MPTS Medical Practitioners Tribunal Service

Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 02/04/2024 - 10/04/2024

Medical Practitioner's name:	Dr Martin GODFREY
GMC reference number:	2484671
Primary medical qualification:	MB ChB 1979 University of Birmingham

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

Summary of outcome
Suspension, 3 months

Tribunal:

Legally Qualified Chair	Mr Stephen Killen
Lay Tribunal Member:	Mr John Kelly
Medical Tribunal Member:	Dr Ann Wolton

Tribunal Clerks:	Mr Andrew Ormsby (02/04/2024 - 09/04/2024) Mr Joel Taylor-Garrett (10/04/2024)

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Kevin McCartney, Counsel, instructed by the MDDUS
GMC Representative:	Ms Fiona Wise, 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.

Overarching Objective

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

Determination on Facts and Impairment - 08/04/2024

1. This determination will be handed down in private. However, as this case concerns Dr Godfrey's misconduct a redacted version will be published at the close of the hearing.

The Outcome of Applications Made during the Facts Stage

2. The Tribunal refused Mr McCartney's application, made on behalf of Dr Godfrey pursuant to Rule 41 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that the hearing should be heard in entirely in private session. The Tribunal's full decision on the application is included at Annex A and a redacted version shall be included with the redacted version of this determination.

3. The Tribunal granted Ms Wise's application, made on behalf of the General Medical Council ('GMC') pursuant to Rule 17(6) of the Rules to amend the Allegation, XXX. Mr McCartney consented to the application and the Tribunal was satisfied that no prejudice or injustice would be caused by granting it.

Background

4. Dr Godfrey qualified in 1979 at the Birmingham Medical School with an MB ChB and he obtained his MRCGP in 1983. From 1983 onwards, Dr Godfrey has worked as a GP at a number of GP Practices, predominantly based in London.

5. At the time of the events which give rise to the Allegation, Dr Godfrey was working as a salaried GP at the Clapham Family Practice. From September 2021 until January 2024, he also worked two days a week as a locum GP at Randolph Surgery in Maida Vale.

6. The Allegation that has led to this hearing can be summarised as follows:

- it is alleged that Dr Godfrey dishonestly applied for a Prescription Identification Number ('PIN') in order to issue private prescriptions for a controlled drug by providing false information within the application form;
- it is alleged that Dr Godfrey issued private prescriptions for a controlled drug for Patient A, a vulnerable person with whom he had a XXX personal relationship;
- it is alleged that Dr Godfrey falsely and dishonestly issued one or more prescriptions in Patient B's name and date of birth, when the prescriptions were in fact intended for Patient A; and
- it is alleged that Dr Godfrey failed to explore non-pharmacological elements of care for Patient A, failed to ensure Patient A's response to treatment was assessed by an appropriate specialist, failed to inform Patient A's GP and failed to make adequate records of the treatment he had provided for Patient A.

7. XXX

8. The events under consideration originally came to light as a result of the Chief Pharmacist of Central & North-West London contacting NHS England ('NHSE') and NHS Improvement Control & Drugs Accountable Officer ('CDAO') alleging that Dr Godfrey had been prescribing a controlled drug ('[XXX]') for Patient A for approximately two years. This was after Patient A's GP raised concerns that Patient A was being prescribed XXX without any evidence of an assessment or a diagnosis.

9. A XXX referral was made XXX and, on 10 February 2022, NHSE received an update XXX, advising XXX, Dr Godfrey had denied prescribing XXX for Patient A. NHSE was informed that Dr Godfrey had stated that the medication which Patient A had taken was obtained from abroad. Shortly thereafter, Dr Godfrey admitted that he had prescribed XXX to Patient A for a period of approximately two years during the Covid-19 pandemic. Dr Godfrey stated that he prescribed the medication in relation to a then presumed, and now confirmed, diagnosis of XXX.

10. Dr Godfrey stated that he initially obtained a small amount of XXX, the medication given to Patient A, from XXX.

11. In order to prescribe the medication himself, Dr Godfrey then applied for a PIN to enable him to prescribe XXX controlled drugs in private practice. In his application form, Dr

Godfrey indicated that the scope of his practice which required the prescribing of such drugs was XXX

12. In response to email correspondence querying the residential address which Dr Godfrey had indicated he would be prescribing from, Dr Godfrey stated '*I have a consulting room on the first floor. So yes please do proceed.*'. This was not correct information.

13. Dr Godfrey used Patient B's name and date of birth on a number of the prescriptions in order to avoid it being identified that he was prescribing medication to Patient A.

14. Dr Godfrey self-referred to the GMC on 17 June 2022, following an NHSE investigation, a Performance Advisory Group meeting held on 8 June 2022 and an NHSE London Region Performers List Decision Panel meeting held on 22 June 2022. In his referral, Dr Godfrey stated the following:

> *'I am making a self-referral on the grounds of concerns that have arisen in relation to my prescribing [XXX] and associated probity concerns. In brief, I prescribed [XXX] to [Patient A] for a period of about 2 years during the covid crisis, in relation to [XXX] and compounded this error by undertaking a number of deceptions in relation to obtaining the prescriptions and being dishonest with [XXX].*
>
> *The Chief Pharmacist and Accountable Officer at CNWL NHS Foundation Trust raised concerned with the NHSEQ Controlled Drug Accountable Officer, who in turn relayed their concerns to the NHSE performance team, who have investigated this in accordance with the NHS Performers List Regulations (as an aside, I understand that it is likely that NHSE will make contact with you in due course in relation to these matters).*
>
> *I have fully accepted my failings in relation to these matters and have complied with the NHSE investigation. …'*

The Allegation and the Doctor's Response

15. The full Allegation against Dr Godfrey, together with Dr Godfrey's response, are as follows:

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

1. On 24 March 2020, you applied to NHS England London Controlled Drugs Accountable Office ('CDAO') for a Prescription Identification Number ('PIN') to issue private prescriptions for controlled drugs and:

    a. within the application form, you provided the information set out in Schedule 1; **Admitted and found proved**
    b. in an email to the CDAO on 25 March 2020, you falsely stated that you had a consulting room on the first floor of your residential address. **Admitted and found proved**

2. The information you provided at paragraphs 1a and 1b, was:

    a. intended to give the impression that you would be issuing private prescriptions in an official capacity; **Admitted and found proved**
    b. an attempt to conceal the reason for your application, which was to issue private prescriptions for Patient A. **Admitted and found proved**

3. You knew that the CDAO would not grant you a PIN number, if you disclosed the reason for your application. **Admitted and found proved**

4. Your actions at paragraphs 1a-b were dishonest by reason of paragraphs 2 and 3. **Admitted and found proved**

5. On one or more occasions between March 2020 and March 2022, you issued private prescriptions for a controlled drug for Patient A as set out in Schedule 2, with whom you had a XXX personal relationship, and:

    a. you did so:
        i. in a non-emergency situation; **Admitted and found proved**
        ii. in the absence of a diagnosis made by an appropriate specialist; **Admitted and found proved**
        iii. without:
            1. fully exploring all non-pharmacological elements of care; **Admitted and found proved**

2. ensuring that Patient A's response to treatment was assessed by an appropriate specialist; **Admitted and found proved**
3. promptly informing Patient A's GP in writing of the prescriptions. **Admitted and found proved**

b. you failed to make adequate records of the treatment you provided to Patient A, including full details of: **Admitted and found proved**
   i. the diagnostic process; **Admitted and found proved**
   ii. management planning; **Admitted and found proved**
   iii. the prescriptions issued to Patient A; **Admitted and found proved**
   iv. Patient A's response to treatment; **Admitted and found proved**

c. in respect of one or more of the prescriptions in Schedule 2 you falsely issued them in Patient B's name and date of birth, when they were intended for Patient A; **Admitted and found proved**

d. Patient A was vulnerable for the reasons set out in Schedule 3. **Admitted and found proved**

6. You knew that the prescriptions referred to at paragraph 5c:
   a. were not intended for Patient B; **Admitted and found proved**
   b. would conceal your XXX personal relationship to Patient A. **Admitted and found proved**

7. Your actions at paragraph 5c were dishonest by reason of paragraph 6. **Admitted and found proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.' **To be determined**

The Admitted Facts

15. At the outset of these proceedings, Dr Godfrey made admissions to all of the paragraphs and sub-paragraphs of the Allegation, as set out above. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

16. In light of the full admissions made by Dr Godfrey, in accordance with Rule 17(2)(l) of the Rules, the Tribunal now has to decide whether Dr Godfrey's fitness to practise is impaired by reason of his misconduct.

Witness Evidence

17. The Tribunal received evidence on behalf of the GMC in the form of a witness statement, dated 21 September 2023, from Ms C, Performance Manager for NHSE, London Regional Team. Ms C was not called to give oral evidence.

18. Dr Godfrey provided his own witness statement, dated 12 March 2024, and also gave oral evidence at the hearing.

19. In addition, the Tribunal received witness statement evidence from the following witnesses on Dr Godfrey's behalf:

- Ms D, a friend of Dr Godfrey's – statement dated 21 December 2023; and
- Ms E, friend of Dr Godfrey's – statement dated 21 December 2023.

20. The Tribunal also received a witness statement from Dr G, Dr Godfrey's Responsible Officer - statement dated 28 December 2023.

Expert Witness Evidence

21. The Tribunal received evidence from Dr F, GP, on behalf of the GMC, who provided an expert report, dated 28 March 2023, a supplemental report, dated 18 October 2023, and further comments, dated 28 February 2024.

Documentary Evidence

22. The Tribunal had regard to the documentary evidence provided by the parties. This included but was not limited to:

- Application form for PIN completed by Dr Godfrey, dated 24 March 2020;
- Email correspondence between Dr Godfrey and NHSE CDAO, in respect of his PIN application form, dated 24 – 25 March 2020;
- List of private prescriptions issued by Dr Godfrey, dated January 2020 – January 2022;

- Prescription issued in Patient A's name, dated 1 October 2020;
- Prescription issued in Patient B's name, dated 22 December 2020;
- Correspondence between NHSE and Dr Godfrey, various dates.

Dr F's Expert Evidence

23. The expert evidence contained within Dr F's three reports was not challenged by Dr Godfrey and Dr F did not, therefore, give oral evidence.

24. In his reports, Dr F outlined his expert opinion which included the following (summarised) comments and conclusions:

- A diagnosis XXX should be made by a specialist XXX, and should be based on a full XXX assessment. Prescribing XXX in the absence of an appropriate diagnosis was seriously below the standard expected of a reasonably competent GP, because the diagnosis of XXX has significant implications and because inappropriate treatment with XXX has the potential to cause significant adverse effects.

- The management of XXX includes non-pharmacological treatments XXX Medication XXX should only be initiated by a healthcare professional with specialist training and expertise. XXX

- XXX is a XXX Controlled Drugs with the potential for misuse and dependence. XXX Controlled Drugs are subject to legal requirements in terms of prescribing, safe custody and record keeping.

- It was not necessary or appropriate for Dr Godfrey to provide medical care for Patient A. Dr Godfrey's personal relationship with Patient A had the potential to influence clinical decision making and this conflict had the potential to adversely affect Patient A's medical care.

- The provision of medical care by Dr Godfrey to Patient A over an extended period of almost two years was seriously below the standard expected, because his actions were a clear breach of fundamental professional guidance, and because his actions placed Patient A at risk of harm from conflicted clinical decision making and sub-optimal care, and because Patient A was placed at risk of harm from inappropriate prescribing.

- Patient A was vulnerable by virtue of XXX

- Dr Godfrey did not ensure that Patient A's response to treatment was assessed initially by an appropriate specialist to ensure that the treatment was appropriate and in their best interest, XXX. This was seriously below the standard expected because clinical guidance in this area is clear and because Patient A was exposed to the risk of harm from long term treatment with XXX medication that may not have been prescribed appropriately.

- Dr Godfrey's actions in using Patient B's name and date of birth on prescriptions XXX was clearly inappropriate and were seriously below the standard expected.

- Dr Godfrey's failure to make adequate records of the treatment provided to Patient A was seriously below the standard expected, because XXX is a significant diagnosis XXX and because information relating to prescribing of controlled drugs such as XXX should be recorded carefully.

- The overall standard of care provided to Patient A by Dr Godfrey was seriously below the standard expected of a reasonably competent GP.

Dr Godfrey's Witness Evidence

25. In his witness statement and in oral examination and cross examination, Dr Godfrey gave the following (summarised) evidence.

26. Until the events under consideration, he has never been the subject of any GMC investigation or proceedings.

27. XXX

28. XXX

29. XXX

30. XXX

31. XXX

32. XXX

33. XXX, Dr Godfrey XXX spoke at length to Dr H about Patient A's symptoms and Dr Godfrey said that Dr H stated that it seemed like Patient A had XXX, although she was of course not able to make any diagnosis. XXX

34. Dr Godfrey XXX then spoke with XXX about this possible diagnosis and she offered to send XXX a week's supply of XXX *'to try on Patient A as an experiment'*. XXX

35. Dr Godfrey said that he XXX then started to read extensively about XXX and discussed at length with Patient A the possibility that she had XXX

36. XXX

37. Dr Godfrey said that he XXX made the decision to give Patient A, XXX the medication obtained from XXX by post. He said that a number of non-pharmacological approaches XXX had been tried with little to no effect before this decision, but he accepted that he *'had not fully explored all relevant nonpharmacological approaches with Patient A'*.

38. XXX

39. Dr Godfrey stated that he XXX felt *'hugely panicked and stressed about what we could do to help Patient A at what we felt was a critical point in [their] life'*. He said that after many discussions XXX, he decided that Patient A needed to urgently restart XXX medication XXX

40. Dr Godfrey described a *'huge amount of [XXX] pressure [XXX] to resolve the situation'* and, after some research about obtaining a private prescription pad for controlled drugs, he proceeded to apply for a PIN. This was for the sole purpose of prescribing XXX medication to Patient A. Dr Godfrey expressed remorse for his actions in prescribing the XXX medication, for example he stated:

> *'I wholly accept that it was entirely wrong to have prescribed these drugs to [Patient A] in the absence of a formal diagnosis [XXX]; my judgment was completely clouded by [XXX]. I am deeply ashamed of my actions and full of remorse for what I did. Furthermore, I wholly accept that [XXX] is not an excuse for what I did'*

41. Dr Godfrey said that he gave his separate XXX address and his credentials as XXX *'deliberately to give the impression that I would be issuing prescriptions in a professional capacity and to conceal that he would be prescribing to Patient A alone*'. Dr Godfrey also said that he had falsely stated that he had a consulting room on the first floor of the address and he '*deliberately told these lies to get a PIN number and private prescribing pad so I could prescribe to Patient A*'. Dr Godfrey said:

> *'I deeply regret giving this misleading information and fully accept that it was inappropriate, deceitful, and unprofessional, along with being in direct contradiction of good medical practice. I am extremely sorry for the actions that I took.'*
>
> *'I wholly accept that this was false information as I did not have a consulting room at my [XXX] address, nor did I undertake any private work; I deliberately told these lies to get a PIN number and private prescribing pad so I could prescribe to Patient A.'*

42. Dr Godfrey acknowledged that the majority of Patient A's prescriptions were made out in the name of Patient B XXX. Dr Godfrey again expressed remorse, stating:

> *'I fully accept that this was wholly dishonest and a terrible error of judgement. I deeply regret my actions and I am ashamed that I lied. I also fully accept that what I did was in direct contradiction to good medical practice.'*

43. Dr Godfrey said that he had monitored Patient A's blood-pressure, weight and height on a monthly basis as reflected in his private medical records for Patient A, but he accepted that his records were scant in detail and he failed to make adequate records of the treatment he provided, including the diagnostic process, management planning, the prescriptions issued to Patient A and XXX response to treatment.

44. Dr Godfrey said that, as far as he was aware, Patient A's GP was aware that he was prescribing XXX, and he referred to entries in Patient A's records which reflected that Patient A informed XXX GP of the position in November 2020. XXX. However, Dr Godfrey accepted that he himself '*never wrote to either Patient A's GP [XXX] to formally confirm that* [he] *was prescribing [XXX]*'.

Submissions

On behalf of the GMC

45. Ms Wise submitted that Dr Godfrey's fitness to practise is currently impaired by reason of his misconduct. She referred the Tribunal to those paragraphs of *Good Medical Practice* (2013) ('GMP') and *Good practice in prescribing and managing medicines and devices* (2013) ('GMC Prescribing Guidance') which she submitted Dr Godfrey had breached in his admitted actions and Ms Wise referred to case law relevant at the stage at which a Tribunal is considering impairment.

46. Ms Wise referred to the overarching objective and submitted that a finding of impairment was necessary to promote and maintain public confidence in the medical profession; and to promote and maintain proper professional standards and conduct for members of that profession.

47. Ms Wise stated that it was correct to note that Dr Godfrey had made admissions at the outset of the GMC investigation and had made efforts to apologise but she submitted that it should also be noted that Dr Godfrey's actions amounted to serious misconduct which related to two separate charges of dishonesty.

48. Ms Wise emphasised that Dr Godfrey had had opportunities to depart from the dishonest path he had embarked upon but had continued to prescribe for Patient A for approximately two years and these actions had put Patient A at risk of harm.

49. Ms Wise submitted that, although Dr Godfrey had attended relevant courses and had demonstrated increasing insight and remediation, there is no reason in the circumstances of this case which would justify a finding that Dr Godfrey's fitness to practise is currently not impaired by reason of misconduct. She submitted that his actions were in breach of the following paragraphs of *Good Medical Practice* ('GMP') (2013):

1, 3, 12, 14, 16, 19, 21a, b,d,e, 65, 66, 71

On behalf of Dr Godfrey

50. Mr McCartney stated that, although Dr Godfrey had admitted misconduct, the doctor still had a significant role to play in maintaining the health, safety and welfare of the public.

51. Mr McCartney submitted that, whilst not suggesting that Dr Godfrey's conduct had been anything other than serious professional misconduct, the issue was whether there was present impairment, rather than impairment two or three years ago.

52. Mr McCartney submitted that, in the circumstances of this case, there was no issue of public protection going forward. He also queried whether there were issues, prospectively, regarding the protection of the public or a risk that Dr Godfrey would harm the reputation of the profession in the future. He submitted that there are no such prospective issues or risk.

53. Mr McCartney also submitted that there is no risk of Dr Godfrey acting dishonestly in the future.

54. Mr McCartney stated that the Tribunal should not ignore the issue of the public interest arising from Dr Godfrey's misconduct, but he submitted that that this is a separate question.

55. Mr McCartney submitted that Dr Godfrey had not been dishonest for his own benefit or to cover up a mistake, but rather the core reason for his dishonesty was due to his concern for Patient A. He stated that events had been spiralling out of control and that Dr Godfrey had made an *'exceptionally bad decision'* in what was, in his mind, an emergency situation.

56. Mr McCartney submitted that, although it was normally difficult to remedy dishonesty, this was not a normal case and, as such, Dr Godfrey's dishonesty was remediable and was highly unlikely to be repeated.

57. Mr McCartney stated that Dr Godfrey has, over the last two years, developed full insight and has worked collaboratively with NHSE, who are now content for him to practise without any restrictions.

58. Mr McCartney emphasised that Dr Godfrey was a doctor of many years' experience and that these events occurred XXX.

59. Mr McCartney emphasised in his submissions that Dr Godfrey's dishonesty was capable of being remediated, had been remediated, and there was no risk of repetition.

The Tribunal's Approach

60. The Legally Qualified Chair ('LQC') provided advice to the Tribunal on the approach it must take and the legal principles it should apply. In particular, the LQC referred the Tribunal to a number of applicable authorities on dishonest misconduct.

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

62. In approaching its decision, the Tribunal was mindful of the two-stage process to be adopted: firstly to consider whether the facts as found proved amount to misconduct which is serious; and secondly, whether as a result Dr Godfrey's fitness to practise is impaired.

63. The Tribunal reminded itself that it must determine whether Dr Godfrey's fitness to practise is impaired today, taking into account his conduct at the time of the events under consideration and any relevant factors since, including whether the matters are remediable, have been remedied and any likelihood of repetition.

64. The Tribunal was reminded of the principles derived from the case of *CHRE v NMC and Grant* [2011] EWHC 927 in which Dame Janet Smith's observations in the Fifth Report of the Shipman Inquiry were endorsed. Dame Janet Smith suggested that questions of impairment could be considered in the light of the following considerations:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> > *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
> >
> > *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
> >
> > *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
> >
> > *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

65. In reaching its decision, the Tribunal must consider the statutory overarching objective, which is:

a. *To protect and promote the health, safety and wellbeing of the public;*
b. *To promote and maintain public confidence in the medical profession; and*
c. *To promote and maintain proper professional standards and conduct for members of the profession.*

The Tribunal's Determination on Impairment

Misconduct

66. The Tribunal first considered whether the facts which have been admitted and found proved amount to misconduct.

Paragraphs 1 – 4 of the Allegation

67. The Tribunal considered Dr Godfrey's actions in dishonestly applying to NHSE CDAO for a PIN solely to issue private prescriptions for a controlled drug to Patient A and falsely stating that he had a consulting room XXX address fell so far short of the standards of conduct reasonably expected as to plainly amount to serious misconduct.

68. The Tribunal noted that dishonest actions breach a fundamental tenet of the medical profession, and it noted that Dr Godfrey's dishonest actions were planned and carried out in full knowledge that he was acting dishonestly.

69. The Tribunal noted that Dr Godfrey admitted that the reason that he had dishonestly applied for a PIN was because he knew that CDAO would not grant him a PIN number, if he disclosed the reason for his application.

70. The Tribunal considered that Dr Godfrey's dishonest actions in making the application and giving misleading information were compounded by his subsequent actions, when challenged, in falsely stating that he had a consulting room XXX.

71. The Tribunal accepted the clear and unchallenged evidence of Dr F and his opinion regarding Dr Godfrey's actions in respect of these paragraphs of the Allegation. The Tribunal

reminded itself of the contents of Dr F's reports, summarised above, and his view that Dr Godfrey's actions, as contained within the Allegation, fell seriously below the standard expected of a reasonably competent GP.

72. The Tribunal noted that Mr McCartney did not seek to persuade the Tribunal that Dr Godfrey's admitted actions were such that they did not amount to serious professional misconduct.

73. The Tribunal reviewed GMP and, in particular, those paragraphs of GMP which Ms Wise submitted had been breached by Dr Godfrey's actions. Taking into account the clear conclusions of Dr F together with Dr Godfrey's admissions and all of the available evidence, the Tribunal agreed with the GMC submissions that the following paragraphs had been breached:

> *'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.'*
>
> *'3 Good medical practice describes what is expected of all doctors registered with the General Medical Council* [...] *It is your responsibility to be familiar with Good medical practice and the explanatory guidance which supports it, and to follow the guidance they contain'*
>
> *'12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.'*
>
> *'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'*
>
> *'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.'

Paragraphs 5 a, b and d of the Allegation

74. The Tribunal considered Dr Godfrey's actions in issuing prescriptions between March 2020 and March 2022 for Patient A, who was vulnerable, in a non-emergency situation; in the absence of a diagnosis made by an appropriate specialist, and without fully exploring all non-pharmacological elements of care, without ensuring that Patient A's response to treatment was assessed by an appropriate specialist, and without promptly informing Patient A's GP in writing of the prescriptions fell so far short of the standards of conduct reasonably expected as to plainly amount to serious misconduct.

75. The Tribunal reached the same conclusion in respect of Dr Godfrey's actions in failing to make adequate records of the treatment he provided to Patient A, including full details of the diagnostic process, management planning, the prescriptions issued to Patient A and Patient A's response to treatment.

76. In reaching its conclusions, the Tribunal again accepted the clear and unchallenged evidence of Dr F and his opinion regarding Dr Godfrey's actions in respect of these paragraphs of the Allegation. The Tribunal reminded itself of the contents of Dr F's reports, summarised above, and his view that Dr Godfrey's actions, as contained within the Allegation, fell seriously below the standard expected of a reasonably competent GP.

77. In particular, the Tribunal had regard to the following excerpts from Dr F's reports:

'Prescribing controlled drugs

Professional guidance on prescribing controlled drugs (GMC, 2013b) sates: (69) You must not prescribe controlled drugs for yourself or someone close to you unless: a. no other person with the legal right to prescribe is available to assess and prescribe without a delay b. emergency treatment is immediately necessary to avoid serious deterioration in health or serious harm. [XXX] is a [XXX] Controlled Drug (CD). CDs are subject to particular legal controls on prescribing because of the potential for misuse, harm and dependency. Dr Godfrey prescribed [XXX] in significant quantities on several occasional over a prolonged period as set out in the table above. My opinion is that

this represented ongoing treatment of a chronic medical condition rather than provision of emergency treatment. My opinion is that it was not appropriate for Dr Godfrey to prescribe [XXX] to [Patient A]. My opinion is that these actions were seriously below the standard expected because they were in clear breach of professional guidance on CD'

'*Close personal relationship and prescribing*

Professional guidance on prescribing (GMC, 2013b) makes it clear that, wherever possible, doctors should avoid prescribing for anyone with whom they have a close personal relationship. Dr Godfrey prescribed [XXX] to [Patient A] in significant quantities on several occasions over a prolonged period as set out in the table above. My opinion is that this was seriously below the standard expected because these actions were a clear breach of fundamental professional guidance on prescribing and because was placed at risk of harm form inappropriate prescribing.'

'Dr Godfrey issued prescriptions to [XXX], on several occasions between April 2020 and January 2021. My opinion is that this was seriously below the standard expected because these actions were a breach of fundamental professional guidance on prescribing and because was placed at risk of harm form inappropriate prescribing'

'Clinical guidance (NICE, 2018) states that people with [XXX] should be reviewed initially by an appropriate specialist until established on a stable dose of medication, followed by ongoing monitoring [XXX]. My opinion is that Dr Godfrey did not ensure that 's response to treatment was assessed initially by an appropriate specialist to ensure that the treatment was appropriate and in [their] best interest, and that the dose had been optimised. In my opinion this was seriously below the standard expected because clinical guidance in this area is clear and because Patient A was exposed to the risk of harm from long term treatment with [XXX] medication that may not have been prescribed appropriately.'

'If it is accepted that Dr Godfrey failed to inform Patient A's GP in a timely fashion that he was prescribing [XXX], then in my opinion this would be a serious failing. This is because [XXX] was a long term treatment that had implications for Patient A's health with the potential to impact on [their] clinical presentation and to interact with other prescribed medication. My opinion is that failure to keep GP fully informed of his prescribing could be misleading for primary care clinicians and could place [them] at

risk of harm from drug interactions. Therefore my opinion is that these failings were seriously below the standard expected.'

'Dr Godfrey failed to make adequate contemporaneous records of the diagnostic process and the [XXX] treatment he provided to Patient A. In my opinion this was in breach of the clear professional requirement for doctors to maintain adequate records and falls seriously below the standard expected. This is because [XXX] is a significant diagnosis [XXX] and because information relating to prescribing of CDs such as [XXX] should be recorded carefully.'

78. The Tribunal noted that Mr McCartney did not seek to persuade the Tribunal that Dr Godfrey's admitted actions were such that they did not amount to serious professional misconduct.

79. The Tribunal reviewed GMP and, in particular, those paragraphs of GMP which Ms Wise submitted had been breached by Dr Godfrey's actions. Taking into account the clear conclusions of Dr F together with Dr Godfrey's admissions and all of the available evidence, the Tribunal agreed with the GMC submissions that the following paragraphs had been breached:

'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.'

'3 Good medical practice describes what is expected of all doctors registered with the General Medical Council […]. *It is your responsibility to be familiar with Good medical practice and the explanatory guidance which supports it, and to follow the guidance they contain'*

'12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.'

'14 You must recognise and work within the limits of your competence'

'16 In providing clinical care you must:

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

b provide effective treatments based on the best available evidence

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.'

'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

…

d any drugs prescribed or other investigation or treatment'

'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'

'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.'

80. Again, taking into account the clear conclusions of Dr F together with Dr Godfrey's admissions and all of the available evidence, the Tribunal agreed with the GMC submissions that the following paragraphs of GMC Prescribing Guidance had been breached:

'17 Wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship.'

'18 Controlled medicines present particular dangers, occasionally associated with drug misuse, addiction and misconduct. You must not prescribe a controlled medicine for yourself or someone close to you unless:

a no other person with the legal right to prescribe is available to assess and prescribe without a delay which would put your, or the patient's, life or health at risk or cause unacceptable pain or distress, and

b the treatment is immediately necessary to:

i save a life

ii avoid serious deterioration in health, or

iii alleviate otherwise uncontrollable pain or distress.'

'19 If you prescribe for yourself or someone close to you, you must:

a make a clear record at the same time or as soon as possible afterwards. The record should include your relationship to the patient (where relevant) and the reason it was necessary for you to prescribe.

b tell your own or the patient's general practitioner (and others treating you or the patient, where relevant) what medicines you have prescribed and any other information necessary for continuing care, unless (in the case of prescribing for somebody close to you) they object.'

Paragraph 5c, 6 and 7 of the Allegation

81. The Tribunal considered Dr Godfrey's actions in knowingly and dishonestly issuing prescriptions which were intended for Patient A using Patient B's name and date of birth XXX fell so far short of the standards of conduct reasonably expected as to plainly amount to serious misconduct.

82. In reaching its conclusions, the Tribunal again accepted the clear and unchallenged evidence of Dr F and his opinion regarding Dr Godfrey's actions in respect of these paragraphs of the Allegation. The Tribunal reminded itself of the contents of Dr F's reports, summarised above, and his view that Dr Godfrey's actions, as contained within the Allegation, fell seriously below the standard expected of a reasonably competent GP.

83. In particular, the Tribunal had regard to the following excerpts from Dr F's reports:

'The GMC Document Bundle includes a copy of a prescription issued on 22.12.20 by Dr Godfrey. The patient information consists of the name and date of birth of [XXX] [Patient B]. In his reflective statement, Dr Godfrey states that the prescription was for [XXX] Patient A, [XXX].'

'My opinion is that this was clearly inappropriate for the following reasons. Professional guidance (GMC, 2013a) makes it clear that doctors should be honest and trustworthy in their professional dealings and should ensure that documents they sign are accurate and not misleading. By issuing a prescription with a false name and date of birth Dr Godfrey placed the dispensing pharmacist in a difficult position by having to

dispense medication based on inaccurate information. This is especially important for CDs such as [XXX] which are subject to additional controls on possession and supply. Therefore my opinion is that Dr Godfrey's actions were seriously below the standard expected.

I would like to add that, in my opinion, an inaccurate date of birth on a prescription could potentially lead to patient harm, [XXX]

[XXX] This means that the inaccurate [XXX] details entered by Dr Godfrey were not associated with any clinical risk to Patient A.

Possession of a [XXX] CD is an offence without prescription or lawful authority, and by issuing a prescription bearing inaccurate demographic details Dr Godfrey placed Patient A in this position in relation to the medicine supplied against this prescription.'

84. The Tribunal noted that Mr McCartney did not seek to persuade the Tribunal that Dr Godfrey's admitted actions were such that they did not amount to serious professional misconduct.

85. The Tribunal considered that Dr Godfrey's dishonest actions with regard to these paragraphs of the Allegation were repeated over a significant period of time and purely designed to avoid detection. These actions had the potential to place a number of people in a difficult situation or indeed to cause harm, including Patient A, Patient B and the dispensing pharmacist (who was entirely unaware of the deception).

86. The Tribunal considered that Dr Godfrey's dishonest actions constituted repeated breaches of a fundamental tenet of the medical profession.

87. The Tribunal reviewed GMP and, in particular, those paragraphs of GMP which Ms Wise submitted had been breached by Dr Godfrey's actions. Taking into account the clear conclusions of Dr F together with Dr Godfrey's admissions and all of the available evidence, the Tribunal agreed with the GMC submissions that the following paragraphs had been breached:

'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.'

'3 Good medical practice describes what is expected of all doctors registered with the General Medical Council (GMC). It is your responsibility to be familiar with Good medical practice and the explanatory guidance which supports it, and to follow the guidance they contain'

'12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.'

'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

[...]

d any drugs prescribed or other investigation or treatment

e who is making the record and when'

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

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

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

b *You must not deliberately leave out relevant information.'*

Impairment

88. Having determined that the facts which were admitted and found proved all amounted to serious misconduct, the Tribunal went on to consider whether, as a result of that serious misconduct, Dr Godfrey's fitness to practise is currently impaired.

89. The Tribunal considered that Dr Godfrey's actions, and in particular his dishonest actions, were difficult to remediate but, overall, it considered them to be capable of remediation.

90. The Tribunal was concerned by Dr Godfrey's dishonest actions and attempts at concealment. These occurred over a protracted period and involved several different aspects of misconduct. There were many opportunities for Dr Godfrey to desist in his actions and to adopt a different course.

91. Dr Godfrey's actions served to undermine the necessary systems in place to ensure that controlled drugs are properly dispensed and recorded.

92. The Tribunal noted that Dr Godfrey considered that his actions occurred in a situation which he XXX considered to amount to an emergency or exceptional situation. While accepting that XXX undoubtedly created stress and anxiety, the Tribunal was not satisfied that the situation did amount to an exceptional or emergency situation.

93. Dr Godfrey, as a very experienced GP, knew the system in place for securing a diagnosis, the prescribing rules, the need for honesty and the steps he ought to have taken.

94. Dr Godfrey had the option of seeking a private assessment of Patient A XXX, which the Tribunal noted was ultimately the course of action adopted after events came to light.

95. The Tribunal was entirely underwhelmed by Dr Godfrey's rationale for not availing of the option for a private assessment at the time – such reason largely being that Dr Godfrey was opposed to stepping away from NHS treatment to the private sector.

96. Further, the Tribunal was concerned that Dr Godfrey, as a highly experienced GP, formed a diagnostic judgment XXX as a result of attending a conference XXX and speaking with a doctor who had not examined Patient A and who herself indicated that she could not diagnose Patient A. Again, Dr Godfrey was entirely aware of the appropriate path to securing an assessment and diagnosis.

97. The Tribunal considered that there were many other options available to Dr Godfrey other than engaging in prolonged dishonesty and potentially putting Patient A's health at risk.

98. The Tribunal acknowledged that Dr Godfrey has from an early stage made full and frank admissions, expressed significant remorse, self-referred to the GMC and has taken significant steps towards remediation. It also bore in mind that Dr Godfrey's misconduct, albeit repeated and protracted, arose from a single set of specific circumstances and occurred in an otherwise unblemished career. His actions were not for personal gain.

99. The Tribunal noted that there are no clinical concerns and NHSE have indicated that they are content for Dr Godfrey to practise unrestricted. The Tribunal noted from the testimonials that Dr Godfrey is considered to be a skilled and experienced GP and those providing the testimonials were aware of the issues under consideration by the Tribunal.

100. The Tribunal considered that Dr Godfrey has in his reflective statement, witness statement and in his oral evidence, demonstrated significant insight into aspects of his misconduct. This insight has been continuing to develop since his actions were brought to light. Dr Godfrey has been engaging with two mentors and has reflected on his actions and indicated that he has a support structure in place to mitigate against any risk of future repetition. When asked if he felt he needed such a support structure to avoid repetition, Dr Godfrey clarified that he would never repeat his misconduct and he had learned a very salutary lesson from these matters.

101. While accepting that Dr Godfrey is highly unlikely to repeat his misconduct and while accepting that Dr Godfrey has taken significant steps toward developing insight and remediating, the Tribunal did, however, harbour a concern that evidence of reflection on, and insight into, the potential harm which might have been caused as a result of his actions was absent from Dr Godfrey's statements and evidence.

102. In the circumstances the Tribunal considered that Dr Godfrey still developing full insight.

103. The Tribunal considered that Dr Godfrey was on a journey to full remediation but concluded that more information must be provided to illustrate how Dr Godfrey would be able to withstand external pressure in the future and more evidence of insight into the potential risk associated with his actions should be provided.

104. Overall, taking all of the available evidence and circumstances into account, the Tribunal considered that a finding of impairment is currently required to meet limbs 2 and 3 of the overarching objective:

- *To promote and maintain public confidence in the medical profession; and*
- *To promote and maintain proper professional standards and conduct for members of the profession.*

105. The Tribunal considered that confidence in the medical profession would be undermined and that there would be a failure to promote and maintain professional standards if a finding of impairment were not made in this case.

106. Accordingly, the Tribunal determined that Dr Godfrey's fitness to practise was impaired by reason of his misconduct.

Determination on Sanction - 10/04/2024

107. This determination will be handed down in private. However, as this case concerns Dr Godfrey's misconduct a redacted version will be published at the close of the hearing.

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

The Evidence

109. Where relevant to reaching a decision on sanction, the Tribunal has taken into account the evidence it received during the earlier stages of the hearing together with its own conclusions on that evidence.

110. The Tribunal also received further oral evidence from Dr Godfrey at this stage.

111. During the course of his oral evidence, Dr Godfrey confirmed that he had considered and reflected on the Tribunal's determination on impairment, and he was asked a number of questions by Mr McCartney relating to the Tribunal's comments at paragraph 103 of that determination, which reads:

> *'The Tribunal considered that Dr Godfrey was on a journey to full remediation but concluded that more information must be provided to illustrate how Dr Godfrey would be able to withstand external pressure in the future and more evidence of insight into the potential risk associated with his actions should be provided.'*

112. Dr Godfrey stated that he knows and *'absolutely'* acknowledges that he should *'never'* have taken management of Patient A's diagnosis and treatment into his own hands. He said that he would never now consider intervening in Patient A's medical treatment, whether for XXX or anything else. Dr Godfrey gave a recent example XXX, and how he did not intervene but instead followed the correct path by XXX.

113. Dr Godfrey said that, no matter how severe the circumstances, he would not be persuaded to prescribe for XXX. He indicated that the last two years, since these matters have been ongoing, have been extremely stressful and through the courses and training he has attended and through his own reflection, he would *'categorically not'* be susceptible to external pressure when it comes to his position and work as a doctor.

114. Dr Godfrey stated that he had *'taken so much time with his mentors'* to discuss the matters which have brought him to the attention of the GMC and he has '*looked under the microscope'* while attending a professionalism course, which he said was a real sea change.

115. Dr Godfrey said that he now understands the *'absolute necessity'* to operate within the rules and there is now '*100% no possibility that* [he] *would knowingly bend the rules or breach GMP*'. He said that there is *'absolutely no chance'* of him acting in the same way as he did.

116. When asked by the medical member of the Tribunal about his views and reflections on the risk to Patient A, Dr Godfrey stated that he had failed to follow the NICE guidelines and Patient A was at risk as he had tried to move too quickly into medical treatment without exploring non-pharmacological options. Dr Godfrey confirmed that, although it had not been

fully articulated at impairment stage, he had reflected on, and learnt from his actions, and he was entirely aware that his actions potentially put Patient A at risk. He identified that, had he been wrong in his diagnosis, Patient A would have been unnecessarily and inappropriately being given medication which can have side-effects. Dr Godfrey stated that, had he been wrong, Patient A's true medical condition would have remained untreated with the risk of it becoming worse.

117. Dr Godfrey said that he does look back and reflect on *'how stupid* [he has] *been'*. He likened it to *'when you narrowly miss an accident on the road'*.

118. Dr Godfrey also emphasised that he was the individual with medical knowledge who should have been aware of the potential risk to Patient A through not following NICE guidelines and that he, ultimately, was responsible XXX.

Submissions

<u>On behalf of the GMC</u>

119. Ms Wise submitted that the appropriate sanction was one of suspension. She referred the Tribunal to those paragraphs of the *Sanctions Guidance* ('SG') which the GMC submit are applicable to this case, which related primarily to suspension and erasure. Overall, referring to paragraphs 91, 92, 93 and 97 of the SG, Ms Wise said that suspension was the minimum sanction which would meet the overarching objective. She said that suspending Dr Godfrey's registration would send out a message to the public and profession regarding behaviour which was unacceptable for a medical practitioner.

120. Ms Wise submitted that there were no exceptional circumstances in this case and that it would be inappropriate to take no action. She stated that paragraph 70 of the SG states that exceptional circumstances are expected to be very rare.

121. Ms Wise reminded the Tribunal that Dr Godfrey's dishonesty had been persistent and covered up and involved multiple prescriptions, but she stated that it is noteworthy and of relevance that Dr Godfrey was open and honest from the outset of the investigation and freely apologised for his actions.

122. Ms Wise also submitted that it is to Dr Godfrey's credit that it was he who voluntarily informed the NHSE that he had used Patient B's name and date of birth on prescriptions intended for Patient A.

123. Ms Wise submitted that the GMC did not seek to persuade the Tribunal that erasure was necessary or appropriate and she reiterated that suspension was the appropriate sanction in order to uphold the overarching objective and send out a message to the public and profession.

124. Ms Wise concluded by submitting that, if the Tribunal were to impose a sanction of suspension in this case, the GMC did not consider that a review hearing would be required.

<u>On behalf of the Dr Godfrey</u>

125. Mr McCartney submitted that, in addition to upholding professional standards and public confidence in the profession, it is part of a regulatory body's duty to ensure that those who can properly and safely provide services to the public are in a position to do so.

126. Mr McCartney stated that the evidence before the Tribunal demonstrated that a fully informed member of the public, having read and heard all of the evidence, including that of insight, reflection and remediation, would consider that there were no concerns.

127. Mr McCartney submitted that the mitigating factors and '*exceptional circumstances*' justify taking no action. He stated that it was an exceptional case in terms of dishonesty as *'it was a rare case where one had admitted dishonesty in circumstances where there was no benefit to the doctor'.*

128. Mr McCartney stated that in this case there was *'was a misplaced dishonesty because* [Dr Godfrey] *wrongly, as he acknowledged, felt that it was the best way to deal with [XXX]'.* Mr McCartney stated that this could be *'admirable'* dishonesty rather than the usual reasons for dishonesty, which tend to involve the covering up of mistakes or financial motives.

129. Mr McCartney submitted that, if one concludes that Dr Godfrey's insight and remediation is complete, in the context of the particular factors of this case, the Tribunal could consider that no action was appropriate as the public would recognise that the finding of impairment, of itself, meets those issues of maintaining public confidence and upholding standards within the profession.

130. Mr McCartney submitted that the further evidence heard at the sanction stage dealt with the Tribunal's residual concerns outlined in their impairment determination regarding the doctor's ability to withstand external pressure and his understanding of potential risks.

131. Mr McCartney submitted that, if the Tribunal does not agree that the taking of no action is justified, it is open to the Tribunal to formulate conditions to allow a development plan to address any such residual concerns.

132. Mr McCartney submitted that, if the Tribunal did not agree, and if it were minded to impose a suspension, then it should remind itself that the GMC do not regard a review as being necessary, which is perhaps informative as to the GMC's view on the reflection, insight and remediation demonstrated by Dr Godfrey.

133. Further, Mr McCartney submitted that, if the Tribunal were to decide that a period of suspension is necessary, it should bear in mind that Dr Godfrey still has much to offer the public and patients as an excellent and highly experienced GP who has occupied numerous responsible positions.

134. Mr McCartney submitted that a fully informed member of the public would expect any such suspension to be *'as short as possible'* to meet the identified regulatory concerns and he said that any suspension should be measured in *'weeks rather than months'*.

135. Mr McCartney also referred to the potential financial impact on Dr Godfrey and his family of any period of suspension. He said that, as a result of being an NHS portfolio GP, Dr Godfrey's pension and financial arrangements *'might not provide the financial comfort blanket he might otherwise have had'*.

136. Mr McCartney concluded by submitting that erasure would be wholly disproportionate in the circumstances and would fail to recognise the extremely positive work that Dr Godfrey had done.

The Tribunal's Determination on Sanction

137. The decision as to the appropriate sanction to impose, if any, is a matter for the Tribunal exercising its own judgement. There is no burden or standard of proof at this stage.

138. In reaching its decision, the Tribunal gave careful consideration to the SG. It bore in mind that the purpose of a sanction is not to be punitive although it may have a punitive effect. The Tribunal recognises that every case will necessarily turn on its own set of circumstances and facts.

139. The Tribunal bore in mind that in deciding what sanction, if any, to impose, it should consider the sanctions available, starting with the least restrictive.

140. Throughout its deliberations, the Tribunal took into account the overarching objective, and it applied the principle of proportionality, balancing Dr Godfrey's own interests with the public interest.

141. When considering the principle of proportionality, the Tribunal had regard to the judgment in the case of *Bolton v. Law Society* [1994] 1 WLR 512, in which Sir Thomas Bingham stated that '*the reputation of the profession is more important than the fortunes of any one individual member. Membership of a profession brings many benefits, but that is part of the price'*.

142. The Tribunal also had regard to the case of *Raschid and Fatnani v. The General Medical Council* [2007] 1 WLR 1460, in which Laws LJ stated that the functions of a fitness to practise tribunal are quite different from those of '*a court imposing retributive punishment'* since *'the panel ... is centrally concerned with the reputation or standing of the profession rather than the punishment of the doctor'.*

143. The Tribunal also took into account:

- its own conclusions in its earlier determination on facts and on impairment;
- GMP;
- the submissions of Ms Wise;
- the submissions of Mr McCartney.

144. The Tribunal accepted the above advice of the LQC.

Aggravating and Mitigating Factors

145. The Tribunal first identified what it considered to be the aggravating and mitigating factors in this case.

Aggravating

146. Dr Godfrey's dishonest actions and attempts at concealment occurred over a protracted period and involved several individual acts.

147. Dr Godfrey's actions placed Patient A's health at risk of potential harm.

148. Dr Godfrey's actions potentially had adverse implications for Patient B, in that the integrity of Patient B's own medical records was compromised.

Mitigating

149. Dr Godfrey's misconduct, although carried out over a period of time, related to one specific set of circumstances and amounted to a one-off aberration in an otherwise long and unblemished career.

150. Dr Godfrey fully engaged with NHSE and the regulatory process and he made full admissions from the outset.

151. Dr Godfrey had expressed remorse for his misconduct from the outset and had offered apologies.

152. It was Dr Godfrey who volunteered the information relating to his misconduct in prescribing in Patient B's name.

Insight and Remediation

153. Taking into account the Tribunal's previous conclusions, together with Dr Godfrey's further evidence at this stage, the Tribunal was satisfied that Dr Godfrey has now demonstrated full insight into his actions. The Tribunal acknowledged Dr Godfrey's considerable efforts to remediate and it accepted from his oral and documentary evidence that he has a full understanding of the inappropriateness of his behaviour.

154. Although the Tribunal had expressed some reservations in this regard in its previous determination, the Tribunal was further reassured about these matters by Dr Godfrey's oral evidence at this stage. It appeared to the Tribunal that this gap simply had not been drawn out sufficiently in the evidence at the previous stage.

No action

155. The Tribunal first considered whether to conclude the case by taking no action.

156. The Tribunal did not consider that there were any exceptional circumstances in this case which would justify such a course.

157. The Tribunal considered that, in the context of the admitted misconduct which involved significant matters of dishonesty over a protracted period of time, it would not be sufficient, proportionate or in the public interest to conclude the case by taking no action.

Conditions

158. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Godfrey's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable.

159. The Tribunal determined that the imposition of conditions on Dr Godfrey's registration would not be appropriate in light of the nature of the matters under consideration. The Tribunal noted that it is very difficult to formulate conditions which go to the issues in this case, which involve dishonest misconduct.

160. The Tribunal further considered that the imposition of conditions on Dr Godfrey's registration would not be appropriate in the circumstances of this case, as such a sanction would not be sufficiently robust as to promote and maintain public confidence in the medical profession and promote and maintain proper professional standards and conduct for members of the profession.

161. In the circumstances, the Tribunal determined that the imposition of conditional registration would not meet the public interest in this case.

Suspension

162. The Tribunal proceeded to consider whether imposing a period of suspension on Dr Godfrey's registration would be appropriate and proportionate.

163. The Tribunal acknowledged that suspension has a deterrent effect and can be used as a signal to the doctor, the profession, and to the public about what is regarded as behaviour unbefitting a registered doctor.

164. The Tribunal took account of the following paragraphs of the SG which indicate circumstances in which it may be appropriate to impose a sanction of suspension:

'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.'

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

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

97 Some or all of the following factors being present […] *would indicate suspension may be appropriate.*

a A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.

[…]

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

f No evidence of repetition of similar behaviour since incident.

g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.

165. The Tribunal further noted the following paragraphs of the SG which indicate that erasure may be an appropriate sanction:

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

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

'128 Dishonesty, if persistent and/or covered up, is likely to result in erasure […]'

166. In reaching its decision on sanction, the Tribunal reminded itself that it has previously concluded that Dr Godfrey's misconduct is remediable. It considered that, while very serious, Dr Godfrey's misconduct is not fundamentally incompatible with continued registration. As previously indicated, the Tribunal considered that Dr Godfrey's misconduct is very unlikely to be repeated. It has determined that Dr Godfrey has developed full insight and has sufficiently remediated.

167. The Tribunal took into account the aggravating and mitigating factors identified above.

168. In all the circumstances of this case, and taking into account the SG and the principle of proportionality, the Tribunal considered that suspension is the appropriate and proportionate sanction to impose in this case. It considered that this sanction is sufficient to meet the overarching objective and, in particular limbs two and three, which are:

- to promote and maintain public confidence in the medical profession; and
- to promote and maintain proper professional standards and conduct for members of the profession.

169. The Tribunal concluded that erasure would therefore be a disproportionate sanction and would be significantly more punitive in nature.

170. The Tribunal then considered the length of the period of suspension to impose. It took into account the following paragraphs of SG in this regard:

> *'99 The length of the suspension may be up to 12 months and is a matter for the tribunal's discretion, depending on the seriousness of the particular case.'*
>
> *'100 The following factors will be relevant when determining the length of suspension:*
>
> *a the risk to patient safety/public protection*
>
> *b the seriousness of the findings and any mitigating or aggravating factors* [...].
>
> *c ensuring the doctor has adequate time to remediate.'*
>
> *'101 The tribunal's primary consideration should be public protection and the seriousness of the findings. Following any remediation, the time all parties may need to prepare for a review hearing if one is needed will also be a factor.'*

171. The Tribunal again took into account the overall circumstances of this case, together with those aggravating and mitigating factors identified above.

172. The Tribunal noted that Dr Godfrey made serious departures from GMP and risked patient safety and public confidence in the profession. Dr Godfrey's misconduct was protracted and repeated. It involved dishonesty. Patient A was vulnerable.

173. As against that, the Tribunal noted that Dr Godfrey has taken remedial action and has developed full insight into his misconduct. He has addressed the serious concerns over a period of time. The Tribunal considered that there are currently no risks to patients or the public.

174. Overall, the Tribunal determined that, in light of Dr Godfrey's full insight and remedial actions, suspension for a period of three months was the minimum sanction which could be imposed which would be sufficient to mark the seriousness of Dr Godfrey's misconduct and meet the public interest.

175. The Tribunal concluded that this period would send a clear message to the medical profession and to the wider public that Dr Godfrey's misconduct was unacceptable.

176. The Tribunal determined that a reasonable and fully informed member of the public would regard a three-month suspension as a sufficient marker of the gravity of this particular case.

177. The Tribunal determined that suspension for three months represents an appropriate balance between satisfying the overarching objective and providing an opportunity for Dr Godfrey to return to practice, recognising that he is an otherwise competent and experienced doctor whose misconduct was entirely out of character and occurred in the context of an adverse and stressful situation XXX.

178. The Tribunal noted Mr McCartney's submissions on the potential financial impact of any period of suspension. The Tribunal considered that, whereas such a consideration may properly be taken into account when assessing proportionality and the interests of Dr Godfrey, the Tribunal had received no evidence in respect of financial matters.

179. In light of its conclusions as to future risk, insight and remediation, and taking into account the length of the suspension together with the GMC's submissions, the Tribunal determined that it is not necessary to direct a review of Dr Godfrey's case.

Determination on Immediate Order - 10/04/2024

180. Having determined that Dr Godfrey's registration should be suspended for three months, the Tribunal now has to decide, in accordance with Rule 17(2)(o) of the Rules, whether Dr Godfrey's registration should be subject to an immediate order.

Submissions

181. On behalf of the GMC, Ms Wise submitted that the GMC did not seek an immediate order in this case. Ms Wise confirmed that Dr Godfrey's registration was not currently subject to an interim order.

182. On behalf of Dr Godfrey, Mr McCartney submitted that he agreed with the GMC that an immediate order was not necessary in this case.

The Tribunal's Determination

183. In reaching its decision, the Tribunal has exercised its own judgement, taking into account all the circumstances. The Tribunal has borne in mind the guidance given in paragraphs 172 - 178 of the SG, in particular:

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate… where immediate action must be taken to protect public confidence in the medical profession.*
>
> *…*
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'*

184. The Tribunal had regard to the submission of both parties that an immediate order was not necessary in this case. The Tribunal was satisfied that an immediate order was not necessary to protect the public, was not in the public interest and was not in the best interests of Dr Godfrey.

185. In light of this, the Tribunal determined to not impose an immediate order.

186. This means that Dr Godfrey's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal. If Dr Godfrey does lodge an appeal, he will remain free to practise unrestricted until the outcome of any appeal is known.

187. This concludes the case.

ANNEX A – 02/04/2024
Application for a private hearing pursuant to Rule 41

188. At the outset of the hearing, Mr McCartney, on behalf of Dr Godfrey made an application, pursuant to Rule 41 of the Rules that the hearing should be held entirely in private.

189. Mr McCartney submitted that the allegations of misconduct are all predicated upon Dr Godfrey prescribing XXX to Patient A XXX.

190. He further noted that the identity of XXX has been anonymised and they will be referred to throughout proceedings as Patient A.

191. XXX

192. XXX

193. XXX

194. XXX

195. XXX

196. XXX

197. XXX

198. Ms Wise, on behalf of the GMC, opposed the application, and submitted that the GMC is a statutory body carrying out a public duty to further the overarching objective, which makes it mandatory for the hearing to be in public, unless case specific facts indicate that the interests of justice require otherwise.

199. Ms Wise submitted that the circumstances of this case do realistically allow for more limited measures than the whole of proceedings to be conducted in private, to be imposed.

200. XXX

201. Further, Ms Wise stated that the allegations that Dr Godfrey faces include allegations of dishonesty and asserted that it was self-evident that it was in the public interest for that to be heard in public.

202. Ms Wise submitted that to further mitigate against XXX, the GMC would not object to the Tribunal using its discretion to move between public and private sessions to protect Patient A's privacy XXX. She stated that instructed counsel for both the GMC and Dr Godfrey would be in a position to indicate to the Tribunal when such matters were to be considered, allowing the Tribunal to move to a private hearing as appropriate.

203. Ms Wise concluded by submitting that the circumstances of this case were not sufficient to justify the entirety of the hearing being conducted in private session.

Tribunal's decision

204. The Tribunal received legal advice from the LQC on the application which included reference to the default position that professional conduct proceedings will be heard in public when a committee or tribunal is determining allegations of misconduct or fitness to practise, as reflected in Rule 41 of the Rules.

205. The LQC referred to Rule 41(2), which provides that:

> *"The Committee or Medical Practitioners Tribunal may determine that the public shall be excluded from the proceedings or any part of the proceedings, where they consider that the particular circumstances of the case outweigh the public interest in holding the hearing in public."*

206. The LQC referred to *R(Miller) v GMC* [2013] EWHC 1934 (Admin), and outlined Article 6 of the European Convention on Human Rights. The LQC indicated that even where one of the Article 6 exceptions to a public hearing can, in principle, be relied upon, the derogation from the general principle ought not to be more than is proportionate – that is, the minimum derogation from the general principle necessary for the purpose of protecting the public interest that has been identified as coming within the scope of the relevant exception.

207. The Tribunal considered that, in light of XXX, the circumstances dictated that significant portions of the hearing would require to be held in private session.

208. However, the Tribunal was not satisfied that the circumstances of the case or the evidence were such that there existed sufficient reasoning or justification to deviate entirely from the default position that the hearing would be in public or at least part public.

209. The Tribunal considered that the matters raised in the Allegation were serious and the public interest requires that as much of the hearing as possible should be held in public.

210. The Tribunal considered the specific wording of the paragraphs of the Allegation and XXX.

211. The Tribunal was conscious of XXX but was satisfied that the hearing could be managed in such a way whereby those elements of the hearing which rightly should be in public session could be, and those elements that required the exclusion of the public could be identified and conducted in private session.

212. The Tribunal concluded that the minimum derogation was that some of the hearing could be in public and those aspect that could be dealt in public should be.

213. Accordingly, the Tribunal refused Mr McCartney's application, pursuant of Rule 41 of the Rules, for the hearing to be heard entirely in private.

SCHEDULE 1

Question 7.1: Please state the scope of your practice requiring the prescribing of XXX CDs (e.g. psychiatry, palliative care, substance misuse, dental sedation etc).
Dr Godfrey's answer: *[XXX]*
Question 7.2: What qualifications do you have for this role?
Dr Godfrey's Answer: *MB ChB MRCGP. [XXX]*

SCHEDULE 2

Date	Medication	Dose and quantity
April 2020	XXX	XXX
May 2020	XXX	XXX
August 2020	XXX	XXX
August 2020	XXX	XXX
1 October 2020	XXX	XXX
22 December 2020	XXX	XXX

SCHEDULE 3

XXX