Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dr Jain has appealed the Tribunal's decisions. The substantive order of 18 months' conditional registration has therefore not taken effect, pending the outcome of the appeal. Dr Jain's registration remains subject to the immediate order of conditions imposed by the Tribunal.

Dates: 10/07/2017 - 28/07/2017
Reconvened: 14/12/2017
Reconvened: 29/01/2018 – 02/02/2018
Reconvened: 14/02/2018 – 15/02/2018
Reconvened: 18/04/2018 – 19/04/2018
Reconvened: 16/07/2018 – 17/07/2018
Reconvened: 21/01/2019 – 25/01/2019

Medical Practitioner's name: Dr Rajesh Raju JAIN

GMC reference number: 6132419

Primary medical qualification: MB BS 1995 Rajasthan University

Type of case
New - Misconduct

Outcome on impairment
Impaired

Summary of outcome
Conditions, 18 months
Review hearing directed
Immediate order imposed

Tribunal:

Medical Tribunal Member (Chair)	Dr Priya Iyer
Lay Tribunal Member:	Miss Susan Hurds
Medical Tribunal Member:	Dr Noel Bevan

Legal Assessor:	Mr Peter Jennings
Tribunal Clerk:	Mr Ian Leslie (10/07/2017 to 19/07/2017 and 24/07/2017 to 28/07/2017) Dr Joshua Kirby (20/07/17) Ms Angela Carney (21/07/2017) Mrs Debra Heaton (14/12/17,

	29/01/2018 - 02/02/2018, 14/02/2018 – 15/02/2018, 18/04/2018 – 19/04/2018, 16/07/2018 – 17/07/2018) Ms Chloe Ainsworth (21/01/2019 – 25/01/2019)

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner: (14/12/17 and 19/04/2018)	Not present and represented
Medical Practitioner: (21 - 25/01/2019)	Present and represented
Medical Practitioner's Representative:	Mr Diarmuid Bunting, Counsel, instructed by the MDS
Medical Practitioner's Representative: (19/04/2018 only)	Ms Banita Sheemar of the MDS
Medical Practitioner's Representative (21 - 25/01/2019)	Ms Lee Gledhill, Counsel, instructed by the MDS
GMC Representative:	Ms Kathryn Johnson, Counsel

Allegation and Findings of Fact

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

Patient A

1. On 27 February 2015 you consulted with Patient A ('Patient A's Consultation') and you failed to:

a. obtain an adequate history in that you:

i. did not spend sufficient time on the appointment to obtain an adequate history; **Found not proved**

~~ii. inappropriately questioned Patient A at length about her sex life;~~ **Amended pursuant to Rule 17(6)**

iii. neglected to discuss sufficiently with Patient A other aspects of her mental state; **Found not proved**

b. XXX:

i. XXX;

ii. XXX;

iii. XXX;

iv. XXX;

v. XXX;

c. prescribe medication appropriately for Patient A in that you:

i. did not discuss with Patient A her attitude to medication; **Found not proved**

ii. did not discuss any benefits that Patient A received from her medication; **Found not proved**

~~iii. increased Patient A's dose of trazodone to a level above what is normally regarded as safe or appropriate;~~ **Withdrawn by the GMC**

~~iv. did not adequately take into account the BNF guidance on recommended doses of trazodone;~~ **Withdrawn by the GMC**

~~v. changed two of Patient A's medications at once without clear clinical indication;~~ **Withdrawn by the GMC**

vi. without discussion or negotiation, doubled her dose of amisulpride; **Found not proved**

d. make an accurate record of Patient A's Consultation in that you did not accurately record in ~~a letter to her GP~~ the notes of the consultation the questions you asked Patient A relating to her sex life.
Amended under Rule 17(6)
Found proved

1A. During Patient A's consultation you inappropriately questioned Patient A at length about her sex life
Amended pursuant to Rule 17(6)
Found proved

2. You knew the medical record described at paragraph 1(d) above was inaccurate. **Found proved**

3. Your actions at paragraph 1(d) above were:

a. misleading; **Found proved**

b. dishonest. **Found not proved**

4. During Patient A's Consultation you asked Patient A questions about her sex life which were not clinically indicated, including:

a. whether she had a boyfriend; **Found not proved**

b. how often she had sex; **Found not proved**

c. whether she had unprotected sex. **Found not proved**

5. During Patient A's Consultation you asked Patient A to show you scars on her stomach and legs, which was not clinically indicated. **Found not proved**

6. Your actions described at paragraphs ~~1(a) (ii),~~ (b) (i)-(v), 1.A 4(a)-(c) and 5 above were sexually motivated. **Amended pursuant to Rule 17(6)**
Found not proved in its entirety

Patient B

7. On 26 February 2015 you consulted with Patient B ('Patient B's First Consultation') and you failed to:

a. communicate appropriately with Patient B in that you denied that her memories of childhood abuse 'go that far back', or words to that effect;
Admitted and found proved

~~b. XXX:~~

~~i. XXX;~~ **Withdrawn by the GMC**

~~ii. XXX;~~ **Withdrawn by the GMC**

c. make an appropriate record of Patient B's First Consultation in ~~a letter to Patient B's GP~~ the notes of the consultation, in that sections of the ~~letter~~ notes were the same as records made by a Community Mental Health Nurse following an assessment on 4 November 2014.
Amended under Rule 17(6)
Admitted and found proved

8. On 24 April 2015 you consulted with Patient B ('Patient B's Second Consultation') and you failed to:

~~a. maintain a professional manner in that you:~~

~~i. made a telephone call while Patient B was speaking with you without explaining to Patient B that you were about to do this;~~
Withdrawn by the GMC

~~iii. looked at your computer for long periods of time;~~ **Withdrawn by the GMC**

~~iv. yawned repeatedly;~~ **Withdrawn by the GMC**

b. obtain an adequate history from Patient B in that you:

i. did not spend sufficient time discussing Patient B's illness to obtain an adequate history; **Found not proved**

ii. repeatedly questioned Patient B about issues related to sexual relationship and sexual side effects from her medication; **Found not proved**

iii. neglected to discuss sufficiently with Patient B other aspects of her mental state; **Found not proved**

c. prescribe medication appropriately for Patient B in that you:

i. increased Patient B's dose of Sertraline without explaining the reason clearly to Patient B; **Found proved**

~~ii. increased Patient B's dose of Sertraline which was not clinically indicated;~~ **Withdrawn by the GMC**

~~iii. dismissed Patient B's concerns about your prescribing advice;~~
Withdrawn by the GMC

d. appropriately advise Patient B in that you:

i. stated that she would be discharged from psychological therapy services, which was not clinically indicated; **Found not proved**

ii. contradicted your advice to Patient B ~~in a letter to her GP~~ <u>in the notes of the consultation</u>, where you stated that she would be followed up by psychological services;
Amended under Rule 17(6)
Found not proved

~~iii. did not offer any further advice to Patient B other than advice relating to the sexual side effects of medication;~~ **Withdrawn by the GMC**

e. communicate appropriately with Patient B and her ex-husband in that you:

i. asked whether Patient B 'lines up her two ex-husbands each night and decides who to sleep with', or words to that effect; **Found proved**

ii. asked Patient B and her ex-husband about sexual dysfunction, which was not clinically indicated; **Found not proved**

~~iii. recommended a website about sexual dysfunction, which was not clinically indicated;~~ **Withdrawn by the GMC**

iv. persisted in discussing Patient B's sex life despite Patient B and her ex-husband stating that they did not wish to discuss this; **Found proved**

~~v. suggested that Patient B was not truthful about aspects of her sex life;~~ **Withdrawn by the GMC**

f. make an appropriate record of Patient B's Second Consultation in ~~a letter to Patient B's GP~~ the notes of the consultation in that:
Amended under Rule 17(6)

~~i. there was no clarity in a risk assessment as to what risks Patient B was thought to present to herself and others;~~ **Withdrawn by the GMC**

~~ii. you gave details of Patient B's mental state which were not discussed during Patient B's Second Consultation.~~ **Withdrawn by the GMC**

iii. you gave details of Patient B's clinical progress which were not discussed during Patient B's Second Consultation. **Found not proved**

9. Your actions as described at paragraphs ~~7(b) (i) (ii) and~~ 8(b) (ii), (e) (i), (ii) and (iv)~~ (v)~~ above were sexually motivated.
Paragraph 9 in relation to paragraphs 7(b)(i), 7(b)(ii) and 8(e)(v) Withdrawn by the GMC
Paragraph 9 in relation to 8(b)(ii), 8(e)(i), 8(e)(ii), and 8(e)(iv) Found not proved in its entirety

10. You knew the details described at paragraphs 8(f) ~~(ii)~~-(iii) above were inaccurate. **Found not proved**

11. Your actions at paragraph 8(f) ~~(ii) and~~ (iii) above were:

a. misleading;
Paragraph 11.a in relation to paragraphs 8(f)(ii) Withdrawn by the GMC
Paragraph 11.a in relation to 8(f)(iii) Found not proved

b. dishonest.
Paragraph 11.b in relation to paragraphs 8(f)(ii) Withdrawn by the GMC
Paragraph 11.b in relation to 8(f)(iii) Found not proved

Patient C

12. On 11 February 2015 you consulted with Patient C ('Patient C's First Consultation') and you failed to:

a. prescribe medication appropriately for Patient C in that you:

i. increased Patient C's dose of Sertraline, which was not clinically indicated; **Found not proved**

ii. did not discuss with Patient C her response to medication; **Found not proved**

iii. did not discuss with Patient C the advantages and disadvantages of taking medication. **Found not proved**

13. On 10 March 2015 you consulted with Patient C ('Patient C's Second Consultation') and you failed to:

~~a. maintain a professional manner in that you:~~

~~i. repeatedly walked around the room;~~ **Withdrawn by the GMC**

~~ii. looked at your computer frequently during the consultation;~~ **Withdrawn by the GMC**

~~iii. yawned frequently;~~ **Withdrawn by the GMC**

b. communicate appropriately with Patient C in that:

i. when Patient C stated that she had been raped, you responded that it was 'impossible to be raped from both ends without lubrication being used', or words to that effect; **Found proved**

ii. you did not pay appropriate attention to Patient C's distress in the consultation; **Found not proved**

c. prescribe medication appropriately for Patient C in that you:

i. increased Patient C's dose of Sertraline, which was not clinically indicated; **Found not proved**

ii. did not discuss with Patient C her response to medication; **Found not proved**

iii. did not discuss with Patient C the advantages and disadvantages of taking medication; **Found not proved**

d. make an appropriate record of Patient C's Second Consultation in the notes of the consultation in that:

i. the sections about mental state and risk assessment were exactly the same in Patient C's Second Consultation letter as in the ~~letter~~ notes of Patient C's First Consultation; **Admitted and found proved**

ii. you copied and pasted elements from previous letters in the ~~letter describing~~ notes of Patient C's Second Consultation. **Amended under Rule 17(6)** **Admitted and found proved**

14. You knew that the contents of Patient C's Second Consultation letter were inaccurate. **Found not proved**

15. Your actions as described as paragraphs 13(d) (i)-(ii) above were misleading. **Found not proved**

Patient D

16. On 17 April 2015, you consulted with Patient D ('Patient D's Consultation') and you failed to:

a. obtain an adequate history from Patient D in that Patient D's Consultation was dominated by questions about Patient D's sex life and libido; **Found proved**

b. communicate appropriately with Patient D in that you:

i. asked excessive questions about Patient D's libido and sexual behaviour; **Found proved**

ii. did not respond appropriately to Patient D's upset at your line of questioning; **Found not proved**

iii. suggested to Patient D that if she carried on seeing a male friend, you would have to admit Patient D to hospital; **Found proved**

c. prescribe medication appropriately for Patient D in that you:

i. offered her a list of medications and asked her 'which she would like to try', or words to that effect; **Found proved**

ii. did not follow published guidance issued by NICE, the BNF and Maudsley Prescribing Guidelines in respect of the prescription for sodium valproate; **Found proved**

iii. initiated a prescription of sodium valproate, which was not clinically indicated; **Found proved**

~~d. make an appropriate record of Patient D's Consultation in a letter to Patient D's GP in that:~~

~~i. you did not detail the questions that you asked of Patient D regarding her sexual relationships and libido;~~ **Withdrawn by the GMC**

~~ii. sections of the letter were the same as records made by a locum specialty doctor in respect of an appointment that took place on 5 March 2015.~~ **Withdrawn by the GMC**

17. Your actions described at paragraphs 16(a) and (b) (i) above were sexually motivated. **Found not proved**

~~18. You knew that the content of Patient D's Consultation letter detailed at paragraphs 16(d) (i) and (ii) above was inaccurate.~~ **Withdrawn by the GMC**

~~19. Your actions as described at paragraphs 16(d) (i) above were:~~

~~a. misleading;~~ **Withdrawn by the GMC**

~~b. dishonest.~~ **Withdrawn by the GMC**

~~20. Your actions as described at paragraph 16(c) (d) (ii) above were misleading.~~
Withdrawn by the GMC

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

Attendance of Press / Public

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

Determination on preliminary procedural matters - 21/07/2017

Mr Bunting:

1. You made an objection to Ms Johnson's line of questioning in relation to Dr G's Fitness to Practise history.

2. The tribunal considers that Dr G has put himself forward as an expert witness and experienced Consultant Psychiatrist. In the interests of justice the tribunal has determined that Ms Johnson can pursue her line of questioning. It is of the view that the matters Ms Johnson seeks to explore are relevant to Dr G's role and evidence in these proceedings as they go, at least, to his neutrality as an expert witness and the weight to be given to his opinion.

3. The tribunal, having had regard to all the circumstances and to the submissions of both parties, also considers that it is fair that these matters be explored.

4. The tribunal is mindful that it is Dr Jain's conduct on which it will focus. It is aware that is not the task of this tribunal to re-open the findings relating to Dr G's Fitness to Practise in the past; it will only consider them in so far as they are relevant to the present proceedings. Appropriate weight will be given by the tribunal to Dr G's evidence.

5. Full reasons will be given in the tribunal's determination on Facts.

Determination on Facts - 19/04/2018

Dr Jain:

First Application to Amend the Allegation

1. Ms Johnson made an application under Rule 17(6) of the General Medical Council ('GMC') (Fitness to Practise) Rules 2004, as amended ('the Rules') to delete the following paragraphs from the allegation:

- 1c (iii, iv, v);
- 7b (i, ii);
- 8a (i, ii, iii);
- 8c (ii, iii);
- 8d (iii);
- 8e (iii, v);
- 8f (i, ii);
- 13a (i, ii, iii);
- 16 d (i);
- 19.

2. Ms Johnson further applied to make the following amendments to paragraphs 9, 11, 18 and 20:

1. Your actions as described at paragraphs ~~7(b) (i) (ii)~~ ~~and~~ 8(b) (ii), (e) (i), (ii) and (iv) ~~(v)~~ above were sexually motivated.

11. Your actions at paragraph 8(f) ~~(ii) and~~ (iii) above were:

    a. misleading;

    b. dishonest.

18. You knew that the content of Patient D's Consultation letter detailed at paragraphs 16(d) ~~(i) and~~ (ii) above was inaccurate.

20. Your actions as described at paragraph 16~~(e)~~(d) (ii) above were misleading.

3. Ms Johnson said that this application was made as the GMC no longer relied on that part of the evidence of Patient B, following the expert evidence of Dr H and, in the case of paragraph 20, owing to a typographical error.

4. Mr Bunting did not oppose any aspect of this application.

5. The tribunal considered that the paragraphs could be deleted and amended accordingly without any injustice to the public interest or to you.

Second Application to Amend the Allegation

6. Ms Johnson made a second application requesting the following paragraphs be deleted as the GMC did not feel that there was evidence to support these paragraphs of the allegation:

- the stem of 16(d) and 16(d)(ii)
- 18
- 20

7. Mr Bunting agreed with the application.

8. The tribunal considered that the paragraphs could be deleted accordingly without any injustice to the public interest or to you.

Third Application to Amend the Allegation

9. Ms Johnson made an application to amend references to 'GP letters' in the paragraphs of the allegation to 'the notes of consultation'. She submitted that the necessity to make these amendments arose out of the evidence given by you that you create a Word document, which you then use to complete the entry in the notes, and which your secretary then uses to create the letters. You had told the tribunal that you yourself did not type the letters. Ms Johnson submitted that, accordingly, there was no prejudice to you as you had given clear and detailed evidence as to what the procedures were.

10. Ms Johnson said that these amendments affected the following paragraphs:

- 1(d) amending 'a letter to her GP' to 'the notes of the consultation';
- 7(c) amending 'a letter to Patient B's GP' to 'the notes of the consultation' and 'letter' to 'notes';
- 8(d)(ii) amending 'in a letter to her GP' to 'in the notes of the consultation';
- the stem of 8(f) amending 'a letter to Patient B's GP' to 'the notes of the consultation';
- the stem of 13(d) amending 'a letter to Patient C's GP' to 'the notes of the consultation';
- 13(d)(i) amending 'letter' to 'notes';
- 13(d)(ii) amending 'letter' to 'notes'.

11. Mr Bunting did not object to the proposed amendments.

12. The tribunal understood that Ms Johnson's application to amend these paragraphs of the allegation was made in the light of evidence given by you concerning the manner in which you compiled your notes of consultations and the way in which the letters to GPs were then constructed. The tribunal accepted that the amendments sought were appropriate and was satisfied that they could be made without injustice. The tribunal was, of course, expressing no view as to whether it

would or would not accept the evidence of any witness, including you, either generally, or on any matters including this one.

Admissions

13. In accordance with Rule 17(2)(d) of the Rules, Mr Bunting admitted the following paragraphs of the allegation on your behalf:

- 1(b)(ii);
- 1(b)(v);
- 7(a);
- 7(c);
- 13(d)(i);
- 13(d)(ii).

14. Therefore, the tribunal announced those paragraphs of the allegation as admitted and found proved, in accordance with Rule 17(2)(e).

Application under Rule 34(13) – Witness F (1)

15. Ms Johnson applied under Rule 34(13), for Witness F to give oral evidence to the tribunal by video-link.

16. Ms Johnson said that the reason for the application in Witness F's case was both for convenience and because he is the carer of Patient B, who is too ill to give evidence. The knowledge of the case had increased Patient B's stress and had added to Patient B's risk of self-harm. For Witness F to travel and give evidence in person, would involve spending at least one night away.

17. Mr Bunting said that he was not aware of anything in Patient B's medical notes to evidence the assertion that Patient B needs a carer. He also queried whether Witness F would need to spend an evening away if he gave live evidence.

18. Mr Bunting said that Article 6(3)(d) of the European Convention on Human Rights (the Convention), as domesticated by the Human Rights Act 1998, is triggered:

> *'Everyone charged with a criminal offence has the following minimum rights…*
>
> *(d) to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;'*

19. Mr Bunting said that the tribunal would have to consider whether granting the application would breach your human rights and your right to a fair trial. He said

that Rule 34(13) of the Rules must dictate that the tribunal should not allow this application.

20. The tribunal noted the two reasons given by Ms Johnson as to why Witness F should give evidence by video-link. First, that it would be impossible to get to Manchester and back to Plymouth without staying overnight and second, that Witness F was unable to leave Patient B as he was her carer and she would be at increased risk of self-harm. The tribunal did not consider that it had been provided with any evidence to support the first assertion such as evidence of attempts to make alternative arrangements or research into flights to Manchester from the airport nearest to Plymouth.

21. Further, the tribunal had not been provided with any medical evidence to support the assertion that Witness F was acting as Patient B's carer or that her risk of self-harm would be elevated by his absence.

22. Having considered the submissions of both Counsel and having had regard to all of the circumstances and to the directions of the Case Manager, the tribunal did not consider that it was in the interests of justice to grant this application. Accordingly, in accordance with Rule 34(14)(c), the application was refused.

23. In the light of its decision, the tribunal did not touch upon the issue of a potential breach of the Convention.

Application under Rule 34(13) – Witness F (2)

24. Ms Johnson subsequently renewed her application on the basis of an email from Witness F outlining his reluctance to leave Patient B who was suffering from physical illness which affected her mental condition and which had put her 'in a very dark place'. Witness F said that there was no one else to care for Patient B. Further, Witness F said that he was currently also responsible for his granddaughter, who was living with him. Ms Johnson said that the consequence of this would be that the GMC would be likely to have to withdraw the remaining allegations in relation to Patient B.

25. Mr Bunting submitted that for a different case management decision to be made there would need to be a significant change in the circumstances. There was no medical evidence to substantiate the assertions that Witness F was unable to leave Patient B. Mr Bunting said that he still wanted to cross-examine Witness F and did not consider that it was in the interests of justice to allow the renewed application.

26. The tribunal requested further information from the GMC in support of its application. However, it was subsequently informed that Witness F was able to attend the hearing centre and give his evidence in person. Accordingly, the tribunal was not required to make any further determination in respect of the matter.

Applications under Rule 34(13) – Dr G

27. Mr Bunting applied, under Rule 34(13), for Dr G to give oral evidence to the tribunal by video-link.

28. Mr Bunting said that on 23 February 2017, at a MPTS Listings conference, your representative advised the MPTS and GMC that it needed to apply for telephone evidence in respect of one witness. Mr Bunting said that it was clear by inference that this was not you but he conceded that it may not have been clear that the reference was to Dr G. Mr Bunting said that on 28 March 2017, the dates of hearings were confirmed with Dr G and he responded saying that he would be away from 15 July to 30 July 2017 on holiday.

29. Mr Bunting said that the parties corresponded again in early July 2017 and were informed of Dr G's availability. Mr Bunting said that the giving of video-link evidence is usually not problematic for an expert. He said that one of the reasons that Ms Johnson wanted Dr G to attend in person is that she would seek to ask questions about previous GMC proceedings that he had attended. Mr Bunting submitted that matters which arose from Dr G's previous disciplinary sanctions were not relevant, and that his evidence could still be given by video-link.

30. Mr Bunting submitted that it was in the interests of justice that Dr G gave evidence by video-link and that you might be prejudiced if the tribunal did not grant this application.

31. Ms Johnson submitted that the GMC did not know that the difficulties related to Dr G's availability until late on 5 July 2017. She said that the GMC would try to accommodate him.

32. Ms Johnson submitted that she wished to cross-examine Dr G in relation to findings of dishonesty that had been made against him in 2008. It was preferable for the tribunal to see this witness in person.

33. The tribunal considered Mr Bunting's application and took into account the submissions made by both counsel, together with the MPTS' guidance on applications for video-link evidence. The tribunal had regard to all of the circumstances of the case, including the unusual nature of the proposed cross-examination.

34. The tribunal was of course concerned that Dr G would be inconvenienced if he had to return to give evidence in person, interrupting his holiday. However, the decision which the tribunal had to make under Rule 34(14) was that it could only grant the application for video-link evidence if it considered that it was in the interests of justice to do so. Whilst video-link evidence is not uncommon in these hearings, in the tribunal's view it was preferable for evidence to be given in person. The tribunal had heard almost all of the evidence of Dr H, the GMC expert, in person. In the tribunal's judgement, particularly in the light of the specific nature of

the cross-examination which was envisaged, fairness to you required the tribunal to hear the evidence of Dr G in the same way as it heard the evidence of Dr H. The tribunal accordingly did not consider that it was in the interests of justice to grant the application for Dr G's evidence to be given by way of video-link. The tribunal therefore refused the application.

Determination on the facts

The tribunal's approach

35. In reaching its decision, the tribunal carefully considered all the evidence adduced, both oral and documentary, as well as the submissions made by Ms Johnson, on behalf of the GMC, and those made by Mr Bunting on your behalf.

36. The tribunal bore in mind that the burden of proof rests on the GMC. It is for the GMC to prove the facts and that you do not have to prove anything. It also bore in mind that the standard of proof is that which is applicable to civil proceedings, namely the balance of probabilities.

37. When considering dishonesty, the tribunal bore in mind that it should first ascertain, subjectively, the actual state of your knowledge or belief as to the facts and should then decide whether your conduct was honest or dishonest by applying the objective standards of ordinary decent people.

Amendment of the allegation

38. In the course of the tribunal's deliberations it noted that, in relation to paragraph 1, it might be possible to form a conclusion that, for example, you had inappropriately questioned Patient A about her sex life, without such questioning resulting in your taking an insufficient history, as alleged in the stem of that paragraph. The tribunal therefore considered whether an amendment of the allegation should be made and parties were recalled and invited to make submissions.

Submissions

39. Ms Johnson submitted that, as originally drafted, the allegation that you failed to take an adequate history, as set out in paragraph 1.a was not intended to mean that the history taken was not sufficient, but would also include whether the history taken was not appropriate. However, she submitted that if the tribunal wished to make the position clearer, there was no objection on behalf of the GMC to an amendment to the allegation.

40. Mr Bunting told the tribunal on your behalf that he was neutral on the matter.

The tribunal's decision

41. The tribunal bore in mind that it had power to amend the allegation as set out in Rule 17(6), provided that any amendment could be made without injustice. It also bore in mind that it should not make an amendment purely to ensure that a part of the allegation would be found proved, when it would otherwise fail. It also took account of the impact of any amendment on the way in which the case had been conducted and defended, on the evidence that was presented, or any change in emphasis.

42. The tribunal was satisfied that the amendment could be made without injustice. The allegation has therefore been amended as follows:

> 1. On 27 February 2015 you consulted with Patient A ('Patient A's Consultation') and you failed to:
>
> a. obtain an adequate history in that you:
>
> i. did not spend sufficient time on the appointment to obtain an adequate history;
>
> ~~ii. inappropriately questioned Patient A at length about her sex life;~~…
>
> 1.A During Patient A's consultation, you inappropriately questioned Patient A at length about her sex life…
>
> 6. Your actions at paragraphs ~~1(a)(ii)~~, (b)(i)-(v), 1.A, 4(a)-(c) and 5 above were sexually motivated.

Background to the case

43. The tribunal noted that the allegations concern your conduct towards Patient A, Patient B, Patient C and Patient D during consultations held with you in 2015 while you were working as a Locum Consultant in Adult Psychiatry for Plymouth Community Healthcare.

Witness evidence received – GMC

44. The tribunal considered the witness statements from the following witnesses:

- Patient A
- Witness E, Patient A's partner
- Ms I, Speciality Personality Disorders Practice Practitioner, Plymouth Community Healthcare
- Patient B
- Witness F, Patient B's carer at the time
- Ms J, Occupational Therapist at Langdon Hospital for Devon Partnership Trust
- Patient C

- Patient D
- Ms K, who supported Patient C when she gave oral evidence to this hearing.

45. Ms I, Ms J, Witness E and Witness F also gave oral evidence in person to the tribunal. Patient A, Patient C and Patient D gave oral evidence by video-link.

46. The tribunal considered a report dated 26 September 2016 commissioned by the GMC and prepared by Dr H dated 18 July 2016, together with his supplemental reports dated 24 March 2017, 3 April 2017, 7 July 2017 and 10 July 2017 respectively.

Evidence on your behalf

47. The tribunal took account of your oral evidence and your witness statement dated 15 June 2017.

48. The tribunal considered a report dated 18 September 2016 commissioned on your behalf and prepared by Dr G, together with his supplemental reports dated 13 June 2017 and 7 July 2017.

Tribunal's assessment of the evidence

49. When considering the evidence of each complainant, the tribunal bore in mind the evidence of Dr H that, if a patient gets upset in a consultation, their recollection may be affected, in that they are more likely to focus on the matter that had caused them upset and less likely to remember other aspects of the consultation. In this respect, the tribunal concluded that it was more likely than not that the complainants would have remembered the things that concerned them the most.

Patient A

50. The tribunal considered that Patient A gave clear, objective evidence to this hearing. She had a good recollection of some parts of her consultation with you, and not of others. She was articulate and helpful, and was willing to concede when she could not recall the details asked of her. The tribunal regarded her evidence as credible.

Witness E

51. Witness E was the partner of Patient A. He had not been present during her consultation with you, but she rang him immediately afterwards. The tribunal regarded his account as corroborating Patient A's account about what happened.

Ms I

52. Ms I met Patient A and her partner professionally after Patient A's consultation with you took place. She was concerned about the comments Patient A had made about you and she arranged for the complaint process to be initiated. At this meeting, Ms I received the first account from Patient A about her concerns. Ms I was not a direct witness of what had occurred. The tribunal regarded Ms I as a straightforward witness who was frank when she could not recall. The tribunal accepted her account.

Patient B

53. Patient B was unable to give oral evidence, although the tribunal received her witness statement. The tribunal took her statement into account, but, when assessing the weight of this evidence, it bore in mind that it had not been tested in cross-examination.

Witness F

54. Witness F, Patient B's carer, was present during her consultation with you. While he did not have a complete recollection of the entire consultation, he recalled the areas that perturbed him. He was also clear that you discussed matters of sexual dysfunction with Patient B, and that you made a comment to Patient B regarding her 'lining up ex-husbands'. Witness F provided a first-hand account which corroborated the evidence provided in Patient B's witness statement.

Ms J

55. Ms J was present as a chaperone during your first consultation with Patient B, and she reported that the patient had been upset during the consultation. The tribunal considered that her evidence was factual and straightforward.

Patient C

56. Patient C was a vulnerable patient who required the services of a support worker to assist her with documents while she gave her oral evidence. She had a clear recollection of significant parts of her consultation with you, but an extremely poor recollection of others. Patient C was not a particularly articulate witness and she appeared not to understand some of the questions posed, but she described, in a measured way and with clarity, her recollection of what had caused her concern. The tribunal also noted that she first complained of your behaviour in a consultation with another health professional on 13 March 2015. It was clear to the tribunal from the record of the consultation on 13 March 2015 that she had not wanted to cause trouble for you. She is recorded to have said that '*she was sorry to run the consultant down as he was trying his best*', but that she had nonetheless been upset and angry about what had happened. Further, the tribunal noted that, although a formal complaint had not been submitted until five months later, Patient C had

required assistance in writing it in order to submit it. The tribunal considered that Patient C's evidence was credible.

Patient D

57. Patient D was articulate and provided clear evidence. She was able to recall the context in which some of your questions were asked and had a detailed recollection of much of the consultation. The tribunal also noted that Patient D had spoken to the receptionist immediately after the consultation to complain of your behaviour. However, the tribunal generally accepted Patient D's evidence, though not necessarily her interpretation of events.

Dr H

58. In the tribunal's view, Dr H was a neutral expert witness who tried to assist the tribunal. However, the tribunal was not impressed with the quality of his evidence. He appeared confused and unclear on the contents of a number of reports that he had prepared, which he was asked to identify and confirm as his. The tribunal noted that, in some instances, Dr H had changed his stance on certain topics from one position to another and, on occasion back again, without adequate, rational explanation. When asked about some of these changes of opinion, he said that he had been rushed in preparing his report. With regard to others, he told the tribunal that the changes had arisen from his further reflection, but was unable to explain any additional factors which had caused him to revise his opinion. The tribunal found these explanations puzzling and it did not find such vacillation from an expert helpful.

Dr G

59. The tribunal appreciated that Dr G gave time to give his evidence during his summer holidays. However, in the tribunal's view, he was not a neutral witness and appeared to have an agenda when giving evidence. He was evasive about his own previous regulatory proceedings and did not always provide straightforward answers. He was reluctant to consider alternative explanations, and some of the opinions he expressed were speculative. Dr G was antagonistic when giving evidence and, at times, behaved as though he was your advocate, in trying to defend what he believed may have happened. Some of his answers were implausible and he frequently strayed into areas which were not relevant. The tribunal was not always assisted by this evidence and it considered that his independence and credibility were questionable. The tribunal therefore treated his evidence with caution.

Your evidence

60. The tribunal noted that you gave a number of accounts at the Rule 7 stage in a letter to the GMC, in your witness statement and in your oral evidence. In these, you significantly changed your account of the various consultations. The tribunal

considered that your evidence was not given in a straightforward manner and was, at times, evasive. You provided information which was not always relevant or helpful and some aspects of your evidence lacked plausibility.

61. XXX.

62. It was submitted on your behalf that your first language is not English and that this may have affected the way you gave your evidence, or given rise to misunderstandings during your consultations. The tribunal bore in mind that the use of English in a tribunal setting may be different from that used in normal speech and during consultations. However, it also noted that you were admitted to the GMC's Specialist Register in September 2005 and worked in the United Kingdom for a further 10 years as a locum consultant. You were revalidated as an Approved Clinician and Responsible Clinician as recently as July 2016. Further, none of the patients concerned said that they had difficulties arising from your use or understanding of language and the tribunal did not become aware of any such issues when you gave evidence in the course of this hearing. In the light of these factors, the tribunal considered that if there were any difficulties in the use of the English language, they were not, in themselves, significant for the allegation before the tribunal.

Testimonial evidence

63. The tribunal gave attention to the positive testimonial evidence which attested to the fact that you are a conscientious and committed doctor, whose integrity has not previously been called into question.

The tribunal's findings

64. The tribunal has considered each paragraph of the allegation separately and made the following findings:

Paragraph 1

> On 27 February 2015 you consulted with Patient A ('Patient A's Consultation') and you failed to:
>
> a. obtain an adequate history in that you:
>
> i. did not spend sufficient time on the appointment to obtain an adequate history; **Found not proved**

65. It was not in dispute that Patient A attended a consultation with you on 27 February 2015.

66. The tribunal took account of the record of Patient A's consultation in her medical records, which included sections entitled 'Progress note', 'Brief Risk Assessment' and Agreed Treatment Plan'. This recorded that the total contact time with Patient A was 60 minutes.

67. Patient A said that her consultation had been arranged as an emergency appointment and had lasted about 10-15 minutes. She said that her appointments usually last for around 30-40 minutes, but that, as this consultation had been arranged as an emergency appointment, she did not think that this was unusual, as emergency appointments are usually shorter. Patient A confirmed that the notes that you had recorded in her medical records were accurate and reflected your discussions with her. She also agreed in her oral evidence that there was sufficient time for discussion during her consultation with you.

68. Dr H's suggestion that you did not spend enough time in the appointment to obtain an adequate history appeared to be based on Patient A's account of the length of the appointment. However, he did not suggest what additional matters should have been discussed and recorded in Patient A's medical records beyond those which had been. Indeed, Dr H told the tribunal that the history as set out in Patient A's medical records was acceptable.

69. The tribunal noted that there was an apparent discrepancy between the length of the consultation recalled by Patient A and length of the consultation as recorded in her medical records. However, given the content of the note that you made in Patient A's medical records and the opinion of Dr H regarding the history that was actually taken, there is no evidence of any shortcomings regarding your history taking in this consultation, whatever its actual length. The tribunal has therefore not found this paragraph of the allegation proved.

iii. neglected to discuss sufficiently with Patient A other aspects of her mental state; **Found not proved**

70. The tribunal noted that the record of your consultation included reference to Patient A's feelings of anxiety, and that she expressed 'hopelessness, helplessness and worthlessness'. She was stated to have negative feelings about herself, and had been experiencing hallucinatory voices. She had negative thoughts but her insight and mental capacity into her mental illness were stated to be 'intact'. Patient A was stated to have 'very negative feelings about herself and her current circumstances', and the long term risk of intention to end her life was stated to be elevated, although she had no active plans in that regard.

71. Patient A accepted that your note of her consultation with you accurately reflected the discussions that took place with you.

72. Dr H wavered in his position regarding the sufficiency of the discussions regarding Patient A's mental state. Initially, he considered that it met expected

standards, but later he changed his mind, but without any apparent explanation. The tribunal was unable to rely on his opinion in this regard.

73. Dr G considered that the discussion of mental state as reflected in the notes of Patient A's consultation with you was acceptable.

74. The tribunal noted that there was a record in Patient A's notes which referred to her mental state. The tribunal had no evidence on which it could rely to indicate, on the balance of probabilities, that you neglected to discuss sufficiently other aspects of her mental health. The tribunal has therefore not found this paragraph of the allegation proved.

b. XXX:

i. XXX;

ii. XXX;

iii. XXX;

iv. XXX;

v. XXX;

75. XXX

76. XXX.

77. XXX

78. XXX

79. XXX.

80. XXX.

81. XXX.

82. XXX.

c. prescribe medication appropriately for Patient A in that you:

i. did not discuss with Patient A her attitude to medication;
Found not proved

83. In her oral evidence, Patient A acknowledged that you had discussed her sleep problems and her prescription for trazodone that you had proposed to increase because you told her that it would help her sleep better. With regard to amisulpride, she said that she could not recall the exact conversation, but that this was prescribed to help get her psychosis and hallucinations under control. She said that you asked her if this medication had been working as that she had had a few reactions to other medications. She also recalled that quetiapine had been discussed because she had previously stopped taking that medication because it had caused her to have an irregular heart rate.

84. It was clear from Patient A's evidence that there was a discussion about her medication. She said that she had understood the rationale for your prescribing of trazodone, and she had discussed previous side effects of her medication with you. In the light of her evidence, the tribunal cannot be satisfied, on the balance of probabilities, that you did not discuss her attitude to medication. It therefore follows that there was no failure to prescribe appropriately. The tribunal has therefore not found this paragraph of the allegation proved.

ii. did not discuss any benefits that Patient A received from her medication; **Found not proved**

85. Patient A said that you asked her if amisulpride had been effective. She told you that it had been effective, but that it was not as good as the quetiapine which she had been prescribed before. She agreed that she had always felt that she had '*some sort of input in my medication*'.

86. It was clear to the tribunal from her evidence that you asked Patient A about the medication she had already been prescribed and that she had described to you the benefits of that medication. In the light of her evidence, the tribunal cannot be satisfied, on the balance of probabilities, that you did not discuss the benefits of her existing medication with her. It therefore follows that there was no failure to prescribe appropriately. The tribunal has therefore not found this paragraph of the allegation proved.

vi. without discussion or negotiation, doubled her dose of amisulpride; **Found not proved**

87. It was not in dispute that you doubled Patient A's dose of amisulpride.

88. The tribunal noted Patient A's evidence that her existing prescription of amisulpride was discussed with her. She also acknowledged that she had been given an opportunity to provide input into her medication.

89. In the light of Patient A's evidence, the tribunal cannot be satisfied, on the balance of probabilities, that you doubled her dose of amisulpride without discussing

it with her. It therefore follows that there was no failure to prescribe appropriately. The tribunal has therefore not found this paragraph of the allegation proved.

> d. make an accurate record of Patient A's Consultation in that you did not accurately record in the notes of the consultation the questions you asked Patient A relating to her sex life. **Found proved**

90. The note of the consultation on 27 February 2015 in Patient A's medical records made no reference to any questions that had been asked relating to Patient A's sex life.

91. You said that discussing psychosexual history was important as any dysfunction in this regard has been found to be one of the major factors for poor compliance with psychotropic medications. However, you acknowledged that you had not recorded any details of any such discussion with Patient A in her medical records. You said that you only record matters of concern.

92. Dr G said that it was not necessary to record every aspect of a patient's consultation in their medical notes.

93. Dr H offered differing opinions about this aspect of the allegation, but his final opinion was that a full account of the consultation should have been recorded.

94. You told the tribunal that a patient's sex life was an important diagnostic criterion. The tribunal has found that you questioned Patient A about her sex life, but that nothing was recorded in her medical notes in that regard. In the light of your evidence of the significance of the questioning and Dr H's opinion regarding your obligations in record keeping, the tribunal is satisfied, on the balance of probabilities, that you did not make an accurate record of the consultation in her medical records when you omitted to refer to your questioning about her sex life. In this respect, the tribunal decided that the medical records were incomplete, and inaccurate in the sense that they did not record something that should have been recorded. The tribunal has therefore found this paragraph proved.

> 1. A During Patient A's consultation, you inappropriately questioned Patient A at length about her sex life.
> **Found proved**

95. Patient A gave a convincing account that you had asked her a number of questions about her sex life, which she regarded as inappropriate and excessive. These included questions asking her if she had a boyfriend, how frequently she had sex and whether it was unprotected sex. She accepted that a symptom of her illness can be reckless behaviour and that other psychiatrists had asked her previously if she had engaged in reckless sexual acts, but she said that none of them had ever asked her the 'in-depth' questions that you had asked. She told the tribunal

that she had particularly remembered this consultation because she regarded it as unusual.

96. Witness E said that Patient A rang him immediately after the consultation. He said that she told him that you had made inappropriate comments and that you had asked her about her personal and sex life.

97. Ms I said that, on 29 July 2015, Patient A came to see her with Witness E and told her about her consultation with you on 27 February 2015. Ms I could not recall if Patient A had told her about the specific questions that you had asked, but she recalled that Patient A said that they were 'quite intrusive and inappropriate'. Patient A had told her that the questions about her sexual behaviour were quite close to the beginning of the consultation and that Patient A had been very taken aback.

98. You said that you could not remember if you had asked Patient A questions about her sex life, but that if you had done so, this was would have been clinically appropriate as it can be an important diagnostic criterion in patients suffering from the kind of condition with which Patient A had been diagnosed. In such cases, you said that you often take prior permission to discuss such a sensitive issue and request the presence of a female colleague.

99. In his report, Dr H said that there was no justification to ask Patient A about whether she had a boyfriend, how often she had sex and whether she had unprotected sex. He said that it was 'entirely inappropriate' for you to have questioned her at length about sexual matters. He accepted in his oral evidence that such questions could have formed part of a full psychiatric history, but he considered that you appeared to have asked these questions out of context and given them a prominence in your history taking which was not justified.

100. The tribunal accepted that, given the nature of Patient A's condition, there was a clinical reason for asking her about reckless behaviour in general. However, against the background that she was attending in consequence of an attempt to end her life, the tribunal took the view that this was not the occasion for the detailed discussion about her sex life that she recounted. It accepted Dr H's evidence that the prominence given to those questions was not justified. Further, there was no evidence to suggest that you had asked her about any reckless behaviour, other than reckless sexual behaviour.

101. You asserted that such questions were addressing important diagnostic criteria. However this was a patient whose condition had already been diagnosed. The tribunal also regarded it as notable that you did not make any record of your questions or Patient A's responses in her medical records, bearing in mind the importance which you said you place on such issues. There was also no evidence before the tribunal that you sought the consent of Patient A to your line of questioning or that you obtained the services of a chaperone, which you said was

your usual practice. The tribunal finds your explanation of why you persisted inconsistent and unsatisfactory.

102. The tribunal has accepted Patient A's account and concluded that, on the balance of probabilities you asked her questions about her sex life, at length, which was inappropriate in those clinical circumstances. The tribunal has found this paragraph of the allegation proved.

Paragraph 2

> You knew the medical record described at paragraph 1(d) above was inaccurate. **Found proved**

103. You said that you regarded aspects of a patient's sex life to be important diagnostic criteria, but you did not include any reference to these matters in your notes of the consultation, which was therefore incomplete and an inaccurate record of the consultation.

104. The tribunal took the view that, given the otherwise apparently comprehensive note that you made of the consultation, and the significance which you said you attached to this information, it was more likely than not that you would have made a reference to it in the medical records. The tribunal was therefore satisfied, on the balance of probabilities, that you knew that the medical record of the consultation was inaccurate, in the sense that it was incomplete. The tribunal therefore finds this paragraph of the allegation proved.

Paragraph 3

> Your actions at paragraph 1(d) above were:
>
> a. misleading; **Found proved**

105. The tribunal has already found that your record of the consultation was inaccurate, in that it was incomplete, and that you knew that this was the case.

106. Dr H told the tribunal that the questions that you had asked could be an important part of a patient's psychiatric history, and that they should have been recorded.

107. The tribunal took the view that any omissions regarding important issues relating to a patient's history could be of concern to a future practitioner caring for the patient. It was therefore satisfied, on the balance of probabilities, that your omissions in this respect were misleading. The tribunal has found this paragraph of the allegation proved.

> b. dishonest. **Found not proved**

108. Both experts were agreed that taking a psychosexual history was a valid topic for discussion during the consultation. The tribunal was not satisfied that Patient A displayed unhappiness during the consultation itself and therefore any motive for dishonesty on your part was weak. In the tribunal's view, there were many other things that you did not record during the consultations which are the subject of this hearing.

109. The tribunal considered that the omission to make a record of your questions and Patient A's responses on sexual topics would not be a logical way of concealment. The tribunal's finding was that your questioning was excessive, rather than that this was a topic that you should not have touched on at all. Accordingly, concealment would be better achieved by making a record, rather than omitting to make one.

110. In the tribunal's judgement, your conduct in not making this record was not dishonest by the standards of ordinary, decent people. The tribunal therefore has not found this paragraph of the allegation proved.

Paragraph 4

> During Patient A's Consultation you asked Patient A questions about her sex life which were not clinically indicated, including:
>
> a. whether she had a boyfriend; **Found not proved**
>
> b. how often she had sex; **Found not proved**
>
> c. whether she had unprotected sex. **Found not proved**

111. Patient A said that you asked her the questions alleged. She explained that she had not been so much upset by the questions but by the way in which they were put to her XXX.

112. You said that you could not remember whether you had asked the questions alleged but that, if you had done, there were clinical reasons for doing so.

113. In his report, Dr H said that there was no justification to ask Patient A about whether she had a boyfriend, how often she had sex and whether she had unprotected sex. However, in his oral evidence, he agreed that these questions could form part of the full psychiatric history. His view was that you had appeared to give them a prominence that was not justified.

114. Both experts were agreed that exploring a patient's psychosexual history is important, but that it needs to be dealt with sensitively and with care and diligence.

115. The tribunal bore in mind that whether the questions are clinically indicated is a different matter from whether they are insensitive. The tribunal accepted Patient A's account and therefore finds, on the balance of probabilities, that you asked the questions alleged. However, in the light of the expert evidence, it is not satisfied, on the balance of probabilities that such questions were not clinically indicated. The tribunal therefore does not find this paragraph of the allegation proved.

Paragraph 5

> During Patient A's Consultation you asked Patient A to show you scars on her stomach and legs, which was not clinically indicated. **Found not proved**

116. Patient A said that you asked to see her scars from previous self-harm on her stomach and legs. She said that she had scars on her arms which would have been visible to you. Patient A acknowledged the possibility of a misunderstanding about what you had asked her, but asserted that she had not actually misunderstood you in this respect. She said that you did not ask her to remove any clothing so that you could see the scars on her stomach and legs and the issue was not pursued.

117. In his oral evidence, Witness E corroborated this account and said that you would have been able to see the scars on Patient A's arms.

118. You said that you would have asked to see Patient A's scars to determine how recent they were, but that you would not have asked to see scars on her stomach or legs. You suggested that you would have asked to see her arms, but that Patient A may have misunderstood you in believing that she needed to show you all her scars.

119. Dr H said that it was not appropriate to ask to see Patient A's scars on her stomach and legs.

120. Dr G said that it was clinically indicated for a doctor to ask to see a patient's scars arising from self-harm.

121. The tribunal accepted the evidence of Patient A and concluded, on the balance of probabilities, that you asked her to show you scars on her stomach and legs. However, the tribunal noted that Patient A had self-harmed on 26 December 2015, and she was seen in an emergency consultation with you on 27 February 2015. On this occasion and in these circumstances, the tribunal accepted the evidence of Dr G that it was clinically indicated for you to have asked to see the scars arising from her self-harm. The tribunal has therefore not found this paragraph of the allegation proved.

Paragraph 6

Your actions described at paragraphs 1(b)(i)-(v), 1.A, 4(a)-(c) and 5 above were sexually motivated.

Paragraph 6 in relation to paragraphs 1.b.i-v and 1A Found not proved

122. XXX.

123. XXX the tribunal was not satisfied, on the balance of probabilities, that your behaviour in this respect was sexually motivated. It has therefore not found these paragraphs of the allegation proved.

Paragraph 6 in relation to paragraph 4.a, 4.b and 4.c Found not proved

124. The tribunal has found that paragraph 4 was not proved in its entirety, in that, although it found that the questions alleged had been posed, it did not find that they were not clinically indicated. It therefore follows that your actions in asking such questions were not sexually motivated. The tribunal has therefore not found these paragraphs of the allegation proved.

Paragraph 6 in relation to paragraph 5 Found not proved

125. The tribunal has not found paragraph 5 proved, in that, although it found that you asked to see the scars on Patient A's stomach and legs, it did not find that this was not clinically indicated. It therefore follows that it is not satisfied that your actions in asking to see these scars were sexually motivated. This paragraph is therefore not found proved.

Paragraph 7

On 26 February 2015 you consulted with Patient B ('Patient B's First Consultation') and you failed to:

a. communicate appropriately with Patient B in that you denied that her memories of childhood abuse 'go that far back', or words to that effect; **Admitted and found proved**

c. make an appropriate record of Patient B's First Consultation in a letter to Patient B's GP, in that sections of the letter were the same as records made by a Community Mental Health Nurse following an assessment on 4 November 2014. **Admitted and found proved**

Paragraph 8

On 24 April 2015 you consulted with Patient B ('Patient B's Second Consultation') and you failed to:

b. obtain an adequate history from Patient B in that you:

i. did not spend sufficient time discussing Patient B's illness to obtain an adequate history; **Found not proved**

126. It was not in dispute that Patient B attended a consultation with you on 24 April 2015, in the company of Witness F, her ex-partner. The record of the consultation showed that it began at 14:03 and included 30 minutes of face to face contact with the patient.

127. Patient B did not give oral evidence, but Witness F agreed with much of what was written in the record. However, he disputed that Patient B had discussed that she was suffering from hypoarousal with you. He also said in his witness statement that:

> *'We cannot have spent more than 5/10 minutes out of a 30 minute appointment slot talking about [Patient B's] illness, which was the reason we were there…'*

Witness F went on to say that the consultation thereafter was dominated by your attempts to discuss sexual matters.

128. You said that you already knew much of Patient B's history from a previous consultation, but that you took sufficient details of her progress. Dr H accepted that, if this was correct, then the history you took was adequate.

129. The tribunal took account of the notes of the consultation which included reference to her obsessions regarding cleanliness and anger outbursts. It was recorded that she tried to avoid situations which cause her to lose her temper. Although the tribunal took account of the evidence of Witness F, there was no evidence before the tribunal to indicate what other matters should have been explored which were not reflected in the note of the consultation.

130. In all these circumstances, the tribunal is not satisfied, on the balance of probabilities, that you did not spend sufficient time discussing Patient B's illness to obtain an adequate history, and that there was a failure in that respect. The tribunal has therefore not found this paragraph of the allegation proved.

ii. repeatedly questioned Patient B about issues related to sexual relationship and sexual side effects from her medication; **Found not proved**

131. Witness F said that when he brought up the issue of how long the side effects of Patient B's medication would last, you had immediately suggested that there was sexual dysfunction. Witness F said that Patient B had been assured that she would not need to discuss sexual matters during her consultation and made it clear that

she did not want to talk about it with you. He said that you pursued the topic and had to be told four times that she did not want to discuss it.

132. You said that you were carrying out your professional duty in asking Patient B about the side effects of her medication, so that she could make an informed decision about it.

133. Both experts were agreed that a patient's psychosexual history is relevant when planning a patient's future care.

134. The tribunal accepted Witness F's account that you asked her repeatedly about her possible sexual dysfunction, but it acknowledges that there was likely to be a clinical indication for you to have done so. In these circumstances, the tribunal does not consider, on the balance of probabilities, that there was a failing on your part to take an adequate history. It therefore does not find this paragraph of the allegation proved.

iii. neglected to discuss sufficiently with Patient B other aspects of her mental state; **Found not proved**

135. In his oral evidence, Witness F agreed that Patient B's aggressive and other behaviour, the side-effects of her medication and her sleep disorder had been discussed. He also acknowledged that the contents of the consultation note were accurate, with the exception of the entry relating to hypoarousal.

136. You denied the allegation and said that you had taken a relevant history, assessed Patient B's mental state and completed a brief risk assessment as well as assessing her mental capacity to consent to treatment during the consultation.

137. There was no evidence before the tribunal to indicate what other matters, not reflected in the summary of the consultation, should have been explored regarding Patient B's mental state. Witness F acknowledges, with one exception, that the summary was accurate. In these circumstances, the tribunal is not satisfied, on the balance of probabilities, that you did not discuss sufficiently other aspects of Patient B's mental state or that there was a failure in that respect. The tribunal has therefore not found this paragraph of the allegation proved.

c. prescribe medication appropriately for Patient B in that you:

i. increased Patient B's dose of Sertraline without explaining the reason clearly to Patient B; **Found proved**

138. The note of the consultation in Patient B's medical records shows that you increased the dose of sertraline from 100mg to 150mg. The note also records that

'She feels her life has changed now since commencing Sertraline 100mg'

139. In her witness statement, Patient B said that it was only at the end of the consultation that you said that you were increasing her prescription for sertraline. She said that she could not believe it as she did not think that you had assessed her or asked her any questions about it and there had been no discussion on the subject. She said that she tried to explain that she thought the dose was too high as she had previously been unable to cope on the suggested dose of 100mg and had reverted to taking 50mg.

140. Witness F said that Patient B had been reluctant for the dose of sertraline to be increased and he said that there was no discussion about it. He said that you told her that you were 'upping it' but that you did not tell Patient B why or ask her whether she wanted this increase.

141. The tribunal noted from Patient B's medical records that Witness F contacted Patient B's GP on 27 April 2015 and communicated Patient B's reluctance to increase the dose of sertraline.

142. You said that you believed that Patient B had been very hesitant about explaining the side effects of sertraline during her consultation, in particular sexual dysfunction, as she was trying to point it out by saying that '*I am not having any feeling down there'*. You said that you had tried to reassure her. You said that you had concerns about her stopping sertraline, as you said that she had responded '*very well'* to it and stopping it could lead to a deterioration in her mental health.

143. Patient B reported that her condition had been responding to her existing medication, and concerns were raised on her behalf by Witness F with her GP three days after the consultation about the increase in her medication. It appears to the tribunal that neither Patient B nor Witness F had any clear understanding from you as to the reasons for the increase of the prescription of sertraline. In these circumstances it was satisfied, on the balance of probabilities, that you did not clearly explain the reasons for the proposed increase in sertraline, and that you should have done so in order to prescribe appropriately. The tribunal has therefore found this paragraph of the allegation proved.

d. appropriately advise Patient B in that you:

i. stated that she would be discharged from psychological therapy services, which was not clinically indicated; **Found not proved**

144. The note of the consultation stated that Patient B was to remain on 'Standard Care' with you as her lead professional. It also stated that she had been provided with the new contact number of the out-of-hours telephone support service, Mental Health Matters, with a follow up appointment to take place in three months.

145. Patient B said that you discharged her, saying that she no longer needed help as the medication was working, which she said that she did not expect at all.

146. Witness F said that you told Patient B that you were cancelling her 'speech therapy', which was a form of therapy where Patient B was able to talk through her problems. He said that you told her that she no longer needed this type of therapy as the medication was working. He said that you did not discuss Patient B's preferences about this.

147. Witness F said, in his oral evidence, that he agreed with the summary contained in the consultation note, apart from the issue of hypoarousal, but the tribunal noted that he had suggested in his witness statement that it had all been made up.

148. In a letter to Patient B's GP dated 5 June 2015 in relation to your clinic on 24 April 2015, you referred to the ongoing care that Patient B was to receive.

149. During a home visit on 8 May 2015, Patient B told Mr L, a care coordinator, that she was doing well and that she did not believe that she needed further therapy. It was also agreed that Patient B should come off the waiting list for psychology and care coordination and that medication would be reviewed with her GP. The nurse reported that her discharge from mental health services would be discussed with the wider team.

150. In a letter dated 13 May 2015 Ms M, Clinical Psychologist, referred to Patient B's discussion with Mr L and confirmed that her case was closed for further psychological intervention at that time.

151. You said that you would not have recommended discontinuing psychological intervention as you had discussed her case for allocation to the care coordinator. In your oral evidence, you said that, in any event, it was not within your remit to discharge the patient from psychological intervention.

152. The tribunal noted the evidence of Patient B and Witness F, but their account was not easy to reconcile with the clinical documentation. The note of the consultation did not indicate that Patient B had been discharged and this was not reflected in the letter that you wrote to Patient B's GP on 5 June 2015. Further, Ms M's letter stated that Patient B was discharged from further psychological intervention as a consequence of the wishes that she expressed to her care coordinator on 8 May 2015. In all these circumstances, the tribunal was not satisfied, on the balance of probabilities, that you told Patient B that she was to be discharged during her consultation on 24 April 2015. The tribunal therefore has not found this paragraph of the allegation proved.

ii. contradicted your advice to Patient B in a letter to her GP, where you stated that she would be followed up by psychological services; **Found not proved**

153. The tribunal has not found that you told Patient B that she would be discharged. In any event, the letter which you sent to Patient B's GP dated 5 June 2015 did not state that Patient B would be followed up by psychological services. The reference to follow up in the letter appears to relate to follow up by your clinic. The tribunal has therefore not found this paragraph of the allegation proved.

e. communicate appropriately with Patient B and her ex-husband in that you:

i. asked whether Patient B 'lines up her two ex-husbands each night and decides who to sleep with', or words to that effect; **Found proved**

154. Patient B stated:

'When we went into the room, Dr Jain asked if [Witness F] was my husband because they had not met previously. I introduced him and explained that he was my second ex-husband. Dr Jain then said something along the lines of "oh what do you do? do you line them up at night and decide which one you want to sleep with". Dr Jain looked liked he was joking when he said this and had it been a friend of mine I would have laughed it off, because we have a bit of an on-going joke that I live with my two ex-husbands, but I didn't think it was appropriate from Dr Jain. It didn't feel right but I just let it go'.

155. Witness F was clear in his evidence that Patient B had accurately heard what she described.

156. You said that you had been pleased to see Patient B's improvement after a long time. You stated that:

'*I jokingly said that her 2 ex-partners might be lining up competitively if they want to get her attention e.g. to cook a meal for them etc which I believe was misheard by the patient and her ex-partner as referring to sex'.*

157. The tribunal notes that you admit that you said something about Patient B's husbands *'lining up'.* The tribunal has accepted the evidence of Patient B and Witness F and has concluded, on the balance of probabilities, that it is more likely than not that you made the comment alleged, and that it was not appropriate to do so. The tribunal has therefore found this paragraph of the allegation proved.

ii. asked Patient B and her ex-husband about sexual dysfunction, which was not clinically indicated; **Found not proved**

158. Witness F told the tribunal that he had raised the issue of the side effects of Patient B's medication with you.

159. You said that Patient B had complained of numbness and that you wished to explore the issue of sexual dysfunction as it might have had an effect on the patient's compliance with medication.

160. There was no dispute that you asked Patient B and Witness F about sexual dysfunction. The tribunal noted the evidence presented that sertraline, which Patient B was taking, can have a side effect of sexual dysfunction. The tribunal therefore concluded that, on the balance of probabilities, there was a clinical indication for your questions about possible sexual dysfunction. Consequently, the tribunal does not consider that there was a failing on your part in this regard. It has not found this paragraph of the allegation proved.

iv. persisted in discussing Patient B's sex life despite Patient B and her ex-husband stating that they did not wish to discuss this; **Found proved**

161. You wrote in the note of the consultation:

'She feels that she is having hypoarousal (sexually) since commencing Sertraline 100mg. She said that she won_t[sic] be able to discuss it in detail with me as I am a male doctor'.

162. Patient B stated that she told you on four separate occasions that she did not wish to discuss her sex life with you. She said that it made her angry because you would not drop the subject.

163. Witness F said that he told you on four separate occasions that they were not prepared to discuss problems with sex and that they simply would not speak to you about that. He said that you seemed to ignore the requests and carried on.

164. You stated that you tried to tell Patient B that sexual dysfunction is a side effect of sertraline but that you stopped discussing it when you realised that she was not comfortable in discussing it. You said that you tried to explain the rationale for why you were having this discussion.

165. The tribunal accepted the account of Patient B and Witness F that you persisted in discussing Patient B's sex life with her. It acknowledges that each of them said that they had asked you to stop on four occasions. The tribunal does not consider that it is material which of them had asked you to stop, but it is satisfied

that it is more likely than not that you were asked on a number of occasions to stop by one or both of them as they did not want to discuss the subject. They had asked you how long the side effects would last, and you had responded by discussing sexual dysfunction. The tribunal was satisfied, on the balance of probabilities, that, if you had communicated appropriately with them, they would have understood the reasons for wanting to discuss their sex lives, even if they did not want to engage further in that discussion. The tribunal has therefore concluded that in persisting with your discussions regarding Patient B's sex life, you did not communicate appropriately with Patient B and Witness F, when you should have done. This paragraph of the allegation is therefore found proved.

> f. make an appropriate record of Patient B's Second Consultation in the notes of the consultation in that:
>
> > iii. you gave details of Patient B's clinical progress which were not discussed during Patient B's Second Consultation.
> > **Found not proved**

166. The tribunal noted that the record of the consultation included:

> *'She updated me on her mental health and progress since her last review. She reported around 95% improvement in her now as she doesn_t[sic] hear any voices, able to socialize and less anger now. She has also stopped smoking. She feels her life has changed now since commencing Sertraline 100mg.'*

167. Initially, Witness F acknowledged that the summary of Patient B's consultation note was accurate, except for the reference to hypoarousal. In cross-examination, he was taken through each aspect of the note in turn and (with that exception) either agreed the accuracy of each comment, or could not recall.

168. You asserted that your note was an accurate record of the consultation.

169. The tribunal was not satisfied on the balance of probabilities that the aspects of Patient B's progress as recorded in the note of her consultation had not been discussed with her during her consultation. The tribunal has therefore not found this paragraph proved.

Paragraph 9

> Your actions as described at paragraphs 8(e) (i)(ii) and (iv) above were sexually motivated.
>
> **Paragraph 9 in relation to paragraph 8.e.i Found not proved**

170. Patient B said that you looked like you were joking, and if it had come from a friend, she would have just laughed it off, but she did not think that it was appropriate coming from you.

171. You did not accept that you had made the comment alleged, suggesting instead that you said that Patient B's two ex-partners might be 'lining up for her attention, for example to cook a meal for them'. You denied that any of your actions were sexually motivated.

172. In the tribunal's view, your comment was inept and insensitive to Patient B's circumstances. The tribunal regards it as both unacceptable and unprofessional. The tribunal noted, however, that you made the comment in the presence of Patient B's carer who was also her ex-husband, and the tribunal was not satisfied, on the balance of probabilities, that it was sexually motivated. The tribunal has therefore not found this paragraph of the allegation proved.

Paragraph 9 in relation to paragraph 8.e.ii Found not proved

173. The tribunal has not found paragraph 8.e.ii proved. As your questions about sexual dysfunction were clinically indicated, the tribunal was not persuaded that they were sexually motivated. The tribunal has therefore not found this paragraph of the allegation proved.

Paragraph 9 in relation to paragraph 8.e.iv Found not proved

174. The tribunal has found that you persisted in discussing Patient B's sex life, although she and her ex-husband stated that they did not wish to discuss this. From the evidence of Witness F, it was apparent to the tribunal that they were unhappy about your pursuing this topic of discussion and the tribunal considers that you conducted this part of the consultation insensitively. However the tribunal has found that there was a clinical indication for your asking about this topic. The tribunal also noted that Patient B drew an adverse inference from the fact that you attempted to obtain a chaperone, which was, in itself, a proper course. Also Witness F did not regard that kind of questioning as relevant, although in the tribunal's view, it was. Witness F said that you were attempting to make a rift between him and Patient B, but he modified that in his oral evidence. At one stage he told the tribunal that he thought you were 'trying it on' with Patient B. The tribunal found this implausible; the more so when Patient B's ex-husband was sitting next to her.

175. Your clinic notes indicated that Patient B suffered from hypoarousal and you were concerned about the effects of sertraline. The tribunal found that there was a clinical indication for your line of questioning, although it was excessive. The tribunal noted that Dr G was critical of the way you asked questions in Patient B's consultation and he suggested that you should have asked your questions sensitively. XXX.

176. Accordingly, while the tribunal considers that you handled this part of the consultation unacceptably, it also considers that the impression formed by Patient B and Witness F is an unreliable foundation for a finding that your questions were sexually motivated. In the tribunal's judgement, it is too great a leap to draw that inference. It has therefore not found this paragraph of the allegation proved.

Paragraph 10

You knew the details described at paragraphs 8(f) (iii) above were inaccurate. **Found not proved**

177. The tribunal has not found that you failed to make an appropriate record of the consultation with Patient B on 24 April 2015. It has not found proved that there were details of Patient B's clinical progress included in her consultation note which had not been discussed in that consultation. It therefore follows that the consultation note was not inaccurate in that respect and therefore you could not have known that this was the case. The tribunal has not found this paragraph of the allegation proved.

Paragraph 11

Your actions at paragraph 8(f) (iii) above were:

a. misleading; **Found not proved**

178. The tribunal has not found that there was any failing on your part in relation to the note you wrote of the consultation on 24 April 2015. It has also not found that the note was inaccurate or that you knew that this was the case. It therefore follows that your actions in that respect were not misleading. The tribunal has not found this paragraph of the allegation proved.

b. dishonest. **Found not proved**

179. The tribunal has not found that there was any failing on your part in relation to the note you wrote of the consultation on 24 April 2015. It has also not found that the note was inaccurate or that you knew that this was the case. It has also not found that your actions were misleading. It follows that your actions in that respect were not dishonest. The tribunal has not found this paragraph of the allegation proved.

Paragraph 12

On 11 February 2015 you consulted with Patient C ('Patient C's First Consultation') and you failed to:

a. prescribe medication appropriately for Patient C in that you:

i increased Patient C's dose of Sertraline, which was not clinically indicated; **Found not proved**

180. It was not in dispute that Patient C attended a consultation with you on 11 February 2015 or that you increased her dose of sertraline from 100mg to 150mg daily. The note of the consultation showed that Patient C was showing evidence of distress and anxiety and was suffering low mood. She had also experienced thoughts of ending her life although she was not regarded as being at high risk to herself at that time.

181. You said that you had increased Patient C's dose of sertraline because she had persistent signs and symptoms of anxiety and depression, together with suicidal thoughts despite good compliance.

182. In oral evidence, Dr H agreed that an increase in the dosage of sertraline might be clinically indicated if a patient was using the medication, was adhering to their prescriptions and was still symptomatic. He also agreed that it would have been a reasonable time to increase the dose of sertraline.

183. In the light of the evidence of Dr H, the tribunal has concluded that the decision to increase the dose of sertraline was a matter for the treating clinician. It has no evidence to suggest that increasing Patient C's medication at that time was not clinically indicated and it has concluded that there was no failing on your part in that respect. The tribunal has therefore not found this paragraph proved.

ii. did not discuss with Patient C her response to medication; **Found not proved**

184. In her witness statement Patient C said that your consultation with her was dominated by discussions about the tablets that she was prescribed. In her oral evidence, she remembered that the consultation had lasted for around 30 minutes, but she was unable to recall further detail.

185. You said that you had discussed an increase in Patient C's medication with her because her present dose had been ineffective, and that you had explained your rationale for doing so.

186. The tribunal accepted the accounts given by you and Patient C, both of which agreed that there had been a discussion about her medication. In these circumstances, and in the absence of other evidence to the contrary the tribunal was satisfied, on the balance of probabilities, that this discussion included reference to Patient C's response to medication. The tribunal has therefore not found this paragraph of the allegation proved.

iii. did not discuss with Patient C the advantages and disadvantages of taking medication. **Found not proved**

187. Patient C acknowledged that there had been a discussion about her medication during the consultation.

188. You said that you had discussed with her the fact that her present dose was providing ineffective and provided a rationale for the proposed increase.

189. In the light of Patient C's account and your evidence, and in the absence of other evidence to the contrary, the tribunal was satisfied that it was more likely than not that you discussed the advantages and disadvantages of her medication with her. The tribunal has therefore not found this paragraph of the allegation proved.

Paragraph 13

On 10 March 2015 you consulted with Patient C ('Patient C's Second Consultation') and you failed to:

b. communicate appropriately with Patient C in that:

i. when Patient C stated that she had been raped, you responded that it was 'impossible to be raped from both ends without lubrication being used', or words to that effect; **Found proved**

190. It was not in dispute that Patient C attended a further consultation with you on 10 March 2015.

191. In her witness statement, Patient C said:

'During the course of explaining the sexual abuse I had suffered within my marriage, I told Dr Jain that I had been raped from both ends. To this, Dr Jain responded that it was impossible to be raped from both ends without lubrication being used'.

192. In her oral evidence, Patient C was clear that she had understood you to mean that what she had described had never happened. She said that she leaned forward and said to you '*believe me, I was raped*'.

193. In your witness statement, you said that you did not recall having made this comment, but you said *'it must have been a very traumatic experience for you'*. You apologised for any misinterpretation.

194. Although initially you asserted that you had definitely not made the comment alleged, in your oral evidence you became unclear as to whether you were

suggesting that you had definitely not made the comment, or whether you accepted the possibility that you made a different comment that might have been misinterpreted. You said that you did not recall the specific phrase and that you may have been cross-checking Patient C's account, as you do in all your consultations.

195. The tribunal accepted the account given by Patient C, and concluded, on the balance of probabilities, that you had made the comment as alleged to Patient C during her consultation with you, which thereby amounted to a failing on your part to communicate with her appropriately. The tribunal has therefore found this paragraph of the allegation proved.

ii. you did not pay appropriate attention to Patient C's distress in the consultation; **Found not proved**

196. In her witness statement, Patient C said that she was shocked, angry and upset by what you said to her and that she started to cry, although you did not react to her crying at all. In her oral evidence, she said that she had not cried during the consultation. Patient C accepted that you had apologised for your remark during the consultation.

197. In the light of the inconsistency in Patient C's account, the tribunal could not ascertain the extent to which Patient C had made her distress visible to you during the consultation. It also noted that you had apparently apologised. In these circumstances, the tribunal is not satisfied, on the balance of probabilities, that you did not pay appropriate attention to her distress and therefore that there was a failing on your part to communicate appropriately with her. The tribunal therefore does not find this paragraph of the allegation proved.

c. prescribe medication appropriately for Patient C in that you:

i. increased Patient C's dose of Sertraline, which was not clinically indicated; **Found not proved**

ii. did not discuss with Patient C her response to medication; **Found not proved**

iii. did not discuss with Patient C the advantages and disadvantages of taking medication; **Found not proved**

198. The record in Patient C's notes shows that she was attending for a review. The note of the consultation recorded that it lasted for 30 minutes face to face with the patient and a further 30 minutes in administration or paperwork. The note set out that there had been no change in her symptoms since her last consultation.

199. Patient C confirmed that the consultation lasted about half an hour, during which you discussed the increased dose of medication and the specific advantages were explained to her. Additionally, you gave her a leaflet on sleep hygiene.

200. You said that Patient C had been on a low dose for many years without significant improvement. You said that the dose of sertraline was increased as this patient continued to have persistent signs of symptoms of anxiety and depression along with suicidal thoughts despite good compliance. You said that Patient C agreed to an increase because the current dose was ineffective and that you explained the rationale for your prescribing. You said that the side effects had been discussed and explained in the previous consultation.

201. Dr H wavered in his opinion, suggesting initially that increasing Patient C's prescription of sertraline was not below expected standards and later suggesting that there was no adequate evidence that such an increase was warranted. He suggested that any increase should not have taken place so soon.

202. Dr G told the tribunal that your actions were not below expected standards and that, as there had been no improvement in the patient's condition, it would have been negligent not to make changes. Dr G said that just because such an increase departed from standard practice did not in itself mean that a doctor had practised inappropriately.

203. In the light of the expert evidence, the tribunal was not satisfied on the balance of probabilities that an increase in sertraline was not clinically indicated. In the light of the notes of the consultation and your evidence and that of Patient C, regarding the discussions which took place, and the information that was imparted, the tribunal is also not satisfied, on the balance of probabilities, that you did not discuss her response to medication or explain the advantages and disadvantages of your proposed prescribing. It therefore follows that there was no failure on your part to prescribe appropriately. The tribunal therefore does not find this paragraph of the allegation proved.

> d. make an appropriate record of Patient C's Second Consultation in a letter to Patient C's GP in that:
>
> > i. the sections about mental state and risk assessment were exactly the same in Patient C's Second Consultation letter as in the notes of Patient C's First Consultation; **Admitted and found proved**
> >
> > ii. you copied and pasted elements from previous letters in the notes of Patient C's Second Consultation. **Admitted and found proved**

Paragraph 14

You knew that the contents of Patient C's Second Consultation letter were inaccurate. **Found not proved**

204. You admitted that the contents of your letter to Patient C's GP dated 31 March 2015, relating to the consultation on 10 March 2015, were exactly the same as that contained in the note of your consultation on 11 February 2015 and that you had copied parts of previous letters and pasted them into that letter. You said that, although you should probably have written 'no change' instead of copying and pasting, the contents of the letter were still accurate, as you had undertaken a brief risk assessment and mental state examination of Patient C and the history set out was still valid.

205. The tribunal acknowledged that the manner and form of the history set out in your letter of 31 March 2015 was inappropriate, as it had been copied and pasted, but it had no evidence before it to indicate that the contents were no longer accurate when you wrote that letter. Accordingly, the tribunal is not satisfied to the required standard that this paragraph of the allegation is proved.

Paragraph 15

Your actions as described as paragraphs 13(d) (i)-(ii) above were misleading. **Found not proved**

206. The tribunal noted that a future practitioner caring for Patient C might have thought that your letter to Patient C's GP dated 31 March 2015 had been expressed as a consequence of the consultation to which it refers, rather than from text cut and pasted from notes of an earlier consultation. However, the tribunal was not satisfied that the record was inaccurate as to Patient C's condition and presentation that day, albeit that the record was made in an inappropriate fashion. The tribunal did not therefore regard the resulting notes as misleading. The tribunal has accordingly not found this paragraph of the allegation proved.

Paragraph 16

On 17 April 2015, you consulted with Patient D ('Patient D's Consultation') and you failed to:

a. obtain an adequate history from Patient D in that Patient D's Consultation was dominated by questions about Patient D's sex life and libido; **Found proved**

207. It was not in dispute that Patient D attended a review consultation with you on 17 April 2015.

208. The note of the consultation recorded the following:

> *'[Patient D] attended for review at Ridgeview. [Patient D] updated me on his [sic] mental health and progress. She told me that after taking the Olanzapine 7.5mg daily after the last consultation she felt_spaced out_[sic] therefore she has gone back to original dose. She has been attending EDMR once a week for the last 12 weeks and has been on Olanzapine 5mgs nocte for the last 3 weeks. She continue [sic] to experience mood swings & her family have commented that she can still be irritable and_snappy"[sic] and when low has to take time off work'.*

209. In the section of the record entitled Mental State Examination, it was stated that Patient D was casually dressed and reasonably well presented. Her speech was stated to be normal and her mood was labile. She was said to have no abnormal thoughts or perceptions and her insight into her mental illness was intact.

210. The tribunal also took account of the note of a consultation with Dr S which Patient D attended on 5 March 2015. Dr S recorded the following:

> *'Has a diagnosis of PTSD [post-traumatic stress disorder]. Bipolar affective disorder and GAD [generalised anxiety disorder]*
>
> *Has been attending EMDR once a week for the last 6 wks and has been on Olanzapine 5mgs nocte for the last several months. Although relatively stable in her mood, her family have commented that she can still be irritable and "snappy" and when low has to take time off work. Currently no history of hypomanic or depressive features. Compliant with medication. No S/E reported.'*

211. Patient D said that you asked her if she was on medication and about her diagnosis, but that you did not ask her anything else about her condition. She said that she told you that she was doing CBT (cognitive behavioural therapy), but that this was not working, which she assumed was due to her post-traumatic stress syndrome. Patient D said that you asked her about her friend, including how old he was and where he worked, but that you went on to ask whether this friend only saw her when she was in a heightened state. She said that you asked whether she had had sexual intercourse with her friend. When she said she had done so, you asked her if she used contraception and if she was at risk of becoming pregnant.

212. Patient D said that you asked her twice during this consultation, as she did not have a boyfriend, '*where did I go to relieve myself*?' Patient D said that she '*found this line of questioning vile and disgusting and not relevant to my consultation*.' She said that she had never been asked such questions about her sex life by any other psychiatrist before. She said that she responded to you saying '*look, I am not a slag*'. She said that you responded saying that '*I am a little bit concerned. You're telling me that you see this guy for sex*', which Patient D said she had never said. She said it was as though you were twisting her words. In her oral

evidence, she accepted that she had not understood that there might be a clinical reason for your questions, but she felt that you could have asked these questions in more polite manner. She also said that you had implied that there was something inappropriate about her friendship with a man, which was not the case.

213. In your witness statement, you said that Patient D did not have a confirmed diagnosis and, as there was insufficient information in the medical records, you had taken a detailed history so that you could differentiate between bipolar affective disorder/rapid cycling affective disorder or mood swings secondary to emotionally unstable personality disorder. You said that Patient D became 'very upset' when you asked her to repeat her full clinical history. You said that as part of the diagnostic criteria for affective disorders you asked her several questions, including questions about her libido and whether there had been any change during the hypomanic/manic phase which could make her vulnerable to sexual exploitation. You said that, on reflection, the consultation seemed to have been misinterpreted.

214. In your oral evidence, you told the tribunal that you had drawn a 'mood chart' which you had discussed with Patient D. You said that this charts a manic episode in a pictorial form, indicating symptoms and depressive episodes and the intervals between them. You said that you established that Patient D was having episodes which were of a sufficient duration and frequency of more than four times in a year, so you arrived at the possibility that she was suffering from rapid-cycling affective disorder rather than emotionally unstable personality disorder where the mood changes every hour. You said that it was very important to know the cycles of the episodes so you could provide a diagnosis.

215. You agreed that you had asked Patient D repeated questions about her sex life and the level of her libido. You said that questioning Patient D about her sexual behaviour and libido was important for your diagnosis. You said that you then went on to discuss her medication, because Patient D had been suffering side-effects from the medication already prescribed. However, you then went on to say that the answers Patient D gave to your questions did not have a bearing on her diagnosis or treatment, but were part of a 'cross-check' on her medical history where you were trying to establish corroborative and consistent evidence, which you needed if you were attempting to depart from a previous diagnosis.

216. Dr H said, on meeting a new patient in an outpatient setting, your consultation should have been conducted gently and systematically, rather than involving insistent questioning. Dr H stated that a patient with elevated mood might have a raised libido and that it would have been standard practice to ask whether they enter into sexual relationships which may make them vulnerable or which they regret. However, intrusive questions about Patient D's libido and sexual partners were excessive and inappropriate.

217. You had marked the record of the consultation as a review appointment. Although you said that you had tried to take a detailed history, the history you wrote

down appeared to the tribunal to a significant degree to draw on Dr S's note of his consultation with the patient on 5 March 2015, which appeared to have been copied and adapted in your own record of your consultation with Patient D on 6 April 2015. If your account that you had not looked back into Patient D's notes to establish her medical history were correct, you would not have been able to do this.

218. In Dr S's note, there was a diagnosis of three conditions, but it appears that Patient D and you may not have regarded this as a firm diagnosis. However, you told the tribunal that, as you knew little about Patient D, it was necessary for you to take a full history. Dr H was also of the view that you needed to take a full history and the tribunal accepts that evidence. Whether or not there was some ambiguity about the existing diagnosis, the tribunal agrees that you should have taken a full history.

219. Given the detailed account you gave about the discussion you had with Patient D involving a mood chart, the tribunal regarded it notable that not only was the mood chart itself not in the records which the tribunal has seen, but there was no reference to this in your record, other than the statement that she was experiencing 'mood swings' which you appear to have lifted from Dr S's earlier note.

220. The tribunal noted that, in relation to another patient who was new to you (Patient A), you made a comprehensive note of the history that you took (with the exception of your questioning about Patient A's sex life). In the tribunal's view, your record in relation to Patient D, except for what you have lifted from Dr S's note, was sparse.

221. The tribunal accepted Patient D's account regarding the degree and extent of your questioning about her sex life and libido. The tribunal accepted the evidence of Dr H that such a level of questioning was inappropriate and excessive. In the light of the lack of recording of Patient D's history except for the material lifted from Dr S's note, the tribunal accepted Patient D's evidence of what you asked her about her condition. The tribunal is satisfied, on the balance of probabilities, that the questioning about Patient D's libido and sex life dominated the consultation and therefore that this amounted to a failure on your part to obtain an adequate history. The tribunal has therefore found this paragraph of the allegation proved.

b. communicate appropriately with Patient D in that you:

i. asked excessive questions about Patient D's libido and sexual behaviour; **Found proved**

222. The tribunal has already accepted the account given by Patient D. It is satisfied, on the balance of probabilities that the questions you asked Patient D about her libido and sexual behaviour were excessive and were a failure to communicate appropriately with her. The tribunal has therefore found this paragraph of the allegation proved.

ii. did not respond appropriately to Patient D's upset at your line of questioning; **Found not proved**

223. In her oral evidence, Patient D said that she had not been upset by your questioning but had been aggrieved and worried by what you asked her as she said that she had never been in a consultation like that before.

224. By Patient D's own evidence, she was not upset by your questioning and, in the view of the tribunal, it therefore follows that you could not have been expected to respond to her upset. The tribunal has therefore not found this paragraph of the allegation proved.

iii. suggested to Patient D that if she carried on seeing a male friend, you would have to admit Patient D to hospital; **Found proved**

225. Patient D stated that you expressed concern that she was seeing her friend for sex, even though she said that she had never said that to you. In her witness statement, Patient D then stated that you told her that:

> *'if this carried on, he would have to admit me to hospital. I didn't understand where he was coming from at all, and what I had said which had made him say this. I started to panic about what he was writing down about the consultation in his notes, as he seemed to twist everything that I was saying'.*

Patient D was also clear in her oral evidence that you told her that you would have to admit her to hospital.

226. The tribunal noted a *'Form for logging concerns raised by patients with staff'* (patient concern form) which was completed by Patient D on 17 April 2015 in which she stated that you had:

> *'implied that she was at risk of admission if she didn't change her ways and also implied that her children were at risk of being taken away from her as she did not have a partner to support her'.*

227. You denied ever having suggested to Patient D that she would be admitted to hospital if she continued seeing her friend. You said that you had been told by Ms O, a receptionist at the surgery, that after Patient D left the consultation, she was worried if you might inform social services about her suitability for parenting or whether she would be admitted to the ward. You said that you had given Patient D no reason to think these things.

228. Dr G said that you would have been justified in suggesting that Patient D needed a warning about her behaviour.

229. The tribunal noted that Patient D on occasion said that you 'implied' or that 'she felt you implied' that she would be admitted to hospital as a result of what you told her in the consultation. However, she was clear in her oral evidence that you had actually said this. In any event, it was clear to the tribunal, in the light of her oral evidence, from the account she gave in her patient concern form, and her contemporaneous account given to Ms O, that you had left her with that impression. The tribunal concluded, on the balance of probabilities, that you suggested to Patient D that if she carried on seeing a male friend, you would have to admit her to hospital, when you should not have done. The tribunal has therefore found this paragraph of the allegation proved.

c. prescribe medication appropriately for Patient D in that you:

i. offered her a list of medications and asked her 'which she would like to try', or words to that effect; **Found proved**

230. Patient D stated that you told her that her olanzapine was not working and asked her what medication she would like to be on instead. She said that you gave her a list. She said she did not understand your approach as she expected you, as the doctor, to tell her which medication she should take. She said that you did not explain the side effects of any of the medications that you mentioned.

231. In her patient concern form dated 17 April 2015, Patient D was reported as stating that you asked her what medication she would like to try and you gave her a list of different drugs such as sodium valproate, which she felt was unprofessional as she did not know anything about the different types of drugs.

232. You said that as Patient D had told you that she was having side effects from olanzapine, which also causes significant weight gain and metabolic syndrome in the long term, you had suggested alternative mood stabilisers and explained their major side effects so that she could make an informed choice. You said that Patient D had not perceived this correctly. You said that she had previously taken the medication you prescribed at your consultation without any side effects so you felt that it was sensible for her to have medication that she had taken without problems in the past.

233. Dr H agreed that it is good medical practice to discuss all different medication options in order to negotiate appropriate medication, whilst also taking into account the practitioner's training experience and knowledge of the evidence base about treatments. He said that based on the strength of the evidence base contraindicating the use of sodium valproate in women of child bearing age, this was not the appropriate next choice of mood stabilising medication, given the existence of other options. He also said that a prescribing decision which could lead to longstanding use of medication needed sufficient discussion to allow the patient time thoroughly to absorb the available evidence. Dr H was of the opinion that an immediate decision

to change medication need only happen in a psychiatric emergency, which was not warranted in the case of Patient D.

234. The tribunal noted that Patient D suffered from problems with her mental health and had extensive experience of consultations. The tribunal acknowledged that it was reasonable for you to have discussed Patient D's medication with her. You accepted that you had given a list of possible drugs to Patient D that she may want to try, and she agreed that you did.

235. However, the tribunal has accepted Patient D's evidence, and considers that it is more likely than not that you did not discuss these possible drugs in detail, including discussing their side-effects with Patient D. The tribunal does not consider, on the balance of probabilities, that giving Patient D a list of medications, without fully explaining them or their side effects, was sufficient to amount to the kind of discussion that was required for her to understand and make any informed decision about her medication, which was a failure on your part to prescribe appropriately. The tribunal has therefore found this paragraph of the allegation proved.

> ii. did not follow published guidance issued by NICE, the BNF and Maudsley Prescribing Guidelines in respect of the prescription for sodium valproate; **Found proved**

236. It was not in dispute that at the consultation with Patient D you initiated semisodium valproate 250mg per day for seven days, directing that the dose should then be increased to 500mg per day, as well as continuing her prescription of olanzapine 5mg at night.

237. The guidance issued by NICE [National Institute for Health and Care Excellence] and entitled *Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care* (September 2014) (the NICE bipolar disorder guidelines) states, under the heading *Managing bipolar disorder in adults in the longer term in secondary care*:

> *1.7.6 Offer lithium as a first-line, long-term pharmacological treatment for bipolar disorder and:*
>
> - *if lithium is ineffective, consider adding valproate*
> - *if lithium is poorly tolerated, or is not suitable (for example, because the person does not agree to routine blood monitoring) consider valproate or olanzapine instead of or, if it has been effective during an episode of mania or bipolar depression, quetiapine'.*
>
> *Discuss with the person the possible benefits and risks of each drug for them'.*

238. The NICE bipolar disorder guidelines go on to state, under the heading *Promoting recovery and return to primary care*:

> *'1.10.28 Do not offer valproate to women of childbearing potential for long-term treatment or to treat an acute episode…*
>
> *1.10.30 When prescribing valproate, be aware of its interactions with other anticonvulsants (particularly carbamazepine and lamotrigine) and with olanzapine and smoking'.*

239. The online NICE guidelines regarding sodium valproate (the NICE sodium valproate guidelines), presented at this hearing, state:

> ***'Conception and contraception***
> *Valproate is associated with teratogenic risks and should not be used in females of child-bearing potential unless there is no safer alternative – this should be fully considered and discussed before prescribing for females of child-bearing age'*

240. The entry relating to the prescribing of sodium valproate contained in the edition of The British National Formulary, edition 69 (BNF) in use at the time of prescribing, states:

> *'**Pregnancy** avoid unless there is no safer alternative and only after a careful discussion of the risk; effective contraception advised in women of child-bearing potential; see also Pregnancy, p304; neonatal bleeding (related to hypofibrinaemia) and neonatal hepatotoxicity also reported'*

While expressing caution about prescribing valproate in women of child bearing age, the entry in the BNF regarding the prescribing of valproate does not, in the view of the tribunal, exclude it.

241. The guidance contained in the chapter dealing with bipolar disorder in The Maudsley Prescribing Guidelines in Psychiatry, which was produced in evidence and was apparently current at the time of these events (the Maudsley guidelines), states:

> ***'Use in women of childbearing age***
>
> *Valproate is an established human teratogen. NICE recommend that alternative anticonvulsants are to be preferred in women with epilepsy and that valproate should not be routinely used to treat bipolar illness in women of childbearing age'.*

242. Patient D said that you asked her if she had any plans to conceive, which she had regarded as irrelevant. When she was asked if you had told her that one of the

side effects of sodium valproate is that it could affect unborn children during pregnancy, she said that you did not explain any side effects of any medication.

243. In your witness statement, you said that you were very cautious in suggesting sodium valproate to patients of childbearing age and that the guidelines were not available at the time of the consultation. However, you said that due diligence was exercised so that Patient D could make an informed decision.

244. In your evidence, you accepted that sodium valproate was not the first drug of choice but that, given that at that time Patient D had no plan to conceive, was using long term contraception and was suffering side-effects from olanzapine, you had to choose a different drug. You said that you gave her a choice, and explained the side effect profile of each. You said that Patient D was on a follow-up plan with her psychiatrist and a GP, she was prescribed a long-term contraceptive and that your prescription was therefore in accordance with NICE guidelines.

245. You also presented extracts from Kaplan and Sadock's *Comprehensive Textbook of Psychiatry*, Ninth edition (Kaplan) which state:

> *…in contrast to lithium, valproate appears particularly effective in those with co-morbid anxiety disorders, with open studies suggesting substantial efficacy in panic disorder, and some effectiveness in PTSD* [Post-traumatic stress disorder]…
>
> *…high rates of response to valproate have been reported in a series of rapid-cycling patients studied by Joseph R Calabrese and colleagues. One placebo-controlled study reported no advantage for valproate on the primary measure of prevention of manic episodes, but valproate was superior to placebo and lithium in lengthening the time to the first depressive episode.'*

246. Dr G said that prescribing sodium valproate to a woman of childbearing age is 'extremely common by doctors in the UK'. He also presented a number of academic articles supporting its use.

247. Dr H accepted that sodium valproate is commonly used for women of child-bearing age with mood disorders in the United Kingdom. However, he said that there was insufficient detailed clinical information to inform any change of medication at the time of the consultation with Patient D. He said that there was no information to suggest that Patient D was seriously unwell and therefore needed an urgent change of medication. He also maintained that sodium valproate should be reserved for cases of significant mood disorder which have not responded to alternatives, and that, even if Patient D's condition was in need of an urgent change, it was still not the right medication to choose. He said that the NICE bipolar disorder guidelines, NICE sodium valproate guidelines, the BNF and the Maudsley guidelines were all based on careful assessment of the scientific literature available and

presented a sounder basis for guiding clinical practice than individual research papers.

248. The tribunal noted that the two extracts from Kaplan were incomplete and were separated by over a thousand pages in the textbook. They did not provide any context for the comments which appeared to compare sodium valproate favourably with lithium. The tribunal noted that whilst the guidelines are guidance only, each of them indicates that sodium valproate presents risks to a female patient, should she become pregnant. In particular, the NICE bipolar disorder guidelines state that valproate should not be used for long term treatment or to treat an acute episode and that lithium is the first line long-term treatment for bipolar disorder. The tribunal therefore accepted Dr H's evidence.

249. You said that the patient was concerned about weight gain from olanzapine, but the tribunal noted that you were not proposing to take the patient off olanzapine and that valproate also has a tendency to lead to weight gain.

250. The tribunal has already found that you did not have an appropriate detailed discussion with Patient D about the medication that you presented to her as options for her care. In the light of the contents of each guidance document and Dr H's evidence regarding the importance of careful discussion with the patient before making any change in medication, the tribunal was satisfied, on the balance of probabilities, that you did not follow the published guidance when prescribing sodium valproate when you should have done. The tribunal has therefore found this paragraph of the allegation proved.

> iii. initiated a prescription of sodium valproate, which was not clinically indicated; **Found proved**

251. It was not in dispute that you initiated a prescription of sodium valproate for Patient D.

252. Although you referred to Patient D having mood swings in the note of your consultation, you also noted that she had no abnormal thoughts or perceptions and that her insight into her mental illness was intact.

253. In your evidence you stated that, as an experienced clinician, you are required to weigh the 'risk/benefit ratio'. You said that as Patient D had told you that she was having side effects with olanzapine, you had suggested other medication to her. You said that, as she had made it clear that she was using a contraceptive, any risks in using sodium valproate had been addressed.

254. Dr H said that the history apparent from Patient D's medical records was inadequate to explain why you had chosen to initiate sodium valproate, as her mood appeared to have been relatively settled. He did not consider that there was any information to suggest that she needed an urgent change in her medication, which

might have justified the consideration of a prescription of sodium valproate. In any event, owing to the risks associated with prescribing this medication for women of childbearing age, he said that this drug was not clinically indicated.

255. The tribunal noted that you saw Patient D at a routine review appointment which had not been arranged to respond to any particular problem or difficulty experienced by Patient D in the state of her mental health. In the light of the notes of your consultation and the evidence of Dr H, the tribunal considers that it is more likely than not that there were insufficient adverse changes in Patient D's mental health condition to justify the prescription of sodium valproate, which was therefore not clinically indicated. It follows that your prescription in that respect was not appropriate. The tribunal has therefore found this paragraph of the allegation proved.

Paragraph 17

> Your actions described at paragraphs 16(a) and (b)(i) above were sexually motivated. **Found not proved in its entirety**

256. The tribunal has already found proved that you did not communicate appropriately with Patient D as you asked excessive questions about libido and sexual behaviour, and that you failed to obtain an adequate history because the consultation was dominated by those questions.

257. Patient D described you as 'sleazy' and believed that your behaviour was sexually motivated. However, Patient D seems to have formed that view for a combination of reasons. She stated that you winked at her as she climbed the stairs to the clinic before the consultation began. This is not a matter which the GMC has set out in the allegation and the tribunal has borne in mind that there may be a number of reasons why someone winks or appears to wink. She said that you never looked at her directly and instead looked at her from the corner of your eye, which made her feel unnerved. Some people however may be disconcerted if one does look at them directly, and the tribunal finds it difficult to regard this as pointing to sexual motivation. Patient D also regarded your questioning about sexual matters as irrelevant, but the tribunal accepts that there was a legitimate reason for asking about the subject: the criticism of your questioning is that it was excessive. Accordingly, the tribunal did not place great weight on Patient D's subjective impression that your behaviour was sexually motivated.

258. In the tribunal's view, this hearing has shown a number of examples, both with this and other patients, where your communication with patients was inappropriate. Your question to Patient D about where she 'relieved herself' was inept and clumsy in the extreme, but your suggestion to her, for example, that you may have to admit her to hospital, whilst worrying to the patient, is not alleged to have anything sexual about it.

259. The tribunal also bore in mind that, although it fell short of a specialist interest in the formal academic or professional sense, you said that you took a special interest in the psychosexual aspects of your patients' conditions. This may go some way to explaining why, with Patient D and others, you sought to discuss those psychosexual aspects of their conditions at greater length than your colleagues would have done.

260. The tribunal considers that you asked questions about a legitimate topic. Your questions were excessive, but the tribunal has other examples of your poor communication with patients which it did not find, or were not alleged, to be sexually motivated. In the tribunal's judgement, to infer sexual motivation from the fact that you asked questions at undue length about a legitimate subject in which you took a particular interest, is again too great a logical leap. The tribunal has not therefore found this paragraph of the allegation proved.

Determination on Impairment - 25/01/2019

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

2. This determination will be read in private. However, as this case concerns Dr Jain's misconduct, a redacted version will be published at the close of the hearing with those matters relating to XXX removed.

The Outcome of Applications Made during the Impairment Stage

3. The Tribunal upheld, in part, the GMC's objection to the admission of documentation presented on behalf of Dr Jain at this stage of the proceedings, under Rule 34(1) the Rules. The Tribunal's full decision on the application is included at Annex A.

4. At the start of the impairment stage of this hearing, based on further evidence placed before the Tribunal by Dr Jain, the Tribunal determined that it was appropriate to adjourn the proceedings. This matter was heard entirely in private as the issues raised were confidential in nature. The Tribunal's full decision on the application is included at Annex B.

5. Having determined that the hearing should be adjourned, the Tribunal issued directions in private session, which are included at Annex C.

6. The Tribunal went on to receive a further application from the GMC in relation to the imposition of an interim order during the period of adjournment, which was heard in private session. The Tribunal's full decision on the application is included at Annex D.

7. The Tribunal upheld the GMC's objection to the admission of documentation presented on behalf of Dr Jain at this stage of the proceedings, under Rule 34(1) of the Rules. The Tribunal's full decision on the application is included at Annex E.

8. XXX.

9. XXX.

The Evidence

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

11. On behalf of the GMC from the following witnesses:

- XXX;
- XXX.

12. Dr Jain provided his own supplementary witness statement dated 21 January 2019. In addition, the Tribunal received evidence from the following witnesses on Dr Jain's behalf:

- XXX;
- XXX.

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

14. The Tribunal also received a bundle of supplementary evidence, presented on Dr Jain's behalf, which included, but were not limited to:

- XXX;
- Codes of ethics and good practice;
- Testimonials;
- CPD certificates;
- Consultation templates;
- Colleague and patient feedback forms;
- Dr Jain's CV;
- Appraisals.

Submissions

15. On behalf of the GMC, Ms Johnson submitted that Dr Jain's actions amounted to misconduct and that his fitness to practise is currently impaired.

16. XXX.

17. Ms Johnson referred the Tribunal to Good Medical Practice 2013 ('GMP'):

> *'7 You must be competent in all aspects of your work, including management, research and teaching.*
>
> *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.'*

In relation to Patient D, Ms Johnson submitted that the Tribunal had set out the guidelines in relation to prescribing sodium valproate to a woman of childbearing age in its determination on facts. Ms Johnson submitted that Dr Jain gave evidence stating that he believed Patient D was indulging in risk taking behaviour and she submitted that, as such, it was important that he have a full discussion with her about the risks of unplanned pregnancies. Ms Johnson summarised that this finding was therefore serious as it had the potential to harm an unborn foetus, which could have exacerbated Patient D's mental health issues. Ms Johnson submitted that Dr Jain's actions in relation to Patient D breached the standard of providing good clinical care.

18. Ms Johnson submitted that the Tribunal also found that Dr Jain failed to take an adequate history of Patient D. She referred the Tribunal to GMP:

> *'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*
>
> *…*
>
> *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.'*

She submitted that probably all NHS staff are overworked and are working in difficult conditions, but that is no excuse for compromising patient care.

19. In relation to Patient A, Ms Johnson submitted that the record of her consultation with Dr Jain was inaccurate and misleading. She pointed to the Tribunal's determination on facts, stating that it was an omission in relation to an important part of the history of the patient, which could be of concern to a future practitioner caring for her.

20. Ms Johnson submitted that in Patient C's case, Dr Jain had stated that there was no change in her presenting conditions. She submitted that Dr Jain's failures in this regard are nonetheless serious failings because they demonstrate an unconscientious approach to his work. She submitted that it may be that the assessment was very similar to a previous assessment and the findings were therefore similar, however it was unlikely an assessment would be identical to the one carried out previously. Ms Johnson submitted that accuracy of record-keeping is essential for the continual care of patients and as such a failure in record-keeping is particularly serious.

21. Ms Johnson submitted that the remainder of the findings against Dr Jain demonstrate a failure on his part to communicate appropriately and adequately with his patients. She submitted that communication was an important aspect of care in all fields of medicine, but even more necessary in psychiatry.

22. Ms Johnson submitted that GMP demands that doctors establish and maintain partnerships with patients:

> *'46 You must be polite and considerate.*
>
> *47 You must treat patients as individuals and respect their dignity and privacy.*
>
> *48 You must treat patients fairly and with respect whatever their life choices and beliefs.'*

She submitted that the Tribunal had found failures in Dr Jain's communication with all four patients. Beginning with Patient A, Ms Johnson submitted that, post-suicide attempt, Dr Jain failed completely to put her at ease, in fact she was made to feel uncomfortable and intimidated. XXX. Ms Johnson submitted that he should have taken more positive action to put Patient A at ease and to ensure that there was no scope for misunderstanding or her feeling uncomfortable. That is the standard that GMP demands.

23. Ms Johnson submitted that Dr Jain had demonstrated a complete disregard for the requirement for Dr Jain to be considerate and that it was not his place to joke about Patient B's domestic circumstance or sex life. She submitted that his persistence in asking questions about Patient B's sex life without explaining why caused considerable distress to both Patient B and her partner. Ms Johnson summarised that these failings were serious and amounted to misconduct.

24. Ms Johnson submitted that Dr Jain's increase in the prescription of sertraline without a proper discussion and where Patient B had wanted a decrease meant there was a risk of non-compliance, which breached paragraph 9 of GMP.

25. Ms Johnson submitted that questioning Patient C about whether she was reliable in her account of being abused was unnecessary and caused her distress as she felt that she had to convince Dr Jain she was telling the truth. Further, Patient D left the consultation being distressed as she felt that Dr Jain was questioning her ability to care for her children.

26. Moving to the issue of impairment, Ms Johnson first addressed the Tribunal on Dr Jain's insight. She submitted that whilst Dr Jain made limited admissions at the outset of the hearing, they do not demonstrate that he has a full understanding of the issues in this case. The Tribunal made twenty-three findings. Dr Jain made six admissions at the start of the hearing before oral evidence was heard. Ms Johnson reminded the Tribunal of its assessment of Dr Jain's evidence, that it had found him to be evasive, not straightforward and some aspects were implausible. She submitted that there has been no unequivocal apology to his patients. He seeks to blame the patients for not understanding the gaps in administration and his heavy workload rather than finding any fault in himself. All four patients' complaints described his failings in a manner which together show a pattern of behaviour.

27. Ms Johnson XXX submitted Dr Jain has twice attempted to reopen the finding made by the Tribunal regarding paragraph 16 of the Allegation concerning sodium valproate. There have been no further complaints in the intervening period, but Dr Jain's opportunity to engage in locum work he reports has been limited. XXX.

28. Dr Jain provided a written submission that Mr Gledhill read into the record. He submitted that Dr Jain is happy XXX to continue to indulge in remedial XXX activities as suggested. He submitted that Dr Jain feels that restrictions on his practice will enable him to demonstrate further improvement through XXX work place supervisors XXX. Mr Gledhill submitted that Dr Jain will leave the consideration of misconduct and impairment to the Tribunal.

29. Dr Jain addressed the Tribunal directly and said:

> *'XXX causes me to indulge in remedial activities so my fitness to practise is impaired and I will accept that and will accept the opinion of those colleagues in spite of the fact that there have not been complaints in the last eighteen months. There is always room for improvement and if my colleagues believe I can improve through a workplace supervisor XXX then it will protect the public and so for the safety of the profession. If the restrictions will help building up the confidence in the medical profession and help me indulge in further remedial activities and accept my current fitness to practise is impaired…'*

The Relevant Legal Principles

30. The Tribunal accepted the advice of the Legal Assessor, which was endorsed by Ms Johnson and the Mr Gledhill. There is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

31. 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. Second, whether the finding of that misconduct could lead to a finding of impairment.

32. The Tribunal must determine whether Dr Jain's fitness to practise is impaired today, taking into account Dr Jain'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.

The Tribunal's Determination on Impairment

Misconduct

Patient A

33. The Tribunal has found that Dr Jain XXX inappropriately questioned her at length about her sex life.

34. The Tribunal also found that Dr Jain did not make an accurate record of the questions he asked Patient A in the notes he made of his consultation with her. He knew that his record was inaccurate and the Tribunal found that his actions were misleading in omitting what he claimed to be an important relevant aspect of clinical history, although not dishonest.

Paragraph 1(b)(i) - 1(b)(v)

35. XXX.

Paragraph 1(d)

36. The Tribunal noted its findings that the records of Patient A were inadequate in that there was no record of Dr Jain's questions relating to her sex life. The Tribunal noted that, during his oral evidence, Dr Jain stated that the questions were an important diagnostic criterion; therefore the Tribunal concluded that it was a serious failing that they were not included in her records.

37. The Tribunal had regard to GMP:

> *'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.'*

By omitting to record that he had asked questions relating to Patient A's sex life, Dr Jain breached the above paragraph of GMP.

Paragraph 1A

38. The Tribunal had regard to its findings that the Dr Jain's questions in relation to Patient A's sex life were not justified at that time. It found that asking unnecessary, intimate questions to be below the standard expected from a reasonably competent medical practitioner.

Paragraph 2

39. The Tribunal had regard to GMP:

> *'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.'*

The Tribunal determined that to knowingly record an inaccurate entry in Patient A's medical records was in breach of the above paragraph of GMP.

Paragraph 3(a)

40. The Tribunal was of the view that a clinical record that is inaccurate can mislead other practitioners and is more than a simple recording error. The Tribunal determined that the misleading record had the potential to change the course of the treatment given to the patient in the future. Further, in the specialty of psychiatry, clinical note accuracy is of paramount importance so that subsequent treating clinicians are well informed when treating the patient in the future. As such the Tribunal found Dr Jain's actions to be a serious failing and amounted to misconduct.

<u>Patient B</u>

41. Dr Jain admitted that he had not communicated appropriately with Patient B in the comments he made to her relating to her memories of childhood abuse. He also admitted that he had not made an appropriate record of her consultation, in that sections of the notes were the same as those contained in records made by a Community Mental Health Nurse following an earlier assessment and had been "copied and pasted".

42. The Tribunal found that Dr Jain did not prescribe medication appropriately for Patient B, when he did not explain clearly the reason for increasing her dose of

Sertraline. The Tribunal also found that Dr Jain did not communicate appropriately with Patient B when he made comments to her about her sleeping arrangements, and when he persisted in discussing her sex life further despite four attempts by Patient B and her ex-husband stating that they did not wish to do so.

Paragraph 7(a)

43. The Tribunal had regard to the following paragraphs of GMP:

> *'31 You must listen to patients, take account of their views, and respond honestly to their questions.*
>
> *32 You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.*
>
> *33 You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.*
>
> *…*
>
> *46 You must be polite and considerate.*
>
> *47 You must treat patients as individuals and respect their dignity and privacy.*
>
> *48 You must treat patients fairly and with respect whatever their life choices and beliefs.'*

The Tribunal noted that Dr Jain had caused Patient B significant distress in suggesting that she would not be able to remember her childhood abuse. The Tribunal determined that Dr Jain should have been mindful of the nature of the consultation. The consequence of his consultation left Patient B with the impression that Dr Jain did not believe her self-report. The Tribunal determined that Dr Jain's actions towards Patient B demonstrated a failure in his duty to communicate appropriately with her.

Paragraph 7(c)

44. The Tribunal viewed Dr Jain's actions in copying a previous entry of Patient B's record as a deliberate attempt to convey the notes were his original notes. The Tribunal determined that this could potentially mislead another clinician and was therefore a serious failure in record-keeping and a fundamental breach of GMP.

Paragraph 8(c)

45. The Tribunal noted that Patient B attended the consultation with Dr Jain with the desire to decrease her dose of sertraline, but left the consultation with an increased dose without understanding the necessity for it. Bearing in mind the importance of proper discussion of treatment prior to prescribing, the Tribunal determined that this fell below the standards expected of a reasonably competent medical practitioner. The Tribunal determined that Dr Jain's failure to adequately communicate the reason for increasing Patient B's dose of sertraline meant there was a risk she would stop taking her medication altogether.

Paragraph 8(e)(i)

46. The Tribunal was of the view that it was inappropriate to make a 'joke' of a sexual nature to a patient, but particularly so to Patient B being aware of her medical history. Dr Jain's choice of words as a senior treating consultant was inappropriate and afforded no respect to Patient B or her ex-husband.

Paragraph 8(e)(iv)

47. The Tribunal noted that Dr Jain ignored the reactions of both Patient B and her husband and persisted in making insensitive comments. The Tribunal determined that he did not respond appropriately to their reaction or modify his method of enquiry accordingly. Further, he did not explain why he persisted in this line of questioning, despite being asked four times not to. The Tribunal determined that this was a serious failing in Dr Jain's ability to communicate with Patient B.

Patient C

48. The Tribunal found that Dr Jain did not communicate appropriately with Patient C when he disputed aspects of her account of being raped. He also admitted that he did not make an appropriate record of the consultation in that the sections about mental state and risk assessment were exactly the same as those contained in a letter arising from a previous consultation, and that he had "copied and pasted" parts of the notes from an earlier consultation.

Paragraph 13(b)(i)

49. The Tribunal had regard to the following paragraphs of GMP:

> *'47 You must treat patients as individuals and respect their dignity and privacy.*
>
> *48 You must treat patients fairly and with respect whatever their life choices and beliefs.'*

The Tribunal determined that Dr Jain's comments to Patient C caused her distress and as such were a serious failure.

Paragraph 13(d)(i)-(ii)

50. The Tribunal had regard to the following paragraphs of GMP:

> *'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'*

The Tribunal determined that Dr Jain's actions could potentially mislead another clinician and were therefore a serious failure in record-keeping and a fundamental breach of GMP.

Patient D

51. The Tribunal found that Dr Jain did not obtain an adequate history from Patient D during a consultation which was dominated by questions about her sex life and libido. He was also found not to have communicated appropriately with her when he asked excessive questions about these matters and when he suggested that he would admit her to hospital if she carried on seeing a male friend. The Tribunal also found that Dr Jain did not prescribe medication appropriately for Patient D and he did not follow published guidelines and initiated a prescription for a drug which was not clinically indicated.

Paragraph 16(a)

52. The Tribunal noted the following paragraph of GMP:

> *'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'*

The Tribunal also had regard to paragraphs 46, 47, 48 and 33 as referenced above.

Paragraph 16(b)(i)

53. The Tribunal determined that asking unnecessary, intimate questions to be below the standard expected from a reasonably competent medical practitioner.

Paragraph 16(c)(i)

54. The Tribunal had regard to the following paragraphs of GMP:

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

55. The Tribunal determined that Dr Jain's actions distressed Patient D and breached GMP.

Paragraph 16(c)(ii) – (iii)

56. The Tribunal determined that in not following the guidelines and initiating a prescription of sodium valproate, which was not clinically indicated, Dr Jain put Patient D at risk.

57. In all the circumstances, the Tribunal has concluded that Dr Jain's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct. The Tribunal found that Dr Jain presents a risk to patients, has brought the profession into disrepute and has breached fundamental tenets of the profession.

Impairment

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

59. The Tribunal accepted, in full, Ms Johnson's submissions as set out above in regard to Dr Jain's failings, lack of insight, concerns as to public safety in the future, and his breaches of the fundamental tenets of GMP.

60. XXX.

61. XXX.

62. In considering the level of insight Dr Jain has demonstrated, the Tribunal had regard to his statement prepared for the July 2018 Hearing where at he sets out:

> *'It is my personal opinion that these concerns were raised largely because of starting a new therapeutic relationship to replace an already established therapeutic relationship with a female consultant of Irish origin; misunderstanding; communication gap; communication skills; assumptions; unkempt clinical environment; poor self-care; heavy workload; paucity of time to type my own clinical notes comprehensively… XXX … I am not absolving myself, but rather identifying the factors which led to the concerns.'*
>
> And later:
>
> *'I can understand the basis for their distress and it is because of this I deeply regret for being a contributor to their ongoing misery.'*

63. On 9 December 2018, Dr Jain provided a statement for the interim order tribunal in December 2018. XXX. In both of those statements and in his supplementary statement dated 21 January 2019, Dr Jain addresses issues of his insight, the risk of repetition and the steps to remediate his actions which he has undertaken. He sets out:

> *'It seems I have failed to meet the expectations on these occasions…I am happy to apologise to these patients if I am given such opportunity.'*

64. The Tribunal noted that Dr Jain has asserted that he has read books and literature to widen his understanding of his failings; attended a record keeping course; completed eCME certification activity; CPD learning log; positive multisourced feedback documentation; completed courses online and CPD activities. XXX. The Tribunal has noted the remediation Dr Jain asserts he has affected in his statement under the heading *'lessons learnt'.*

65. The Tribunal found Dr Jain's level of insight to be limited for a number of reasons including:

(i) His continued challenge to paragraph 16 of the Allegation, which was found proved.
(ii) XXX.
(iii) XXX.
(iv) XXX.
(v) XXX.
(vi) XXX.
(vii) Dr R's observations of Dr Jain's overreliance on diagnostic criteria.
(viii) Dr Jain's assertion that he accepts his fitness to practise is impaired due to other professional's opinions and not seemingly his own reflection.

66. The Tribunal found Dr Jain's misconduct to be remediable. There was little evidence to suggest that the remediation required has developed very far Dr Jain asserts that he has changed his practice in the way that he communicates, but the Tribunal has not been presented with independent professional evidence of this. Through XXX ongoing guidance at work his conduct could be remediated.

67. XXX.

68. The Tribunal finds there is a risk of repetition of the misconduct without remediation. In his present role as a senior consultant psychiatrist, Dr Jain continues to present a risk to patients. That risk will increase should Dr Jain XXX experience great anxiety or pressure in the workplace.

69. In all the circumstances, the Tribunal cannot, at this time, be satisfied that, at this time, it is unlikely that Dr Jain would not repeat his misconduct. In the Tribunal's judgment there remains a risk to patients; a risk that he may bring the profession into disrepute; and a risk that he might breach the fundamental professional tenets of making the care of the patient his first concern and protecting their health, of treating patients politely and considerately, and of working in partnership with patients.

70. The Tribunal has therefore determined that Dr Jain's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 25/01/2019

1. Having determined that Dr Jain'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.

2. This determination will be read in private. However, as this case concerns Dr Jain's misconduct, a redacted version will be published at the close of the hearing with those matters relating to XXX removed.

The Evidence

3. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

4. Dr Jain provided his own statement dated 25 January 2019. He also provided testimonials from his Responsible Officer and colleagues.

Submissions

5. On behalf of the GMC, Ms Johnson submitted that an order of conditions is necessary to protect the public and that this is the main reason for imposing a sanction. She submitted that there is also a need to maintain public confidence in the profession and thirdly a need to maintain proper standards of behaviour or conduct in the profession. Ms Johnson submitted that the Tribunal has found breaches in GMP and that action is to be taken when there have been serious breaches in GMP, where patient safety has been put at risk or where public confidence in the profession has been undermined.

6. Ms Johnson submitted that the Tribunal must consider XXX, the extent of his insight and the remediation he has undertaken. She submitted that the Tribunal has found Dr Jain has demonstrated little insight, his remediation has been limited and that these can be seen as aggravating factors in the case.

7. XXX. She submitted that there had been limited remediation. Ms Johnson referred the Tribunal to the testimonials that Dr Jain produced submitting that the authors have not had the opportunity to consider the Tribunal's findings.

8. Ms Johnson addressed the Tribunal on taking no action on Dr Jain's registration. She submitted that no action should only be taken in exceptional circumstances, but that this is not an exceptional case.

9. Ms Johnson moved to address the Tribunal on imposing an order of conditions. She submitted that the Sanctions Guidance 2018 ('SG') sets out the purpose of conditions. She submitted that they are to help a doctor XXX remedy deficiencies in practice. Ms Johnson submitted that the Tribunal must determine if conditions are workable and whether Dr Jain is capable of developing his insight when considering the imposition of conditions. Ms Johnson submitted that Dr Jain has complied with the interim order of conditions imposed on him since July 2018 and that an order of conditions will meet the Tribunal's overarching objective to protect the public.

10. On behalf of Dr Jain, Mr Gledhill submitted that when doctors are faced with fitness to practise procedures, they begin a journey and sometimes they have to hear the evidence in the totality, hear the judgement and digest the information to reflect on them and recognise the need for insight and remediation. He submitted that this is not always easy. XXX.

11. XXX.

12. XXX.

13. Mr Gledhill then read part of Dr Jain's statement into the record:

> '*At this stage of the proceedings, I accept the decision of the Tribunal that my conduct in 2015, during the consultations in which the allegations arose, was below the standard expected of a consultant psychiatrist and therefore amount to misconduct and impairment.*
>
> *XXX.'*

14. Mr Gledhill submitted that Dr Jain has worked the best part of three and a half years since the incidents. He submitted that once Dr Jain's shortcomings were highlighted he sought to address them. Mr Gledhill submitted that the incidents occurred during a narrow period of time. He submitted that there must have been *'something unusual'* about that working environment and that there is evidence of difficulties in that trust at that time. Further, there was some acknowledgement in evidence that it was not an easy environment and not well resourced. Mr Gledhill submitted that in other more supportive environments Dr Jain did not have the same difficulty.

15. XXX.

16. Mr Gledhill submitted that it has taken this adversity for Dr Jain to realise the extent of XXX, his behaviour and the impact it has on his patients. He submitted that Dr Jain now uses chaperones XXX. XXX. Mr Gledhill submitted that with more stringent conditions Dr Jain will be unable to obtain work. This will result in him becoming deskilled XXX.

17. In relation to supervision, Mr Gledhill submitted that there was significant resistance to employing someone at consultant level who needs supervision. He submitted that anything more than the standard level of supervision would result in it being difficult for Dr Jain to obtain employment. Turning to the length of the appointments that Dr Jain be permitted to undertake, Mr Gledhill submitted that locum jobs are often a lot shorter than four months. Restrictions would lead to his being unable to undertake his Section 12 services.

18. Mr Gledhill pointed to the number of testimonials before the Tribunal to support his good character. He submitted that Dr Jain intends to return at his review hearing and

show the progress he has made. Mr Gledhill reminded the Tribunal of the negative press attention that Dr Jain has received during the course of the hearing and stated that he may have difficulty obtaining employment because of this XXX.

19. Mr Gledhill next addressed the Tribunal on a period of suspension. He submitted that this would not assist Dr Jain at this time and that it would not achieve anything additional that could not be achieved through conditions. He submitted that conditions would be inevitable at the end of any period of suspension and that suspension would only lead to deskilling XXX.

20. Turning to erasure, Mr Gledhill submitted that in all the circumstances erasure was a 'step too far' from the evidence before the Tribunal. In the light of all the positive evidence before the Tribunal, Mr Gledhill submitted that it would be disappointing to see Dr Jain's name removed from the medical register and that this would be *'draconian and disproportionate'*.

The Tribunal's Determination on Sanction

21. The Tribunal accepted the Legal Assessor's written legal advice.

22. The decision as to the appropriate sanction, if any, to impose in this case is a matter for the tribunal exercising its own judgement. In reaching its decision, the tribunal has taken account of the SG and the statutory overarching objective, which includes protecting and promoting the health, safety and wellbeing of the public, promoting and maintaining public confidence in the profession, and promoting and maintaining proper professional standards and conduct.

23. The Tribunal reminded itself that the main reason for imposing sanctions is to protect the public and that sanctions are not imposed to punish or discipline doctors, but that they may have a punitive effect. Throughout its deliberations, the tribunal has applied the principle of proportionality, balancing Dr Jain's interests with the public interest.

24. The Tribunal has already set out its decisions on the facts and impairment and it took those determinations into account during its deliberations on sanction. It first considered the aggravating and mitigating factors in this case and then moved on to consider each sanction in ascending order of severity, starting with the least restrictive.

Aggravating and Mitigating Factors

25. The Tribunal gave careful consideration to the mitigating and aggravating factors present in Dr Jain's case.

26. In mitigation, the Tribunal took into account Dr Jain's previous career without action by his regulator. It noted XXX the pressurised work environment in 2015,

which he asserted may have contributed to the misconduct. The Tribunal had sight of the recent testimonials by Dr Jain's colleagues and their presentation of him as a doctor of good standing and character. The Tribunal noted that Dr Jain was now willing to apologise, albeit at a late stage in the hearing. It accepted that Dr Jain's insight into his misconduct XXX is a journey and that whilst Dr Jain's insight is in its infancy, it is developing. The Tribunal was satisfied by Dr Jain's acceptance that his fitness to practise is impaired and that he needs conditions on his registration to manage his practice. Further, the Tribunal acknowledged that Dr Jain made some admissions at the beginning of the hearing and that there has been no repetition of the misconduct. He has complied with the conditions imposed since July 2018.

27. XXX.

No action

28. In coming to its decision as to the appropriate sanction, if any, to impose, the Tribunal first considered whether to conclude Dr Jain's case by taking no action.

29. The Tribunal concluded that in view of the nature and gravity of his misconduct, to take no action on his registration would be wholly inappropriate. It noted that there are no exceptional circumstances in this case to warrant taking no action. The Tribunal concluded that taking no action would not reflect the findings of facts as this would not send an appropriate message to him or meet the over-arching objective.

Conditions

30. The Tribunal noted that both Ms Johnson and Mr Gledhill were in agreement that conditions were the appropriate and proportionate sanction in this case.

31. The Tribunal accepted the submissions on behalf of Dr Jain and the GMC that suspension and erasure would not be appropriate in this case.

32. The Tribunal considered the following paragraph of SG:

> *'80 In many cases, the purpose of conditions is to help the doctor to deal with their health issues and/or remedy any deficiencies in their practice or knowledge of English, while protecting the public. In such circumstances, conditions might include requirements to work under supervision.*

XXX.

33. The Tribunal considered the paragraph 82 of SG:

> *'82 Conditions are likely to be workable where:*

a the doctor has insight

Whilst Dr Jain has not yet demonstrated the level of insight to convince the Tribunal there is no risk of repetition, the Tribunal formed the view that Dr Jain has the motivation to develop his insight further and is satisfied that with XXX supervision he should be able to so.

34. The Tribunal also considered:

c the tribunal is satisfied the doctor will comply with them

Dr Jain has been under conditions for six months and complied with them, which indicates that he is likely to continue to comply with conditions.

35. The Tribunal further considered:

d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.

The Tribunal accepted XXX that Dr Jain has the potential to respond positively to supervision XXX.

36. The Tribunal had regard to paragraph 84 of the SG:

'84 Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:

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

XXX.

37. The Tribunal had further regard to:

d willing to be open and honest with patients if things go wrong (Good medical practice, paragraphs 55 and 61)

XXX.

XXX. The Tribunal noted that Dr Jain has shown a willingness to abide by conditions and the Tribunal is satisfied that he could develop insight.

38. In all the circumstances, the Tribunal has concluded that an order of conditions is the appropriate and proportionate sanction to impose in Dr Jain's case. It has determined to impose conditions on Dr Jain's registration for a period of eighteen months, which will afford him the time and opportunity to obtain suitable employment and to work with his XXX workplace supervisors to XXX ensure that his clinical skills are kept up to date.

39. The following conditions are not confidential and will be published:

'1. He must notify the GMC within seven calendar days of the date these conditions become effective:

a of the details of his current post, including his job title, job location and responsible officer (or their nominated deputy) information

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

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

d of any training programmes he is in

e of the contact details of any locum agency he is registered with.

2. He must notify the GMC:

a of any post he accepts, before starting it

b 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

c 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 approved by his responsible officer (or their nominated deputy) and must inform the GMC of these arrangements.

b He must not start/restart work until his responsible officer (or their nominated deputy) has approved his workplace reporter and this approval has been forwarded to the GMC

5. a He must get the approval of the GMC Adviser before accepting any post.

b He must keep his professional commitments under review and limit his work if the GMC Adviser tells him to.

c He must stop work immediately if the GMC Adviser tells him to and must get the approval of the GMC Adviser before returning to work.

6. He must not work in any post for more than nine sessions per week.

7. a He must be supervised in all of his posts by a clinical supervisor, as defined in the Glossary for undertakings and conditions. His clinical supervisor must be approved by his responsible officer (or their nominated deputy) and he must inform the GMC of these arrangements.

b He must not start/restart work until his responsible officer (or their nominated deputy) has approved his clinical supervisor and this approval has been forwarded to the GMC.

8. He must not work:

a. out-of-hours

b. on-call.

9. He must not work in any locum post or fixed term contract of less than three months duration.

10. He must have a mentor who is approved by his responsible officer (or their nominated deputy).

11. He must get the approval of the GMC before starting work in a non-NHS post or setting.

12. He must inform the following persons of the conditions listed at 1 to 11:

a His employer and/or contracting body

b His responsible officer (or their nominated deputy)

c His immediate line manager at his place of work, at least 24 hours before starting work (for current and new posts including locum

posts)

d Any prospective employer and/or contracting body, at the time of application

e The responsible officer of any organisation where he has, or has applied for, practising privileges and/or admitting rights, at the time of application

f Any locum agency he is registered with

g His regional section 12 approval tribunal (or Scottish equivalent).

40. XXX.

Review

41. The Tribunal determined to direct a review of Dr Jain's case. A review hearing will convene shortly before the end of the period of conditional registration, unless an early review is sought. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Jain to demonstrate how he has remediated and developed his insight into his XXX misconduct. The reviewing Tribunal would therefore be assisted by:

- XXX;
- Report/s from the workplace supervisor;
- XXX;
- XXX.

Dr Jain could also provide any other information that he considers might assist.

Determination on Immediate Order - 25/01/2019

1. Having determined to impose conditions on Dr Jain's registration for a period of eighteen months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC Ms Johnson submitted that an immediate order must be imposed on Dr Jain's registration. She submitted that the Tribunal has found there is a risk to patient safety and that therefore it is appropriate to impose an immediate order. She referred the Tribunal to the appropriate areas of the SG (paragraphs 172-178). Ms Johnson submitted that the interim order needs to be revoked.

3. On behalf of Dr Jain, Mr Gledhill submitted that an immediate order is not opposed.

The Tribunal's Determination

4. In reaching its decision, the Tribunal had regard to its previous determinations and the submissions made by Ms Johnson and Mr Gledhill.

5. The Tribunal had particular regard to paragraphs 173 and 178 of *SG*, which state:

> '*173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety…'*
>
> '*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*.'

6. The Tribunal determined that it was necessary to impose an immediate order of conditions in the terms of those in the substantive order. There remains a risk to patient safety by Dr Jain hence the conditions in place from July 2018 to date and the decision of the Tribunal today to impose conditions for eighteen months.

7. This means that Dr Jain's registration will be subject to an immediate order of conditions from today. The substantive direction, as already announced, will take effect 28 days from today, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

8. The interim order currently imposed on Dr Jain's registration will be revoked when the immediate order takes effect today.

9. That concludes this case.

Confirmed
Date 25 January 2019 Dr Priya Iyer, Chair

Annex A – 17/07/2018

Application regarding the admissibility of documentary evidence

1. Ms Johnson made an application that parts of a witness statement made by Dr Jain which he proposed should be presented at this stage of the proceedings should be declared inadmissible. She submitted that the task before the Tribunal at this stage of the proceedings was to make an assessment of whether or not its findings of fact amounted to misconduct, and if so, whether Dr Jain's fitness to practise is impaired.

2. Ms Johnson submitted that four specific pages of Dr Jain's witness statement were focused on the Tribunal's findings at paragraphs 16.2 and 16.3 of the allegation, which had been found proved. She submitted that Dr Jain does not accept those findings and was now suggesting a defence to that part of the allegation, rather than providing evidence of mitigation. Ms Johnson said that Dr Jain was seeking to argue that the NICE guidelines did not apply and therefore that his prescription of sodium valproate had been clinically indicated.

3. Ms Johnson submitted that this material was irrelevant to the Tribunal's task at this stage and therefore should not be admitted into evidence. She acknowledged that it would be difficult for the Tribunal to reach its decision on admissibility without seeing the documentation, but that if the Tribunal considered that it was necessary to see the document before reaching a decision, the GMC should be granted time to seek the expert opinion of Dr H in relation to the issues raised by Dr Jain in his witness statement. She reminded the Tribunal that it should bear in mind fairness to both parties when reaching its decision.

4. Mr Bunting submitted that the documentation to which the GMC objected was admissible and was relevant to the Tribunal's assessment of the seriousness of Dr Jain's misconduct, as a result of the unchallenged findings of the Tribunal. He submitted that this evidence was also relevant to the Tribunal's assessment of Dr Jain's insight. He said that the fact that Dr Jain does not agree with the findings of this Tribunal is a matter within his gift and that it was similarly up to him if he sought to put his actions in context. Mr Bunting submitted that doing so was not the same as reanalysing the facts.

5. Mr Bunting submitted that it was not necessary to involve Dr H in the issue as there was no intention to revisit the facts in this case. However, he submitted that if Dr H were to be involved, this would only be required once the Tribunal had made its decision as to whether the disputed sections of Dr Jain's statement should be admitted.

6. The Tribunal bore in mind that it has the discretion to admit any evidence which it considers is fair and relevant, pursuant to Rule 34(1).

7. The Tribunal took the view that it was not possible to reach an informed decision regarding the admissibility of the evidence in dispute without reading the entirety of Dr Jain's witness statement, including the sections which were in dispute. It therefore directed that a full copy should be provided for it to consider. It did not consider that it was necessary for it to give consideration to whether the GMC should be given time to obtain Dr H's opinion unless it decided that the disputed evidence was relevant and should be admitted.

8. Having given consideration to the witness statement of Dr Jain, the Tribunal then gave consideration to whether the paragraphs in dispute, namely paragraphs 45-63 inclusive, were relevant. It noted that in these paragraphs, Dr Jain suggested that the expert witnesses and the Tribunal had overlooked, in their consideration of the allegation relating to Patient D, the important detail that she additionally suffered from post-traumatic stress disorder. He set out detailed discussions relating to his decision to choose the prescription of sodium valproate with reference to medical literature. Dr Jain set out the factors that he had considered when deciding to prescribe and he sought to put forward evidence of clinical audits, which he suggested provided a justification for his not having followed NICE guidelines.

9. The circumstances in which the Tribunal has power in law to re-visit findings which it has made and announced are very limited and Mr Bunting has not asked the Tribunal to do this in the present case. The question of the relevance of paragraphs 45-63 of the witness statement depends on whether they are relevant to the questions of misconduct and impairment.

10. The Tribunal took the view that the evidence contained in paragraphs 45-61 and paragraph 63 of Dr Jain's witness statement went not to the degree of seriousness of his actions or the other factors relevant to impairment, but rather supported his defence to paragraph 16 of the allegation, in respect of which the Tribunal has already made its findings. These paragraphs of his witness statement amounted to a clear attempt to re-open the findings of the Tribunal. The Tribunal did not find that there was any discussion in those paragraphs to support the submission that this evidence was aimed at assisting the Tribunal in its assessment of the seriousness of Dr Jain's shortcomings. Accordingly, the Tribunal took the view that this evidence was not relevant at this stage of the hearing.

11. However, the Tribunal acknowledged that the evidence contained in paragraph 62 of Dr Jain's witness statement related to his Continuing Professional Development activities and the steps he has taken in relation to prescribing in a later case. It determined that this evidence was relevant to the matters that it would be considering at the impairment stage of these proceedings.

12. In summary, the Tribunal therefore determined to admit the witness statement of Dr Jain into evidence, with the exception of paragraphs 45-61 and paragraph 63.

ANNEX B – 17/07/2018

XXX

ANNEX C – 17/07/2018

XXX

ANNEX D – 17/07/2018

1. Dr Jain's hearing before a Medical Practitioners Tribunal is now due to adjourn XXX and will not reconvene until dates in January 2019 when the Tribunal will resume its consideration of whether his fitness to practise is impaired. The role of this Tribunal is now to consider whether the doctor's registration should be restricted on an interim basis, either by suspension or by imposing conditions on his registration. In accordance with section 41A (1) of the Act, the Tribunal will make an order if it is satisfied that there may be impairment of a doctor's fitness to practise, which poses a real risk to the public or may adversely affect the public interest or the interests of the practitioner and, after balancing the interests of the doctor and the public, that an interim order is necessary to guard against such risk.

2. The Tribunal has already announced its findings on the facts. It found that Dr Jain did not maintain a professional manner in a consultation with Patient A including having inappropriately questioned her at length about her sex life, although the Tribunal did not find that his actions were sexually motivated. It found that he did not communicate appropriately with Patient B or prescribe appropriately for her. It also found that he did not communicate appropriately with Patient C. He was also found not to have obtained an adequate history from Patient D, communicated appropriately with her or prescribed appropriately. Additionally, the Tribunal found that there were shortcomings in Dr Jain's medical record-keeping.

3. XXX.

4. The Tribunal has considered all of the information presented to it and the submissions made by Mr Bunting on behalf of Dr Jain and by Ms Johnson, on behalf of the GMC.

5. Ms Johnson submitted that an interim order of conditions is necessary for the protection of the public, is in the public interest and in Dr Jain's own interests. XXX.

6. Ms Johnson told the Tribunal that Dr Jain's case had been considered by an interim orders tribunal on 7 June 2018 (the June Tribunal) after this Tribunal's findings of fact had been announced. XXX.

7. XXX.

8. Mr Bunting said that Dr Jain is presently working as a locum consultant for the Norfolk and Suffolk Foundation Trust, and that no concerns have been raised regarding his conduct or competence. XXX.

9. Mr Bunting submitted that an order of conditions would affect Dr Jain's employability, especially when dealing with agencies for locum placements. He said that there is no information to suggest that there is a risk to the public. He submitted that a bystander would not 'raise an eyebrow' if no interim order were to be imposed and that, when considering proportionality, an order might have adverse consequences for Dr Jain. He submitted that no order was required.

10. In reaching its decision, the Tribunal took into account the guidance '*Imposing interim orders – guidance for the Interim Orders Tribunal, Tribunal Chair and the Medical Practitioners Tribunal'(18 February 2016)'.*

11. In accordance with Section 41A of the Medical Act 1983, as amended, the Tribunal has determined, based on the information before it today, that it is necessary to impose an interim order. It has determined to impose an order of conditions for a period of nine months as follows:

The following public conditions will be published:

1 He must notify the GMC within seven calendar days of the date these conditions become effective:

a of the details of his current post, including his job title, job location and responsible officer (or their nominated deputy) information

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

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

d of the contact details of any locum agency he is registered with]

2 He must notify the GMC:

a of any post he accepts, before starting it

b 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

c if he applies for a post outside the UK.

3 He must allow the GMC to exchange information with his employer and/or any contracting body for which he provides medical services.

4 a He must ask for a report from the person advising the GMC, for consideration by this tribunal, before any review hearing.

b He must keep his professional commitments under review and limit his work if recommended to do so by the person advising the GMC.

c He must stop work immediately if the person advising the GMC recommends that he does.

5 He must inform the following persons of the conditions listed at 1 to 4:

a his employer and contracting body

b his responsible officer (or their nominated deputy)

c his immediate line manager at his place of work, at least one working day before starting work (for current and new posts including locum posts)

d any prospective employer and/or contracting body, at the time of application

e The responsible officer of any organisation where he has, or has applied for, practising privileges and/or admitting rights, at the time of application

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

g his regional section 12 approval panel (or Scottish equivalent).

XXX.

12. The Tribunal has determined that, based on the information before it today, there are concerns regarding Dr Jain's fitness to practise which pose a real risk to members of the public, which may adversely affect the public interest and may adversely affect Dr Jain's interests. After balancing Dr Jain's interests and the interests of the public, the Tribunal has decided that an interim order is necessary to guard against such a risk.

13. In reaching its decision, the Tribunal has borne in mind its findings at the facts stage of this hearing. XXX.

14. The Tribunal acknowledged that no information has been presented to suggest that any concerns about Dr Jain's clinical skills or competence have arisen in his present locum position. XXX. However, against the background of the Tribunal's findings of fact XXX the Tribunal took the view that there is a risk to patients, if Dr Jain were to be allowed to practise unrestricted and that therefore an order is necessary for the protection of the public. XXX.

15. Whilst the Tribunal notes that the order places restrictions on Dr Jain's ability to practise medicine it is satisfied that the order imposed is the proportionate response. The Tribunal has concluded that the conditions imposed are sufficient to protect the public interest against the identified risks. XXX. Furthermore, it has taken the view that the conditions imposed will allow him to continue to practise medicine during the period of time that will be required for his case to be concluded before this Tribunal. The Tribunal has determined that, in all the circumstances of this case, an order for suspension of his registration would not be proportionate.

16. The Tribunal decided that the interim order should be imposed for a period of nine months, given the period of time that is likely to be required XXX for this hearing to be concluded.

17. The order will take effect from today and will be reviewed within six months.

18. Notification of this decision will be served upon Dr Jain in accordance with the Medical Act 1983, as amended.

ANNEX E – 24 January 2019

Application regarding the admissibility of documentary evidence

1. Ms Johnson made an application that the second supplementary witness statement, dated 21 January 2019, made by Dr Jain, which he proposed should be presented at this stage of the proceedings should be declared inadmissible. She submitted that, in July (at Annex A), the Tribunal had removed certain paragraphs from Dr Jain's previous witness statement on the basis that Dr Jain was attempting to reopen facts that had already been determined. Ms Johnson submitted that they related to paragraph 16 of the Allegation in respect of which the Tribunal has already made its findings. She submitted that the Tribunal's position should remain the same now as there has been no change to make these matters relevant.

2. Mr Gledhill submitted that Dr Jain was fearful that the wrong area of the Maudsley Guidelines was placed before the Tribunal as they do not state absolutely that a woman of childbearing age should not be given sodium valproate. Mr Gledhill acknowledged that the Tribunal has already found against Dr Jain in this matter.

3. The Tribunal bore in mind that it has the discretion to admit any evidence which it considers is fair and relevant, pursuant to Rule 34(1).

4. The Tribunal had regard to the second supplementary witness statement of Dr Jain, dated 21 January 2019. It viewed the statement as an attempt by Dr Jain to reopen the facts and provide further evidence and explanation for his decision to choose the prescription of sodium valproate. Dr Jain suggested that the Tribunal had not had access to the correct page of the Maudsley Guidelines when determining on paragraph 16 of the Allegation and stated that the diagnosis of Patient D was 'Rapid Cycling Affective Disorder', but that the Tribunal had been given information relating to 'Bipolar Affective Disorder'. Further, he set out detailed discussions relating to his decision to choose the prescription of sodium valproate with reference to medical literature.

5. The Tribunal viewed the witness statement as a second attempt by Dr Jain to revisit the facts stage of the hearing when he had every opportunity to raise these matters at the previous stage. The Tribunal noted that Dr Jain has been represented by legal counsel and as such has had the benefit of legal advice throughout the hearing. The Tribunal has already determined the facts and concluded that this evidence was not relevant at this stage of the hearing.

6. The Tribunal therefore determined to uphold the GMC's application to not admit the second supplementary witness statement of Dr Jain, dated 21 January 2019.

ANNEX F – 24 January 2019

XXX

ANNEX G – 23 January 2019

XXX.