs to be proved; rather, the Tribunal must determine whether the central body of material facts alleged against the doctor is established on the balance of probabilities.

17. The LQC advised the Tribunal that, having considered the documentary and agreed evidence, it should subject the oral evidence to careful scrutiny when assessing reliability and credibility. She explained that reliability concerns the inherent quality and accuracy of a witness's evidence, whereas credibility concerns whether the Tribunal can believe the witness's account based upon their truthfulness and veracity. She referred the Tribunal to *R (Dutta) v GMC [2020] EWHC 1974 (Admin)* in relation to the assessment of oral evidence.

18. In relation to the expert evidence, the LQC reminded the Tribunal that although the expert had been called by the GMC, the expert's duty was to assist the Tribunal. She advised that the Tribunal was not bound by either the expert's oral evidence or the conclusions contained within the report. However, if the Tribunal departed from the expert's opinion, it should provide clear reasons for doing so. She referred to the authorities of *English v Emery Reimbold & Strick Ltd*, *Phipps v GMC* and *Yeong v GMC*, which establish that a coherent and reasoned expert opinion should be met with a coherent and reasoned explanation if rejected.

19. The LQC reminded the Tribunal that expert evidence was only one part of the overall evidence and should be weighed alongside all other evidence in the case. She advised that the Tribunal was entitled to draw reasonable inferences using common sense and ordinary human experience, but it should avoid speculation and determine the case solely on the evidence presented before it.

20. The LQC reminded the Tribunal that, at the facts stage, its role was limited to determining whether the alleged facts occurred. It was not yet considering misconduct, impairment or sanction. She advised the Tribunal to consider each allegation separately, including any sub-particulars, and to determine whether those facts were proved on the balance of probabilities. She further advised that where allegations alleged a failure, the Tribunal must first be satisfied that there existed a professional duty or obligation which had not been met.

21. The LQC further advised the Tribunal that words used within the allegations should generally be given their ordinary meaning using ordinary rules of language and interpretation. In relation to allegations of sexual motivation, she referred the Tribunal to *R v H [2005] EWCA Crim 732*, *Basson v GMC [2018]* and *GMC v Haris [2020]*. She advised that, to find conduct sexually motivated, the Tribunal must be satisfied both that a reasonable person would regard the conduct as sexual and that, in all the circumstances, the conduct was in fact sexual. She noted the guidance in *Basson* that sexual motivation may involve conduct carried out either for sexual gratification or in pursuit of a future sexual relationship.

22. In relation to allegations of inappropriate conduct, the LQC advised that the standard to be applied was objective rather than subjective, namely the standard expected of a reasonably competent professional acting in accordance with the relevant professional norms and standards.

23. Finally, in relation to the allegations of dishonesty, the LQC referred the Tribunal to the test set out in *Ivey v Genting Casinos*. she advised that the Tribunal must first determine the doctor's actual state of knowledge or belief as to the facts. If satisfied as to that subjective element, the Tribunal must then consider whether, by the standards of ordinary decent people, the conduct was dishonest. She reminded the Tribunal that it is not necessary for the doctor to have appreciated that their conduct would be regarded as dishonest by those standards.

24. The LQC reminded the Tribunal that it had heard evidence that Dr McCann was a person of good character. She advised that good character is a relevant factor which the Tribunal should take into account when assessing both Dr McCann's credibility and the likelihood of him having acted in the manner alleged across the allegations. However, she emphasised that good character is not a defence to the allegations and is simply one factor to be considered alongside all of the evidence in the round. The weight to be attached to Dr McCann's good character was a matter for the Tribunal.

Background and context

Brune Medical Centre

25. Dr McCann worked at the Willow Group as a locum GP. Two incidents occurred whilst working at the practice. The first relates to Patient G. Patient G attended the surgery on 8 April 2019, due to a post-menopausal bleed and Dr McCann failed to make an urgent suspicion of cancer referral to the post-menopausal bleeding clinic (in accordance with NICE guidelines) that day and not for a further three weeks, until 30 April 2019. The referral was only made as a result of the patient raising concerns that she had not received any contact from the hospital. When the referral was made it was marked as routine and was not typed by the medical secretary until 9 May 2019.

26. Patient F attended a minor operations clinic on 15 July 2019 expecting to have her labia trimmed at the surgery. She informed the GP at the clinic that Dr McCann had told her that the procedure could be carried out at the surgery, when in fact it could not. The Governance Team became aware of the incident after the GP reported it, when Patient F attended the appointment. Patient F's medical records dated 28 March 2019, under Dr McCann's name for the consultation on that date, recorded under "*History*" the words "labia abnormal", under "*Examination*" the words "*labia long and pendulous*", and under "*Comment*" the words "*contact CCG*". Dr McCann did not contact the CCG.

XXX Health Centre

Ms A

27. Dr McCann worked as a locum at XXX Health Centre between June 2019 and August 2019. While working there, he met Ms A, a XXX at the health centre, in early June 2019. Ms A was performing a dressing change on the lower leg of a male patient in his 70s. Ms A was kneeling on the floor in front of him. The door was shut and Dr McCann entered the room and asked whether she could chaperone him. The patient and Dr McCann then engaged in a conversation during which several inappropriate comments were exchanged.

28. On 17 June 2019, she called a patient into the room and was just about to shut the door when Dr McCann appeared and leant into the room through the doorway and asked if she could chaperone him. She explained she could not as she had just called a patient in for an urgent ECG so would not be able to. Dr McCann then tutted and slapped her on her upper arm with his hand, forceful enough for it to sting. Ms A felt that Dr McCann had homed in on

her and had once again overstepped the mark. She decided to write a complaint to give it to the practice and went home and informed her husband about the incident.

29. On 25 June 2019, Ms A was in her room sat at her desk writing up some notes from a patient, Dr McCann came in and asked for dressing packs and a scalpel. She pointed up at a cupboard where they were kept across the corridor from her door. Dr McCann was persistent and adamant she went to look for them for him. Dr McCann followed her in and the door shut behind them. Dr McCann pulled out a non-medical knife and he said '*do you think this is big enough for the job*'. Ms A was terrified and she froze. Dr McCann eventually left the cupboard. Ms A immediately reported the matter to a colleague. She also wrote a letter of complaint on 30 June 2019.

XXX Medical Practice

Ms B

30. Ms B is a clinical pharmacist and she worked at the XXX Medical practice whilst Dr McCann was a locum GP there. On 15 April 2020, Dr McCann walked up the corridor towards Ms B and said to her "*why do you cover yourself, it would be nice to see what's underneath*" and said this whilst looking at her chest. She was shocked and said he should not say things like that and it was not a nice thing to say to people. Ms B did not report the incident.

31. On or around 27 May 2020 Ms B went to the office behind the reception at the XXX Medical Practice to speak to the receptionist. Dr McCann entered after her and he asked the other receptionist to help him put on his personal protective equipment. Ms B was facing the back of the office during her conversation with the receptionist, and she had her back facing the other receptionist and Dr McCann. Her attention was on the receptionist when suddenly she felt something hit her backside forcefully. She turned around and saw Dr McCann directly behind her and it looked as though he had just hit her backside with his knee. He did not have her consent to do so. He then said "*you've been hit by a doctor*" and laughed. She raised a formal complaint against Dr McCann in an email on 3 July 2020.

32. On 10 June 2020 concerns were received from the Westropp Medical Practice/Taw Hill Medical Practice where Dr McCann had been working as a locum GP and he was advised not to attend the surgery.

33. On the same date 10 June 2020, the GMC were contacted by the professional standards manager at NHS England to notify the GMC of numerous concerns raised against Dr McCann which had resulted in his suspension from the medical performers list with

immediate effect. The concerns which had led to his suspension were in relation to his conduct whilst working at the Taw Hill Medical Practice in Swindon namely his own temporary registration to the practice as a patient and his subsequent self-prescribing of XXX in April and May 2020

Patient C

34. In relation to Patient C, he prescribed Patient C with large quantities of zolpidem and lorazepam.

Patient I

35. In July 2020, Westrop Surgery conducted a partner review of Dr McCann's patients, which identified several prescribing concerns between 29 April and 29 May 2020. These included concerns relating to Patient I, a patient with bipolar disorder who had been prescribed quetiapine and venlafaxine, but who was also prescribed 45 tablets of diazepam 5mg and 28 tablets of zopiclone 7.5mg on 7 May 2020, followed by a further 28 tablets of zopiclone 7.5mg on 20 May 2020.

Patient E

36. The review in July 2020 also identified concerns regarding the treatment of Patient E, who had multiple medical conditions.

Patient H & Patient D

37. An investigation into Dr McCann was conducted by NHS England ('NHSE'). As part of the investigation, several record audits were conducted of his patients at the practice which identified issues with Patient H and the controlled drug audit identified issues with Patient D. Dr McCann was referred to the interim orders tribunal on 30 June 2020 and thereafter this restricted his practice preventing him from undertaking GP locum work.

<u>Appraisal</u>

38. On 16 March 2020 Dr McCann submitted an NHS appraisal form in which he selected *'I have nothing to declare'* in response to the probity statement *"in relation to suspensions, restrictions on practice or being subject to an investigation of any kind since my last appraisal*". This was untrue as Dr McCann knew that he had been the subject of a GMC investigation since September 2019.

Self-prescribing

39. On 2 April 2020 and 19 May 2020, Dr McCann issued prescriptions to himself.

Working Details Form

40. On 30 September 2019, 30 October 2019, 9 December 2019 and 1 July 2020 Dr McCann failed to complete and return the Working Details From ('WDF').

XXX

41,. XXX

42. XXX

43. XXX

The Tribunal's Analysis of the Evidence and Findings

Paragraph 1a (i)(ii)(iii), b& c(i)(ii)

44. The allegation concerns Dr McCann's conduct towards Ms A, a XXX colleague, whilst working at XXX Medical Centre in June 2019. It is alleged that, whilst Ms A was kneeling on the floor performing a dressing change on a male patient's lower leg, Dr McCann made comments to the patient of a sexual nature about Ms A being "*on her knees*" in front of him.

45. It is further alleged that, on 17 June 2019, Dr McCann slapped Ms A on the upper arm after she informed him that she could not act as a chaperone for him. Finally, it is alleged that, on 25 June 2019, whilst Ms A was searching in the stock room for a scalpel for Dr McCann, he stood behind her holding a non-medical knife with the blade pointing upwards and asked words to the effect of whether it was "*big enough to do the job*".

46. The Tribunal had regard to the evidence of Ms A. Ms A provided a detailed account of the incidents alleged and gave clear evidence regarding the background and circumstances surrounding the allegations. The Tribunal further took into account Ms A's victim impact statement, in which she stated that the incidents had affected her to such an extent that she felt unable to return to work.

'I wrote a letter of complaint against Dr McCann to [XXX] on 30 June 2019 (Exhibit JLF1), [XXX] responded by letter dated 12 August 2019 to advise that they had carried out an internal investigation into the issues l raised. A copy of this letter can be found at Exhibit lLF2. Enclosed with this letter was a letter of apology from Dr McCann which can be found at Exhibit lLF3. Dr McCann offered to meet me to apologise in person but I didn't want to see him again.

After the final incident I didn't go into work the next day due to a migraine brought on by the stress of the situation. I thought I would be able to go back after this, but I couldn't do it. About a week later a representative of Symphony Informed me that I would need a fit note which would take me to the end of my notice period. I got a fit note as requested but I wasn't comfortable In taking time off in this manner as physically I was OK. I couldn't afford to stay off work on statutory sick pay, so I asked if they would let me go before my notice period, to which they eventually agreed.'

47. The Tribunal considered this allegation as a whole. It had regard to the apology letter in which Dr McCann acknowledged that his actions had been inappropriate.

'1 am writing 'to you to say how sorry I am that my clumsy attempt at humour caused you such distress. At the time I had no idea that I had frightened or offended you. If I had I would ha.ve apologized Immediately. On reflection, my actions were thoughtless and totally inappropriate in a clinical situation.

To realise that I had hurt and possibly even intimidated a professional· colleague makes me feel most uncomfortable an regretful. You have every right to feel safe and unmolested in the workplace and to realise that I transgressed those boun8aries 'calls my judgement into question.

While I realise that in some ways the damage has been already done, I still want to send you me deeply felt apology for my behaviour and hope that you may find a way of forgiving me for my inappropriate transgression.

I want to take this opportunity to wish you week in your future career and if it would be acceptable to you, I should dearly wish to apologise to you in person. I also realise that this may not be your wish and I fully understand if you want to draw a line under this issue and move on with your life.

Please accept my best wishes for your future professional career.'

48. Overall, the Tribunal considered Ms A to be a credible witness who provided a consistent account, and that she had no reason to fabricate such events.

49. The Tribunal was satisfied that Ms A regarded Dr McCann's behaviour as unwanted and intimidating conduct. Further, the Tribunal considered that Dr McCann's behaviour was objectively intimidating, and that it was reasonable for Ms A to perceive his actions and behaviour in that way. The Tribunal also took into account that Dr McCann had admitted to engaging in such behaviour.

50. Accordingly, the Tribunal found the entirety paragraph 1 of the Allegation proved.

Paragraph Two

51. The Tribunal noted that sexual motivation may be defined as conduct carried out either in pursuit of sexual gratification or in pursuit of a future sexual relationship. The Tribunal therefore went on to consider whether Dr McCann's behaviour, as set out in paragraph 1, was sexually motivated.

52. The Tribunal considered whether Dr McCann's actions were carried out in pursuit of sexual gratification. In doing so, it took into account Ms A's complaint and her evidence that she perceived the conduct to be sexually motivated and to contain an underlying sexual tone. The Tribunal considered that the comments made by Dr McCann were not merely general workplace banter, but were clearly sexualised in nature.

53. In particular, the Tribunal considered the comments: *"what's it like having a pretty young [XXX] on her knees in front of you*"; *"I bet it's a long time since you've had a young girl bending on her knees in front of you*"; and "*I hope so*", when the patient said "she'll be on her knees in front of you in a few minutes".

54. The Tribunal took into account the evidence of Ms A:

> *'This interaction was accompanied by some tactile nudges between them which seemed to be used to enhance the understanding that they both understood that a sexually explicit act from a younger female would be nice at their time of life. The exchange between the patient and Dr McCann then finished. I did not report it at the time as I put it down to misjudged banter and I did not want to appear at this point to be overreacting to a one-off piece of mistaken judgement.'*

55. The Tribunal determined that such comments towards a colleague were inappropriate and demonstrated sexual motivation.

56. The Tribunal noted that Dr McCann admitted in his letter of apology to Ms A *'he admitted this was a clumsy attempt at humour and that he had apologised'.*

57. Accordingly, the Tribunal found the entirety paragraph two of the Allegation proved.

Paragraph 3a(i)(ii)&b(i)(ii

58. The allegation concerns Dr McCann's conduct towards Ms B, a colleague who XXX. It is alleged that, on 15 April 2020, Dr McCann looked at Ms B's chest area and said words to the effect of, "*why do you cover yourself, it would be nice to see what's underneath*".

59. It is further alleged that, on or around 27 May 2020, Dr McCann approached Ms B from behind, hit her bottom with his knee or another part of his body, and said words to the effect of, *"you've been hit by a doctor*", before laughing

60. The Tribunal noted the statement of Ms B and the relationship she had with Dr McCann.

> *'My relationship with Dr McCann is a professional one. I only worked with him on [XXX] and [XXX] as those were the days I would work in the Practice at the time. I didn't work with him often, but when I did,he seemed approachable and willing to help if I had any questions.'*

61. The Tribunal also noted that Ms B described how she felt shocked after the incidents,

> *As I was talking to the Nurse, Dr McCann walked up the corridor towards me. He said to me "why do you cover yourself, it would be nice to see what's underneath". He said this to me whilst looking at my chest. I assume he was referring to my [XXX] as I wear it to cover my hair and my chest. I was shocked and told him that he shouldn't say things like that and that it's not a nice thing to say to people.'*
>
> .....
>
> *On 13 May 2020, I remember going to the office behind reception at the Practice to speak with [Ms N], the Receptionist. Dr McCann entered after me and asked the other Receptionist to help him put on his Personal Protective Equipment. I*

was facing the back of the office during my conversation with [Ms N] and I had my back facing the other Receptionist and Dr McCann. My attention was on {Ms N] when, suddenly, I felt something hit my backside forcefully. I turned around and saw Dr McCann directly behind me. It looked as if he had just hit my backside with his knee. He then said, "you've been hit by a doctor" and laughed. I was in shock and didn't know what to say but I knew I had to say something.'

62. The Tribunal considered that Ms B's account was consistent throughout both her initial statement and her complaint, and that she did not appear to embellish the events. The Tribunal found Ms B's evidence to be credible and consistent, noting that she described the incidents in a straightforward and matter-of-fact manner. The Tribunal also took into account Ms B's reaction as described in her statement and was satisfied that the conduct amounted to clearly unwanted attention.

63. The Tribunal further noted Ms B's evidence that, prior to these incidents, she had found Dr McCann to be helpful at work and had worked alongside him without difficulty. The Tribunal considered that this supported the credibility of her account and demonstrated that she had no apparent reason to fabricate the complaint.

64. The Tribunal determined that the behaviour alleged was unacceptable in a workplace setting and particularly inappropriate for a doctor who was in a position of authority.

65. Accordingly, the Tribunal found the entirety of paragraph 3 of the Allegation proved.

Paragraph 4a

66. The allegation is that Dr McCann's actions, as set out in paragraphs 3(a)(i), 3(a)(ii), 3(b)(i) and 3(b)(ii), were sexually motivated.

67. The Tribunal took into account Ms B's witness statement in which she explained that she did not report the first incident on 15 April 2020 because she did not know how to deal with sexual harassment and had never previously experienced anything similar, either at work or socially. The Tribunal noted her evidence that she felt uncomfortable discussing the matter with her male manager and initially assumed that ignoring Dr McCann's comments would discourage further behaviour. The Tribunal also noted that Ms B stated she had given Dr McCann *"the benefit of the doub*t" because of his age and profession, but that following the second incident on 27 May 2020 she felt compelled to report the matter.

68. The Tribunal further took into account Ms B's complaint and her evidence regarding the significance of XXX. The Tribunal considered that Dr McCann's conduct directly

undermined that purpose by staring at Ms B's chest, making comments about what was "*underneath*", and later striking her bottom. The Tribunal determined that these were unwanted acts of a sexualised nature. It also took into account that, after striking her bottom, Dr McCann stated, "*you have been hit by a doctor*".

69. Accordingly, the Tribunal was satisfied that the conduct was sexually motivated and that the contact described at paragraph 3(b)(i) was carried out without Ms B's consent.

Paragraph 4b

70. The allegation is that the conduct described at paragraph 3(b)(i), namely hitting Ms B's bottom with his knee or another part of his body, was carried out without Ms B's consent.

71. The Tribunal noted Ms B's complaint in which she stated: *"I certainly don't welcome any similar gesture from anyone. I have never been touched that way by any of my close male friends/colleagues/superiors.*"

72. The Tribunal was satisfied that the conduct described at paragraph 3(b)(i) was not consensual and that Ms B did not consent to Dr McCann hitting her bottom.

73. Accordingly, the Tribunal found paragraph 4(b) proved.

Paragraph 5

74. The allegation is that, on 16 March 2020, Dr McCann submitted an NHS appraisal form ("the Form") in which he selected *"I have nothing to declare*" in response to the probity statement: "In relation to suspensions, restrictions on practice or being subject to an investigation of any kind since my last appraisal", when that statement was untrue.

75. The Tribunal noted that Dr McCann had been notified on a number of occasions about the GMC investigation. In particular, the Tribunal had regard to the evidence of the Investigation Officer, who explained the process by which doctors are informed of investigations and required to complete a Work Details Form ("WDF").

76. The Tribunal noted the Investigation Officer's evidence that, on 30 September 2019, Dr McCann was sent correspondence disclosing the GMC investigation and enclosing a blank WDF for completion. The Tribunal further noted the evidence that, following a telephone call with Dr McCann on 30 October 2019, the Investigation Officer again emailed Dr McCann with a copy of the letter dated 30 September 2019 and requested that he provide a completed WDF by 6 November 2019.

77. The Tribunal was therefore satisfied that Dr McCann was aware that he was the subject of a GMC investigation prior to completing the NHS appraisal form dated 16 March 2020. The Tribunal noted that, within that appraisal form, Dr McCann selected "I have nothing to declare" in response to the probity question relating to investigations.

78. Having considered all of the evidence, the Tribunal was satisfied that the statement made by Dr McCann in the appraisal form was untrue.

79. Accordingly, the Tribunal found paragraph 5 proved.

Paragraph 6

80. The Tribunal considered whether Dr McCann knew that the probity declaration he made on 16 March 2020 was untrue, namely that he had been the subject of a GMC investigation since September 2019.

81. The Tribunal had regard to the evidence of the GMC Investigation Officer, including the correspondence sent to Dr McCann on 30 September 2019 notifying him of the GMC investigation and enclosing a Work Details Form. It also noted the subsequent correspondence and telephone call on 30 October 2019, during which the investigation was discussed with Dr McCann and the documentation was re-sent to him by email.

82. The Tribunal was satisfied that Dr McCann had been clearly informed of the GMC investigation well before completing the appraisal form dated 16 March 2020. It also noted that, despite this, Dr McCann selected "*I have nothing to declare*" in response to the probity question asking whether he had been subject to any investigation since his last appraisal.

83. Taking all the evidence into account, the Tribunal determined that Dr McCann knew the declaration was untrue at the time he completed the form.

84. Accordingly, the Tribunal found paragraph 6 proved.

Paragraph 7

85. The Tribunal considered whether Dr McCann's conduct, as set out at paragraph 5, was dishonest by reason of paragraph 6. It noted that Dr McCann's declaration in his appraisal form under the probity section was untrue. He should have declared, in response to the statement "*in relation to suspensions, restrictions on practice or being subject to an*

investigation of any kind since my last appraisal", that he had been the subject of a GMC investigation. The Tribunal considered Dr McCann's actual state of knowledge or belief as to the facts .The Tribunal has concluded that Dr McCann knew the probity declaration was untrue and that he did not honestly believe that the declaration was true at the time he completed the form Dr McCann was therefore dishonest due to the first stage of Ivey and Genting.

86. The Tribunal was satisfied that Dr McCann knew he had been the subject of a GMC investigation since September 2019 and therefore knew that the declaration he made on 16 March 2020 was false.

87. Applying the test for dishonesty, the Tribunal determined that ordinary decent people would consider Dr McCann's conduct to be dishonest.

88. Accordingly, the Tribunal found paragraph 7 proved.

Paragraph 8

89. The allegation is that on 2 April and 19 May 2020 Dr McCann prescribed himself medication as set out in Schedule 1 when it was not necessary for him to obtain these items urgently.

90. The Tribunal considered the evidence relating to Dr McCann's self-prescribing on 2 April and 19 May 2020. *XXX*

91. The Tribunal also noted the expert evidence of Dr L that there had been an earlier occasion, on 31 January 2020, when Dr McCann had consulted another GP at the practice regarding medication. The Tribunal considered this significant, as it demonstrated that Dr McCann had access to another doctor and was able to seek independent medical advice and treatment rather than prescribing medication for himself.

92. The Tribunal was satisfied from the patient records that Dr McCann had prescribed the medication to himself on 2 April and 19 May 2020. XXX

93. It also had regard to Dr L report:

> *'Professional guidance (GMC, 2013a) states that doctors should be registered with a GP and that" wherever possible, you must avoid prescribing for yourself'.*

94. Having considered all the evidence, the Tribunal determined that these instances of self-prescribing fell seriously below the standard expected of a doctor. It noted that professional guidance (GMC, 2013) is clear that doctors must avoid prescribing medication for themselves.

95. Accordingly, the Tribunal found paragraph 8 proved.

Paragraph 9a

96. The Tribunal considered whether Dr McCann between 12 February and 22 April 2020 had issued prescriptions for lorazepam and zolpidem in excessive quantities and/or at excessive frequency.

97. The Tribunal had regard to the dates and quantities of the prescriptions issued by Dr McCann to Patient C between 12 February and 22 April 2020. These included repeated prescriptions for lorazepam and zolpidem over a relatively short period, including:

- 12.02.20 – Lorazepam 1mg, take one as needed, 28 tablets; Zolpidem 5mg, take two at night, 28 tablets
- 28.02.20 – Lorazepam 1mg, one four times daily as required, 112 tablets; Zolpidem 5mg, take two at night, 56 tablets
- 11.03.20 – Lorazepam 1mg, four times daily, 84 tablets; Zolpidem 5mg, take two at night, 56 tablets
- 20.03.20 – Lorazepam 1mg, four times daily, 112 tablets; Zolpidem 5mg, take one or two at night, 56 tablets
- 27.03.20 – Lorazepam 1mg, one three to four times daily, 84 tablets; Zolpidem 5mg, take two at night, 56 tablets
- 08.04.20 – Lorazepam 1mg, four times daily, 28 tablets
- 13.04.20 – Zolpidem 5mg, take two at night, 28 tablets; Lorazepam 1mg, three times a day as needed, 42 tablets
- 22.04.20 – Lorazepam 1mg, take one as needed, 42 tablets; Zolpidem 5mg, take two at night, 28 tablets

98. The Tribunal had regard to the expert evidence of Dr L, who stated that the quantities prescribed were excessive within the relevant timeframe. He further opined that, even if the timeframe itself had been appropriate, the quantities prescribed remained excessive.

99. The Tribunal accepted Dr L's expert opinion on this matter and determined that Dr McCann's conduct fell seriously below the standard expected of a reasonably competent GP.

100. Accordingly, the Tribunal found paragraph 9(a) proved.

Paragraph 9b

101. The Tribunal considered whether Dr McCann prescribed lorazepam and zolpidem to Patient C despite relevant information in the patient's background history indicating a pattern of drug-seeking behaviour.

102. The Tribunal had regard to the medical records, which contained multiple entries suggesting repeated requests for early or frequent prescriptions. It also noted Dr L's expert evidence that these entries were consistent with drug-seeking behaviour and that Dr McCann ought to have recognised this as a clinical concern requiring careful management.

103. The Tribunal specifically considered the entry on 8 April 2020, in which Dr McCann recorded concerns that the patient was displaying drug-seeking behaviour. The Tribunal accepted Dr L's evidence that, although Dr McCann appeared to identify the risk, there was no corresponding change in his prescribing practice. The Tribunal further noted that the previous consultation on 27 March 2020 had resulted in a 28-day supply, yet only 12 days later the patient was seen again and further medication was issued.

104. The Tribunal also considered the consultation on 13 April 2020, following the 8 April 2020 entry, in which Dr McCann prescribed temazepam 20mg in addition to ongoing medication. The Tribunal accepted Dr L's evidence that this escalation in prescribing, including the introduction of an additional benzodiazepine at a significant dose, was not a clinically logical response to concerns about overuse.

105. The Tribunal accepted Dr L's expert opinion that Dr McCann failed to appropriately take into account the relevant background information when prescribing to Patient C and his conduct fell seriously below the standard expected.

106. Accordingly, the Tribunal found paragraph 9(b) proved.

Paragraph 9c

107. The Tribunal considered whether Dr McCann issued prescriptions for lorazepam and zolpidem to Patient C without agreeing a process of stabilisation and reduction of the patient's prescribed doses.

108. The Tribunal had regard to Dr L's expert evidence that there was no agreed or structured plan for stabilisation or reduction in respect of these medications, although there was evidence that such approaches may have been considered with other clinicians involved in the patient's care. The Tribunal also noted that, whilst there was some discussion about reduction on 22 April 2020, prescriptions for both zolpidem and lorazepam were nonetheless issued on that date.

109. The Tribunal accepted Dr L's evidence that, where a patient repeatedly presents shortly after being issued with a four-week supply, a reasonably competent GP would consider tighter controls, such as issuing a shorter supply and implementing a structured reduction plan. The Tribunal also noted his evidence that there was limited documentation in the patient's records setting out any clear or workable plan for reduction of consumption.

110. The Tribunal further accepted Dr L's opinion that a proper process of stabilisation and dose reduction should have been agreed and implemented in relation to Patient C's care, and that Dr McCann's approach fell seriously below the standard expected.

111. Accordingly, the Tribunal found paragraph 9(c) proved.

Paragraph 10a(i)-(iv)

112. The Tribunal considered whether on 12 March 2020, Dr McCann's consultation with Patient D was inadequate in that you: a. failed to obtain a history of: Patient D's presenting complaint; the frequency of Patient D's migraines; the severity of Patient D's migraines and whether Patient D had taken any treatment that day

113. The Tribunal considered paragraph 10(a)(i)–(iv) as a whole. The Tribunal noted the medical record as follows:

> *'12 March 2020 08:48*
>
> *History: Migraine script was on Gabapentin . Prev Gp stopped Gabapentin and prescribed pregabalin. Now has pain*
> *above her R eye . had 3 migraines and persistent headache . Constipated'*

114. The Tribunal noted that there was a note made of the presenting complaint, previous and current medications and possible side effects. It further observed that the absence of detailed documentation in the consultation record did not, of itself, establish that an appropriate history had not been obtained.

115. Accordingly, the Tribunal was not satisfied that the allegation had been proved.

Paragraph 10 b(i)(ii)

116. The Tribunal considered whether Dr McCann failed to give advice that: Patient D should stop taking topiramate when starting gabapentin and gabapentin was not recommended for prophylaxis of episodic migraine.

117. In light of its findings at paragraph 10a(i)-(iv). The Tribunal approached the entirely of paragraph 10(b) on the basis that there was no reliable evidence that an inadequate history had been taken or that appropriate clinical advice had not been given. The Tribunal noted that the absence of detailed contemporaneous records did not, of itself, discharge the burden of proof.

118. The Tribunal also had regard to the expert evidence, which suggested that Dr McCann had a responsibility to properly record the care provided. However, it accepted that this did not, in itself, establish that he failed to take a history or failed to provide appropriate clinical advice to the patient.

119. Taking all the evidence together, the Tribunal was not satisfied that the burden of proof had been met.

120. Accordingly, paragraph 10(b)(i)(ii) was not proved.

Paragraph 10c(i)(ii)

121. The Tribunal considered whether Dr McCann failed to provide appropriate treatment in that: he prescribed gabapentin, which was not recommended for the prophylaxis of episodic migraine.

122. The Tribunal noted that the patient had requested gabapentin, stating that it had previously been effective for her. It further noted that there was evidence suggesting the patient may have been experiencing side effects from topiramate, which could have influenced the change in medication.

123. The Tribunal also considered that Dr McCann's record-keeping was poor. It would have been expected that the rationale for stopping or changing medication would be clearly documented, including whether this was due to side effects or advice from neurology. The Tribunal considered that such documentation would not have required extensive recording, but would have been important clinical information.

124. The Tribunal accepted that, on the evidence, there were competing possible explanations, including that the patient wished to return to gabapentin because it had previously been effective. The Tribunal also noted that Patient D was under the neurologist who suggested different medications for her migraine, but the Tribunal was not provided with any documentary evidence.

125. Taking all of the evidence into account, the Tribunal was not satisfied that the burden of proof had been met.

126. Accordingly, paragraph 10 (i)(ii) was not proved.

Paragraph 10d(i)(ii)(ii)

127. The Tribunal considered whether Dr McCann failed to record:

i.in the alternative to paragraph 10(a), an adequate history;
ii. in the alternative to paragraph 10(b), his advice to Patient D;
iii. his reasons for prescribing gabapentin.

128. In light of its findings at paragraphs 10(a)–(c), the Tribunal accepted that, whilst it could not be satisfied that Dr McCann had failed to take a history, provide advice, or prescribe appropriately, his record-keeping in relation to the consultation was inadequate.

129. The Tribunal determined that the clinical records did not adequately document the history obtained, the advice given to Patient D, or the rationale for prescribing gabapentin. The Tribunal considered that these were important aspects of the consultation which ought reasonably to have been recorded.

130. Accordingly, the Tribunal found paragraph 10(d) proved in its entirety.

Paragraph 11a & 11b

131. The Tribunal considered whether Dr McCann on the 19 March 2020 failed to arrange adequate treatment or follow up of Patient E who presented with elevated cardiovascular risk and did not:

a. begin treatment with atorvastatin and then arrange to monitor Patient E's response to the drug;
b. refer Patient E to a specialist nephrology clinic;

132. The Tribunal found insufficient evidence in respect of paragraph 11a&b. In his oral evidence Dr L outlined that he would have not expected Dr McCann to have referred Patient E to the nephrology clinic or prescribe him atorvastatin on 19 March 2020.

133. The Tribunal accepted Dr L's evidence and accordingly found paragraph 11 a&b not proved.

Paragraph 11c

134. The Tribunal considered whether Dr McCann failed to seek advice from a diabetes specialist regarding Patient E's diabetic treatment on 19 March 2020.

135. The Tribunal noted that the Metformin 1g/ sitagliptin 50 mg had been commenced 4 February 2020 and that there was evidence of some improvement following the introduction of the medication. It also had regard to the consultation records and the expert evidence of Dr L. The Tribunal also noted that Patient E was not taking any other medication for diabetes prior to this date.

136. The Tribunal noted Dr L's evidence that it was not necessary, on that particular day, to refer Patient E to a diabetes specialist. The Tribunal further accepted that Dr McCann had a management plan in place for Patient E, including arranging blood tests and planning a review within three months.

137. The Tribunal considered that referral to a specialist could properly form part of longer-term management, but it was not satisfied that such a referral was required on 19 March 2020. The Tribunal also noted Dr L's evidence that a nurse was also involved in Patient E's diabetes care and treatment.

138. Accordingly, the Tribunal was not satisfied that the allegation was proved.

Paragraph 11d

139. The Tribunal considered the evidence from Dr L in respect of this allegation and he did not consider that arranging a follow-up appointment within seven to fourteen days was necessary on that date..

140. Accordingly, the Tribunal found paragraph 11(d) not proved.

Paragraph 12a

141. The Tribunal considered whether Dr McCann failed to assess the psychological and/or physical issues leading to Patient F's presentation.

142. The Tribunal had regard to Patient F's statement

> *'During the appointment, I consulted with Dr McCann regarding a possible labia reduction surgery. I informed him that since having three children my labia were not the same and how it was affecting my day-to-day life. At this point Dr McCann advised my that I was incredibly lucky as he was qualified to conduct this type of surgery but that he would need to see what the issue was by conducting an internal examination.*
>
> *…..*
>
> *Following the examination, Dr McCann offered me the labia reduction surgery which he advised would involve trimming my labia under a local anaesthetic and would take place at the Surgery by him. He then walked out with me to the receptionist and booked me an appointment for 15 July 2019 which I understood to be for the labia surgery. I did not hear the conversation between the receptionist and Dr McCann so I cannot comment on this. I was then given my appointment date by the receptionist for 15 July 2019 but I was not given any paperwork or confirmation of what the appointment was for. Furthermore, I did not receive any further correspondence from Dr McCann or the Surgery in relation to the planned labia surgery. I thought that it was odd not to receive any follow up information or pre-procedure information. However, I was just so relieved that it was going ahead and put my full trust in the fact the doctor would know exactly what he was doing.'*

143. It also had regard to Dr L expert report

> *'My opinion is that Dr McCann should have assessed whether Patient F 's concerns related mainly to the appearance of her labia, or whether she experienced any*

functional problems such as: irritation from rubbing, the need to avoid tight clothing, pain during sex or restriction of activities such as cycling or swimming.

My opinion is that failure to assess the psychological and physical issues leading to Patient F 's presentation was seriously below the standard expected because this information was needed for Dr McCann to assess the nature of Patient F 's concerns and to give appropriate advice.

….

Labiaplasty is a complex procedure that may take 1 -2 hours and is usually performed under general anaesthetic or sedation by a gynaecologist or plastic surgeon. In my opinion labiaplasty should not be performed by a GP'

144. It also took into account Dr McCann's response to the complaint;

'I was concerned to receive the complaint from Willow group . The patient in question was a very troubled lady due to abnormally long Labia Minora . While I recognise that this procedure was not really appropriate to be dealt with in primary care, my intention to help this young woman perhaps clouded my judgement. Whilst motivated solely by concern for the detrimental impact which this condition was having on her psychological wellbeing, I now realise that it would have been better to refer this to the secondary care sector. I was fortunate to hove had a very hands on Gynaecology placement, but now realise that, despite my clinical experience, this would hove been more appropriately dealt with in a hospital setting. With respect to my medical records I have decided to initiate an audit process which will start with a review of my last 4 weeks medico/ records and subject them to a standard which will examine:'

145. The Tribunal noted that, although there was some limited reference within Dr McCann's letter to psychological impact, there was no adequate exploration of the full psychological impact that the proposed surgery may have had on Patient F. The Tribunal considered that a reasonably competent GP would have been expected to discuss the issues in greater depth, including the effect on the patient, possible alternatives, and an appropriate way forward, before proceeding to discuss surgery. In respect of the assessment of the condition the Tribunal noted that Dr McCann conducted an physical examination and there was a discussion about the physical impact of the condition upon her.

146. The Tribunal concluded that Dr McCann progressed towards surgical intervention without carrying out an adequate assessment of the underlying psychological issues and his conduct fell below the expected standard of a doctor.

147. Accordingly, the Tribunal found paragraph 12(a) proved insofar as Dr McCann failed to assess the psychological issues leading to Patient F's presentation, but not proved in respect of any failure to assess physical issues.

Paragraph 12b

148. The Tribunal considered whether Dr McCann inappropriately performed an internal vaginal examination which was not clinically indicated.

149. The Tribunal noted the witness statement of Patient F:

> *'I then lay on the bed and Dr McCann conducted the examination by inserting his fingers into my vagina. I can confirm that I was offered a chaperone by Dr McCannwhich I accepted for the internal examination. Dr McCannwore a head torch and extensively examined both visually and touching my labia. The appointment lasted for approximately 20 minutes but due to the lapse of time, I do not remember all the details of the appointment.'*

150. The Tribunal concluded that carrying out an examination of the relevant area was not, in itself, outside the bounds of appropriate clinical practice. Patient F had complained that her labia were enlarged and causing discomfort, and the Tribunal accepted that examination of the area prior to any consideration of surgery could be an appropriate clinical step.

151. However, the Tribunal noted that there was no evidence within the medical records that Dr McCann had in fact performed an internal vaginal examination other than what Patient F had stated in her evidence. *'I then lay on the bed and Dr McCann conducted the examination by inserting his fingers into my vagina.'* Dr L's description of an internal vaginal examination did not align with Patient F's description of what occurred during the examination as above. This was inconclusive and the Tribunal also noted that Dr McCann, in his response letter to the complaint, did not refer to having carried out such an examination.

152. Accordingly, the Tribunal was not satisfied that the allegation was proved and therefore found paragraph 12(b) not proved.

Paragraph 12c (i) and (ii)

153. The Tribunal considered that these were important matters which ought properly to have formed part of the consultation and discussion with Patient F before any consideration of surgical intervention. The Tribunal found that neither issue was adequately discussed as there was no contemporaneous record of this issue within the medical notes or noted in the patient's account.

154. The Tribunal, having regard to its above findings, determined that Dr McCann failed to discuss:

i. alternative treatments to labial surgery;
ii. the benefits and risks of labial surgery.

155. The Tribunal considered its earlier findings and the expert report and accepted the expert's evidence on this issue.

156. Accordingly, the Tribunal found paragraph 12(c)(i) and (ii) proved.

Paragraph 12d

157. The Tribunal then considered whether Dr McCann failed to ensure that labial surgery was appropriate prior to offering to perform labial surgery on Patient F. The Tribunal noted that there was no discussion recorded of any treatment options other than surgery, and no evidence that alternative approaches had been explored with Patient F before surgery was proposed. The Tribunal also noted that the entry in Patient F's records was brief and lacking in detail, with no adequate documentation of the patient's concerns, the impact upon her, or any clear treatment plan.

158. The Tribunal accepted that Dr McCann examined Patient F and, based on his own clinical judgment, considered that surgery was appropriate. However, the Tribunal determined that he failed to take sufficient steps to ensure that surgery was in fact the appropriate course before offering to perform the procedure and was inappropriate and fell seriously below the standard expected.

159. Accordingly, the Tribunal found paragraph 12(d) proved.

Paragraph 12e (i)–(iii)

160. The Tribunal then considered whether Dr McCann failed to record an adequate:

i. history;
ii. diagnosis;
iii. management plan.

161. The Tribunal had regard to its earlier findings regarding Dr McCann's poor record-keeping. It determined that the clinical notes relating to Patient F were brief and lacked sufficient detail in relation to the patient's history, any clear diagnosis, and the proposed management plan.

162. Accordingly, the Tribunal found paragraph 12(e)(i)–(iii) proved.

Paragraph 12(f)(i) and (ii)

163. The Tribunal next considered if Dr McCann had booked Patient F for labial surgery at the GP Practice, which was inappropriate:

i.as a GP minor surgery room is not a suitable clinical setting for such a surgery; in
ii. that you intended to perform the labial surgery yourself.

164. The Tribunal noted Patient F's evidence that Dr McCann stated he would carry out the procedure and then took her to reception to arrange an appointment for surgery on 15 July 2019. As far as Patient F understood, the surgery had effectively been arranged at that stage. The Tribunal also noted that Patient F did not subsequently receive any correspondence or paperwork relating to the proposed surgery.

165. The Tribunal noted that Dr McCann had booked Patient F in for surgery which was inappropriate in a GP surgery setting. It noted that Patient F has turned up to the appointment on 15 July 2019.

'I was then given my appointment date by the receptionist for 15 July 2019 but I was not given any paperwork or confirmation of what the appointment was for.

……

On 15 July 2019, I arrived at the Surgery for what I believed to be for labia reduction surgery but I was seen by another doctor. I do not remember the name of this doctor now. It was a female doctor and I am sure it will be on my medical records. When I queried my labia surgery with this doctor she was shocked that Dr McCann had agreed to do the procedure at the Surgery and could not believe it. The doctor then advised that no GP could do this without a surgical setting.'

166. The Tribunal noted that Patient F attended the surgery expecting to undergo the procedure, only to be informed that the surgery could not be carried out. The Tribunal

determined that Dr McCann had misinformed the patient regarding the arrangements for surgery.

167. The Tribunal noted that Dr McCann's consultation notes were limited and lacked sufficient detail. There was little evidence within the records as to precisely what had been discussed during the consultation or what information had been provided to Patient F. However, having considered the evidence as a whole, the Tribunal was satisfied that Dr McCann had booked, or caused Patient F to believe she had been booked, for surgery and he had intended to perform the procedure himself.

168. The Tribunal also had regard to Dr McCann's response to the complaint in which he admitted that surgery in a GP setting was inappropriate.

> *'I now realise that it would have been better to refer this to the secondary care sector. I was fortunate to hove had a very hands on Gynaecology placement, but now realise that, despite my clinical experience, this would hove been more appropriately dealt with in a hospital setting'*

169. It also noted the expert report of Dr L:

> *'Labiaplasty is a complex procedure that may take 1 -2 hours and is usually performed under general anaesthetic or sedation by a gynaecologist or plastic surgeon. In my opinion labiaplasty should not be performed by a GP (unless they have relevant specialist experience) and should not be carried out in the setting of a minor surgery clinic in a GP practice because of the lack of necessary equipment and staff.'*

170. The Tribunal also took into account the harm and consequences suffered by Patient F as a result of the failed surgery arrangements. It noted that Patient F had booked two weeks off work, incurred childcare costs, and was subsequently informed that there was a long waiting list for the procedure. The Tribunal further noted that Patient F ultimately decided to pursue private treatment at a cost of over £3,000.

> *'In preparing for the appointment, Dr McCann advised me that I would need two weeks off after the procedure to recover. So, on his advice I informed my place of work of the procedure and that I would be off from work and would have a sick note for this. I also arranged childcare and for a friend to pick me up from the Surgery and drop me off at home with the understanding that I may not be fit to drive after the labia surgery due to being under a local anaesthetic.*

…..

It has been utterly life changing and the fact all of this happened made it an awful time of my life.

The private procedure cost me £3,000. Due to Dr McCann's conduct and my experience I want to forget about this and move on'.

171. Accordingly, the Tribunal found paragraph 12(f)(i) and (ii) proved.

Paragraph 12g

172. The Tribunal then considered whether Dr McCann failed to contact the local CCG to ascertain whether an NHS referral was possible;

173. It had regard to the email sent from Brune Medical Centre to Dr McCann's recruitment agency dated 24 July 2019:

'Following investigation from appointment orr.28th March 2019. The consultation from Dr McCann was very short and brief with very little detail regarding his examination or outcome of the app9intment. He has also added a consultation on the 3rd April which had no contents at all and looking at the appointment system the patient was not seen on that day. Dr McCann stated in his consultation on the 28m March 2019 that he would contact the CCG, There-is nothing In the patients records to relate to this being carried out.'

174. Based on this evidence it is clear no referral was made to the CGC.

175. Accordingly, the Tribunal find paragraph 12g proved.

Paragraph 12h

176. The Tribunal considered whether Dr McCann failed to refer Patient F to an appropriate specialist for an opinion on possible surgical options.

177. The Tribunal accepted Dr L's evidence that Patient F should have been referred to an appropriate specialist, including, if applicable, an appropriate private specialist, for consideration of possible surgical options. Dr McCann in his response accepted that the patient should have been referred to secondary care.

178. The Tribunal also accepted Dr L's opinion that the failure to appropriately advise and refer Patient F fell seriously below the standard expected because it was likely to cause an avoidable delay in accessing appropriate care and placed Patient F at risk of inconvenience and distress.

179. Accordingly, the Tribunal found paragraph 12(h) proved.

Paragraph 13 a&b

180. The Tribunal considered whether, following Dr McCann's consultation with Patient G on 8 April 2019 in relation to post-menopausal bleeding ("PMB"), he failed to :a. make an urgent suspected cancer referral to the PMB clinic in accordance with NICE Guidelines. b. make a referral until 30 April 2020.

181. The Tribunal noted that Dr McCann saw Patient G on 8 April 2019 but did not make an urgent referral at that stage. It found that a routine referral was only dictated on 30 April 2020, following prompting by the patient. The Tribunal further noted that there was then an additional delay of approximately nine days before the referral was ultimately sent on 9 May 2020.

182. The Tribunal had regard to Dr McCann's response

> *'It is my usual practice to make the referral with the patient in the room so they know what to expect. Strictly speaking best practice would indicate that PMEJ should b~ referred as a 2 week wait referral. At my previous practice in Poole we would refer the patient directly to the postmenopausal bleeding clinic and nat2 WW. What I was not made aware of was a 3 to 4 week delay in typing referrals which I was told about in July. As consultants read their referrals at least once per week this referral should have been flagged up by the consultant within one week of my referral. Having taken advice, in no way would this tumour have gone from one stage to another in 3 weeks. The time frame for advancing by one stage would be measured in months if not a year. I would be grateful if you would pass on my heartfelt apology to the patient concerned'.*

183. It also noted the expert opinion of Dr L.

> *'On 08.04.19, Dr McCann noted "Refer PMB clinic' but he did not dictate the letter until 30.04.19. The reason for this delay is unknown. My opinion is that a reasonably*

competent GP should dictate a 2ww referral in a timely fashion - ideally on the day, but certainly within 2-3 days. My opinion is that a delay of 22 days was seriously below the standard expected because of the potential for Patient G to suffer harm from a delayed diagnosis of cancer.'

Date	*Service*	*Comments*
14.06.19	*Admin entry*	*Fast track referral made to gynaecology (urgent entry suspicion of cancer)*
28.06.19	*Admin entry*	*Gynaecology appointment at Queen Alexander Hospital entry Seen by Miss LH (Locum Consultant) Pelvic ultrasound scan, hysteroscopy and biopsy performed, and endometrial cancer diagnosed*
14.08.19	*Admin entry*	*PatientG had TAH (total abdominal hysterectomy) and entry BSO (bilateral salpingo-oophorectomy) and BPLND (Bilateral Pelvic Lymph Node Dissection)*

184. It accepted the expert evidence that the referral should have been made urgently and in accordance with NICE Guidelines at the time of the initial presentation.

185. Although the Tribunal noted that no actual harm ultimately came to Patient G, it determined that the referral was not made when it should have been and was not carried out in a timely manner and fell seriously below the standard expected.

186. Accordingly, the Tribunal found paragraphs 13(a) and (b) in its entirety proved.

Paragraph 14

187. The Tribunal considered whether, on 5 May 2020, Dr McCann prescribed 56 tablets of diazepam (5mg) to Patient H which was excessive given that he had already prescribed 28 tablets of diazepam (5mg) on 29 April 2020.

188. The Tribunal reviewed the medical records and noted that, on 29 April 2020, Dr McCann prescribed 28 tablets of diazepam 5mg, to be taken twice daily. It further noted that, on 5 May 2020, only six days later, Dr McCann prescribed a further 56 tablets of diazepam 5mg, this time to be taken four times daily.

189. The Tribunal had regard to the expert evidence of Dr L, who stated that although diazepam can be an appropriate treatment for acute muscle spasm, it should generally only be prescribed on a short-term basis of up to three or four days. Dr L further stated that it was not appropriate to prescribe a further supply of diazepam so soon after the earlier prescription, particularly in the absence of evidence of severe muscle spasm.

190. The Tribunal also noted Dr L's evidence that the second prescription significantly increased both the dosage and frequency, allowing Patient H to take up to 20mg of diazepam daily for a further 14 days. Dr L considered that this prescribing exposed Patient H to risks including tolerance, dependency, and adverse effects associated with diazepam.

191. The Tribunal accepted the expert evidence of Dr L and concluded that the prescribing was excessive, inappropriate and fell seriously below the standard expected.

192. Accordingly, the Tribunal found paragraph 14 proved.

Paragraph 15(a), (b) and (c)

193. The Tribunal considered whether Dr McCann's actions, as set out in paragraph 14, exposed Patient H to:

a. the risk of harm from tolerance and/or dependency;
b. adverse effects of diazepam;
c. the risk of drug interactions with Patient H's other medications, including opioids and gabapentin.

194. The Tribunal had regard to the expert evidence of Dr L.

> *'My opinion is that Dr McCann should have been especially careful when prescribing diazepam on this occasion because of the risk of drug interactions with Patent H 's regular medication (Co-codamol 30/ 500 and gabapentin), the tramadol prescribed by Dr McCannon 29 April 2020, and the morphine solution prescribed by Dr McCannon 5 May 2020.Codeine, tramadol and morphine are all opioid analgesics and adverse effects such as sedation may be additive in combination. Gabapentin is also a sedative drug and opioids should be used with caution in combination with gabapentin.'*

195. It noted his opinion that Dr McCann should have exercised particular caution when prescribing diazepam in this case because of the risk of interaction with Patient H's existing medications, including co-codamol 30/500, gabapentin, tramadol prescribed on 29 April 2020, and morphine solution prescribed on 5 May 2020.

196. The Tribunal accepted Dr L's evidence that codeine, tramadol and morphine are all opioid analgesics and that adverse effects, including sedation, may be addictive. It also accepted his evidence that gabapentin is a sedative medication and that opioids should be prescribed with caution when combined with gabapentin.

197. The Tribunal was therefore satisfied that the prescribing exposed Patient H to the risks identified in paragraphs 15(a), (b) and (c).

198. Accordingly, the Tribunal found the entirety of paragraph 15 proved.

<u>Paragraph 16a, b &c</u>

199. The Tribunal considered whether, on 7 May 2020, Dr McCann prescribed Patient I, who was already taking psychoactive medication for bipolar disorder, with:

a. 45 tablets of diazepam (5mg);
b. 28 tablets of zopiclone (7.5mg);

and whether this was inappropriate in that he changed Patient I's medication without psychiatry advice or discussion.

200. The Tribunal had regard to the medical notes of Patient I;

'07 May 2020 16:57 Taw Hill Surgery, Surgery: MCCANN, Desmond (Dr) (Clinical Practitioner Access Role)

History: Feeling v low says quetiapine making her feel worse . No thoughts of self harm . She is consumed by
anxiety .
Examination: Withdrawn but calm and quite rational
Diagnosis: QOF Smoking indicator - patient must be offered support/treament in L24M
Plan: Stop quetiapine . Diazepam for 4/52 and zopiclone for her insomnia also short term only and pt aware of this
See me Tuesday .
Additional SCR dataset uploaded under COPI Regulations (Y237d)
Diazepam 5mg tablets - 45 tablet - one tab 8 hrly prn
Zopiclone 7.5mg tablets - 28 tablet - one tablet to be taken at night
ETP Medication Cancellation Sent
ETP FP10: Printed On Thu 07 May 2020 17:14 By Dr Desmond Mccann
Summary Care Record Update - This patient's preference is for only core items to be included in their Summary
Care Record. This has been overridden so that additional items will be included in this patient's Summary Care'

201. The Tribunal had regard to the expert evidence of Dr L, who confirmed that Patient I was already prescribed psychoactive medication, namely quetiapine and venlafaxine, as evidenced within the medical records, including the entry dated 21 April 2020. The Tribunal also noted the consultation record dated 7 May 2020, confirming that Dr McCann prescribed 45 tablets of diazepam 5mg and 28 tablets of zopiclone 7.5mg.

202. The Tribunal accepted Dr L's evidence that this prescribing was inappropriate because Patient I had a history of severe and enduring mental illness and was under active psychiatric review, with psychiatry maintaining oversight of her medication. The Tribunal noted Dr L's evidence that, whilst a GP may make minor adjustments to medication, commencing a relatively prolonged course of diazepam and zopiclone without prior discussion or consultation with psychiatry fell below the expected standard.

203. The Tribunal also accepted Dr L's evidence that the addition of these medications constituted a "change" to Patient I's medication regime. It further accepted his evidence that consultation with psychiatry would have been particularly important given the patient's mental health history and the potential availability of support from the mental health team during periods of deterioration.

204 The Tribunal then considered paragraph 16(c), namely whether prescribing a combination of diazepam and zopiclone was inappropriate because it exposed Patient I to an increased risk of adverse effects. The Tribunal accepted Dr L's evidence that both medications are sedative drugs and that prescribing them together increased the risk of adverse effects, including excessive sedation and associated complications.

205. Accordingly, the Tribunal found paragraph 16a, b &c proved

Paragraph 17a-17c

206. The Tribunal considered whether, having changed Patient I's medication as set out in paragraph 16, Dr McCann's prescribing was inappropriate in that it:

a. was excessive in quantity;
b. was excessive in dosage;
c. exposed Patient I to:
   i. the risk of adverse effects;
   ii. overuse;
   iii. tolerance and/or dependency.

207. In relation to 17a The Tribunal accepted the expert evidence of Dr L that the prescription of 45 tablets of diazepam was excessive in quantity, particularly given Patient I's mental health history and benzodiazepine dependency.

208. In relation to paragraph 17b the Tribunal considered Dr L's evidence regarding dosage. It noted that Dr L initially stated that his principal concern related to the quantity prescribed rather than the dosage itself. However, he also stated that prescribing diazepam 5mg three times daily for 15 days was excessive, particularly as a starting dose.

209. Dr L confirmed in his evidence that dosage of 5mg of diazepam three times a day according to the BNF guidelines was within the parameters. Dr L concluded that in respect of the diazepam prescription this was excessive in quantity. The Tribunal accepted Dr L's evidence that, although the dosage issue was not his most serious concern, the prescribing nonetheless fell below the expected standard. The Tribunal accepted Dr L's evidence and found paragraph 17a proved and paragraph 17b not proved.

210. In relation to paragraph 17(c)(i)–(iii), the Tribunal accepted Dr L's evidence that the prescribing exposed Patient I to the risk of adverse effects, overuse, and tolerance and/or dependency.

211. The Tribunal accepted that the nature, quantity and combination of the prescribed medications created those risks.

212. Accordingly, the Tribunal found paragraphs 17(a), (c)(i)–(iii) proved and 17b not proved.

Paragraph 18

213. The Tribunal considered whether, having changed Patient I's medication as set out in paragraph 16(b), Dr McCann's prescribing was inappropriate in that:

a. it was excessive in quantity;
b. it exposed Patient I to the risk of tolerance and/or dependency.

214. The Tribunal accepted the expert evidence of Dr L that the prescription of 28 tablets of zopiclone was excessive in quantity. The Tribunal noted Dr L's evidence that prescribing a full month's supply of zopiclone in these circumstances fell below the standard expected of a reasonably competent GP. It also accepted his evidence that such prescribing exposed Patient I to risks including overuse and drug interactions.

215. In relation to paragraph 18(b), the Tribunal accepted Dr L's evidence that prescribing zopiclone in the quantity prescribed exposed Patient I to the risk of tolerance and/or dependency.

216. Accordingly, the Tribunal found paragraphs 18(a) and (b) proved.

Paragraph 19 a,b,d (i)(ii)

217. The Tribunal considered whether, on 20 May 2020, Dr McCann prescribed Patient I with 28 tablets of zopiclone 7.5mg in circumstances that were inappropriate, as alleged at paragraphs 19(a), (b) and (d).

218. The Tribunal noted that it could be certain that Patient I had been prescribed zopiclone. However, it could not be satisfied, on the evidence before it, as to precisely what

other medications Patient I was taking and or prescribed at the relevant time, including whether she was concurrently taking quetiapine and the previously prescribed diazepam.

219. The Tribunal noted that the diazepam issued on 7 May 2020 should, (according to the prescribing records)on its face, have lasted until approximately 22 May 2020. However, the Tribunal also had regard to evidence contained within the medical records suggesting that Patient I had been sharing medication with her husband.

220. The Tribunal carefully reviewed the medical records and noted that there were multiple entries on 19 May 2020 relating to quetiapine prescriptions issued at different times, together with entries indicating that certain prescriptions had ended. The Tribunal took into account Dr L evidence in relation to the prescriptions and specifically the Quetiapine. In his oral evidence he told the Tribunal that he could not say definitively what prescription was a repeat prescription and which one had been prescribed to Patient I . The Tribunal went through the prescribing records and table in detail with Dr L. It noted that, even upon reviewing the records, Dr L himself was not entirely certain which prescriptions had in fact been issued, repeated or stopped. Dr L also accepted that the records were confusing.

221. Given the level of uncertainty arising from the medical records, the Tribunal was not satisfied that there was sufficient evidence before it to infer what medications had been prescribed and or stopped in respect of Patient I. It was satisfied that the evidence when taken at its highest was that there had been prescriptions of several medications. That was not sufficient for a finding and the GMC had not proved the allegation on the balance of probabilities.

222. Accordingly, the Tribunal found paragraphs 19(a), (b) and (d)(i)–(ii) not proved.

Paragraph 19c

223. The Tribunal considered whether Dr McCann changed Patient I's medication without seeking psychiatry advice or discussion.

224. The Tribunal noted that, in July 2019, following Patient I's move to England, she had been referred to the local mental health service for advice regarding her medication. The Tribunal also noted that Patient I had a documented history of mental illness, as recorded within her medical records.

225. The Tribunal determined that Dr McCann changed Patient I's medication without seeking further advice or discussion with psychiatry beforehand. It also noted that there was no evidence within Patient I's medical records of any consultation or communication with psychiatric services prior to the medication changes.

226. Accordingly, the Tribunal found paragraph 19(c) proved.

Paragraph 20

227. The Tribunal considered whether Dr McCann had failed to complete and return the Working Details Form which the GMC sent to you by email on 30 September 2019, 30 October 2019, 9 December 2019 and 1 July 2020.

228. The Tribunal noted the statement of the investigation officer;

> 'A *blank WDF is sent out by the GMC when an investigation is disclosed to a doctor. We ask doctors to complete the WDF to provide details of their employer(s), usually from within the last six months (though this may change depending on when the allegations date back to). Once we receive a completed WDF from a doctor, we will disclose the GMC's investigation to the doctor's employer and will ask the employer if they have any fitness to practise concerns.*
>
> *I did not receive a response from Dr McCann to my letter dated 30 September 2019, I therefore sent a 'pathfinder' email to Dr McCann on 29 October 2019 ('Exhibit NW/02') using the email address that we had on our case management system, 'Siebel'.*
>
> *On 30 October 2019, Dr McCann called me in response to my pathfinder email sent on 29 October 2019 ('Exhibit NW/03'). I advised Dr McCann that I had written to him to disclose the GMC's investigation, Dr McCann said that he had not received anything by post. I therefore emailed Dr McCann on 30 October 2019 ('Exhibit NW/04') with a copy of my letter dated 30 September 2019 which included a blank WDF. I requested that Dr McCann provide a response to the WDF by 6 November 2019.*
>
> *On 6 December 2019, I received an email from Dr McCann requesting a further copy of the WDF by email ('Exhibit NW/06'). I emailed Dr McCann back on 9 December 2019 with a further copy of the WDF ('Exhibit NW/07') and also sent a copy of this to Dr McCann's registered address.*

On 1 July 2020, I sent a further WDF to Dr McCann and requested that he complete and return the same ('Exhibit NW/10'). I again copied in Dr McCann's legal representative to this email.

To date, I have not received a completed WDF from Dr McCann, despite my requests above for Dr McCann to complete the same.'

229. The Tribunal considered the documentary evidence before it, including the statement of the Investigation Officer. The Tribunal was satisfied that the GMC had sent Working Details Forms to Dr McCann by email on 30 September 2019, 30 October 2019, 9 December 2019 and 1 July 2020.

230. The Tribunal determined that, despite these repeated requests and reminders, Dr McCann failed to complete and return the Working Details Form to the GMC.

231. Accordingly, the Tribunal found paragraph 20 proved.

Paragraph 21

232. XXX

233. XXX

234. XXX

Paragraph 22

235. XXX

236. XXX

237. XXX

The Tribunal's Overall Determination on the Facts

XXX Medical Practice

1. You engaged in unwanted conduct towards Ms A (a XXX colleague) in that:

a. in June 2019, whilst Ms A was kneeling on the floor to perform a dressing change on a male patient's lower leg, you said to the patient words to the effect:
   i. 'what's it like having a pretty young XXX on her knees in front of you'; Determined and found proved
   ii. 'I bet it's a long time since you've had a young girl bending on her knees in front of you'; Determined and found proved
   iii. 'I hope so', when the patient said 'she'll be on her knees in front of you in a few minutes'; Determined and found proved

   or words to that effect;

b. On or around 17 June 2019, you slapped Ms A on her upper arm with your hand, after she told you that she could not act as a chaperone for you; Determined and found proved.

c. on 25 June 2019, whilst Ms A was in the stock room searching for a scalpel for you, you came and stood behind her, took out a non-medical knife with the blade pointing upwards and said:
   i. 'Do you think this will do?'; Determined and found proved
   ii. 'Do you think this is big enough to do the job?'; Determined and found proved

   or words to that effect.

2. Your actions as set out at paragraph(s) 1ai, 1aii and 1aiii were sexually motivated. Determined and found proved

XXX Medical Practice

3. You engaged in unwanted conduct towards Ms B, a colleague who wears a xxx, in that:
   a. on 15 April 2020 you:
      i. looked at her chest area; Determined and found proved
      ii. said 'why do you cover yourself, it would be nice to see what's underneath', or words to that effect; Determined and found proved
   b. on or around 27 May 2020 you approached Ms B from behind and:
      i. hit Ms B's bottom with your knee or another part of your body; Determined and found proved
      ii. said 'you've been hit by a doctor', or words to that effect and laughed. Determined and found proved

4. Your actions as set out at paragraph(s):
   a. 3ai, 3aii, 3bi and 3bii were sexually motivated; Determined and found proved
   b. 3bi were carried out without Ms B's consent. Determined and found proved

Appraisal

5. On 16 March 2020, you submitted a NHS appraisal form ('the Form') in which you selected *'I have nothing to declare',* in response to the probity statement, '*In relation to suspensions, restrictions on practice or being subject to an investigation of any kind since my last appraisal',* which was untrue. Determined and found proved

6. You knew that your probity declaration was untrue, in that you had been the subject of a GMC investigation since September 2019. Determined and found proved

7. Your action as set out at paragraph 5 was dishonest by reason of paragraph 6. Determined and found proved

Self-prescribing

8. On 2 April and 19 May 2020 you prescribed yourself medication as set out in Schedule 1 when it was not necessary for you to obtain these items urgently. Determined and found proved

Patient C

9. Between 12 February and 22 April 2020 you issued prescriptions for lorazepam and zolpidem to Patient C as set out in Schedule 2 which was inappropriate in that you prescribed these medications:
   a. in excessive quantities and/or at excessive frequency; Determined and found proved
   b. despite relevant information within Patient C's background history which indicated a pattern of drug-seeking behaviour; Determined and found proved
   c. without agreeing a process of stabilisation and reduction to Patient C's prescribed dose of these medication(s). Determined and found proved

Patient D

10. On 12 March 2020, your consultation with Patient D was inadequate in that you:
    a. failed to obtain a~~n~~ history of: Amended under Rule 17(6)
       i. Patient D's presenting complaint; Determined and found not proved
       ii. the frequency of Patient D's migraines; Determined and found not proved
       iii. the severity of Patient D's migraines; Determined and found not proved

iv. whether Patient D had taken any treatment that day; **Determined and found not proved**

b. failed to give advice that:

i. Patient D should stop taking topiramate when starting gabapentin; **Determined and found not proved**

ii. gabapentin was not recommended for prophylaxis of episodic migraine; **Determined and found not proved**

c. failed to provide appropriate treatment as you:

i. prescribed gabapentin which was not recommended for the prophylaxis of episodic migraine; **Determined and found not proved**

ii. added gabapentin 300mg, use as directed, 100 capsules, to the repeat prescribing system without arranging to review Patient D to assess the efficacy and tolerability of this medication; **Determined and found not proved**

d. failed to record:

i. in the alternative to paragraphs 10a, an adequate history; **Determined and found proved**

ii. in the alternative to paragraph 10b, your advice to Patient D; **Determined and found proved**

iii. your reasons for prescribing gabapentin. **Determined and found proved**

Patient E

11. On 19 March 2020 you failed to arrange adequate treatment or follow up of Patient E who presented with elevated cardiovascular risk, in that you did not:

a. begin treatment with atorvastatin and then arrange to monitor Patient E's response to the drug; **Determined and not found proved**

b. refer Patient E to a specialist nephrology clinic; **Determined and found not proved**

c. seek advice from a diabetes specialist on diabetic treatment; **Determined and found proved**

d. arrange a follow up appointment with Patient E within seven to fourteen days. **Determined and found not proved**

Patient F

12. On 28 March 2019, your consultation with Patient F (who presented with a history of abnormal labia) was inadequate in that you:

a. failed to assess the psychological and/or physical issues leading to Patient F's presentation; **Determined and found proved**

b. inappropriately performed an internal vaginal examination which was not clinically indicated; **Determined and found not proved**

c. failed to discuss:

i. alternative treatments to labial surgery; **Determined and found proved**

ii. benefits and risk of labial surgery; **Determined and found proved**

d. failed to ensure that labial surgery was appropriate prior to offering to perform labial surgery on Patient F; **Determined and found proved**

e. failed to record an adequate:

i. history; **Determined and found proved**

ii. diagnosis; **Determined and found proved**

iii. management plan; **Determined and found proved**

f. booked Patient F for labial surgery at the GP Practice, which was inappropriate:

i. as a GP minor surgery room is not a suitable clinical setting for such a surgery; **Determined and found proved**

ii. in that you intended to perform the labial surgery yourself; **Determined and found proved**

g. failed to contact the local CCG to ascertain whether an NHS referral was possible; **Determined and found proved**

h. failed to refer Patient F to an appropriate specialist for an opinion on possible surgical options. **Determined and found proved**

Patient G

13. On 8 April 2019, following your consultation with Patient G who presented with post-menopausal bleeding ('PMB') you failed to make:

a. an urgent suspicion of cancer referral to the PMB clinic in accordance with NICE Guidelines; **Determined and found proved**

b. a referral until the 30 April ~~2020~~ 2019 **Determined and found proved** Amended under Rule 17(6)

Patient H

14. On 5 May 2020 you prescribed 56 tablets of diazepam (5mg) to Patient H, which was excessive given that you had already prescribed 28 tablets of diazepam (5mg) on 29 April 2020. **Determined and found proved**

15. Your actions set out in paragraph 14 exposed Patient H to:

a. the risk of harm from tolerance and/or dependency; **Determined and found proved**

b. adverse effects of diazepam; **Determined and found proved**
c. the risk of drug interactions with Patient H's other medications including opioids and gabapentin. **Determined and found proved**

Patient I

16. On 7 May 2020 you prescribed Patient I, who was already taking psychoactive medication for bipolar disorder ('medications'), with:
    a. 45 tablets of diazepam (5mg); **Determined and found proved**
    b. 28 tablets of zopiclone (7.5mg); **Determined and found proved**

    which was inappropriate in that you changed Patient I's medications without psychiatry advice/discussion;
    c. a combination of both diazepam and zopiclone which was inappropriate because it exposed Patient I to an increased risk of adverse effects. **Determined and found proved**

17. Having changed Patient I's medications as set out in paragraph 16a your prescribing: was in appropriate as it:
    a. was excessive in quantity; **Determined and found not proved**
    b. was excessive in dosage; **Determined and found proved**
    c. exposed Patient I to:
        i. the risk of adverse effects; **Determined and found proved**
        ii. overuse; **Determined and found proved**
        iii. tolerance and/or dependency; **Determined and found proved**

18. Having changed Patient I's medication as set out in paragraph 16 b your prescribing was inappropriate in that it:
    a. it was excessive in quantity; **Determined and found proved**
    b. it exposed Patient I to the risk of tolerance and/or dependency. **Determined and found proved**

19. On 20 May 2020, you prescribed Patient I with 28 tablets of zopiclone 7.5mg which was inappropriate in that:
    d. Patient I was already being treated for night sedation with quetiapine by a psychiatrist; **Determined and found not proved**
    e. you prescribed an additional supply of quetiapine 25mg (28 tablets) and advised Patient I to take up to 4 tablets at night; **Determined and found not proved**
    f. you changed Patient I's medications without seeking psychiatry advice/discussion; **Determined and found not proved**

d. it exposed Patient I to:
   i. over-sedation from:
      A. your additional supply of 28 tablets of quetiapine 25mg (28 tablets) on the same date and 28 tablets of zopiclone on 7 May 2020; **Determined and found not proved**
      B. a repeat prescription of quetiapine 25mg (30 tablets) issued on the same date; **Determined and found not proved**
   iii. drug interactions with her existing medication(s). **Determined and found not proved**

WDF

20. You failed to complete and return the Working Details Form which the GMC sent to you by email on 30 September 2019, 30 October 2019, 9 December 2019 and 1 July 2020. **Determined and found proved**

21. XXX

22. XXX

And that by reason of the matters set out above your fitness to practise is impaired because of your:

a. misconduct in respect of paragraphs 1 to 20; **Determined and found proved**
b. XXX

Determination on Impairment – 31/07/26

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

2. The Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential. This determination will be handed down in private but as this case also concerns Dr McCann's misconduct, a redacted version will be published at the close of the hearing.

The Evidence

3. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence as follows.

1. XXX;
2. Correspondence from Dr McCann's family.

Submissions

4. On behalf of the GMC, Ms Dudley-Jones submitted that it is always a matter for the Tribunal exercising its own independent judgment as to whether Dr McCann's fitness to practise is currently impaired. However, she submitted that the Tribunal's findings demonstrated that the matters found proved amounted to serious professional misconduct and that Dr McCann's fitness to practise was currently impaired by reason of XXX his misconduct XXX.

5. She submitted that the misconduct spanned a significant period of time, from the beginning of 2019 through to 2020, and involved conduct occurring whilst Dr McCann was practising as a General Practitioner across a number of medical practices.

6. She reminded the Tribunal that it had made findings of fact in respect of sexually motivated conduct towards two female colleagues whilst Dr McCann was at work. She submitted that these were deliberate and purposeful behaviours which represented serious breaches of professional boundaries.

7. She submitted that, whilst working as a locum GP at XX Health Centre, Dr McCann made wholly inappropriate sexual comments to Ms A in the presence of a patient. She submitted that those comments were disgusting and entirely inappropriate in any professional setting.

8. She further submitted that, on 17 June 2019, Dr McCann slapped Ms A on the upper arm after she declined to act as his chaperone because she was treating another patient. She submitted that Ms A considered that Dr McCann had once again overstepped professional boundaries and that Ms A reported the incident shortly afterwards.

9. She reminded the Tribunal that, on 25 June 2019, Dr McCann persuaded Ms A to accompany him into a clinical store cupboard before producing a non-medical knife and

asking whether it was "big enough for the job". She submitted that the Tribunal had accepted that Ms A was terrified by this incident and immediately reported the matter.

10. She submitted that, whilst working at XXX Medical Practice, Dr McCann directed sexually inappropriate comments towards Ms B by asking why she covered herself because it would be "nice to see what's underneath" whilst looking at her chest.

11. She further submitted that, on a separate occasion, Dr McCann deliberately struck Ms B on the buttocks with his knee, without her consent, before saying, "You've been hit by a doctor", and laughing. She submitted that this was deliberate, purposeful and sexually motivated conduct.

12. Ms Dudley-Jones submitted that the Tribunal had also found Dr McCann to have acted dishonestly when completing his NHS appraisal documentation by failing to disclose that he was the subject of a GMC investigation. She submitted that honesty within the appraisal process is fundamental to professional regulation and revalidation and that his dishonesty was particularly serious given that he was practising as a locum GP across numerous surgeries.

13. She further submitted that Dr McCann failed to return Working Details Form (WDF) requested by the GMC on four separate occasions between September 2019 and July 2020. She submitted that this prevented the GMC from identifying where he was practising and from making appropriate enquiries or informing relevant employers of the concerns under investigation. She submitted that this conduct was deliberate and compounded the regulatory risks already presented by his locum practice.

14. She submitted that Dr McCann also self-prescribed XXX when there was no clinical urgency requiring him to do so. She submitted that this was particularly serious in light of the evidence concerning XXX and represented a clear departure from the standards set out in *Good Medical Practice*.

15. She reminded the Tribunal that it had found multiple failures in Dr McCann's clinical practice affecting six different patients between March 2019 and May 2020.

16. She submitted that those failures included delaying an urgent suspected cancer referral for Patient G, providing incorrect advice to Patient F regarding a surgical procedure, inadequately documenting that consultation, prescribing excessive quantities of zolpidem and lorazepam to Patient C despite a history of drug-seeking behaviour, and inappropriate

prescribing of diazepam and zopiclone to Patient I. She further submitted that NHS England audits identified additional prescribing concerns relating to Patients H and D.

17. She submitted that, as Dr L explained in his expert evidence, Dr McCann's actions fell seriously below the standard expected of a reasonably competent General Practitioner and represented multiple and wide-ranging departures from accepted clinical practice.

18. She submitted that the Tribunal had found numerous breaches of the principles contained within *Good Medical Practice 2013 (GMP)*, including duties relating to patient care, prescribing, honesty and integrity, maintaining professional boundaries and preserving public trust.

19. Ms Dudley-Jones submitted that Dr McCann's misconduct fell squarely within the definition of serious professional misconduct. She submitted that his actions seriously undermined public confidence in the profession, placed patients at risk of harm, caused actual harm in certain instances, brought the profession into disrepute and breached fundamental tenets of medical practice.

20. She submitted that issues of insight and remediation were matters for the Tribunal. However, she submitted that, whilst there had been limited apologies, there remained no persuasive evidence of genuine insight or meaningful remediation in relation to the sexually motivated misconduct, dishonesty, prescribing failures, clinical deficiencies or repeated failures to cooperate with the regulator. She further submitted that the Tribunal would also have regard to the continuing concerns relating to XXX.

21. Ms Dudley-Jones submitted that, applying the principles in *Grant v NMC*, this was one of those cases in which the misconduct was so serious, and involved such fundamental breaches of the standards expected of the profession, that a finding of current impairment was required. She submitted that such a finding was necessary not only to protect the public but also to maintain public confidence in the medical profession and to uphold proper professional standards. She submitted that those important public interest considerations would be undermined if the Tribunal were not to make a finding of impairment.

22. Finally, Ms Dudley-Jones submitted that all the misconduct fell at the higher end of the spectrum of seriousness.

The Relevant Legal Principles

23. The LQC advised the Tribunal that its task was to determine, firstly, whether the facts found proved amounted to misconduct, and that misconduct was serious, and then whether the finding of that misconduct which was serious poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

24. The LQC advised that this case involved several distinct aspects which the Tribunal would need to consider, namely the findings relating to sexually motivated and unwanted conduct, dishonesty, self-prescribing, clinical consultations and prescribing, XXX, and Dr McCann's failure to provide a Working Details Form, all of which had been identified in the GMC's submissions.

25. The LQC reminded the Tribunal that the question was whether Dr McCann's fitness to practise was impaired today. In reaching that decision, the Tribunal should consider Dr McCann's conduct at the time of the events, whether the misconduct was capable of remediation, whether it had in fact been remedied, the likelihood of repetition, and the extent to which Dr McCann had demonstrated insight and remorse.

26. The LQC referred the Tribunal to the MPTS Guidance (The Guidance) on impairment which came into effect in November 2025, including the structured approach contained within the Guidance. She advised the Tribunal to consider where each category of misconduct lay on the spectrum of seriousness, identifying the appropriate starting point for assessing seriousness and whether there were features which increased or reduced its seriousness. She reminded the Tribunal to consider whether the misconduct should properly be regarded as being of low, medium or high seriousness.

27. She further advised the Tribunal to consider any relevant contextual factors, whether circumstances had changed since the events occurred, and whether any such changes increased, reduced or had no impact upon the assessment of current risk.

28. The LQC advised the Tribunal to consider how Dr McCann had responded to the allegations. She noted that Dr McCann had neither attended the hearing nor been represented. Nevertheless, the Tribunal should consider whether there was any evidence before it demonstrating insight into the concerns identified or any evidence that he had taken steps to reduce the risk of similar concerns arising in the future. In answering these questions the Tribunal will have regard to the facts found proved at the first stage of the hearing and any further relevant evidence presented to the Tribunal.

29. The LQC also advised the Tribunal to consider whether Dr McCann had maintained his professional knowledge and skills and what impact, if any, that had upon the assessment of current risk. The Tribunal should then determine whether Dr McCann posed a current or ongoing risk and, if so, whether that risk was properly characterised as low, medium or high.

30. There is no burden or standard of proof at this stage of the proceedings and the decision on impairment is a matter for the independent judgment of the Tribunal. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

31. The LQC reminded the Tribunal that Ms Dudley-Jones had already taken it through the relevant provisions of *Good Medical Practice (2013) (GMP)* and advised that there was no need to repeat those provisions. The LQC observed that the applicable edition was the 2013 version of *Good Medical Practice*, which was in force during the period of the allegations between 2019 and 2020.

32. The LQC advised the Tribunal that it was required to provide adequate reasons for its decision and referred it to the principles set out in *Grant v Nursing and Midwifery Council* when considering the question of current impairment.

33. Finally, as the allegations fall under more than one ground for impairment, an assessment of current and ongoing risk must be made in respect of each of them.

The Tribunal's determination on impairment

<u>The MPTS Guidance on impairment: Steps 2A to 2E</u>

34. At all times, the Tribunal had regard to *MPTS Guidance for Tribunals (Section three: MPT Hearings > Part B > Stage 2: Impairment > Steps 2(a) to (e)* ('The Guidance').

35. The Tribunal had regard to the following paragraphs of the GMP 1, 2, 14, 15a, b, c, 16a, d, f, g, 17, 18, 19, 21a-e, XXX, 35, 36, 37, 44, 47, 48, 49a-c, 51a and b, 65, 66, 68 , 71 and 73.

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

2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

14 You must recognise and work within the limits of your competence. You must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK.

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

a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient
b promptly provide or arrange suitable advice, investigations or treatment where necessary
c refer a patient to another practitioner when this serves the patient's needs.8 Is there a legal basis for considering impairment?

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

d consult colleagues where appropriate

f check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications

g wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship

17 you must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.

18 You must make good use of the resources available to you.

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:

> *a relevant clinical findings*
> *b the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
> *c the information given to patients*
> *d any drugs prescribed or other investigation or treatment e who is making the record and when*

XXX

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

36 You must treat colleagues fairly and with respect.

37 You must be aware of how your behaviour may influence others within and outside the team.

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

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

47 You must treat patients as individuals and respect their dignity and privacy.

48 You must treat patients fairly and with respect whatever their life choices and beliefs.

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

c who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care

51 You must support patients in caring for themselves to empower them to improve and maintain their health. This may, for example, include:

a advising patients on the effects of their life choices and lifestyle on their health and well-being

b supporting patients to make lifestyle changes where appropriate

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

66 You must always be honest about your experience, qualifications and current role.

68 you must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

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

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

b You must not deliberately leave out relevant information

73 You must cooperate with formal enquiries and complaints procedures and must offer all relevant information while following the guidance in 'Confidentiality'

Sexual misconduct – Ms A and Ms B (paragraphs 1 – 4)

Step 2a: legal basis for considering impairment

36. The Tribunal noted that the facts found proved amounted to unwanted sexualised conduct towards work colleagues, namely Ms A and Ms B.

37. The Tribunal considered that this behaviour represented a serious departure from the professional standards expected of a registered medical practitioner, as set out in *Good Medical Practice.* In determining whether Dr McCann's actions amounted to misconduct, the Tribunal had regard to the standards expected of medical practitioners, including paragraphs 35, 36, 37 and 65 of *Good Medical Practice*.

38. The Tribunal was mindful that Dr McCann's behaviour towards both Ms A and Ms B should be viewed in the context that there was an inherent power imbalance in their relationship. Dr McCann's conduct as found proved in these allegations was sexually motivated. The Tribunal found that there had been a clear breach of GMP paragraph 36 in respect of colleagues as he did not treat Ms A or Ms B with respect or fairly. He continued with conduct that was unwanted and his actions were disturbing and unacceptable. Further by engaging in unwanted conduct of a sexual nature in circumstances where a power balance existed, he had breached one of the fundamental tenets of the profession, undermined trust and confidence in the profession, and brought the profession into disrepute. The Tribunal was satisfied that Dr McCann's behaviour was a serious departure from the standards expected of a registered medical practitioner. Taking into account all of the guidance and circumstances, the Tribunal concluded that Dr McCann's conduct amounted to serious professional misconduct and determined that there is a legal basis for considering impairment.

Step 2b: Where on the spectrum of seriousness does the allegation lie?

39. The Tribunal also had regard to the Introduction to the Guidance and determined that the case fell within Case Type 1: Sexual Misconduct, which indicates that cases involving sexual misconduct will usually fall at the higher end of the spectrum of seriousness because of the significant risk they pose to public confidence in the profession.

'63 Whilst a range of behaviour can be seen, the nature of the departure from the professional standards usually means these concerns or allegations fall at the higher end of the spectrum of seriousness. Even a single incident of sexual misconduct can have a significant harmful impact and pose a high level of risk to public protection

66. Most allegations relating to sexual misconduct have a starting point of a high level of seriousness and therefore fall at the higher end of the spectrum of seriousness. This means the starting point for assessing current and ongoing risk to public protection will usually be high.

69. The level of risk associated with a sexual misconduct allegation will generally be medium or high.

40. The Tribunal determined that the appropriate starting point for assessing the seriousness in this regard was at the higher end of the spectrum. It had regard to paragraph 31 of the Guidance, which identifies sexual misconduct as a type of misconduct that will usually be regarded as falling within the higher range of seriousness.

31 Allegations that are likely to fall at the higher end of the spectrum of seriousness include, but are not limited to: sexual assault, indecency or sexual harassment

41. The Tribunal considered that Dr McCann's conduct created an uncomfortable working environment for Ms A and Ms B.

42. The Tribunal also considered whether Dr McCann had exploited the imbalance of power that existed between himself and his colleagues, given his position as a senior clinician. It considered that the difference in professional standing and age was a relevant aggravating factor. The Tribunal found that Dr McCann's conduct involved an abuse of the professional trust and boundaries inherent in the doctor–colleague relationship.

43. In assessing the overall seriousness of the misconduct, the Tribunal considered that the conduct presented a high level of risk to public confidence in the medical profession and to the maintenance of proper professional standards. Although the misconduct was not directed towards patients and therefore did not present the highest level of risk to patient safety, the Tribunal recognized that the behaviour caused significant emotional harm to Ms A and Ms B and undermined confidence in doctors as professionals.

44. Taking all matters into account, including the physical /sexual misconduct, the repeated conduct, the abuse of professional boundaries, the imbalance of seniority and the

emotional harm caused, the Tribunal concluded that the misconduct fell towards the higher end of the spectrum of seriousness. It determined that the combination of these factors placed the misconduct firmly within the higher category identified in the relevant guidance and represented a serious departure from the standards expected of a registered medical practitioner.

Prescriptions (paragraphs 9, 14, 15, 16 – 19)

45. The Tribunal noted that the facts found proved established breaches of GMP, in particular paragraphs 16a, 16d and 16f, as well as GMC Guidance on prescribing. The Tribunal also had regard to the Introduction to the Guidance and determined that the case fell within Case Type 5: Clinical Concerns. It determined that Dr McCann had issued prescriptions inappropriately and in excessive quantities to Patients C, H and I.

Patient C

Step 2a: legal basis for considering impairment

46. The Tribunal first considered whether there was a legal basis for finding impairment with regard to the proven facts. The Tribunal reminded themselves that Dr McCann had prescribed lorazepam and zolpidem in excessive frequencies and quantities to Patient C. The Tribunal noted that Patient C had repeated requests for early prescriptions which should have alerted Dr McCann that Patient C was demonstrating drug-seeking behaviour.

47. The Tribunal referred to Dr L's expert evidence on this allegation that stated that the quantities prescribed were excessive within the relevant timeframe. Dr L had further opined that, even if the timeframe itself had been appropriate, the quantities prescribed remained excessive. The Tribunal accepted this expert view and determined that Dr McCann's conduct fell seriously below the standard expected of a reasonably competent GP. The Tribunal found that Dr McCann's conduct was seriously deficient in this instance and concluded that allegations in relation to Patient C did amount to serious misconduct.

Patient H

Step 2a: legal basis for considering impairment

48. The Tribunal reminded themselves of their findings at the Facts stage regarding Patient H in that Dr McCann had prescribed an excessive amount of diazepam to Patient H and that this exposed Patient H to risks of harm from tolerance, dependency, adverse effects

of diazepam and a risk of drug interactions with other medications. The Tribunal also reminded themselves of Dr L's expert advice which stated diazepam should only be prescribed on a short-term basis and that it was not appropriate that a second prescription of diazepam was provided so soon after the earlier prescription. The Tribunal found that this represented a serious departure from what is expected from a reasonably competent medical professional.

Patient I

Step 2a: legal basis for considering impairment

49. The Tribunal reminded themselves of their findings at the facts stage regarding Patient I and noted that Dr McCann prescribed inappropriately. The Tribunal found that Patient I was a psychiatric patient exposed to a risk of tolerance and/or dependency. The Tribunal also considered Dr L's expert evidence which had concluded that both medications being prescribed together increased the risk of adverse effects and complications. The Tribunal had considered and accepted this evidence.

50. The Tribunal found that Dr McCann's actions in relation to Patients C, H and I seriously undermined public confidence in the medical profession, placed patients at risk of harm, caused actual harm in certain instances, brought the profession into disrepute, and breached fundamental tenets of medical practice. The Tribunal was satisfied that Dr McCann's behaviour was a serious departure from the standards expected of a registered medical practitioner taking into account all of the guidance and circumstances, the Tribunal conclude that Dr McCann's conduct amounted to serious professional misconduct and determined that there is a legal basis for considering impairment.

Step 2b: Where on the spectrum of seriousness does the allegation lie?

51. The Tribunal considered the relevant Guidance at step 2b relating to where on the spectrum of seriousness the allegations around Dr McCann's misconduct in relation to prescribing lie. The Tribunal found that the allegations against Dr McCann in terms of his prescribing activity fell into the higher level of the spectrum of seriousness and noted a number of factors which increased this level of seriousness further.

52. The Tribunal noted that Dr McCann's conduct was not an isolated incident and was repeated with multiple patients at several consultations. The Tribunal also noted that there was a risk of harm or potential harm to patients, especially to one patient whose drug

dependency had not been picked up and another who he prescribed to without obtaining psychiatric advice.

53. The Tribunal considered that Dr McCann should have identified these issues as an experienced medical professional and should have taken a more cautious approach in his prescribing. The Tribunal found that Dr McCann had shown a disregard for professional standards.

54. The Tribunal concluded that Dr McCann had undermined a clinical system designed to protect the public to prevent incorrect prescribing.

Consultations (paragraph 10, 12 and 13)

Patient D

Step 2a: legal basis for considering impairment

55. The Tribunal noted in the case of Patient D that there had been a failure by Dr McCann to accurately record an adequate history, advice to Patient D and reasons for prescribing gabapentin. The Tribunal considered paragraphs 19 and 21 of GMP had been breached. The Tribunal also had regard to the Introduction to the Guidance and determined that the case fell within Case Type 5: Clinical Concerns. The Tribunal was satisfied that Dr McCann's behaviour was a serious departure from the standards expected of a registered medical practitioner. Taking into account all of the guidance and circumstances, the Tribunal concluded that Dr McCann's conduct amounted to professional misconduct and determined that there is a legal basis for considering impairment.

Patient F

Step 2a: legal basis for considering impairment

56. The Tribunal reminded themselves of the background relating to Patient F where Dr McCann had failed to appropriately assess, advise and refer Patient F in relation to their condition and options available. The Tribunal noted that there were breaches of GMP in respect of paragraphs 14, 15, 16, 21, and 49. The Tribunal also had regard to the Introduction to the Guidance and determined that the case fell within Case Type 5: Clinical Concerns. The Tribunal noted that they had found all of allegation 12 proved apart from 12(b) at the Facts stage. The Tribunal was satisfied that Dr McCann's behaviour was a serious departure from the standards expected of a registered medical practitioner. Taking into account all of the

guidance and circumstances, the Tribunal concluded that Dr McCann's conduct amounted to serious professional misconduct and determined that there is a legal basis for considering impairment.

Patient G

Step 2a: legal basis for considering impairment

57. The Tribunal had regard to the findings and noted that Dr McCann had failed to make an urgent referral for Patient G regarding post-menopausal bleeding in accordance with NICE guidelines. The Tribunal noted that GMP had been breached, namely paragraphs 15, 16, 18 and 44. The Tribunal also had regard to the Introduction to the Guidance and determined that the case fell within Case Type 5: Clinical Concerns. The Tribunal considered that whilst no harm came to Patient G, the fact that Dr McCann did not make the referral on time and only did so when prompted to do so at a later point. The Tribunal was satisfied that Dr McCann's behaviour was a serious departure from the standards expected of a registered medical practitioner. Taking into account all of the guidance and circumstances, the Tribunal concluded that Dr McCann's conduct amounted to serious professional misconduct and determined that there is a legal basis for considering impairment.

Step 2b: Where on the spectrum of seriousness does the allegation lie?

58. The Tribunal considered Patients D, F and G together in relation to an assessment of seriousness.

59. The Tribunal considered that the allegations against Dr McCann relating to Patient F had a profound impact and was significantly embarrassing for Patient F. When reviewing the facts found proved and assessing the impact on Patient F, the Tribunal found that there was a breach of the professional standards and therefore a high level of seriousness.

60. The Tribunal considered public safety and the risk factors with regard to Dr McCann's conduct with Patient F. The Tribunal found that the fact Dr McCann was willing to undertake this procedure himself, which was not clinically safe and unregulated, placed the conduct in a higher level of risk to public protection. The Tribunal noted that Dr McCann had demonstrated a disregard for regulatory guidance and surgical procedures which are required to be carried out in very specific environments which again pushed the level of seriousness into the higher end. The Tribunal found that Dr McCann had demonstrated a reckless disregard for patient safety and undermined systems designed to protect the public

and as the consequences of his actions relating to Patient F could have been serious. The Tribunal therefore considered the level of seriousness to be high.

61. The Tribunal considered the nature of the allegation and harm that could have been caused to Patient G and found that the allegations relating to Patient G falls at the higher end of seriousness. The Tribunal noted that while no actual harm was caused to Patient G, the urgent referral was not made when it should have been made, and the potential consequences could have been serious. For this reason the Tribunal places this allegation into the higher category of seriousness.

62. The Tribunal referred to Dr L's expert evidence during the Facts stage and noted that a delay of 22 days rather than a two-week referral was seriously below the standard expected of a reasonably competent doctor. The Tribunal also noted that the eventual referral was a routine referral rather than an urgent one, which the Tribunal found to be an additional point that increased the level of seriousness.

63. The Tribunal found that Dr McCann had minimised his responsibility for his poor performance as he stated he was not aware of a delay in typing of the referrals. The Tribunal considered that Dr McCann should have arranged for an urgent referral in the first instance and that when he eventually did make a referral it was not the correct kind. The Tribunal found that Dr McCann had shown limited acceptance of responsibility but did however acknowledge that Dr McCann had apologized. The Tribunal however still found that these factors fell into the higher seriousness range despite an admission and explanation from Dr McCann in respect of this incident.

64. Having considered Patients F and G, along with the failure in record-keeping relating to Patient D, the Tribunal is satisfied that the seriousness is at the higher end of the spectrum.

Dishonesty – Appraisal (paragraphs 5-7)

Step 2a: legal basis for considering impairment

65. The Tribunal found that on 16 March 2020, Dr McCann submitted an NHS appraisal form in which he declared that he had "nothing to declare" in response to the probity question asking whether he had been subject to any investigation since his last appraisal. The Tribunal found that this declaration was untrue because Dr McCann had been the subject of an ongoing GMC investigation since September 2019 and that he knew the declaration was false. The Tribunal concluded that Dr McCann had acted dishonestly. It noted that honesty in

the appraisal and revalidation process is fundamental to maintaining professional standards and public confidence.

66. The Tribunal was particularly concerned that Dr McCann's conduct demonstrated a disregard for the fundamental principles of professional honesty and integrity as honesty is a basic quality expected of all doctors. The Tribunal considered that paragraphs 65, 71a and 71b had been breached in this allegation by Dr McCann. The Tribunal also had regard to the Introduction to the Guidance and determined that the case fell within Case Type 2: Dishonesty. The Tribunal found that dishonesty in relation to a doctor's professional appraisal undermined the integrity of the appraisal and revalidation process, breached a fundamental tenet of the medical profession, and was liable to undermine public confidence in both the profession and its regulatory processes. Dr McCann's misconduct had involved serious dishonesty which was incompatible with the high standards expected of a doctor.

67. In respect of allegations 5, 6 and 7 relating to the appraisal, the Tribunal was satisfied that Dr McCann's behaviour was a serious departure from the standards expected of a registered medical practitioner. Taking into account all of the guidance and circumstances, the Tribunal concluded that Dr McCann's conduct amounted to serious professional misconduct and determined that there is a legal basis for considering impairment.

Step 2b: Where on the spectrum of seriousness does the allegation lie?

68. In assessing the seriousness of the misconduct, the Tribunal considered that honesty and integrity are fundamental tenets of the medical profession and that candour within the appraisal and revalidation process is essential to maintaining public confidence and effective professional regulation. It had regard to paragraph 31c of the Guidance *'Allegations that are likely to fall at the higher end of the spectrum of seriousness include, but are not limited to: dishonesty, other than where it occurred outside of the doctor's professional role and was not persistent or repeated, and the value or other benefit derived was not significant'* It found that Dr McCann's conduct involved a deliberate decision to deceive and withhold information, an abuse of his professional position, and a clear disregard for professional standards. In the absence of any explanation or insight, the Tribunal was not satisfied that he recognised the seriousness of his wrongdoing or that he would act honestly and openly in the future.

69. The Tribunal concluded that the misconduct involved dishonesty in a professional context and that "repeated, persistent or deliberate dishonesty" ordinarily falls at the higher end of the spectrum of seriousness.

WDF Form (paragraph 20)

Step 2a: legal basis for considering impairment

70. The Tribunal noted that the facts found proved established that Dr McCann had failed to complete and return the WDF requested by the GMC on four separate occasions. The Tribunal found that this failure prevented the GMC from identifying where Dr McCann was practising and from making appropriate enquiries or informing relevant employers of the concerns under investigation. It concluded that the repeated failures were deliberate and significantly impeded the GMC's ability to carry out its regulatory functions, particularly given that Dr McCann was practising as a locum GP across multiple locations. The Tribunal reminded itself that Dr McCann had a duty to provide the GMC as his regulator with accurate and timely information. The Tribunal determined that in not doing so undermined the role of the GMC to protect the public.

71. The Tribunal determined that Dr McCann had breached paragraph 73 of *GMP*. The Tribunal was satisfied that Dr McCann's behaviour was a serious departure from the standards expected of a registered medical practitioner. Taking into account all of the guidance and circumstances, the Tribunal concluded that Dr McCann's conduct amounted to serious professional misconduct and determined that there is a legal basis for considering impairment.

Step 2b: Where on the spectrum of seriousness does the allegation lie?

72. The Tribunal found that Dr McCann had failed to cooperate with his regulator, thereby undermining the GMC's ability to protect patients and maintain public confidence in the medical profession. His repeated failure to comply with the GMC's requests breached his professional obligation to engage openly with regulatory processes and represented a serious departure from the standards expected of a registered medical practitioner and accordingly the Tribunal found the level of seriousness to be at the high end of the spectrum.

XXX (paragraphs 21 and 22)

XXX

73. XXX

74. XXX

75. XXX

XXX

76. XXX

77. XXX

78. XXX

79. XXX

80. XXX

81. XXX

Self-prescribing (paragraph 8)

Step 2a: legal basis for considering impairment

82. The Tribunal had regard to Dr L's report in respect of self-prescribing.

83. The Tribunal noted that the facts found proved established that Dr McCann had self-prescribed medication on 2 April and 19 May 2020 when there was no clinical urgency requiring him to do so. The Tribunal took into account the records confirming the prescriptions, together with the evidence of XXX. It concluded that, in light of XXX, his decision to self-prescribe controlled and prescription-only medication represented a significant departure from accepted professional standards.

84. The Tribunal found that Dr McCann had breached the guidance in GMP paragraph 16g concerning self-prescribing except in limited circumstances of clinical necessity, thereby placing himself and potentially patients at risk, undermining confidence in his professional judgment, and breaching a fundamental tenet of the medical profession. The Tribunal was satisfied that Dr McCann's behaviour was a serious departure from the standards expected of a registered medical practitioner. Taking into account all of the guidance and circumstances, the Tribunal concluded that Dr McCann's conduct amounted to serious professional misconduct and determined that there is a legal basis for considering impairment.

Step 2b: Where on the spectrum of seriousness does the allegation lie?

85. In considering where on the spectrum of seriousness the allegation in relation to Dr McCann's self-prescribing, it took into consideration the above findings that XXX.

86. The Tribunal considered that the starting point for assessing the level of seriousness was high due to the fact that Dr McCann self-prescribed XXX, when on a previous occasion he had requested another colleague to prescribe routine medications for him. The Tribunal found that Dr McCann was concealing his behaviour when he self-prescribed XXX (a controlled drug) XXX. The Tribunal had regard to whether there were any features increasing or decreasing the seriousness of the allegation, and the seriousness of the doctor's departure from professional standards. The Tribunal agreed that there was a reckless disregard for professional standards. Dr McCann had access to another doctor to obtain these prescriptions, the conduct was deliberate and repeated on two occasions. Taking into account all of these matters the Tribunal determined that the conduct remains at the high end of the spectrum of seriousness as these are features that increase the seriousness of the allegation.

87. The Tribunal went on to consider all of the allegations collectively in following the next stages of the Guidance.

Step 2c: What is the impact of any relevant context known about Dr McCann and/or their working environment?

88. The Tribunal had regard to paragraph 45 of the MPTS Guidance, which asks the Tribunal to consider: *"What is the impact of any relevant context known about the doctor and/or their working environment?"* It considered whether any such context affected its assessment that the allegations fell at the high end of the spectrum of seriousness.

89. In doing so, the Tribunal considered whether there was any relevant personal context, role-related context, or working environment context that might explain, mitigate, or otherwise reduce the level of seriousness of the misconduct or the current and ongoing risk to public protection.

90. The Tribunal noted that evidence of relevant context that may decrease the level of risk to public protection posed by a doctor will generally carry less weight in cases that fall at the higher end of the spectrum of seriousness. This is because the risk to public protection arising from allegations at the higher end of the spectrum is typically more difficult to mitigate and address.

91. The Tribunal did not have any direct evidence of any relevant personal, role-related, or working environment context relating to Dr McCann at the time of the events. The only material before it was XXX.

92. The Tribunal noted that this observation was made some time after the events in question and appeared to be based on information obtained XXX rather than on contemporaneous evidence. The Tribunal did not have any further evidence to substantiate or explain this account, nor did it have evidence addressing whether XXX had a causal or contributory impact on the misconduct.

93. The Tribunal also noted that, prior to the matters giving rise to these proceedings, Dr McCann had enjoyed a long and otherwise unblemished career. However, it further noted Dr McCann's limited engagement with these proceedings. He did not provide any further evidence to assist the Tribunal, and it did not have the benefit of his oral or written evidence that might have assisted it in determining whether there were any relevant contextual factors operating at the time of the events. The Tribunal did consider the 2026 letters from XXX and correspondence from Dr McCann's family but did not find them relevant to the allegations they were considering.

94. In those circumstances, the Tribunal concluded that there was insufficient evidence of relevant contextual factors that would reduce the seriousness of the misconduct or materially affect its assessment of the current and ongoing risk to public protection. While XXX provided some indication of matters that may have been relevant during the period in question, the Tribunal was unable to place significant weight on that evidence in the absence of contemporaneous or corroborative material.

95. The Tribunal were not satisfied beyond an admission to some of the allegations that Dr McCann's actions were capable of remediation, as very limited steps had been taken by Dr McCann to demonstrate this. The Tribunal also found that they had been provided with very little evidence of insight or personal context.

Step 2d: How has Dr McCann responded to the allegation?

96. The Tribunal considered how Dr McCann had responded to the allegation and whether he had demonstrated insight into the concerns in this case. Paragraph 74 states:

> *'How has the doctor responded to the allegation(s)?*

74. The MPT should consider the evidence available to them to establish if the doctor has:

a. shown insight into their own practice, behaviour and/or impact of a health condition

b. taken steps which have reduced the risk of similar allegations occurring again (remediation), such as participating in training, supervision, coaching or mentoring relevant to the allegation, …..

c. kept their knowledge and skills up to date.'

97. The Tribunal also noted from the Guidance that evidence of insight and remediation will have a different impact on the assessment of current and ongoing risk to public protection in each case, depending on the nature of the allegation and individual circumstances of the case. In cases where the allegation falls at the higher end of the spectrum of seriousness, and therefore the starting point for assessing current and ongoing risk to public protection is high, evidence of insight and remediation will usually carry less weight and therefore will have less impact, if any, on the assessment of current and ongoing risk to public protection. This is because the risk to public protection arising from these allegations is generally more difficult to address.

98. In relation to the sexual misconduct allegations the Tribunal noted that Dr McCann wrote a letter of apology to Ms A shortly after the incident. It also noted that, during XXX, Dr McCann stated that his comments towards Ms A had been a clumsy attempt at humour. In relation to the knife incident, he told XXX that [Ms A] had become angry with him while he was attempting to locate some instruments, and that he had taken out his Swiss Army knife without intending to cause any harm. He suggested that his actions may have been influenced by disinhibition resulting from the alcohol he had consumed the previous evening.

99. In relation to Ms B, the Tribunal noted that Dr McCann denied the allegation in its entirety.

100. The Tribunal also noted that Dr McCann has had limited engagement with the GMC proceedings. While the Tribunal took into account the apology to Ms A and XXX, these were made some time after the events and were not supplemented by any oral evidence, witness statement, reflective statement, or other material that would enable the Tribunal to assess the extent of Dr McCann's current insight.

101. The Tribunal had been provided with Dr McCann's response, but found his explanation, insight and apology to be limited in respect of Patient F. With regards to Patient G the Tribunal considered Dr McCann's response. The Tribunal acknowledged that Dr

McCann had taken some responsibility by apologising but had minimised his responsibility for his poor performance as he stated he was not aware of a delay in typing of the referrals. The Tribunal considered that Dr McCann should have arranged for an urgent referral in the first instance and that when he eventually did make a referral it was not an urgent referral. The Tribunal considered that if this referral had not been followed up by Patient G there was a risk it could have been missed. The Tribunal could not identify any factors that brought the risk down. The Tribunal found that there was a current and ongoing risk to public protection on all three grounds and the risk was high because of the potential harm that could have been caused to Patient G by Dr McCann's failures.

102. XXX

103. Further, in relation to the remainder of the allegations, namely dishonesty, prescribing to patients, self-prescribing and misconduct, there was no evidence before the Tribunal of meaningful reflection, remediation, or any steps taken to address the causes of the misconduct or to prevent a recurrence of similar behaviour. Accordingly, the Tribunal concluded that there was no reliable evidence of current insight or remediation sufficient to demonstrate that the concerns arising from Dr McCann's misconduct had been adequately addressed or any future risks mitigated.

104. The Tribunal also took into account the absence of any evidence that Dr McCann has maintained his professional knowledge and clinical skills since the events in question. The Tribunal noted that Dr McCann's provided CPD was not directly relevant to these issues. The Tribunal noted that Dr McCann had apologised to Patient G regarding the cancer referral incident, but the Tribunal considered there was no evidence of targeted learning by Dr McCann to address their findings. The Tribunal noted Dr McCann's defence bundle that consisted of his CV, patient surveys from January 2020, two UK Diving Medical Conference certificates from November 2020 and two testimonials from July 2020. The Tribunal found this was the only evidence it could consider in terms of Dr McCann's response. The Tribunal noted that there had been some responses from Dr McCann with respect to Patients A, F and G, but that the responses were very limited.

105. Having considered all of the evidence, the Tribunal concluded that the misconduct has not been remedied. In the absence of evidence of insight, remediation, or steps taken to reduce the risk of repetition, the Tribunal determined that there remains a significant risk of repetition and, consequently, a continuing risk to public protection.

Step 2e: Tribunal's decision as to whether Dr McCann poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

106. Taking the allegations as a whole and having regard to all of the information before it, the Tribunal considered Dr McCann's lack of insight, his lack of remediation, and his limited response to some of the allegations. The Tribunal was concerned that his failure to appreciate the gravity of his actions meant that it could not be satisfied that he was highly unlikely to repeat the misconduct in the future.

107. The Tribunal concluded that these factors had either no mitigating impact or increased the current and ongoing risk that Dr McCann presents to public protection. Accordingly, it determined that the risk to public protection can only properly be assessed as high.

108. The Tribunal considered each of the three limbs of public protection.

Protecting, promoting and maintaining the health, safety and wellbeing of the public (patient safety)

109. The Tribunal accepted that there was evidence of Dr McCann's inappropriate prescribing and treatment of patients. It also took into account XXX, and the risk these posed to patient safety. The Tribunal concluded that patient safety was clearly engaged in this case.

110. Accordingly, the Tribunal determined that Dr McCann poses a current and ongoing risk to the health, safety, and wellbeing of the public, and that a finding of impairment is required on the ground of patient safety.

Promoting and maintaining public confidence in the profession (public confidence)

111. As to the second limb, public confidence, the Tribunal considered that a member of the public, aware of all the circumstances in this case, would be very concerned and public confidence would inevitably be undermined if a finding of impairment was not made.

Promoting and maintaining professional standards and conduct (upholding professional standards)

112. As to the third part of public protection, upholding professional standards, the Tribunal reminded itself of its earlier conclusion that Dr McCann's misconduct represented a

serious departure from the standards of conduct expected of medical practitioners. The Tribunal considered that a finding of impairment is required to send a clear signal to Dr McCann, the profession, and the public of the unacceptability of his misconduct.

113. In all the circumstances, the Tribunal concluded that the current and ongoing risk posed by Dr McCann to public protection is high and that a finding of impairment is necessary, by reference to all three parts of public protection.

114. The Tribunal has therefore determined that Dr McCann's fitness to practise is impaired by reason of his misconduct XXX.

115. The Tribunal considered that taken individually and cumulatively the allegations relating to the patients amount to serious professional misconduct. The Tribunal noted that Dr McCann's conduct involved multiple and serious instances over a period of time with three incidents relating to prescribing issues, two incidents involving consultation issues and an incident related to failing to obtain an adequate history.

116. The Tribunal were not satisfied that the overall risk is low, due to lack of evidence of insight, remediation or context that is likely to reduce the risk. The Tribunal found that a finding of impairment is necessary to uphold proper professional standards and uphold public confidence in the profession. Dr McCann's conduct has involved serious incidents spanning from 2019 to 2020 that include aspects of dishonesty, unwanted sexual conduct and clinical issues which are all incompatible with the reasonable conduct expected of a doctor. The Tribunal considered that the public would mark these factors as unacceptable behaviour from a doctor.

117. The Tribunal found that Dr McCann had violated a fundamental tenet of the profession and had brought the medical profession into disrepute. The Tribunal applied the test in *Grant* and found that all parts of that test are applicable and engaged in this case in terms of finding impairment.

118. Accordingly, in all the circumstances of this case, the Tribunal therefore concluded that Dr McCann's fitness to practise is currently impaired due to the reasons set out above and by reason of his misconduct XXX. It considered that a finding of impairment is necessary to promote and maintain public confidence in the medical profession, to promote and maintain proper professional standards and conduct for the members of the profession and to protect, promote and maintain the health, safety and wellbeing of the public.

Determination on Sanction – 02/08/26

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

120. The Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential. This determination will be handed down in private but as this case also concerns Dr McCann's misconduct XXX, a redacted version will be published at the close of the hearing.

Submissions

On behalf of the GMC

121. On behalf of the GMC, Ms Dudley-Jones submitted that the Tribunal are assisted by the Guidance, which sets out the sanction bandings for specific categories of misconduct.

122. She submitted that in making the decision regarding sanction the Tribunal must ensure they are proportionate, transparent and fair.

123. She submitted that the Guidance sets out that the sanction should be *'what is required but no more than necessary to achieve public protection*'. At paragraph 10 it details the approach to be followed by the Tribunal is to consider the least restrictive sanction first and work upwards.

> *10 "Case law is clear that the need to protect the public always outweighs the interests of any individual medical professional. And while restrictive action is not put in place to punish or discipline a doctor, a sanction may have a punitive effect yet still remain necessary"*

124. Ms Dudley-Jones also referred the Tribunal to the relevant caselaw of *Bolton v Law Society [1994] 1 WLR 512, 519*

> *"The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price'*

125. Ms Dudley Jones took the Tribunal through its findings on impairment and submitted that, when considered cumulatively, Dr McCann's misconduct fell at the higher end of the spectrum of seriousness and placed him within the higher level of risk to public protection. She submitted that taking no action nor imposing conditions would be appropriate or sufficient in the circumstances of this case.

126. Ms Dudley Jones further submitted that a period of suspension would be insufficient to protect the public, maintain public confidence in the medical profession, and uphold proper professional standards.

127. In all the circumstances, the GMC submitted that the sanction of erasure was the only appropriate and proportionate outcome.

128. Ms Dudley Jones referred the Tribunal to paragraph 55 of the Sanctions Guidance, which provides that erasure may be the proportionate response where:

> *"A doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise."*

129. She also referred the Tribunal to paragraph 57 of the Guidance, which identifies the circumstances in which erasure may be the only proportionate response. She submitted that factors (a), (c) and (d) were clearly engaged in this case:

> *(a) where conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public;*
> *(c) the doctor has shown a persistent lack of insight into the seriousness of the allegations concerning their behaviour or performance and the potential or actual consequences; and/or*
> *(d) the seriousness of the facts found proved, and/or the impact of any relevant contextual factors that increase the current and ongoing risk to public protection, mean that allowing the doctor to remain on the register would undermine public confidence in the profession.*

130. Ms Dudley Jones submitted that the Tribunal had already made a number of findings relevant to each of these factors during its determination on impairment and relied upon

those findings in support of the GMC's submission that erasure was the only appropriate and proportionate sanction.

The Tribunal's Approach

131. The Tribunal was reminded that the decision as to the appropriate sanction, if any, was a matter for the Tribunal exercising its own independent judgment.

132. The Tribunal considered its decision at impairment stage, submissions from the GMC and the documentary evidence adduced during the course of these proceedings including the recent psychiatrist letter. No submissions were received from or on behalf Dr McCann.

133. In making its decision, the Tribunal had regard to the principle of proportionality, and it weighed Dr McCann's interests with those of the public. Throughout its deliberations the Tribunal bore in mind that the purpose of a sanction is not to punish the doctor, although any sanction imposed may have a punitive effect. However, case law makes clear that the reputation of the medical profession as a whole is more important than the interests of an individual doctor.

134. In making its decision on sanction the Tribunal has to consider what in light of its findings of impairment is the proportionate response needed to protect the public. The Tribunal had determined that all three limbs of public protection were engaged in this case, and it now had to consider what regulatory action, if any, is needed to protect the public. The Tribunal referred to the sanctions banding(s) as set out in Part C of the Guidance and considered the level of current and ongoing risk the doctor poses to public protection. It also considered the impact of any specific sanction type, where applicable, and any other relevant factors or information that would inform its decision.

135. The Tribunal has also borne in mind that in deciding what sanction, if any, to impose, it should consider all the sanctions available, starting with the least restrictive and then consider each sanction in ascending order.

Sanction

136. In considering which sanction, if any was appropriate, the Tribunal considered the relevant sanction bandings set out within the Guidance for each of the case types under consideration in this case.

137. The different case types under consideration here are:

- Case Type 1: Sexual misconduct
- Case Type 2: Dishonesty;
- Case Type 5: Clinical concerns
- XXX

138. In reaching its decision on the appropriate sanction, the Tribunal had regard to paragraphs 66, 68 and 69 of the Guidance Introduction Document on Sexual misconduct Case Types, which states:

> *66. Most allegations relating to sexual misconduct have a starting point of a high level of seriousness and therefore fall at the higher end of the spectrum of seriousness. This means the starting point for assessing current and ongoing risk to public protection will usually be high.*
>
> *68. In such cases the MPT's decision on risk should reflect this and a conclusion that the doctor poses a current and ongoing risk to public protection may be needed even in cases where the doctor has shown insight and taken steps to try and remediate. Where the MPT concludes that the doctor poses a current and ongoing risk, this will result in them finding that the doctor's fitness to practise is impaired.*
>
> *69. The level of risk associated with a sexual misconduct allegation will generally be medium or high.*

Lower level of risk to public protection	*Medium level of risk to public protection*	*Higher level of risk to public protection*
Suspension up to 6 months	*Suspension 6 to 12 months*	*Suspension 12 months to Erasure*

139. In reaching its decision on the appropriate sanction, the Tribunal had regard to paragraphs 96 – 98 of the MPTS Guidance Introduction Document on Dishonesty Case Types, which state:

> *'96. The proportionate sanction in response to an allegation of dishonesty will depend on the extent of the doctor's behaviour and the impact it's assessed to have on each of the three parts of public protection.*

97. Where the level of current and ongoing risk to public protection is medium or high, this will require consideration of suspension or erasure.

98. When deciding on sanction, the MPT should consider the sanctions banding for dishonesty cases in Part C of Section 3: MPT hearings.

Lower level of risk to public protection	*Medium level of risk to public protection*	*Higher level of risk to public protection*
Suspension up to 3 months	*Suspension 3 to 9 months*	*Suspension 9 months to Erasure*

140. In reaching its decision on the appropriate sanction, the Tribunal had regard to paragraphs 168, 170 and 171 of the MPTS Guidance Introduction Document on Clinical concerns Case Types, which state:

168. Allegations relating to clinical concerns can fall at the lower, mid-range or higher end of the spectrum of seriousness depending on the circumstances of the case. This means the starting point for assessing current and ongoing risk to public protection could be low, medium or high.

170. However, where the starting point for assessing risk is high, evidence of relevant context known about the doctor and/or their working environment and evidence of insight and remediation that decrease risk may have less impact because allegations falling at the higher end of the spectrum of seriousness can be more difficult to remediate. The MPT's decision on risk should reflect this and a conclusion the doctor poses a current and ongoing risk to public protection may be needed. If so, this will result in them finding that the doctor's fitness to practise is impaired.

171. Where an allegation about a clinical concern leads to a finding of impairment, it may engage one or more of the three parts of public protection. Whilst the MPT must consider the individual circumstances of the case, it will be unusual for a proven allegation about a clinical concern not to impact on patient safety.

Lower level of risk to public protection	*Medium level of risk to public protection*	*Higher level of risk to public protection*
Conditions 12 to 24 months	*Conditions 24 to 36 months to 6 months Suspension 6 months*	*6 months suspension – Erasure*

141. In reaching its decision on the appropriate sanction, the Tribunal had regard to XXX.

142. The Tribunal considered the findings in the round when determining the appropriate sanction. It noted that, with the exception of the XXX, each of the case types engaged by its findings placed Dr McCann within the higher risk to public protection and therefore within the suspension to erasure sanction banding under the Guidance.

143. XXX

144. XXX

145. XXX

No action

146. The Tribunal first considered whether to conclude the case by taking no action. It considered paragraphs 13 – 16 of Section 3 of the MPTS Guidance which relate to consideration of 'Taking no action'. It noted in particular paragraph 13 states:

> *'Where a doctor's fitness to practise is impaired, it will usually be necessary for the MPT to restrict the doctor's registration to achieve public protection. But there may be exceptional circumstances to justify an MPT taking no action. Exceptional circumstances are unusual, special, or uncommon, so such cases are likely to be very rare.'*

147. It determined that there were no exceptional circumstances in this case which could justify it taking no action. It noted that the GMC submitted taking no action would neither be appropriate nor proportionate in the circumstances of this case and that this fell well below the indicative sanction bandings as set out above.

148. Given the serious findings against Dr McCann, the Tribunal determined that to take no action would be neither appropriate nor proportionate given its earlier findings and would fail to uphold the statutory overarching objective.

Conditions

149. The Tribunal next considered whether to impose conditions on Dr McCann's registration. It bore in mind that any conditions imposed would need to be appropriate,

workable, measurable and proportionate and it reminded itself of the relevant paragraphs of the guidance:

> *17. Conditions are suitable for those cases where the doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period of time, with the aim they should be able to safely return to unrestricted practice in the future.*
>
> …
>
> *20. Where conditions are put in place, they should be appropriate, workable, and measurable.*
>
> *21. To be appropriate, conditions must address the specific findings about the current and ongoing risk to public protection posed by the doctor.*
> …
>
> *23. Conditions are likely to be workable where:*
>
> *a. the doctor has shown insight*
> *b. time is needed for the doctor to take steps to address the findings (remediate), for example through retraining, study, supervision and/or seeking medical treatment*
> c. *the doctor is willing to remediate, and the MPT is satisfied the doctor will comply with them*

150. With regard to the '*case types of sexual misconduct, clinical concerns and dishonesty*', the Tribunal considered the relevant sanction bandings in the Sanctions Guidance. It noted that, where there is a high level of risk to public protection and where the nature of the misconduct falls at the higher end of the spectrum of seriousness, the Guidance provides for a sanction ranging from suspension to erasure and does not identify conditions as an appropriate sanction. The Tribunal considered that this reflected the level of risk identified in Dr McCann's case and supported its conclusion that conditions would be insufficient.

151. The Tribunal had regard to the Guidance, and relevant case type XXX, a sanction of conditions may be appropriate where the conditions are workable, measurable and there is confidence that the doctor will comply with them.

152. The Tribunal considered whether conditions would be appropriate in this case. However, it noted that Dr McCann had disengaged from these proceedings since 2021 and had provided no evidence demonstrating insight into XXX, remediation, or the steps he had taken to XXX. There was no evidence before the Tribunal that Dr McCann would be willing or able to comply with any conditions that might be imposed.

153. XXX

154. In the absence of any direct engagement from Dr McCann, regarding XXX, insight, remediation or willingness to engage with regulatory proceedings, the Tribunal could not be satisfied that conditions would be workable or that Dr McCann would comply with them. Accordingly, it concluded that a sanction of conditions was not appropriate.

155. The Tribunal further concluded that it would not be possible to formulate conditions that were appropriate, workable and measurable to address the misconduct and XXX identified in this case. In any event, even if workable conditions could have been formulated, the Tribunal was satisfied that they would not be a proportionate response. Such a sanction would be insufficient to maintain public confidence in the medical profession or to uphold proper professional standards, having regard to the seriousness and cumulative nature of the findings

Suspension

156. The Tribunal then went on to consider whether to impose a period of suspension. In doing so it considered the following paragraphs of the Guidance.

> *44. Restrictive action of suspension is intended to address the level of current and ongoing risk to public protection and is not intended to be punitive. However, as it prevents a doctor from working and earning a living within that profession, it can have this effect. Suspension can also have a deterrent effect and be used to send a signal to the individual doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.*
>
> *45. Suspension may be proportionate in cases where some, or all, of the following factors are present:*
>
> *a. conditions are not appropriate, measurable and/or workable*

b. the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or
c. the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.

157. The Tribunal reminded itself that the purpose of a period of suspension is to manage any current and ongoing risk to public protection while providing a doctor with the opportunity to address the concerns identified and, where appropriate, to return safely to unrestricted practice.

158. The Tribunal considered whether a period of suspension would be sufficient and proportionate in the circumstances of this case. In doing so, it had regard to its earlier findings that Dr McCann's misconduct represented a serious departure from the standards expected of a registered medical practitioner.

159. The Tribunal noted that the findings included serious dishonesty, clinical failings and sexual misconduct. It considered that there was no evidence that Dr McCann had remediated his misconduct, demonstrated genuine remorse, or developed sufficient insight into the seriousness of his actions and their impact. Whilst the Tribunal had regard to the apology made to Ms A, it concluded that, viewed in the context of Dr McCann's subsequent lack of engagement with these proceedings, it was insufficient to demonstrate meaningful insight or remediation.

160. The Tribunal also noted that there was no evidence that Dr McCann had engaged with XXX. In the absence of any meaningful engagement with either the regulatory process or XXX, the Tribunal was not satisfied that a period of suspension would achieve its intended purpose of enabling Dr McCann to address the concerns and return safely to unrestricted practice.

161. Accordingly, the Tribunal concluded that a sanction of suspension would be insufficient to protect the public, maintain public confidence in the medical profession, uphold proper professional standards, or satisfy the overarching objective.

Erasure

162. The Tribunal then went on to consider whether erasure would be the appropriate and proportionate sanction in the circumstances of this case. In doing so it bore in mind paragraphs 56 and 57 of the Guidance, namely:

> *56. Erasure takes away a doctor's registration which means they are no longer entitled to practise in the UK at all, or anywhere else where they are required to hold GMC registration. It is used to protect the public in the most serious cases. It also has a deterrent effect as it sends a signal to the individual doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.*
>
> *57. Erasure may be the proportionate response where:*
>
> > *a. conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public*
> > *b. the doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place*
> > *c. the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or*
> > *d. the seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection mean the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession.*

163. The Tribunal considered that the factors set out in paragraph 57 of the Guidance were engaged in this case. It was satisfied that neither conditions nor suspension would be sufficient to address the level of current and ongoing risk identified. The Tribunal concluded that the seriousness of Dr McCann's misconduct was fundamentally incompatible with continued registration.

164. In reaching that conclusion, the Tribunal took into account that Dr McCann had disengaged from the regulatory process and had provided no evidence that he would be willing or able to comply with any regulatory restrictions. The Tribunal reminded itself of its earlier conclusion at the impairment stage, namely that Dr McCann's actions demonstrated a blatant disregard to his obligations as a doctor and to his profession. His conduct constituted serious departures from GMP and he had breached fundamental tenets of the profession, in particular the need to ensure that his conduct justifies patients trust in him and the public trust in the profession. The Tribunal were satisfied that the above paragraphs of the

Guidance were engaged in this case and that his conduct was fundamentally incompatible with being a registered medical practitioner.

165. The Tribunal also considered XXX. However, the Tribunal was required to consider all of the findings cumulatively. Taking the findings of sexual misconduct, dishonesty, clinical concerns and XXX together, the Tribunal concluded that the overall seriousness of the case was such that erasure was the only appropriate and proportionate sanction.

166. The Tribunal balanced the interests of Dr McCann, including the significant impact that erasure would have on his career and livelihood, against the need to protect the public, maintain public confidence in the medical profession and uphold proper professional standards. It concluded that the wider public interest and the overarching objective outweighed Dr McCann's personal interests.

167. In those circumstances, the Tribunal found that no sanction short of erasure would be sufficient to maintain public confidence in the profession, uphold proper professional standards, protect the public, and satisfy the overarching objective.

168. Accordingly, having regard to all of its findings and the circumstances of the case, the Tribunal determined that the appropriate and proportionate sanction was to direct that Dr McCann's name be erased from the Medical Register.

Determination on Immediate order – 02/08/26

169. Having determined that Dr McCann's name should be erased from the medical register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

170. On behalf of the GMC, Ms Dudley Jones submitted in light of the Tribunal's findings an immediate order of suspension is necessary in this case, given the need to protect the public.

171. The Tribunal received no submissions from Dr McCann.

The Tribunal's determination

172. The Tribunal considered that it may impose an immediate order if it is necessary for the protection of members of the public or is otherwise in the public interest. The decision whether to impose an immediate order is at the discretion of the Tribunal, exercising its own judgment taking into account all the circumstances.

173. The Tribunal had regard to paragraphs 83 and 84 of the Guidance (*MPT Hearings > Part C: stage three – sanction > Step 3: decide on sanction > Immediate and interim orders following sanction)*, which provide:

> *'83 The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.*
>
> *84 It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:*
>
> *a the doctor poses a risk to patient safety*
>
> *b the risk to one or more parts of public protection is high, and/or*
>
> *c immediate action is needed to maintain public confidence in the medical profession.'*

174. The Tribunal considered that, in light of its previous findings regarding the seriousness of Dr McCann's XXX and misconduct, together with its assessment that there remained a high risk to public protection, an immediate order was necessary. It concluded that all three limbs of the overarching objective were engaged, namely the protection of the public, the maintenance of public confidence in the medical profession, and the upholding of proper professional standards.

175. Overall, it was satisfied that the factors set out in paragraph 84 of the Guidance were present and supported the imposition of an immediate order. The Tribunal considered that it would be wholly inconsistent with its findings to permit Dr McCann to continue to potentially practise without restriction during the appeal period.

176. Accordingly, it determined that an immediate order was necessary to protect the public and maintain confidence in the profession pending the outcome of any appeal.

177. This means that Dr McCann's registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

178. The interim order currently in place on Dr McCanns registration will be revoked when the immediate order takes effect.

179. That concludes this case.

Annex A – 18/05/2026
Service and Proceedings in Absence

180. Dr McCann is neither present nor legally represented at this hearing. The Tribunal therefore considered whether the relevant documents had been served in accordance with the General Medical Council (Fitness to Practice Rules) 2004 as amended.

181. The Tribunal was provided with a copy of a Service bundle and referred to the documents relevant to proof of service including but not limited to the following:

- Screenshot of Dr McCann's Registered Address
- Email enclosing Notice of Allegation (NOA), dated 2 April 2026;
- Proof of delivery of NOA, dated 2 April 2026;
- Letter enclosing NOA dated 2 April 2026;
- Email enclosing Notice of Hearing (NOH), dated 2 April 2026;
- Letter enclosing NOH dated 8 April 2026;
- Proof of delivery of NOH dated 9 April 2026.

182. Ms Elizabeth Dudley-Jones, Counsel for the GMC, submitted that notice of the hearing had been properly served on Dr McCann. She referred the Tribunal to the Service bundle and the documents contained within it, including various items of correspondence sent to Dr McCann in February 2026 and subsequently in March and April 2026.

183. Ms Dudley-Jones further submitted that the service hearing bundle contained documentation demonstrating engagement by both Dr McCann and Mr M, XXX, in response to correspondence from the GMC. She noted that, whilst XXX had been provided to the GMC or the Tribunal. She further noted that these communications referred specifically to the present hearing and included acknowledgements from both Dr McCann and Mr M that they were aware of the proceedings.

184. Ms Dudley-Jones submitted that Dr McCann was well aware of the proceedings and knew that there was an upcoming MPTS hearing. She stated that Dr McCann had been spoken to directly by the lawyer formerly responsible for conduct of the case on 5 January 2026. During that conversation, the case was discussed, and it was also explained to Dr McCann that he had the option of making an application for voluntary erasure in relation to the proceedings.

185. Ms Dudley-Jones further submitted that, on 6 March 2026, Dr McCann wrote to the MPTS stating his intention to disengage from the process as he no longer intended to practise. She noted that this correspondence had been sent only eight weeks earlier.

186. She also referred to correspondence from Mr M, XXX. Ms Dudley-Jones submitted that the correspondence made clear that he and XXX were aware that Dr McCann had an upcoming MPTS hearing. She submitted that it is the GMC's position that he has voluntarily absented himself from these proceedings.

187. She submitted that there is a clear public interest to proceed with this hearing. Although witnesses have been stood down and are on notice, there is still nevertheless an expert witness due to give evidence tomorrow regarding a large number of clinical allegations relating to Dr McCann's seriously substandard care of his patients. She submitted that there remains a pressing need to hear that evidence and not to adjourn the case

188. Ms Dudley-Jones submitted that it was clear Dr McCann had made a decision not to engage with the proceedings. She submitted that there was no additional evidence before the Tribunal and no XXX, beyond the representations made by Mr M and others acting on his behalf.

189. In all the circumstances, Ms Dudley-Jones submitted that the GMC's position was that it was both safe and appropriate for the Tribunal to proceed with the case in Dr McCann's absence

190. The Tribunal had regard to the Service bundle provided by the GMC as well as the submissions made by Ms Dudley- Jones.

191. The Tribunal noted that the Service bundle included confirmation of Dr McCann's current registered address. It also noted the email and letter from the GMC containing the Notice of Allegation, sent on 2 April 2026, together with the proof of service dated 9 April 2026 in respect of the Notice of Hearing letter sent by the MPTS on 8 April 2026.

192. The Tribunal also noted that the main hearing bundle contained telephone attendance notes of calls with Dr McCann, together with emails sent to the GMC acknowledging the hearing. It further noted correspondence from Mr M, who, together with others, XXX, indicating that they too were aware of the hearing.

193. The Tribunal therefore determined that notice of this hearing has been served in accordance with the relevant provisions and must now decide whether to proceed in the doctor's absence pursuant to Rule 31.

194. Having considered the evidence before it and the submissions made by Ms Dudley-Jones, the Tribunal was satisfied that notice of this hearing had been served on Dr McCann in accordance with Rule 40 of the Rules, and paragraph 8 of Schedule 4 to the Medical Act 1983, as amended.

Proceeding in Absence

195. The Tribunal then went on to consider whether it would be appropriate to proceed with this hearing in Dr McCann's absence pursuant to Rule 31 of the Rules. The Tribunal was conscious that the discretion to proceed in the absence of a doctor should be exercised with the appropriate care and caution, balancing the interests of the doctor with the wider public interest.

196. In deciding whether to proceed with this hearing in Dr McCann's absence, the Tribunal carefully considered all the information before it.

197. The Tribunal accepted the advice of the LQC who referred to the relevant Rules and judgment in the cases of *El-Huseini v GMC, Lovett v HCPC [2018] EWHC 1014(Admin) , R v Jones (Anthony) [2003] AC 1, HL and GMC v Adeogba [2016] EWCA Civ 162.*

The Tribunal had regard to the following factors:

- Fairness to the doctor is of prime importance but is not determinative.
- The Tribunal must also consider fairness to the GMC and the public interest.
- The nature and circumstances of Dr McCann's behaviour in absenting himself.
- Whether the behaviour was voluntary and therefore whether he waived his right to be present.
- Whether an adjournment would result in Dr McCann's attendance on a subsequent occasion.
- An expert witness had made themselves available to give evidence albeit virtually.
- General public interest in hearing cases expeditiously.
- The need to balance the Dr McCann's interests with the statutory overarching objectives.

198. The Tribunal had regard to a GMC telephone note dated 18 December 2025 in which it stated:

> *'Dr McCann expressed their frustration with the GMC process and advised that they wished to withdraw from the process, that they were 70 years old and had no intention of practising again.'*

199. It also took into account a most recent email sent to the MPTS dated 6 March 2026 from Dr McCann:

> *'I wish to disengage from this process as I no longer intend to practice.*
> *Dr D F Mccann'*

200. The Tribunal considered this to be a clear indication that Dr McCann did not wish to engage with this process. In the circumstances, the Tribunal determined that it was appropriate to proceed in Dr McCann's absence. It concluded that Dr McCann had voluntarily absented himself from the proceedings, that no application for an adjournment had been made, and that an adjournment would be unlikely to secure Dr McCann's attendance or participation at a future hearing.

201. The Tribunal took into account that concerns regarding XXX. The Tribunal also noted that the GMC had continued to communicate with XXX, and that Dr McCann himself had engaged directly with the process, including through correspondence sent from his own email address in which he made clear that he no longer wished to practise or to engage further in the proceedings.

202. The Tribunal further noted that Mr M and XXX were aware of the hearing and that no request had been made on Dr McCann's behalf seeking an adjournment.

203. In reaching its decision, the Tribunal was satisfied that it was in the public interest and public safety for the hearing to proceed as listed. The Tribunal determined that no unfairness or injustice would be caused to Dr McCann in proceeding today. It also took into account the practical arrangements already in place for the hearing, including that an expert witness had been scheduled to attend and give evidence the following day.

204. The Tribunal therefore concluded that it would be both fair and in the public interest for this hearing to proceed without further delay. It exercised its discretion to proceed in Dr McCann's absence in accordance with Rule 31 of the Rules.

Schedule 2 – Patient C

Date	Prescription
12.02.20	Lorazepam 1mg, take one as needed, 28 tablets Zolpidem 5mg, take two at night, 28 tablets
28.02.20	Lorazepam 1mg, one four times daily as required, 112 tablets Zolpidem 5mg, take two at night, 56 tablets
11.03.20	Lorazepam 1mg, four times daily, 84 tablets Zolpidem 5mg, take two at night, 56 tablets
20.03.20	Lorazepam 1mg, four times daily, 112 tablets Zolpidem 5mg, take one or two at night, 56 tablets
27.03.20	Lorazepam 1mg, one three to four times daily, 84 tablets Zolpidem 5mg, take two at night, 56 tablets [sic]
08.04.20	Lorazepam 1mg, four times daily, 28 tablets
13.04.20	Zolpidem 5mg, take two at night, 28 tablets Lorazepam 1mg, three times a day, as needed, 42 tablets
22.04.20	Lorazepam 1mg, take one as needed, 42 tablets Zolpidem 5mg, take two at night, 28 tablets