PUBLIC RECORD

Dates: 01/03/2021 - 09/03/2021

Medical Practitioner's name: Dr Peter BRUEGGEMANN

GMC reference number: 4050614

Primary medical qualification: State Exam Med 1991 Universitat der Gesamthochschule Essen

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Not Impaired

Summary of outcome

Warning

Tribunal:

Legally Qualified Chair	Mr Robert Ward
Lay Tribunal Member:	Mr Peter Scofield
Medical Tribunal Member:	Dr Richard Brighton-Knight

Tribunal Clerk:	Mr Laurence Millea

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Simon Cridland, Counsel, instructed by Gordons Partnership LLP
GMC Representative:	Mr Nick Walker, Counsel

Attendance of Press / Public

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

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 - 09/03/2021

Background

1. Dr Brueggemann qualified in 1991 from the University of Essen Medical School, Germany, and started his surgical and GP training in the UK in February 1992. Prior to qualifying as a GP in 1999, Dr Brueggemann held a number of positions as a House Officer and Senior House Officer in General and Orthopaedic Surgery between 1992 and 1998. He completed his FRCS Part I in 1997 and Part II in 1999, joining the Holt Medical Practice ('the Practice') in 1998. Dr Brueggemann became a GP Principal at the Holt Medical Practice in 1999 and remained there until his retirement from general practice in March 2018. He currently works as an Aeromedical Examiner ('AME') for the Civil Aviation Authority ('CAA'), performing medical assessments for private pilots (from 2011) and commercial pilots (from 2016).

2. At the time of the events giving rise to the Allegation, Dr Brueggemann was practising as a GP at the Practice, where he was also a partner. Dr Brueggemann also conducted minor operations there under a community minor surgery contract for North Norfolk Clinical Commissioning Group ('NNCCG').

3. The allegation that has led to Dr Brueggemann's hearing can be summarised as failing to provide good clinical care, arising from Dr Brueggemann's treatment of Patients A – Q. It is alleged that there were failures to carry out a number of actions that were required for the treatment and care of the patients, including; failure to send histological specimens to the laboratory, failure to refer red flag identifiers, failure to diagnose lesions, failure to write to the patients' General Practitioner with a final diagnosis, and failure to keep legible records.

4. Concerns regarding Dr Brueggemann were first raised in November 2017, when it was discovered that a patient who underwent a procedure to have a mole removed did not have a sample sent to histology. The patient's care moved to the dermatology department at

Norfolk and Norwich Hospital, where it was identified that there were no histology results, and a Quality Improvement Report ('QIR') was subsequently raised. When the Practice was informed of the concern it was decided that it was necessary to conduct an internal review of Dr Brueggemann's minor surgery patients. The Practice subsequently notified NHS England of the concerns identified in respect of Dr Brueggemann's practice. The NNCCG also notified NHS England of the concerns after undertaking a full review of files relating to minor skin surgery carried out by Dr Brueggemann since January 2016. These concerns were raised with the GMC on 9 March 2018 by Person R, Project Officer, NHS England Midlands & East (East) Performance, Appraisal & Revalidation Team.

The Outcome of Applications Made during the Facts Stage

5. The Tribunal granted applications made by Mr Nick Walker, Counsel, on behalf of the GMC, made pursuant to Rule 29(2) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to adjourn for two periods of 24 hours on the first and second day of proceedings. This was prior to the opening of the GMC case, and was in order to allow parties further time to prepare their cases and consider the joint statement from the expert witnesses. These applications were supported by Mr Simon Cridland, Counsel, on behalf of Dr Brueggemann.

6. The Tribunal granted an application made by Mr Walker, on behalf of the GMC, made pursuant to Rule 17(6) of the Rules, to amend paragraphs of the Allegation. This application was not opposed by Mr Cridland. Full details of the Tribunal's decision can be found at Annex A.

The Allegation and the Doctor's Response

7. The Allegation made against Dr Brueggemann is as follows:

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

1. You failed to provide good clinical care to one ~~of~~ or more of the patient(s) set out in:
   Amended under Rule 17(6)

   a. Schedule 1, in that you did not send a histological specimen of their excised lesion(s) to the laboratory for analysis;
      Admitted and found proved

b. Schedule 2, in that despite the presence of red flag identifiers, you excised one or more lesions when you should have referred the patient(s) for specialist treatment;
Admitted and found proved

c. Schedule 3, in that you did not adequately and appropriately diagnose their lesion(s);
Admitted and found proved

d. Schedule 4, in that you did not write a letter communicating a final diagnosis to the patient's General Practitioner;
Admitted and found proved

e. Schedule 5, in that you did not keep legible records;
Admitted and found proved

~~f. Schedule 6, in that you did not use a dermatosope in your examination of the lesion(s).~~
Amended under Rule 17(6)

Patient E

2. On 25 November 2015 Patient E attended a consultation with you about a lesion on her left ring finger, which had not healed since you operated on 21 January 2015, and you failed to refer her to a specialist in secondary care.
Admitted and found proved

Patient F

3. On 5 January 2016 you excised a lesion on Patient F's nipple and you failed to adequately record:

a. a written description of the nature of the lesion, including its:

i. shape; Admitted and found proved

~~ii. location;~~ Amended under Rule 17(6)

~~iii.~~ ii. colour;
Amended under Rule 17(6), Admitted and found proved

b. a final diagnosis;
Admitted and found proved

~~c. details of the operative procedure undertaken, including:~~

~~i. the size of incision;~~

~~ii. the location of lesion;~~

~~iii. how the operative procedure went.~~
Amended under Rule 17(6)

Patient G

4. On 5 January 2016 you excised a lesion on Patient G's neck and you failed to adequately record:

a. a written description of the nature of the lesion, including its:

i. size; Admitted and found proved

ii. shape; Admitted and found proved

iii. location; Admitted and found proved

iv. colour; Admitted and found proved

b. a final diagnosis; Admitted and found proved

~~c.~~ details of the operative procedure undertaken, including~~:~~

~~i. the size of incision;~~

~~ii.~~ the location of the lesion~~;~~

iii. ~~how the operative procedure went~~.
Amended under Rule 17(6), Admitted and found proved

Patient H

5. On 29 March 2016 you excised a lesion on Patient H's right breast and you failed to adequately record:

a. a written description of the nature of the lesion, including its:

i. size; Admitted and found proved

ii. shape; Admitted and found proved

iii. location; Admitted and found proved

iv. colour; Admitted and found proved

b. a final diagnosis; Admitted and found proved

~~c.~~ details of the operative procedure undertaken, including~~:~~

~~i. the size of incision;~~

~~ii.~~ the location of the lesion~~;~~

~~iii. how the operative procedure went~~.

Amended under Rule 17(6), Admitted and found proved

Patient I

6. On 31 May 2016 you excised a lesion on Patient I's back and you failed to adequately record:

a. a written description of the nature of the lesion, including its:

i. size; Admitted and found proved

ii. shape; Admitted and found proved

iii. colour; Admitted and found proved

b. a final diagnosis; Admitted and found proved

~~c. details of the operative procedure undertaken, including:~~

~~i. the size of incision;~~

~~ii. the location of lesion;~~

~~iii. how the operative procedure went~~.

Amended under Rule 17(6)

Patient J

7. On 19 July 2016 you excised a lesion on Patient J's back and you failed to adequately record:

   a. a written description of the nature of the lesion, including its:

      ~~i. size;~~ Amended under Rule 17(6)

      ~~ii.~~ i. shape;
      Amended under Rule 17(6), Admitted and found proved

      ~~iii.~~ ii. location;
      Amended under Rule 17(6), Admitted and found proved

      ~~iv.~~ iii. colour;
      Amended under Rule 17(6), Admitted and found proved

   b. a final diagnosis; Admitted and found proved

   c. details of the operative procedure undertaken, including~~:~~

      ~~i. the size of incision;~~

      ~~ii.~~ the location of the lesion~~;~~

      iii. ~~how the operative procedure went~~.
      Amended under Rule 17(6), Admitted and found proved

Patient K

8. On 14 September 2016 you excised a lesion from Patient K's back and you failed to adequately record:

   a. a written description of the nature of the lesion, including its:

      i. size; Admitted and found proved

      ii. shape; Admitted and found proved

      iii. colour; Admitted and found proved

   b. a final diagnosis; Admitted and found proved

~~c. details of the operative procedure undertaken, including:~~

~~i. the size of incision;~~

~~ii. the location of incision;~~

~~iii. how the operative procedure went.~~

Amended under Rule 17(6)

Patient L

9. On 14 September 2016 you excised a lesion on Patient L's left arm and you failed to adequately record:

a. a written description of the nature of the lesion, including its:

i. size; Admitted and found proved

ii. shape; Admitted and found proved

iii. location; Admitted and found proved

iv. colour; Admitted and found proved

b. a final diagnosis; Admitted and found proved

~~c.~~ details of the operative procedure undertaken, including~~:~~

~~i. the size of incision;~~

~~ii.~~ the location of the lesion~~;~~

iii. ~~how the operative procedure went~~.

Amended under Rule 17(6), Admitted and found proved

Patient M

10. On 15 November 2016 you excised four lesions on Patient M's anterior chest wall and you failed to adequately record:

a. a written description of the nature of the lesion, including its:

i. size; Admitted and found proved

ii. shape; **Admitted and found proved**

iii. colour; **Admitted and found proved**

b. a final diagnosis; **Admitted and found proved**

~~c. details of the operative procedure undertaken, including:~~

~~i. the size of incision;~~

~~ii. the location of lesion;~~

~~iii. how the operative procedure went.~~

Amended under Rule 17(6)

Patient N

11. On 15 March 2017 you excised a lesion under Patient N's right axilla and you failed to provide good clinical care, in that you did not:

a. identify red flag symptoms and signs, in that the lesion had changed in size and colour;
Admitted and found proved

b. adequately record:

i. a written description of the nature of the lesion, including its:

1. size; **Admitted and found proved**

2. shape; **Admitted and found proved**

3. location; **Admitted and found proved**

4. colour; **Admitted and found proved**

ii. a final diagnosis; **Admitted and found proved**

~~iii.~~ details of the operative procedure undertaken, including~~:~~

~~1. the size of incision;~~

~~2.~~ the location of **the** lesion~~;~~

~~3. how the operative procedure went~~.

Amended under Rule 17(6), Admitted and found proved

Patient O

12. On 29 March 2017 you excised lesions from Patient O's back and abdomen and you failed to provide good clinical care in that you did not:

~~a. write to Patient O's General Practitioner following the surgery, until you were prompted to do so when Patient O contacted Holt Medical Centre;~~

~~b.~~ adequately record: Amended under Rule 17(6)

~~a.~~ i. a written description of the nature of the lesion on Patient O's back, including its:

~~i. size;~~ Amended under Rule 17(6)

~~ii.~~ 1. shape;

Amended under Rule 17(6), Admitted and found proved

~~iii.~~ 2. location;

Amended under Rule 17(6), Admitted and found proved

~~iv. colour;~~

Amended under Rule 17(6)

~~b.~~ ii. a written description of the nature of the lesion on Patient O's abdomen, including its~~:~~

~~i.~~ shape;

~~ii. colour;~~

Amended under Rule 17(6), Admitted and found proved

~~c.~~ iii. a final diagnosis;

Amended under Rule 17(6), Admitted and found proved

~~d.~~ iv. details of the operative procedure undertaken, including~~:~~

~~i. the size of incision;~~

~~ii.~~ the location of the lesion~~;~~

~~iii. how the operative procedure went~~.

Amended under Rule 17(6), Admitted and found proved

Patient P

13. On 10 April 2017 Patient P attended a consultation with you and you failed to provide good clinical care, in that you did not:

a. give adequate regard to Patient P's history of prostate cancer, including taking into consideration that it may have caused ~~a~~ metastasis;

Amended under Rule 17(6), Admitted and found proved

b. adequately record:

~~a.~~ i. the history of the lesion;

Amended under Rule 17(6), Admitted and found proved

~~b.~~ ii. a written description of the lesion, including its~~:~~

~~i. size;~~

~~ii. shape;~~

~~iii. colour;~~

iv. adhesion to underlying tissue;

Amended under Rule 17(6), Admitted and found proved

~~c.~~ iii. any advice given to Patient P about the risks of surgery.

Amended under Rule 17(6), Admitted and found proved

14. On 26 April 2017 you excised Patient P's lesion and you failed to:

~~a. undertake an examination of Patient P's blood pressure;~~

Amended under Rule 17(6)

~~b.~~ **adequately** consider an alternative diagnosis of metastatic deposit from prostate cancer;
Amended under Rule 17(6), Admitted and found proved

~~c. arrange for Patient P to undergo further investigations prior to attempting an excision of the lesion, including a pre-operative diagnostic ultrasound scan;~~
Amended under Rule 17(6)

~~d.~~ **b.** record that you undertook an examination of Patient P's blood pressure.
Amended under Rule 17(6), Admitted and found proved

Patient Q

15. On 11 May 2017, Patient Q attended a consultation with you and you failed to provide good clinical care, in that you did not:

    a. adequately record:

        i. a written description of the nature of the lesions, including their:

            1. size; **Admitted and found proved**
            2. shape; **Admitted and found proved**
            3. location; **Admitted and found proved**
            4. colour; **Admitted and found proved**
            5. adhesion to underlying tissues; **Admitted and found proved**

        ~~ii. a suspected diagnosis;~~ **Amended under Rule 17(6)**

    b. include a diagram of the lesions within your records.
    Admitted and found proved

16. On 17 May 2017, you excised one or more of Patient Q's lesions and you failed to:

    a. accurately record which of Patient Q's two lesions was excised; **Admitted and found proved**

    b. consider that the lesion could be malignant, given that it was open and ulcerated;
    Admitted and found proved

c. save ~~and successfully deliver~~ a histological specimen of the excised lesion **to be sent** to the laboratory for analysis;
Amended under Rule 17(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

8. At the outset of these proceedings, through his counsel, Mr Simon Cridland, Dr Brueggemann admitted to the entirety of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). 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.

Impairment

9. In light of Dr Brueggemann's admissions to the Allegation made against him, the Tribunal then had to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts found proved, Dr Brueggemann's fitness to practise is impaired by reason of misconduct.

Witness Evidence

10. The Tribunal received evidence on behalf of the GMC in the form of a witness statement from Dr S, GP Partner at Holt Medical Practice, dated 13 April 2020. Dr S was not called to give oral evidence.

11. Dr Brueggemann provided his own witness statement, dated 17 February 2021, and also gave oral evidence at the hearing.

12. The Tribunal also received evidence on behalf of Dr Brueggemann in the form of statements from the following witnesses who were not called to give oral evidence:

- Ms T, Healthcare Practitioner at Holt Medical Practice, dated 19 February 2021;
- Ms U, Healthcare Assistant at Holt Medical Practice, dated 25 February 2021.

13. The Tribunal also received in support of Dr Brueggemann 13 testimonials from colleagues and employers, all of which it has read.

Expert Witness Evidence

14. The Tribunal also received evidence from three expert witnesses. Dr V, on behalf of the GMC, provided the following documentary evidence:

- Expert report, dated 29 August 2018;
- Addendum report, dated 12 April 2019;
- Amended report, dated, 12 April 2019;
- Expert report, dated 25 September 2019;
- Supplemental report, dated17 March 2020;
- Supplemental report dated 5 January 2021.

15. Dr W, on behalf of the GMC, provided the following documentary evidence:

- Expert report, dated 9 July 2020;
- Supplemental report, dated 5 January 2021.

16. Dr X, on behalf of Dr Brueggemann, provided an expert report, dated 18 February 2021.

17. The Tribunal also received a signed joint statement from all three expert witnesses, dated 1 March 2021.

18. The expert witnesses' evidence was provided to assist the Tribunal in determining the standards to be expected of a registered practitioner undertaking minor surgery within a GP setting, specifically in relation to Dr Brueggemann's care and treatment of patients A to Q, whom he operated on between June 2013 and May 2017. None of the three expert witnesses were required to give oral evidence because their written evidence was sufficient.

Documentary Evidence

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

- Various CPD documentation and records for Dr Brueggemann, various dates, March 2018 – February 2021;
- CAA Audit Result, dated 24 January 2019;
- Dr Brueggemann's appraisals for 2019-2020 and 2020-2021, dated 11 March 2019 and 28 February 2020 respectively;
- Dr Brueggemann's reflective statement, dated 25 February 2021.

Submissions

20. On behalf of the GMC, Mr Walker submitted that Dr Brueggemann has conceded that his actions amounted to misconduct, that nothing has been provided to the Tribunal to the contrary, and therefore the allegation of misconduct is clearly made out in this case.

21. Mr Walker submitted that the position of the GMC is that Dr Brueggemann's fitness to practise is currently impaired. He submitted that the events in question occurred over an extended period of time, affecting multiple patients on multiple occasions, and would likely appal fellow members of the profession and members of the public alike.

22. In his submissions, Mr Walker acknowledged that Dr Brueggemann has taken these proceedings seriously, been cooperative throughout, been fulsome in his admissions, and has revealed the personal impact these events and proceedings have had on him.

23. Mr Walker submitted that, despite Dr Brueggemann's engagement with proceedings, his failures to send excised samples to histology for testing and his failure to identify 'red flag' cases, when considered in light of the other criticisms about his practice which have been made, and accepted by Dr Brueggemann, amounts to clear evidence of impairment.

24. Mr Walker submitted that this is a case where a Tribunal cannot say with any degree of certainty that Dr Brueggemann's fitness to practise is not impaired as of today, and that despite the passage of time since the events, his failures were too wide ranging and over too long a period of time to find otherwise.

25. Mr Walker directed the Tribunal's attention to Good Medical Practice (2013 edition) ('GMP'). He submitted that Dr Brueggemann had put patients at unwarranted risk of harm and breached fundamental tenets of the profession, by breaching GMP guidance. He submitted that Dr Brueggemann's conduct involved ignoring what should have been clear and obvious factors. He further submitted that although this was done without intent or malice it makes it difficult to have confidence in his remediation.

26. Mr Walker suggested that there may be evidence of Dr Brueggemann minimising certain aspects of the facts found proved. He cited the testimonial of Dr Y, which referred to a patient in the singular, and he questioned whether Dr Brueggemann might have provided that impression rather than acknowledging that his dealings with several patients were under investigation at that time. He further suggested that Dr Brueggemann, when relying on a half hour CPD course on record keeping, was concentrating more on the question of his handwriting rather than the content and clinical reasoning contained within the records.

27. Mr Walker submitted that Dr Brueggemann made assumptions and did not look at the relevant guidance, and that given the apparent minimisation and focus on handwriting by Dr Brueggemann, the Tribunal should not be satisfied that full insight has been demonstrated. He submitted that whilst Dr Brueggemann stated that he no longer wishes to practise as a GP or undertake minor surgery, he potentially has years of practice left and would be entitled to do so were his fitness to practise found not impaired and he was allowed to practise unrestricted.

28. Mr Walker submitted that, given the extent of Dr Brueggemann's failures, the period over which they occurred and the risk to patient safety, a finding of impairment should be made in order to uphold proper standards in the profession and maintain public confidence, in line with the overarching objective.

29. Mr Walker emphasised the need to mark the seriousness of Dr Brueggemann's misconduct with a finding of impairment, as per paragraph 74 of *CHRE v NMC and Paula Grant* [2011] EWHC 927, despite any insight, remediation and reduction of the risk of repetition achieved by him.

30. In response to a question from the Tribunal, Mr Walker accepted that the allegation at paragraph 1(e), relating to a failure to keep legible records in relation to one patient only, if taken alone the Tribunal may struggle to find misconduct, but when considering the case as a whole, matters that are more and less serious should all be factored.

31. On behalf of Dr Brueggemann, Mr Cridland submitted that Dr Brueggemann accepts that his actions amounted to serious failings and that he is guilty of serious professional misconduct when his actions are considered cumulatively.

32. Mr Cridland reminded the Tribunal that the matter for consideration is whether Dr Brueggemann's fitness to practise is impaired as of today and submitted that the concerns relate solely to minor surgery and not his conduct or practice as a GP. This is supported by the testimonials provided on his behalf, which demonstrate that he is considered a competent and respected practitioner by those professionals best placed to assess him on such matters. He asked the Tribunal to not only look back at the facts of the case but also forwards to the likely future of Dr Brueggemann.

33. Mr Cridland submitted that Dr Brueggemann had only been sending those cases he had concerns about for histological analysis, but by the time matters came to light with the NNCCG and GMC, he had already identified that this was incorrect (from a course he attended in June 2017) and had corrected his practice in that regard. Once the investigation commenced, he immediately gave up minor surgery, and retired from General Practice shortly after in 2018.

34. Mr Cridland submitted that the reflective statement provided by Dr Brueggemann is entirely his own, with no input from his legal representatives, and demonstrated abundant insight. Dr Brueggemann has an appropriate degree of insight and professional responsibility, and has admitted the entirety of the facts alleged against him, accepting the seriousness of his failings during his evidence. Mr Cridland submitted that this acceptance demonstrated Dr Brueggemann's strength of character. Dr Brueggemann has made a heartfelt apology, recognising that he put patients at potential risk of harm and expressing his desire to apologise to all affected patients individually. Mr Cridland drew the Tribunal's attention to the praise of Dr Brueggemann from fellow professionals in the testimonials from 2018 and 2021.

35. Mr Cridland submitted that these matters are historical, occurring over four years ago with no repetition since. He said that any risk of repetition was no more than fanciful. Dr Brueggemann now only works in a limited and specific role as an AME with the CAA and there is no realistic prospect of him carrying out any minor surgery going forward as he has given up his GP role and conducting minor surgery, and has no intention of returning to these fields. He is closely monitored in his current role and is audited every three years, and there has been no repetition or concerns raised since the events which are the subject of these proceedings. Mr Cridland drew the Tribunal's attention to CAA audits in 2018 and 2019, which included being observed; neither audit raised concerns about Dr Brueggemann's practice.

36. Mr Cridland submitted that Dr Brueggemann's reflective statement demonstrated insight in abundance, with full admissions having been made and a candid acceptance of the seriousness of the failings followed by a heartfelt apology.

37. Mr Cridland submitted that any risk to patient safety is predicated on the risk of repetition, and that since this is highly unlikely, there would be no ongoing risk to patient safety were Dr Brueggemann allowed to practise unrestricted.

38. Mr Cridland submitted that Dr Brueggemann is a responsible, reliable and caring member of the medical profession and should be given credit for his insight, remorse and for his long and otherwise unblemished career with the NHS.

39. Mr Cridland submitted that were the Tribunal to find it necessary to mark the seriousness of Dr Brueggemann's departures from GMP in order to maintain standards in the profession or uphold public confidence, a finding of impairment need not be made. He pointed out that it is open to the Tribunal to issue a warning were a finding of impairment not made in this case. Therefore, a finding of impairment is not required in order to uphold the overarching objective.

The Relevant Legal Principles

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

41. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first, whether the facts as found proved amounted to misconduct and that the misconduct was serious, and then whether the finding of that misconduct which was serious could lead to a finding of impairment.

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

43. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High

Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin.* In particular, the Tribunal considered whether its findings of fact showed that Dr Brueggemann's fitness to practise is impaired in that 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 and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. Has in the past breached or is liable to breach in the future one of the fundamental tenets of the medical profession; and/or*
>
> *d. ...'*

44. The case of *Grant* also includes the following guidance in respect of determining impairment:

> *73. "Sales J also referred to the importance of the wider public interest in assessing fitness to practise in Yeong v. GMC [2009] EWHC 1923 (Admin), a case involving a doctor's sexual relationship with a patient. Pointing out that Cohen was concerned with misconduct by a doctor in the form of clinical errors and incompetence, where the question of remedial action taken by the doctor to address his areas of weakness may be highly relevant to the question whether his fitness to practise is currently impaired, Sales J considered that the facts of Yeong merited a different approach. He upheld the submission of counsel for the GMC that:*
>
> > *"... Where a [Fitness to Practise Panel] considers that the case is one where the misconduct consists of violating such a fundamental rule of the professional relationship between medical practitioner and patient and thereby undermining public confidence in the medical profession, a finding of impairment of fitness to practise may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession. In such a case, the efforts made by the medical practitioner in question to address his behaviour for the future may carry very much less weight than in a case where the misconduct consists of clinical errors or incompetence."*

74. I agree with that analysis and would add this. In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.

75. I regard that as an important consideration in cases involving fitness to practise proceedings before the NMC where, unlike such proceedings before the General Medical Council, there is no power under the rules to issue a warning, if the committee finds that fitness to practise is not impaired. As Ms McDonald observes, such a finding amounts to a complete acquittal, because there is no mechanism to mark cases where findings of misconduct have been made, even where that misconduct is serious and has persisted over a substantial period of time. In such circumstances the relevant panel should scrutinise the case with particular care before determining the issue of impairment.

76. I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

45. The High Court has commented that a Tribunal should consider both the volume and the similarity of the non-serious misconduct, as well as the presentation of the case, before concluding that a series of non-serious misconduct can amount to a finding of serious misconduct (*Schodlok v General Medical Council [2015] EWCA Civ 769, paragraph 72*).

46. The High Court has commented, in the case of *GMC v Nyamasve [2018] EWHC 1689,* that when considering impairment, it is important for a Tribunal to assess a doctor's insight, remediation and the risk of repetition of the wrongdoing. In particular:

- the greater the insight a doctor has in relation to his/her wrongdoing, the more confident a tribunal can be that the wrongdoing can be remediated;

- a tribunal can have confidence that there is unlikely to be repetition only if it is satisfied that there is a candid and full acceptance of both the wrongdoing and why it is wrong.

The Tribunal's Determination on Impairment

Misconduct

47. In considering whether Dr Brueggemann's actions amounted to misconduct, the Tribunal was mindful of the following paragraphs of GMP, which it considered applicable in this case:

> *8* *You must keep your professional knowledge and skills up to date.*
>
> *11* *You must be familiar with guidelines and developments that affect your work.*
>
> *15* *You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> *a* *adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
>
> *b* *promptly provide or arrange suitable advice, investigations or treatment where necessary*
>
> *c* *refer a patient to another practitioner when this serves the patient's needs.*
>
> *16* *In providing clinical care you must:*
>
> *…*
>
> *b* *provide effective treatments based on the best available evidence*
>
> *19* *Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*

21 *Clinical records should include:*

a *relevant clinical findings*

b *the decisions made and actions agreed, and who is making the decisions and agreeing the actions*

c *the information given to patients*

d *any drugs prescribed or other investigation or treatment*

e *who is making the record and when.*

Paragraph 1

1(a)

48. The Tribunal was of the opinion that if Dr Brueggemann had spoken to colleagues more and looked at relevant guidance, it would have been clear to him that he should have sent histological specimens for analysis. The evidence of Dr X, Dr Brueggemann's expert witness, was that this has been accepted practice for around 20 years.

49. Dr Brueggemann has admitted that his actions amounted to misconduct, and the Tribunal determined that this failure amounted to a clear breach of GMP. The Tribunal found that this was misconduct which was serious.

1(b)

50. The Tribunal noted that in multiple cases the referring GP did not mention the presence of red flag identifiers and the referral system had reviewed and allocated cases to Dr Brueggemann. The Tribunal concluded that Dr Brueggemann nonetheless had a duty to identify these factors and refer the patients appropriately. Dr Brueggemann has admitted that these failures were misconduct. The Tribunal found that this was misconduct which was serious.

1(c)

51. The Tribunal found that Dr Brueggemann was unable to diagnose adequately the patients' lesions as a consequence of his failure at paragraph 1(a) to send samples for analysis, that he had a duty to do so, and that this failure amounted to misconduct which was serious.

1(d)

52. The Tribunal noted that Dr Brueggemann had submitted an operating note, but that by not sending a sample to histology for analysis he would not have been able to provide a final diagnosis. Therefore, Dr Brueggemann prevented a final diagnosis from being made and subsequently could not have sent a final diagnosis to the patients' GP. Dr Brueggemann had failed in his duty as a natural consequence of his multiple failings at paragraphs 1(a) to 1(c). The Tribunal found that this was misconduct which was serious.

1(e)

53. The Tribunal determined that one illegible record does not constitute misconduct, noting the submission of Mr Walker that this paragraph of the allegation now related to a single patient.

Paragraph 2

54. At the facts stage, Dr Brueggemann admitted that he was under a duty to refer Patient E and that he failed to do so. The Tribunal formed the view that this was a breach of paragraph 15 of GMP, which carried a potential risk of harm to the patient, and was a clear breach of the fundamental tenets of the medical profession, risking public confidence in the profession being harmed. Accordingly, the Tribunal determined that this failure did amount to misconduct which was serious, but recognised that the evidence shows that other treating doctors had not made specialist care referrals either.

Paragraphs 3 to 16

55. The Tribunal noted that Dr Brueggemann had admitted that his actions or omissions amounted to a failure to do what he was required to in respect of these paragraphs, and these facts have been found proved. Whilst some of his actions or omissions might not, in themselves, amount to misconduct which was serious, the Tribunal was mindful of the principle in *Schodlok* that although individual failures considered to be less serious may not amount to misconduct, they can be considered cumulatively, and may therefore amount to misconduct which was serious.

56. The Tribunal emphasised that Dr Brueggemann's failures did amount to a significant departure from multiple paragraphs of GMP, as set out above. He had failed to provide adequate care and undertake the necessary processes in the treatment of multiple patients, over an extended period of time,

57. The Tribunal therefore concluded that Dr Brueggemann's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct which was serious.

Impairment

58. Having found that the facts found proved amounted to misconduct which was serious, the Tribunal went on to consider whether, as a result of that misconduct, Dr Brueggemann's fitness to practise is currently impaired.

59. The Tribunal accepted the submissions of Mr Walker that Dr Brueggemann's failures occurred over a number of years, affected a number of patients, failed to uphold standards and put patients at unwarranted risk of harm, all of which have been accepted by Dr Brueggemann.

60. However, it considered that the context in this case was important, noting that the expert witness Dr X states that the Minor Surgery Enhanced Service ('MS ES') specifications require a referring GP to make a diagnosis and that only benign lesions listed in the specifications are referred for minor surgery. In his expert report, Dr X stated that:

> *"It is also important to understand that the clinician providing Minor Surgery services receives referrals from three different sources – from other practices within the CCG, from colleagues within his/her own practice and from the GP's own patients within his/her Practice. The specifications of the MS ES require the referring GP to make the diagnosis and ensure that only appropriate benign lesions listed in the specifications are referred. Where the diagnosis is unclear or a skin cancer is suspected other referral pathways are more appropriate. The MS service is primarily a 'removal' service not a 'diagnostic' service. In this respect the GP providing the service is the agent of the referring GP and their role is to ensure the appropriate procedure is performed to a good standard. However the clinician providing the MS ES must do more than blindly remove lesions from referred patient but exercise*

their own judgment [sic] concerning the appropriateness of the procedure by asking.

1. Has the referring clinician missed a suspicious lesion or a malignancy?
2. Is the referring clinician requesting a diagnosis? In which case either decline the request (because he/she is NOT a GPwSI [GP with Special Interest] in dermatology) or ensure the specimen is sent for histology.
3. Is excision the most appropriate procedure or should other procedures be considered eg cryotherapy, curettage, shave biopsy to minimize scarring, or diagnostic punch biopsy as an alternative to excision biopsy if the referring GP is seeking a diagnosis.
4. If the referring physician has referred a pigmented lesion has he/she completed the 7-point checklist to minimize the risk of missing a melanoma? If not a further history should be taken, the checklist completed and if the score is 3 or more the patient should be returned to the referring GP for further management.
5. Has the surgeon discussed whichever of the above are relevant in order to obtain written informed consent from the patient.

…

The specific competencies prescribed for a GPwSI in Minor Surgery relate to the execution of procedure itself, not to diagnosis. Equally the assessment of the lesion should not involve rediagnosing the lesion, which the GP should have done; but be confined to excluding obvious malignancy and assessing those features which are relevant to the procedure itself.

…

Dr Brueggemann is not contracted to re-assess and re-diagnose every lesion he is referred – just to take them out if appropriate. The referring GP should have made the diagnosis. It is not Dr Brueggemann's role to decide if a lesion fulfills the CCG's referral criteria - the referring GP should have done this done this and had funding approved by the CCG."

61. The Tribunal emphasised that whilst Dr Brueggemann still had a duty to ensure proper examination, diagnosis and treatment occurred, this context does go some way to mitigating his misconduct. For example, in the case of Patient F, who was referred to Dr Brueggemann internally by Dr S, Dr S stated "*Itchy spot on right nipple for years. 0.7cm area sl raised rough, looks benign*."

62. The Tribunal identified multiple cases where the documentary evidence demonstrated that the referring GPs indicated that the lesions were benign or not clinically significant, and flagged/referred them to Dr Brueggemann as such. Whilst Dr Brueggemann carried out the minor surgery procedures, other doctors with primary responsibility for the patients had made the same judgements, treating the red flag indicators in the same manner as Dr Brueggemann. Again, this context was viewed as important by the Tribunal when assessing whether Dr Brueggemann's fitness to practise was impaired.

63. In his report, expert witness Dr X also stated that:

> *"A significant allegation is that he failed to send off all excised tissue for histology. He claims that he only started to do this following a MS update in 2017 and prior to this he interpreted the guidance as not requiring histology to be sent unless there was a particular reason to do so. He signs himself as GP with a Special interest in Minor Surgery. At no point does he assert he has any specific dermatology experience nor that he is a GPwSI in dermatology."*

64. The Tribunal was of the view that the requirements and guidance relating to minor surgery of skin lesions was an aspect of practice that Dr Brueggemann did not fully understand or grasp and that he lacked the knowledge and skills in that area that he ought to have had. The Tribunal felt that Dr Brueggemann could have identified and raised that this was not his area of expertise and he could have undertaken additional CPD to ensure his knowledge and skills were up to date and adequate.

65. The Tribunal recognised that Dr Brueggemann realised he should have been sending excised specimens to histology in all but exceptional cases following his minor surgery refresher course in June 2017, which was many months before the concerns were raised. Therefore, the Tribunal acknowledged that he had improved his practice of his own volition rather than as a result of adverse findings following a review of his clinical practice. This was a significant factor in demonstrating to the Tribunal that he had begun the process of insight and remediation even before coming under investigation.

66. However, the Tribunal considered Dr Brueggemann's account as to why, once he had realised that he had not been adhering to current guidelines and corrected his practice, he did not conduct a retrospective review of all such patients he had treated. In his oral evidence he stated that he had looked back and concluded that he had sent any suspicious looking cases to histology and those that did not raise suspicions were not a cause for concern. The Tribunal was of the opinion that at that time, prior to the local and GMC investigations, Dr Brueggemann had still not fully realised the importance of these actions and the potential risk to patient safety.

67. In reaching its decision on impairment, the Tribunal was mindful that it must consider the current position. It was of the view that whilst there were clearly serious failings by Dr Brueggemann at the time, it is now nearly four years since the last of these events. He has demonstrated significant insight, and the Tribunal noted how he has clearly been personally affected by his own failures, leaving his GP practice for this reason.

68. The Tribunal determined that the levels of reflection and insight demonstrated by Dr Brueggemann, both in his written statements and oral evidence, were high. His remediation indicated that the risk of repetition of these behaviours is very low. His CAA work provides good evidence of the quality of his practice from audits and continuous monitoring, along with up to date NHS appraisals. All the evidence indicates that he is currently providing an effective service and is adhering to prescribed guidelines in a highly regulated area of practice. In addition, the Tribunal had regard to the testimonial evidence on behalf of Dr Brueggemann, which spoke highly of his professionalism and clinical practice.

69. The Tribunal was reassured that Dr Brueggemann is supported and more intensely supervised in his current AME role and is meeting required standards, having passed his relevant, regular audits. Further, when asked about dealing with cases and situations where he may not have the requisite knowledge during his oral evidence, Dr Brueggemann stated he makes sure that he refers to specialists appropriately when issues arise. His 2020 – 2021 appraisal states *"Dr Brueggemann feels that he is able to get additional advise [sic] from his Chief Medical Officer and also his peers to validate his practice and provide the best possible outcome for the patients."*

70. The Tribunal acknowledged that Dr Brueggemann would be entitled to return to General Practice if he wished to do so and were allowed to practise unrestricted, but accepted his stated position that he has no intention whatsoever of doing so. It also

concluded that were he to do so, the level of insight and remediation he has demonstrated make it highly unlikely that such behaviour would be repeated.

71. Therefore, the Tribunal determined that a finding of impairment is not necessary to protect patient safety.

72. The Tribunal then considered whether a finding of impairment is necessary to uphold proper standards in the profession and/or maintain public confidence in the profession.

73. In doing so it was mindful of the case law set out in paragraph 73 of *Grant*, which distinguished 'clinical errors' cases, into which Dr Brueggemann's case falls, from misconduct cases involving behaviour such as sexual assaults; the former type of case not usually requiring a finding of impairment to mark the seriousness of the matter if remediation has been demonstrated, in contrast to the latter type of case. The Tribunal also considered the principle set out in paragraph 75 of *Grant*, namely that it may not be necessary to make a finding of impairment in order to mark the seriousness of the misconduct where there is an option to issue a formal warning, as is the case in MPT proceedings.

74. The Tribunal considered that the insight and remediation demonstrated by Dr Brueggemann carried significant weight when considering the professional and public interest. The Tribunal also recognised that members of the public and other members of the profession would take into account the context of the misconduct.

75. The Tribunal concluded that, in all the circumstances, it would not be necessary to make a finding of current impairment in order to mark the seriousness of the misconduct.

76. The Tribunal has therefore determined that Dr Brueggemann's fitness to practise is not impaired.

Determination on Warning - 09/03/2021

1. As the Tribunal determined that Dr Brueggemann's fitness to practise was not impaired it considered whether, in accordance with s35D(3) of the 1983 Act, a warning was required.

Submissions

2. On behalf of the GMC, Mr Walker submitted that issuing a warning would be appropriate in this case, referring the Tribunal to paragraphs 11 and 14 of the Guidance on Warnings (February 2018) ('the Guidance').

3. Mr Walker submitted that the Tribunal found Dr Brueggemann's actions amounted to significant departures from multiple paragraphs of Good Medical Practice (2013 edition) ('GMP'), and it should follow from that assessment that a warning is required to mark the seriousness of Dr Brueggemann's actions. The Guidance states:

> ***11*** *Warnings allow the GMC and MPTS tribunals to indicate to a doctor that any given conduct, practice or behaviour represents a departure from the standards expected of members of the profession and should not be repeated. They are a formal response from the GMC and MPTS tribunals in the interests of maintaining good professional standards and public confidence in doctors. The recording of warnings allows the GMC to identify any repetition of the particular conduct, practice or behaviour and to take appropriate action in that event. Breach of a warning may be taken into account by a tribunal in relation to a future case against a doctor, or may itself comprise misconduct serious enough to lead to a finding of impaired fitness to practise.*

4. Mr Walker submitted that a warning would uphold public confidence in the profession. He further submitted that it would also provide public protection in the event that further misconduct by Dr Brueggemann occurred, because the warning could be taken into account during any future fitness to practise proceedings. He then referred to paragraph 14 of the Guidance:

> ***14*** *Warnings should be viewed as a deterrent. They are intended to remind the doctor that their conduct or behaviour fell significantly below the standard expected and that a repetition is likely to result in a finding of impaired fitness to practise. Warnings may also have the effect of highlighting to the wider profession that certain conduct or behaviour is unacceptable.*

5. Mr Walker submitted that, as at paragraph 14 of the Guidance, a warning would serve the purpose of acting as a deterrent, not only to Dr Brueggemann, but also to other members of the profession, and to uphold the overarching objective in respect of professional standards.

6. On behalf of Dr Brueggemann, Mr Cridland submitted that the decision as to whether to issue a warning was at the Tribunal's discretion, referring the Tribunal to the MPTS Tribunal Circular, dated 4 April 2019, and the Guidance.

7. Mr Cridland submitted that the Tribunal may be assisted by paragraph 21 of the Guidance, as Dr Brueggemann's misconduct related to more generalised concerns about his practice.

> *21 Given the terms and function of a warning, it will normally be appropriate to issue a warning following a specific breach of Good medical practice or allegation of misconduct rather than more generalised concerns about the standard of a doctor's practice.*

8. Mr Cridland also submitted that the Tribunal should consider paragraph 33 of the Guidance, all sub-paragraphs of which are applicable in this case. He submitted that Dr Brueggemann had demonstrated these mitigating factors, as found in the Tribunal's Determination on Facts and Impairment, and that the aggravating factors were not present in this case.

> *33 However, if the decision makers are satisfied that the doctor's fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate. These might include:*
>
> - *the level of insight into the failings.*
>
> *a A genuine expression of regret/apology.*
> *b Previous good history.*
> *c Whether the incident was isolated or whether there has been any repetition.*
> *d Any indicators as to the likelihood of the concerns being repeated.*
> *e Any rehabilitative/corrective steps taken.*
> *f Relevant and appropriate references and testimonials.*

The Tribunal's Determination on Warning

9. In reaching its determination, the Tribunal has had regard to all the facts of this case, the submissions of both Mr Walker and Mr Cridland, and has taken into account the Guidance and the MPTS Tribunal Circular, dated 4 April 2019, in relation to warnings guidance.

10. The Tribunal reiterated its finding at the impairment stage that the likelihood of repetition is very low. Therefore, it determined that a warning was not necessary to protect patient safety.

11. The Tribunal also noted that whilst it found that Dr Brueggemann's fitness to practise is not currently impaired, this finding was due to the level of insight demonstrated and the low risk of repetition, which does not diminish the seriousness of his failures. Dr Brueggemann's failings occurred over an extended period of time and put patients at risk of unwarranted harm, and were found to have amounted to significant breaches of GMP.

12. The Tribunal determined that a warning would be appropriate and proportionate in this case and that such a warning would mark the seriousness of the departures from GMP to both the public and fellow members of the profession, as well as Dr Brueggemann. This would serve to maintain and uphold proper standards in the profession and protect public confidence. It concluded that to not issue a warning could not be justified in light of the circumstances of the case and the applicability of the Guidance in respect of its earlier findings of fact and misconduct.

13. The Tribunal therefore determined to impose the following Warning on Dr Brueggemann's registration:

> 'Dr Brueggemann,
>
> On 9 March 2021, a fitness to practise Tribunal found that between June 2013 and May 2017 you failed to carry out a number of actions that were required for the proper treatment and care of multiple patients, including; failure to send histological specimens to the laboratory, failure to refer red flag identifiers, failure to diagnose lesions, and failure to write to the patients' General Practitioner with a final diagnosis. These actions were found to amount to misconduct and represent a significant breach of Good Medical Practice (2013 edition) ('GMP').
>
> This conduct does not meet with the standards required of a doctor. It risks undermining public confidence and professional standards in the profession and it must not be repeated. The required standards are set out in Good Medical Practice

and associated guidance. In this case, paragraphs 8, 11, 15, 16(b), 19 and 21 of Good Medical Practice are particularly relevant. These paragraphs state:

> *8* *You must keep your professional knowledge and skills up to date.*
>
> *11* *You must be familiar with guidelines and developments that affect your work.*
>
> *15* *You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> *a* *adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> *b* *promptly provide or arrange suitable advice, investigations or treatment where necessary*
> *c* *refer a patient to another practitioner when this serves the patient's needs.*
>
> *16* *In providing clinical care you must:*
>
> *…*
>
> *b* *provide effective treatments based on the best available evidence*
>
> *19* *Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
>
> *21* *Clinical records should include:*
> *a* *relevant clinical findings*
> *b* *the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
> *c* *the information given to patients*
> *d* *any drugs prescribed or other investigation or treatment*

e *who is making the record and when.*

Although this Warning does not place any restriction on your registration, it is a necessary response to your misconduct.'

14. This Warning will be published on the List of Registered Medical Practitioners (LRMP) in line with the GMC Publication and Disclosure Policy, which can be found at www.gmc-uk.org/disclosurepolicy.

15. The Interim Order currently imposed on Dr Brueggemann's registration will be revoked with immediate effect

16. That concludes this case.

Confirmed
Date 09 March 2021 Mr Robert Ward, Chair

ANNEX A – 09/03/2021

Application to amend the Allegation

1. Mr Walker, on behalf of the GMC, made an application under Rule 17(6) of the General Medical Council ('GMC') (Fitness to Practise Rules) 2004 as amended ('the Rules') for the particulars of the Allegation to be amended.

2. Rule 17(6) states:

> 'Where, at any time, it appears to the Medical Practitioners Tribunal that—
>
> (a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and
>
> (b) the amendment can be made without injustice,
>
> it may, after hearing the parties, amend the allegation in appropriate terms.'

Submissions

3. On behalf of the GMC, Mr Walker submitted that the proposed amendments were made on an agreed basis following further discussions between both counsel and the three expert witnesses in this case, after further medical records were obtained.

4. Mr Walker submitted that there are no new allegations included and the amendments are largely the deletion of those paragraphs of the Allegation that the expert witnesses felt were unsubstantiated or ought to be denied as they are unsupported either by their opinion, or consideration of the evidence in this case.

5. Mr Walker submitted that there are two material amendments proposed, to the wording at paragraphs 14(a), where "adequately" has been added, and 16(c), which removes reference to a "successful delivery", reflecting the fact that it was not Dr Brueggemann's responsibility to take any sample to the laboratory himself. These amendments are set out below:

*14(a) **adequately** consider an alternative diagnosis of metastatic deposit from prostate cancer;*

*16(c) save ~~and successfully deliver~~ a histological specimen of the excised lesion **to be sent** to the laboratory for analysis;*

6. Mr Walker submitted that Schedule 5, in relation to paragraph 1(e) is now only in respect of one patient, and that Schedule 6 has been removed as there is now no allegation that Dr Brueggemann failed to use a dermatoscope.

7. Mr Walker submitted that it is expected that Dr Brueggemann will make admissions to the entirety of the Allegation should the amendments be granted, and therefore the Tribunal is invited to grant the application in this case. He added that the expert witnesses were notified that admissions would likely be made if the appropriate amendments could be agreed between them.

8. On behalf of Dr Brueggemann, Mr Cridland submitted that he supports the proposed amendments.

9. Mr Cridland submitted that the proposed amendment to paragraph 14(a) reflects Dr Brueggemann's statement that he gave some consideration to this matter and aligns with the wording of paragraph 13 of the Allegation.

10. Mr Cridland submitted that adding the words "to be sent" to paragraph 16(c) makes it clear that if a GP sends a specimen for histological analysis, it is not the GP's responsibility to ensure the delivery itself was successful. Therefore, the amendment clarifies the allegation and is supported.

The Tribunal's Determination

11. The Tribunal was satisfied that the proposed amendments reflected the agreed position of the three expert witnesses in the case, and updated the Allegation in light of the additional medical records received and provided to the expert witnesses.

12. The Tribunal acknowledged that the application was supported by both parties and the amendments were largely deletion of allegations which were, in the view of the expert witnesses, unsupported by evidence or expert opinion. The additional changes, highlighted

by both counsel in their submissions, appeared to be sensible and accurately reflected the circumstances of the case and the focus of the GMC allegations for the respective paragraphs.

13. The Tribunal also noted the submissions that Dr Brueggemann would make admissions to the entirety of the Allegation if the application was granted and the amendments were made, so the amendments were clearly not viewed as causing an injustice by Dr Brueggemann or his legal representatives.

14. Given the logical and reasoned justification for making the amendments, in light of the most up to date and agreed evidence, and given the application was supported by both parties, the Tribunal determined that the amendments could be made fairly, without any injustice, and therefore granted the application.

Schedule 1 – failure to send histological specimen to the laboratory

Patient	Date of excision(s)	Location of excision(s)
A	11 June 2013	Left ear
B	13 May 2014	Sternum
C	14 April 2015	Lip
D	18 August 2015	Neck
F	5 January 2016	Nipple
G	5 January 2016	Neck
H	29 March 2016	Right breast
I	31 May 2016	Back
J	19 July 2016	Back
K	14 September 2016	Back
L	14 September 2016	Left arm
M	15 November 2016	Anterior chest wall
N	15 March 2017	Under the right axilla
O	29 March 2017	Back and abdomen

Schedule 2 – red flag identifiers

Patient	Red flag identifier	Referral
F	the location of the lesion on the nipple	urgently to Patient F's General Practitioner for onward referral to the breast clinic
H	the location of the lesion on the breast	urgently to Patient G's General Practitioner for onward referral to the breast clinic
I	the large size and quickly	urgently to specialist skin cancer services

	growing nature of the lesion	
J	previous history of squamous cell cancer of the lip	urgently to specialist skin cancer services
N	the changing nature of the appearance of the mole in size and colour	down a two-week rule pathway for skin cancer
O	the changing appearance of two moles	to specialist surgical services for excision of the lesions
P	the patient's prostate cancer diagnosis	to specialist surgical services
Q	the size of the lesion	to a plastic surgery or specialist surgical unit

Schedule 3 – failure to diagnose lesions

Patient	Date of excision(s)	Location of lesion(s)
F	5 January 2016	nipple
G	5 January 2016	neck
H	29 March 2016	right breast
I	31 May 2016	back
J	19 July 2016	back
K	14 September 2016	back
L	14 September 2016	left arm
M	15 November 2016	anterior chest wall x 4 lesions
N	15 March 2017	right axilla
O	29 March 2017	back and abdomen
Q	17 May 2017	Occiput x 2

Schedule 4 – failure to write to General Practitioner with final diagnosis

Patient	Date of excision(s)
F	5 January 2016
G	5 January 2016
H	29 March 2016
I	31 May 2016
J	19 July 2016
K	14 September 2016
L	14 September 2016
M	15 November 2016
N	15 March 2017
P	26 April 2017
Q	17 May 2017

Schedule 5 – failure to keep legible records
Amended under Rule 17(6)

Patient	Date of excision(s)
~~F~~	~~5 January 2016~~
~~G~~	~~5 January 2016~~
~~H~~	~~29 March 2016~~
~~J~~	~~19 July 2016~~
K	14 September 2016
~~L~~	~~14 September 2016~~
~~M~~	~~15 November 2016~~
~~N~~	~~15 March 2017~~
~~Q~~	~~17 May 2017~~

~~Schedule 6 - failure to use a dermatoscope~~

Amended under Rule 17(6)

~~Patient~~	~~Date of excision(s)~~
~~G~~	~~5 January 2016~~
~~K~~	~~14 September 2016~~
~~L~~	~~14 September 2016~~
~~M~~	~~15 November 2016~~