MPTS Medical Practitioners Tribunal Service

Record of Determinations
Medical Practitioners Tribunal
Review on Papers

PUBLIC RECORD

Date: 17 October 2024

Medical Practitioner's name: Dr Martin WHITENBURGH

GMC reference number:	3612866
Primary medical qualification:	MB ChB 1991 University of Liverpool
Type of case	**Outcome on impairment**
Misconduct	Not impaired

Summary of outcome

Order revoked

Tribunal/Legally Qualified Chair:

Legally Qualified Chair:	Mr Malcolm Dodds

Review on the Papers

This case was reviewed on the papers, with the agreement of both parties, by a Legally Qualified Chair.

Overarching Objective

Throughout the decision making process the chair 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.

1. I have reviewed the background to Dr Martin Whitenburgh's case, which was first considered by a fitness to practise panel/medical practitioners tribunal in October 2023 when conditions were imposed for 12 months.

2. Dr Whitenburgh qualified in 1991 from the University of Liverpool. He completed his medical training and became a General Practitioner (GP). Since 2005, Dr Whitenburgh has been a GP Principal and Medical Director at the Cockhedge Medical Practice ('the Practice').

3. While working at the Practice on 14 April 2021 Ms B, the partner of Patient A, (one of Dr Whitenburgh's patients) made a complaint to the Practice about Patient A's use of the drug co-codamol that had been prescribed by Dr Whitenburgh. On 18 April 2021, Ms B emailed a complaint in similar terms to NHS England (NHSE). An NHSE employee contacted Dr Whitenburgh stating that they had a safeguarding concern for this patient given the amount of medication he may have taken and the levels of toxicity he may have. While investigating that complaint the GMC learned that on one or more occasions between 14 to 26 April 2021, it was alleged that Dr Whitenburgh had spoken to Patient A and repeatedly asked Patient A to drop the complaint, asked whether Ms B was 'mentally unstable', or words to that effect, said 'what is it going to take for this to go away?' or words to that effect and suggested that he would pay £5000 if the complaint was dropped. It was also alleged that on 25 April 2021 Dr Whitenburgh on or more occasions telephoned Patient A from his personal mobile number outside of normal working hours. There was a separate concern about prescribing that was dealt with by a separate tribunal in February 2023.

4. The allegations were considered by the MPTS Tribunal on 9-20 October 2023 (the October 2023 Tribunal). The Tribunal considered written and oral evidence from Patient A and other evidence. It considered written and oral evidence from Dr Whitenburgh and from a witness Ms C. The Tribunal determined that the following allegations were proved: On one or more occasions, between 14-26 April 2021, he spoke to Patient A, by telephone, in which he discussed the complaint which had been raised by Patient A's partner ('Ms B') and he asked whether Ms B was 'mentally unstable', or words to that effect; and that he repeatedly asked Patient A to drop the complaint and/or not take it any further;

5. It determined that the following allegations were not proved: the suggestion of paying £5000; and the use of the words 'what is it going to take for this to go away?' or words to that effect; and that of inappropriately phoning Patient A on 25 April 2021.

6. The Tribunal noted that Ms B's original complaint was entirely legitimate and identified an issue in the electronic prescribing system being used by Dr Whitenburgh's practice. This issue led to a number of changes to Dr Whitenburgh's prescribing practices. It considered that Dr Whitenburgh's comment about Ms B's mental instability was, in this context, an attempt to discredit her. In the light of the inherent power imbalance between a doctor and a patient, and the importance of upholding the right of any person to complain about healthcare matters and have their complaint taken seriously, whether or not they have a diagnosed mental health condition, it took the view that the actions proved against Dr

Whitenburgh amounted to serious misconduct. It found that Dr Whitenburgh's actions had breached paragraph 65 of GMP. His conduct, in repeatedly asking Patient A to drop the complaint against him, and casting aspersions in relation to Ms B, did not justify the trust patients and the wider public had in him, as a GP and a member of the wider medical profession. It took the view that fellow practitioners would consider Dr Whitenburgh's proven conduct to be deplorable. The Tribunal considered that Dr Whitenburgh had shown a reflective approach towards the over-prescribing of co-codamol to Patient A. He addressed the issue appropriately, notifying relevant bodies and taking steps immediately to ensure that Patient A could not continue to access such volumes of co-codamol. This appropriate and comprehensive response was not, however, replicated in relation to the concerns raised with NHSE about Patient A feeling pressured by Dr Whitenburgh to drop the complaint. The Tribunal noted that Dr Whitenburgh's apologies related to his prescribing error rather than the way in which he behaved towards Patient A or the comment he made about Ms B. The Tribunal was concerned that Dr Whitenburgh had not provided evidence to demonstrate that he understood the importance of taking complaints seriously, treating complainants with respect and ensuring that appropriate complaints procedures are followed consistently. The Tribunal concluded that without such evidence, Dr Whitenburgh's insight into his actions and their wider impact on patients, the public and the profession, could only be considered limited. He provided to the Tribunal evidence of training he had undertaken but the Tribunal was of the view that there was little of direct relevance to its findings. The Tribunal was satisfied that Dr Whitenburgh could make some progress in terms of remediation but without evidence showing that he currently understood the importance of taking complaints seriously, treated complainants with respect and ensured that appropriate complaints procedures are followed consistently his remediation was not yet complete. The Tribunal was not satisfied that Dr Whitenburgh fully understood, reflected on and remediated his misconduct and that a risk of repetition remains. The Tribunal concluded that, in seeking to undermine a patient's right to complain, Dr Whitenburgh's conduct potentially put patients at risk of harm. It further considered that this conduct, and questioning a complainant's mental stability was an attempt to discredit her complaint that risked bringing the profession into disrepute. Without further evidence of remediation, it considered that Dr Whitenburgh might be liable in the future to put patients at risk of harm and bring the profession into disrepute should another complaint arise. It found that Dr Whitenburgh was impaired by reason of misconduct.

7. In considering sanction the Tribunal identified the following aggravating factors: Dr Whitenburgh's conduct was found to have been capable of causing harm to patients by undermining their ability to complain and raise concerns; and he had not yet demonstrated sufficient insight or remediation into the specific misconduct found in these proceedings. It identified the following mitigating factors: Dr Whitenburgh was a man of previous good character who had been a qualified medical practitioner for 33 years and until April 2021 had no previous fitness to practise history; he had demonstrated that he was capable of remediation through the work he has undertaken regarding his over-prescribing as set out by the February 2023 Tribunal and in evidence in the proceedings; he had completed some relevant CPD and has co-operated fully with his regulator; and testimonials confirmed that he

was of good standing with his peers and in his community. The Tribunal bore in mind that Dr Whitenburgh's misconduct spanned a brief period and related to one patient and one complaint, that the circumstances were unusual and that the misconduct was limited when considered against the many years he had practised without incident before April 2021 and since without any evidence of repetition. It considered the Sanctions Guidance. It considered that Dr Whitenburgh needed to develop a deeper understanding of appropriate complaints handling and the impact of his actions and that he could do so most effectively through a period of structured supervised training and development specifically targeted at developing his understanding of the importance of taking complaints seriously, treating complainants with respect and ensuring that appropriate complaints procedures are followed consistently. The Tribunal considered that conditions would allow him to embed this learning and reassure a future Tribunal that there has been no repetition of his misconduct whilst still providing the necessary GP support for patients at the Practice. The Tribunal was satisfied that imposing conditions on Dr Whitenburgh's registration would have a significant deterrent effect and send out the message that such conduct as that which was proved against him was not acceptable. It determined to impose a sanction of conditions for 12 months with a review hearing.

8. The conditions imposed were:

1 He must personally ensure the GMC is notified of the following information within seven calendar days of the date these conditions become effective:

a the details of his current post, including:

i his job title

ii his job location

iii his responsible officer (or their nominated deputy)

b the contact details of his employer and any contracting body, including his direct line manager

c any organisation where he has practising privileges and/or admitting rights

d any training programmes he is in

e the organisation on whose medical performers list he is included

f the contact details of any locum agency or out of hours service he is registered with.

2 He must personally ensure the GMC is notified:

a of any post he accepts, before starting it

b that all relevant people have been notified of his conditions, in accordance with condition 8

c if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings

d if any of his posts, practising privileges or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination

e if he applies for a post outside the UK.

3 He must allow the GMC to exchange information with any person involved in monitoring his compliance with his conditions.

4 a He must have a workplace reporter appointed by his responsible officer (or their nominated deputy).

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his workplace reporter

ii he has personally ensured that the GMC has been notified of the name and contact details of his workplace reporter.

5 a He must design a personal development plan (PDP), with specific aims to address the deficiencies in the following areas of his practice:

- Complaints handling, specifically:
    - The importance of taking complaints seriously
    - Treating complainants with respect
    - Ensuring that appropriate complaints procedures are followed consistently.
- Treating patients with respect and dignity, especially where concerns have been raised about a patient's care or his clinical practice.

b His PDP must be approved by his responsible officer (or their nominated deputy)

c He must give the GMC a copy of his approved PDP within three months of these substantive conditions becoming effective.

d He must give the GMC a copy of his approved PDP on request.

e He must meet with his responsible officer (or their nominated deputy), as required, to discuss his achievements against the aims of his PDP.

6 a He must keep a log detailing any complaint or concern he or the practice where he works receives.

b He must give the GMC a copy of this log on request.

7 a He must have an educational supervisor appointed by his responsible officer (or their nominated deputy) specifically to provide supervision for:

i the development of his PDP

ii progress towards meeting the aims of his PDP

iii any learning and development relevant to his handling of any concern or complaint received by him or the practice where he works

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his educational supervisor

ii he has personally ensured that the GMC has been notified of the name and contact details of his educational supervisor.

8 He must personally ensure the following persons are notified of the conditions listed at 1 to 7:

a his responsible officer (or their nominated deputy)

b the responsible officer of the following organisations:

i his place(s) of work, and any prospective place of work (at the time of application)

ii all his contracting bodies and any prospective contracting body (prior to entering a contract)

iii any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application)

iv any locum agency or out of hours service he is registered with

v If any of the organisations listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within that organisation. If he is unable to identify this person, he must contact the GMC for advice before working for that organisation.

c the responsible officer for the medical performers list on which he is included or seeking inclusion (at the time of application)

d the approval lead of his regional Section 12 approval tribunal (if applicable) - or Scottish equivalent

e his immediate line manager and senior clinician (where there is one) at his place of work, at least 24 hours before starting work (for current and new posts, including locum posts).

9. The Tribunal directed a review shortly before the expiry of the conditional registration. The Tribunal reminded Dr Whitenburgh that the onus was on him to demonstrate compliance with the conditions imposed and how he has developed insight and remediated his misconduct. It advised that the following might assist the reviewing Tribunal: His PDP and all relevant supporting documentation including details of any relevant CPD; the complaints log; a report, or series of reports, from his educational supervisor and RO about his achievements against the aims of his PDP; the Practice's complaints policy and details of any review that has been undertaken and its outcomes; written evidence demonstrating the development of insight into his misconduct and the relevant targeted remediation he has completed. The Tribunal did not make an immediate order so the conditional registration took effect 28 days from the date on which written notification of the decision was deemed to have been served, unless he lodged an appeal. No appeal was lodged. The conditions took effect from 17 October 2023.

10. After the Tribunal hearing Dr Whitenburgh drew up a PDP dated 4 December 2023 which was approved by Dr D on 4 January 2024 (his responsible officer (RO)). I note the report from his education supervisor (ES), Dr E dated 10 January 2024 that he had reviewed Dr Whitenburgh's PDP, confirmed that Dr Whitenburgh had undertaken relevant courses and had begun to reflect on them; that Dr Whitenburgh had reviewed the Practice's complaints policy and met with his RO to discuss it and was making good progress. I have seen the completed PDP dated 6 May 2024. Dr D (RO) approved the completed PDP and complaints log on 22 July 2024.

11. There are GMC reports dated 12 January 2024 and 2 July 2024 confirming Dr Whitenburgh's compliance with his conditions.

12. Dr Whitenburgh completed 3 Parliamentary Ombudsman Complaints courses. He attended a slideshow regarding complaints presented to staff during an inhouse PLT event (17.1.24). He attended the following CPD courses: Introducing concerns and complaints; How to recognise and resolve complaints early; Engaging with patients and families in complaints; How to clarify the complaint and explain the investigation process; Complaints handling; How to investigate and respond to complaints; and Writing a good response and providing a remedy. He has reflected after each course. He exhibits certificates of completion and reflective statements in response to the courses.

13. His appraisal for 2024 – 2025 had a particular focus on complaints handling in the workplace.

14. He completed a complaints log which gave him the opportunity to reflect on each individual concern raised by a patient, provide a measured approach in his response so ensuring that any complaint is dealt with effectively and in a timely manner. He highlighted a written complaint which he discussed with his ES and responded to on 8 April 2024. He

provided a copy of the Practice Complaints log highlighting the details of complaints and how they had been resolved.

15. Dr E (ES) reported on 2 July 2024 that Dr Whitenburgh had made excellent progress, that he had been very diligent in completing all that he was required in plenty of time; that he had been reflective about his practice taking in good medical practice guidelines and that all undertakings had been completed in full to Dr E's satisfaction.

16. I have considered Dr Whitenburgh's ten page reflective statement dated 16 August 2024. In my judgement he genuinely reflects on what went wrong when he dealt with the complaint in April 2021 and what he would now do differently. I note that complaints are now forwarded to a complaints manager and discussed by the Practice team making it highly unlikely that the difficulties of April 2021 could arise. Dr Whitenburgh states: 'Most importantly I have learnt from the experience. I now understand the importance of empathetic handling of complaints and to not take them personally. Consequently, I will not allow them to influence my subsequent decisions and actions. I have learnt to use complaints as an opportunity to improve overall service quality and to share findings and improvements with my practice team to foster a culture of continuous improvement'. He fully reflects on the impact of poor complaint handling, the importance of the patient complaints process, the importance of taking complaints seriously, the impact of a poorly handled complaint and the importance of clear complaints procedures. He outlines the remedial steps he has taken. He and the Practice Manager had reviewed and updated the Practice Complaints Policy in January 2024 to ensure it was comprehensive and up to date (a copy of the revised Policy is in the bundle I have read). The Policy outlines how complaints could be made, the process for handling them, and the expected timelines for responses. They had reviewed the procedures for managing complaints to enhance efficiency and ensure a more responsive approach. A designated Complaint Officer had been appointed to ensure accountability and a consistent approach to handling issues. They had ensured telephone calls were recorded to help maintain accurate records and respond to complaints and issues more effectively. The Practice had held an in-house Protected Learning Time (PLT) event to increase staff awareness and proficiency in handling complaints; and providing ongoing training to staff on how to handle complaints professionally and empathetically. The Practice Manager now provides annual updates to all staff on complaint handling procedures to maintain high standards of patient care. Dr Whitenburgh presented to his team on how to handle complaints in primary care which enabled his staff to update themselves, discuss and revise the handling of complaints collectively as a team. The generic version of this presentation was located on a national social media platform designed by Practice Managers. The members of this group share their knowledge, skills and experience to uplift the overall standards in General Practice across the UK. I also note that the Practice was named as the best GP surgery (out of 19 surgeries) in Warrington in 2024 according to patients, with an overall approval rating of 92% which was a significant improvement to the 63% received in 2023.

17. Dr Whitenburgh also provide feedback results from colleagues which showed positive scores close to the mean national scores. He provided positive feedback from thirty five patients including comments such as 'very helpful', 'caring', 'understanding', 'empathetic', 'I feel at ease', 'so nice and understanding' and 'listening'. The results are summarised in a December 2023 report. He also provided a testimonial dated 6 July 2024 from the Practice Manager that states that 'Following the tribunal last year Martin has learnt the importance of taking complaints seriously and of treating complainants with empathy and understanding. He has learnt not to take the complaint personally with the help of the complaint handling courses he has undertaken.'

18. I have considered the GMC submissions that Dr Whitenburgh has developed the requisite insight, embedded his learning in his own practice and that of the Practice where he works, now appreciates the importance of a robust and clear complaints procedure and the negative impact on patients when complaints are not properly dealt with. The GMC submit that Dr Whitenburgh is not currently impaired and that the order for conditional registration be revoked.

19. On 1 October 2024 Dr Whitenburgh gave written agreement to the proposed order. On 4 October 2024 an Assistant Registrar of the GMC gave written agreement to the proposed order.

20. Throughout the decision making process I have 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

21. In reaching my decision I have taken into account the Sanctions Guidance. I have borne in mind that the purpose of conditions is not to be punitive but to protect patients and the wider public interest.

22. I have applied the principles of proportionality weighing the interests of Dr Whitenburgh with the public interest. The public interest includes amongst other things the protection of patients, the maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

23. I note that there has been no repetition of the misconduct.

24. I note that Dr Whitenburgh demonstrated insight and remediation into the issues about over prescribing to which he responded appropriately and comprehensively. I note the substantial mitigation highlighted by the Tribunal (set out in paragraph 7 above). I note that the Tribunal found the misconduct occurred over a brief period, in relation to one patient and in unusual circumstances. I am satisfied that Dr Whitenburgh has undertaken the suitably targeted, structured and supervised training and development the October 2023 Tribunal

envisaged. I am satisfied that he has provided the relevant documents the Tribunal recommended he provide. I am satisfied that he has fully complied with his conditional registration. I am satisfied that Dr Whitenburgh has now demonstrated an appropriate and comprehensive approach to the concerns that were highlighted by the October 2023 Tribunal in the same way that he responded to the issue of over prescribing. Considering the concerns raised by the October 2023 Tribunal I am satisfied that he now recognises the legitimacy of complaints, that he now upholds the right to complain and that he now recognises the importance of taking complaints seriously. His actions have in my view regained lost trust as demonstrated by his Practice being voted as the best in Warrington in 2024. He has expressed remorse for his misconduct. I find that he has fully understood, reflected on and remediated his misconduct. He has provided comprehensive evidence that demonstrates his understanding of taking complaints seriously, treating complainants with respect and ensuring appropriate complaints procedures are consistently followed. I find no risk of repetition. I find that he has undertaken and reflected on training directly relevant to the October 2023 Tribunal concerns.

25. Having considered the documents and submissions I consider that Dr Whitenburgh has both fully complied with the conditions and provided the documentation the October 2023 Tribunal recommended that he provide. I am satisfied that there has been directed learning and targeted remediation to satisfy a medical practitioners tribunal that he has developed the requisite insight into the matters of concern raised by the October 2023 Tribunal. The documents indicate that Dr Whitenburgh has sought to embed learning not only into his own individual practice but also as an ongoing measure within the practice including all his staff members. The documents suggest that he does now appear to appreciate the importance of a robust and clear complaints process and that he understands the negative impact that it can have on patients when such a process falls short of its requirement. I find that Dr Whitenburgh is no longer impaired. I revoke the order for conditional registration. The review hearing on 15 November 2024 can be vacated.