PUBLIC RECORD

Dates: 21/08/2023 - 04/09/2023

Medical Practitioner's name: Dr Richard SCOTT

GMC reference number: 2890748

Primary medical qualification: BChir 1983 University of Cambridge

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

Summary of outcome
Warning

Tribunal:

Legally Qualified Chair	Ms Amarjit Sagar
Lay Tribunal Member:	Ms Karen Naya
Medical Tribunal Member:	Dr Alan Shepherd

Tribunal Clerk:	Miss Racheal Gill

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Michael Phillips, Counsel, instructed by Mr I of Camerons Solicitors LLP
GMC Representative:	Ms Rina-Marie Hill, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 30/08/2023

Background

1. Dr Richard Scott qualified with BChir at the University of Cambridge in 1983 and has had full registration with the GMC since 1 February 1985. Prior to the events which are the subject of the hearing, Dr Scott started his medical career as a trainee in surgery. Between 1990 and 1995 he ran two mission hospitals in Tanzania. He returned to England in 1995 where he retrained in General Practice. Dr Scott was a partner and is now a salaried General Practitioner ('GP') at Bethesda Medical Centre, a role he has held since 1 April 2019.

2. The allegation that has led to Dr Scott's hearing relates to the treatment and care provided by Dr Scott to Patient B when he attended a consultation about his mental health on 25 January 2022. Concern was subsequently raised in relation to the spiritual discussion that took place during the consultation.

3. By way of background, Patient B was at the time a 19-year-old man with a history of Attention Deficit Hyperactivity Disorder ('ADHD') who received a regular prescription of Concerta XL 36 milligrams ('mg') two tablets daily. Patient B had been seen by child and adolescent general psychiatry and ADHD focussed services. Patient B had previously been seen by various GPs and other clinicians about his mental health and other unrelated conditions.

4. On 25 January 2022, Patient B attended Bethesda Medical Centre ('the Practice') with his mother, to seek support for his mental health. Patient B had a consultation with Dr Scott

while his mother waited outside. During that consultation, Dr Scott discussed with Patient B and recorded his personal history, background of the problems leading to Patient B presenting and his current mental wellbeing. Dr Scott suggested to Patient B that there were three options available to him to consider which could improve his mental health: anti-depressant medication, a self-referral to Insight (a counselling organisation) or spirituality. The consultation comprised of two parts, with a pause in between when Patient B left the consulting room, waited outside the door for a short while and re-entered the consultation room where Dr Scott was. This was treated as a new Consultation which would focus solely on the spiritual option and a spiritual discussion took place. Dr Scott discussed his own religious and/or spiritual beliefs with Patient B. Dr Scott held Patient B's hands and prayed with him. At some point during the consultation, Dr Scott also gave Patient B a Gideon's Bible (Gideons edition of the New Testament and Psalms of the Christian scriptures), which patient B took and asked Patient B to sign a Consent to Discuss Faith form (consent form) which he did. Patient B was subsequently sent a letter from the Practice on 2 February 2022 enclosing a questionnaire relating to his consultation with Dr Scott and requesting feedback.

5. It alleged that Dr Scott knew that Patient B was a vulnerable patient by reason of his mental health. It is alleged that during the consultation, Dr Scott undertook a religious and/or spiritual discussion, discussed his own religious and/or spiritual beliefs, clasped Patient B's hands and facilitated a prayer. It is also alleged that Dr Scott failed to ensure that Patient B welcomed his actions, and that he did not feel pressurised into partaking in each of these.

6. On 11 February 2022, Patient B's mother made a complaint about Dr Scott to NHS England ('NHSE') on Patient B's behalf. On 28 March 2022, NHSE wrote to Patient B, seeking further information about Patient B and acknowledging receipt of the complaint. In the same correspondence, Patient B was offered the opportunity to speak with a GP Senior Clinical Adviser. On 30 March 2022, Dr A from NHSE undertook a telephone interview with Patient B regarding his consultation with Dr Scott.

7. On 12 April 2022, the GMC was notified of a complaint made against Dr Scott by Patient B via NHSE.

8. On 22 November 2022, Dr Scott was notified of the Case Examiner's decision to refer the allegations for determination by the Medical Practitioner's Tribunal (MPT). Dr A interview notes would have been sent to Dr Scott sometime after 7 April 2022.

9. On 10 June 2022, Dr Scott wrote a letter to NHSE responding to complaints made by Patient B. Dr Scott provided a summary of Patient B's care by the Practice prior to his consultation on 25th January 2022. Information regarding the Practice's Faith Discussion

Protocol, Consent form and Spiritual Discussion Questionnaire was also provided by the Practice via email to the GMC on 20 June 2022 and 19 July 2022.

The Outcome of Applications Made during the Facts Stage

10. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), in respect of amendments to paragraph 2(e) of the Allegation. Ms Hill, Counsel on behalf of the GMC, submitted that the amendment served to improve the form of the allegation, rather than of any substance or content. The application was not opposed by Mr Phillips, Counsel on behalf of Dr Scott. The Tribunal was satisfied that the proposed amendments could be made without injustice to the GMC or Dr Scott. It therefore decided to grant the application to amend the Allegation, as set out below.

11. The Tribunal refused the GMC's application, made pursuant to Rule 34(1) of the Rules, to adduce further evidence in the form of a previous Warning determination from 10 years ago in 2012, in relation to Dr Scott. The application was opposed by Mr Phillips. The Tribunal's full decision on the application is included at Annex A.

The Allegation and the Doctor's Response

12. The Allegation made against Dr Scott is as follows:

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

Patient B

1. At all material times, you knew that Patient B was vulnerable by reason of their mental health.
   To be determined

2. On 25 January 2022 you consulted with Patient B and you:

   a. undertook a religious and/or spiritual discussion with Patient B;
      To be determined

   b. discussed your own religious and/or spiritual beliefs with Patient B;
      To be determined

c. clasped Patient B's hands;
To be determined

d. facilitated a prayer with Patient B;
To be determined

e. failed to ensure that Patient B:
~~i. ensure that Patient B:~~

i. ~~1.~~ welcomed one or more of your actions as described at paragraphs 2.a., 2.b., 2.c. and 2.d;
To be determined

ii. ~~2.~~ did not feel pressurised into partaking in one or more of the actions described at paragraphs 2.a., 2.b., 2.c., and 2.d.
To be determined

The Facts to be Determined

13. No facts were admitted. In light of the above, the Tribunal had to determine all of the paragraphs of the Allegation.

Witness Evidence

14. The Tribunal received evidence on behalf of the GMC from the following witness:

- Patient B, complainant, gave evidence in person and provided a witness statement dated 22 August 2023;

15. Dr Scott provided his own witness statement dated 7 July 2023 and his response to Patient B's complaint dated 15 September 2022. He also gave oral evidence at the hearing.

Expert Witness Evidence

16. The Tribunal also received evidence from three expert witnesses. The expert reports were directed at assisting the Tribunal to understand whether Dr Scott adequately assessed Patient B in relation to the spiritual discussion, and if any of Dr Scott's care fell below the standards expected of a reasonably competent GP.

17. Dr C, a GP, on behalf of the GMC, gave oral evidence via videolink. His area of expertise is General Practice. He provided three reports.

- Expert report, dated 21 June 2022.
- Supplementary expert report, dated 31 August 2022.
- Supplementary expert report, dated 15 March 2023.

18. Dr D, a GP, on behalf of Dr Scott, gave oral evidence via videolink. His area of expertise includes General Practice. He provided two reports.

- Expert report, dated 3 May 2023.
- Supplementary expert report, dated 5 June 2023.

19. Dr E, a Professor of Psychiatry and Medicine, gave evidence via video link, on behalf of Dr Scott. He provided one expert report dated 5 June 2023.

20. Dr C and Dr D discussed their findings, following which they provided a joint report to identify the extent the issues could be agreed and where agreement was not possible, to identify those issues. They provided this joint expert report on 27 July 2023.

Documentary Evidence

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

- Medical records of Patient B, various dates.
- Faith Discussion Protocol, Spiritual Discussion patient feedback form, and the Consent to Discuss Faith Form adopted by the Practice.
- Dr A, GP Senior Clinical Adviser NHS England, Telephone interview notes with Patient B, dated 30 March 2022.
- Dr Scott's response to NHSE, dated 10 June 2022.

The Tribunal's Approach

22. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Scott does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

23. The Tribunal accepted the Legally Qualified Chair's ('LQC') legal advice to first consider the contemporaneous evidence and other documentary evidence then oral evidence of witnesses to establish whether Dr Scott; knew at all material times that Patient B was vulnerable by reason of their mental health and whether he carried out the acts alleged

in 2 (a) (b) (c) and (d). If the Tribunal concludes that the Dr Scott did carry out these actions, it should then consider whether each of those actions were welcomed by Patient B. For this, the Tribunal would need to consider the issue of consent. The Tribunal would need to consider whether Patient B consented, whether any consent, either expressly or impliedly given, allowed Dr Scott to engage with him in the ways alleged.

24. Finally, the Tribunal would need to consider whether consent was informed, maintained or withdrawn at any time.

25. The Tribunal was referred to the authority of *Byrne v General medical Council (2021) EWHC 2237 Admin)* in relation to contemporaneous evidence. Objective matters shown in contemporaneous evidence are best on which to base fact finding.

26. The Tribunal was advised on how to approach the witness evidence, that credibility can be divisible. In relation to expert evidence, as was held in *Cullen v General Medical Council 2005 EWH5 353 Admin*, if the Tribunal rejects the evidence of an expert, it must give reasons for doing so.

27. The Tribunal was advised that it is entitled to draw inferences about evidence it has read or heard however it must not speculate. Due allowance should be made for the way in which the passage of time may have created difficulties for a witness or the Doctor in recalling events. An honest witness can be a mistaken witness.

28. Applying the principles set out in *R (Dutta) v General Medical Council [2020] EWHC 1974 (Admin),* the Tribunal must not assess a witness credibility exclusively on their demeanour when giving evidence. The Tribunal should consider the reliability of the evidence as a global picture and not in isolation.

29. The Tribunal accepted the LQC's advice and suggested approach.

The Tribunal's Analysis of the Evidence and Findings

30. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Paragraph 1

31. The Tribunal considered whether at all material times, Dr Scott knew that Patient B was vulnerable by reason of their mental health.

Mental Health

32. The Tribunal first considered whether Patient B had mental health issues.

33. The Tribunal bore in mind that prior to the Consultation on 25 January 2022, Dr Scott undertook a telephone call consultation as indicated below by the term 'tel'.

34. The Tribunal noted that there was no definitive record of whom was present in the call, but Dr Scott asserted it was between himself and Patient B. Dr Scott may have recorded his findings from the telephone consultation under 'History' in Patient B's medical records at 10.25am:

> *"tel – spoke to Young Minds this a.m re : suicidal thoughts*
> *massive stress – 12/12 ago – XXX*
> *not as bad as he was then – but getting that way*
> *beginning to pull his hair*
> *any minor aggravation – leads to rage – hits things and himself, without feeling pain*
> *then snaps out of it*
> *not down but some suicidal thoughts*
> *see me p.m"*

35. By Dr Scott's account, he consulted with Patient B on the phone. After this initial telephone consultation, Dr Scott arranged to see Patient B later that day. Patient B stated he does not remember speaking to Dr Scott over the phone, however he did not deny that he provided information about his personal circumstances and how he was feeling. Both Patient B and Dr Scott agree on the content of the discussion, namely that it included Patient B speaking of his grandparent's XXX, his mother's XXX and difficult circumstances in relation to his uncle and cousin. Whether the discussion took place over the phone or not, it is relevant that it took place on 25 January 2022 prior to Patient B attending the Consultation later in the day. During this telephone call, Dr Scott received information and was alerted to the fact that Patient B had begun to pull his hair, was experiencing anger issues and suicidal thoughts and as such spoke to Young Minds.

36. On 25 January 2023, Dr Scott recorded Patient B's 'Examination' as:

> *"In Sixth Form still*
> *Didn't attend today after did a bad exam 2-3/52 ago – result yesterday*
> *was teary, demoralised*

even without exam result his mental well-being still poor
then bad event affects him
describes himself as walking, limping
….
feels world is against him – but doesn't like to feel this way
and used to enjoy stuff eg. school subjects, but lost touch with them…."

37. Dr Scott further recorded under the Comments section of Patient B's medical record as:

"Happiness 3-4/10
Not tearful, some emotional lack
Sleeps well apart from last fortnight
Eats ok
Imp – not antidep. Today
…
He ran g Mind today – a/a
suicidal thoughts – he Q everything – whats the point?
Plan – given Insights tel – as another counsellor might be able to help him more
Spirit discussion – with permission"

38. The Tribunal took into account Dr Scott's medical notes of Patient B in its assessment of Patient B's mental health. The Tribunal noted three references to suicide in his medical notes on the 25 January. He felt that the world was against him, and he questioned everything. He did not want his mental health to deteriorate further. It accepted the matters as set out in Patient B's medical records, that Patient B at the time of the 25 January 2022 Consultation had significant social stressors from family difficulties, he had low mood and suicidal thoughts.

39. The Tribunal was also aware of the previous medical history of Patient B. In December 2020, Patient B was referred to the adult mental health team, Invicta Health. On 7 December 2020, Invicta Health wrote to Patient B's GP. The letter stated that Patient B was referred by a CAMHS clinical nurse specialist in ADHD to Psychiatry-UK. There was no evidence of a mental illness at this time, beyond his ADHD and its associated symptoms therefore Invicta Health did not offer Patient B an assessment.

40. On 8 December 2020, Single Point Access Team ('SPoA') wrote to Patient B's GP. The letter stated that Patient B was referred by his GP to a Mental Health Triage. The summary of the GP referral stated that Patient B recently transitioned from CAHMS to Adult Services and

that *"this is obviously a very vulnerable period in a young man's life."* The letter detailed that Patient B *"He reports that he has been struggling with anger management and that he has been taking out his frustrations on object and more recently he states that he has been having thoughts of harming others. He has been pulling his hair, kicking walls, head butting the walls. He feels that he has been having intrusive thoughts about hurting others, feeling angry and thoughts of being violent. He states that he feels that he is not in control. As a result of the above, he was stopped from attending school from 20/09/20 with the plan for a further assessment and plan to safeguard others at school."*

41. The Tribunal bore in mind that Patient B's medical records were available to Dr Scott to review prior to the consultation with Patient B.

42. In Patient B's witness statement, dated 22 August 2022, "*This statement relates to a consultation I attended with Dr Scott at Bethesda Medical Centre ('the Centre') on 25 January 2022 for the problems I was having around my mental health at the time….*

> ….
> *My mental health had deteriorated because of various difficult events in my immediate and extended family including caring commitments, bereavement and cancer diagnoses, and I also had my A-Level exams coming up. I had a lot of anger and violent thoughts in my head. While I would try to keep it in, I said some horrible things to friends, and lost some of them*
> ….
> *I wanted to do anything I could to make myself better mentally.*
> …
> *Dr Scott introduced himself and explained that he helps people with their mental health. I explained what had been going on in my life recently, as set out above, and he gave me three options, going into detail on the third option*
> …."

43. In oral evidence, Patient B told the Tribunal that he attended the consultation with Dr Scott because his mental health was being affected by a number of factors including his grandmother's XXX and the adverse effect this XXX had on his mother, who was at the time spending a lot of time with her. Further he stated his own mother had been given XXX. Patient B also said that his uncle had XXX and his cousin XXX. He told the Tribunal that he has had an ADHD diagnosis since the age of 10 and has been taking Concerta as medication for his ADHD.

44. Two months after the Consultation, Dr A undertook a telephone interview with Patient B on 30 March 2022. The Tribunal noted that this was the first recorded conversation following up from the Consultation.

> *"The reason for the contact was patient [B] was experiencing a low mood and previously had suffered with his mental health and did not want his mental health to deteriorate further. Patient [B] described for me the background to his mental health deterioration and the precipitating factors."*

45. The Tribunal turned to Dr Scott's evidence. In Dr Scott response to NHSE, 10 June 2022, he writes:

> *"I will begin by examining his computer records since I first had involvement with patient B on 7/9/20*

46. He then provided detailed relevant entries pertaining to Patient B which include:

> *"…*
> *On 10/9/20, he had a telephone call with his own GP, Dr G. He was really stressed and worried that whilst awaiting counselling he might harm someone or himself. Dr G noted that his mental health has declined during the Covid pandemic and that he was easily angered.*
> *…*
> *19/10/20….He had a telephone call with Ms H….she also noted that…he'd struggled with anger outburst since the beginning of what had proved to be a difficult year…He had become greatly anxious about losing people but struggled to express this and she conclude his behaviour was likely connected to his anxiety"*

47. Having looked at these records, Dr Scott would have been aware that Patient B's mental health had declined in the past.

48. On the day of the face-to-face consultation, Dr Scott's made the following entries in the patient record;

> *"…*
> *On 25/1/22, I had a telephone consultation with Patient B after he'd spoken to the organisation "Young Minds" that morning concerning suicidal thoughts. He admitted to massive stress… He stated that he wasn't as bad now as he was then (18 months ago), but was beginning to get that way. He was pulling his hair and any minor*

aggravation lead to rage. He hit things and himself, without seeming to feel pain, then snapped out of it.

…

Patient B attended my surgery on the afternoon of 25/1/22. I noted that he was back at school but hadn't attended that day as he'd had a bad exam result the previous day. This left him teary and demoralised. However, even without this result his mental health was poor. Bad events affected him and he described himself as limping through life

….

On assessing his happiness on an average day then, Patient B self-scored at 3-4/10.

…

In terms of treatment, my impression at the time was that anti-depressants were not warranted…I gave him the telephone number for Insight – the NHS counselling service as this might prove helpful, Finally, having explored both medication and counselling, I asked permission to tackle his issues from a third, spiritual, angle.

…"

49. The Tribunal considered that Dr Scott may have abstracted information for his NHSE response from his contemporaneous medical records of Patient B and his previous medical history. The Tribunal accepted these matters in relation to assessing Patient B's mental health. It was clear to the Tribunal that by providing Patient B three options (medication, counselling, and spiritual discussion) Dr Scott's focus in the Consultation concerned helping Patient B's mental health. It also appeared to the Tribunal that Dr Scott acknowledged himself that Patient B was experiencing mental health issues.

50. In cross-examination, Dr Scott said that at the time of the Consultation, Patient B's mental health was *"not that bad."* He said that Patient B was *"demoralised"* and *"down"* hence the low happiness score but considered him *"not particularly depressed"* which led to his opinion that anti-depressants were not necessary.

51. The Tribunal was of the view that someone does not need to have a diagnosis of a serious mental health condition, in order to have mental health issues. It was aware of Patient B's lack of a formal mental health diagnosis beyond his ADHD. However in view of his mental health history which included low mood, self-harm, references to suicidal thoughts and the additional contextual history of significant social stressors, which were escalating, the Tribunal was satisfied that Patient B could be identified as suffering from mental health issues at the time of the Consultation.

<u>Vulnerable</u>

52. The Tribunal next considered the expert witness evidence in relation to Patient B's vulnerability.

53. Dr C, instructed by the GMC, opined in oral evidence that he regarded vulnerability as being a continuum from someone who is not vulnerable at all to a very vulnerable person who would be considered vulnerable according to safeguarding legislation. Dr C conceded that in that sense, Patient B did not fit the legal definition of a vulnerable adult for the purposes of adult safeguarding, as set out in the Care Act 2014 and as stated in NHSE guidance. However, Dr C opined that Patient B was vulnerable as he was more at risk than another member of the population who didn't have his mental health problems, his specific history, and his age. As such he was more at risk of abuse or neglect. Dr C accepted that he does not have particular expertise in vulnerability, but for his extensive experience as a GP.

54. Dr C made reference to Patient B's medical records in that on 25 January 2022, Patient B presented with anxiety and depressive symptoms and ADHD. In Dr C's opinion these were enduring mental health problems.

55. Dr D, instructed by Dr Scott's representatives, opined that vulnerability was difficult to define, *"vulnerability is not a medical term in terms of clinical medicine, it seems more of a psychological or social or sociological term".* In his view, he struggled to see vulnerability on a continuum and vulnerability is very much dependent on who is making an assessment, whether it is a medical assessment or a social assessment of vulnerability. He opined that Patient B was not someone he considered a vulnerable adult. He stated that Patient B was at the time 19 years old, and he would not consider an adult patient in view of their age to be vulnerable. Further he opined that while ADHD can certainly cause behavioural issues, it would not be something which would cause the same vulnerability as for example a learning disability or perhaps Autism Spectrum Disorder. Dr D conceded that all patients who came to see their GP could be considered vulnerable, however looking at the presentation of Patient B as a whole, did not consider him to be vulnerable compared to other peers of his age with that diagnosis.

56. The Tribunal bore in mind that Dr Scott said that he did not accept that Patient B was vulnerable. He stated that Patient B was a young man in the sixth form of grammar school, he was capable enough to attend the consultation alone without his mother, did not have learning disabilities nor was he psychotic. Dr Scott stated that he *"does not say that [Patient B] was vulnerable, but more needy than the average patient, I choose to treat needy patients more intensely".* Dr Scott did not explain what he meant by needy. Dr Scott told the Tribunal

that to say that Patient B was vulnerable because of his mental health had *"no scientific basis behind it whatsoever."*

57. The Tribunal considered Dr Scott's use of the term 'needy' to describe Patient B. It did not accept that Patient B was needy. Dr Scott provided no explanation of what he meant by this. He stated that Patient B's mental health was not bad but accepted that he was *'demoralised with some suicidal thoughts'*. The Tribunal interpretated 'needy' to suggest that Patient B was seeking clinical and emotional help for his problems. Dr Scott had discussed two other clinical options with Patient B prior to the spirit discussion. This demonstrated to the Tribunal that Dr Scott considered Patient B needed more than just emotional support but possible clinical support for his mental health.

58. The Tribunal also took into account Patient B's medical history when considering its assessment of Patient B's mental health. It accepted that in 2020, prior to the Consultation, Patient B was not diagnosed with a mental illness beyond his ADHD however, he was considered vulnerable by health care professionals.

59. The Tribunal also considered Patient B stating *"what's the point"* suggested he was in need of help. He also stated that he was "open to anything" and wanted help with his struggles to improve his mental wellbeing. The Tribunal concluded that this placed Patient B in a vulnerable position as his mental health was in a poor state, he was desperate for help and did not know what to do.

60. The Tribunal considered the definition of 'vulnerable' and if Patient B was considered vulnerable in regard to his mental health. It bore in mind that it was accepted by both parties that Patient B did not meet the legal definition of vulnerable. The Tribunal applied the term vulnerable in a reasonable and common-sense way. The Oxford dictionary describes a vulnerable person as being someone who is weak and easily hurt physically or emotionally.

61. Mr Phillips further submitted, in absence of a legal definition on vulnerability all tribunals should have regard to the Equal Treatment Bench Book ('ETBB') and the Presidential guidance on vulnerable witnesses. The Tribunal noted however that the ETBB provided guidance on vulnerable witnesses giving evidence at court and the reasonable adjustments that would be required. The ETBB focusses on the statutory regime in the criminal courts. It defines vulnerable witnesses as those under the age of 18, have a disability or various other factors apply. It is note worthy however that the ETBB in its disability glossary recognises ADHD as a disability which would therefore identify Patient B as vulnerable in this context. However, the Tribunal did not consider this to be analogous to the definition of a patient who may or may not be vulnerable.

62. The Tribunal also took into account the GMC's sanction guidance which described Vulnerable patients as:

> ***145*** *Where a patient is particularly vulnerable, there is an even greater duty on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of certain characteristics or circumstances, such as:*
> *a presence of mental health issues*
> *b being a child or young person aged under 18 years*
> *c disability or frailty*
> *d bereavement*
> *e history of abuse or neglect.*

63. The Tribunal had established that Patient B suffered from mental health issues. The Tribunal further agreed with Dr C's opinion that vulnerability can be viewed as a continuum, in view of Patient B historical medical records. The Tribunal went on to consider Patient B's young age at the time, his ongoing anxiety about the risk of losing family members to be relevant when considering the sanctions guidance. By virtue of Patient B's mental health issues that the Tribunal has identified above, the common definition of vulnerable and the Sanctions Guidance, the Tribunal was satisfied that Patient B was vulnerable by reason of his mental health.

64. It also concluded that at all material times, Dr Scott was aware of these matters as he had been aware of Patient B's medical history, had obtained a history of his current state in the morning of the consultation and again during the further full medical examination that took place at the beginning of the first consultation on 25/01/2022, before providing Patient B with the three options.

65. Therefore the Tribunal found paragraph 1 of the Allegation proved.

<u>Paragraph 2(a)</u>

66. The Tribunal considered whether on 25 January 2022 Dr Scott undertook a religious and/or spiritual discussion with Patient B.

67. The Tribunal considered Patient B's witness statement, dated 22 August 2022, he said that Dr Scott provided him three options to help with his mental health and that Dr Scott offered 'spirituality' as the third option. Patient B stated that Dr Scott initially said *"something along the lines that the World health Organisation had said spirituality was one of the main*

factors in keeping a healthy mind. He said that a lot of his patients have a more positive outlook of their lives after talking through this option." Patient B said he was content with what Dr Scott had initially described and thought it would be beneficial for him therefore continued the spiritual discussion.

68. Patient B described in more detail his version of the content of the spiritual discussion in his witness statement:

> *"He said the main thing to focus on was religion - he asked if I was religious and I said that I wasn't, but that I'd been to church a few times, that it had been part of my scout activities when I was younger, and that all of my previous schools were Church of England schools, so I knew about Christianity but didn't follow it. He started speaking about Christianity and I started to feel uneasy, and I wondered how this was supposed to help me with my mental health. He said other clients had benefitted from this and it would benefit me, and mentioned a specific religious organisation. I don't remember the name, it was some sort of church in the local area that he said would benefit me, though I wasn't clear on how. When I mentioned my previous schools were Church of England schools, but that my current Sixth Form was not, he said that because of this, I'd been disconnected from God and that that was the reason for my misfortunes. That was one of the things that sticks in my mind from what he said. He said that I needed to reconnect with God, or the Lord Jesus Christ, or something along those lines…."*

69. Patient B said in oral evidence that his interpretation of 'spirituality' was *"something like meditation, breathing exercises that would help me with my mental health"* and he was happy to engage in this conversation with his understanding of what spirituality meant. He stated that *"not for one second"* did he think the spirituality discussion would be about the Christian faith.

70. The Tribunal noted that Patient B was unclear whether this spiritual conversation took place in part one or two of the Consultation, however he was clear from his evidence, that the conversation took place. He stated in oral evidence that the thought the spiritual conversation lasted about 20 minutes.

71. The Tribunal took into account Patient B's medical records on 25 January 2022. Dr Scott recorded at 10:25 *'spirit. discussion - with permission'.* Dr Scott logged a further entry at 15:40:

> *"spirit discussion*
> *has been to some Christian schools*
> *discussed, prayed, GioGen suggested, Gideons"*

72. The Tribunal noted Dr Scott's oral account was that the spiritual discussion with Patient B was recorded in detail and took place with permission. However, there was no mention in the record entry of: the topic of discussion, which beliefs/experiences were shared, questions asked of Patient B, details of anecdotes offered. More importantly, there was no record of Patient B's response in that part of the consultation.

73. The Tribunal considered Dr Scott's response to NHSE, dated 10 June 2022, he stated that a 'spiritual discussion' took place shortly after Patient B entered the consulting room for the second time. He said he noted in previous computer records that Patient B had been to Christian schools and with that information, he discussed how Christian faith might help Patient B with his mental health. He also mentioned in his NHSE response that he suggested XXX Church to Patient B and gave him a Gideons Bible to read.

74. The Tribunal also noted that in his response to NHSE, Dr Scott disputed that he offered Patient B 'spiritualism' which in his view is an alternative to faith and not aligned with Christianity.

75. In his witness statement, dated 15 September 2022, Dr Scott sought to clarify Patient B's comment that he said that the *"the main thing to focus on was religion",* he stated that *"religion, or more accurately faith did form the main focus of this separate consultation, where we focussed on the scientifically-documented benefits to health from faith."*

76. Dr Scott accepted that Patient B told him that he does not follow the Christian faith, but having talked with Patient B about his previous experiences of the *Christian faith* in terms of church and his attendance at Church of England schools, he suggested to Patient B that *"this previous Christian input at church and school may have sowed a seed in him, which if nurtured could help him mentally."*

77. The Tribunal also noted that in Dr Scott's oral evidence, he accepted that he had engaged in a spiritual discussion with Patient B.

78. The Tribunal considered the chronology of the Consultation and noted that Patient B's evidence was that the spiritual discussion took place in the first part of the consultation. However, having reviewed the medical records and heard Dr Scott's account, it concluded that it was more likely that Dr Scott had offered Patient B a third option of a 'spirit discussion' in the first part of the consultation and then Patient B left and re-entered the consultation room to mark the commencement of the spiritual discussion. It noted that Patient B provided a detailed account of the nature of the spiritual discussion and stated he did not recall the

details of the second consultation. In view of his evidence, the Tribunal concluded that a spiritual discussion did take place, but Patient B may have been mistaken as to when this occurred.

79. The Tribunal considered that both accounts of Dr Scott and Patient B were consistent with each other that a religious and/or spiritual discussion occurred. The Tribunal was of the view that the spiritual discussion was in effect only about the Christian faith. It also accepted that the accounts are supported by contemporaneous evidence in Patient B's medical notes written by Dr Scott.

80. Therefore the Tribunal found paragraph 2(a) of the allegation proved.

Paragraph 2(b)

81. The Tribunal considered whether on 25 January 2022 Dr Scott discussed his own religious and/or spiritual beliefs with Patient B.

82. The Tribunal bore in mind Patient B's witness statement, dated 22 August 2022, he described:

> *"Dr Scott mentioning a miraculous event in particular remained with me even after the consultation. While Dr Scott didn't specifically tell me to look for a miraculous event, he did say other patients would see a beam of light, or something happening in their lives, that would give them an indication that God was on their side. He said he had spoken to God and that was why he was the doctor he was today. After the consultation I genuinely tried to look for signs for two or three days, even considering that streetlights flickering outside could be a message, until I realised that what I was doing was making me more and more stressed, when I should have been focusing on my mental health. That same night I cried and told myself that the organisation Insight was the last option I had that would help."*

83. The Tribunal considered Dr Scott's account, he said he was unsure what Patient B referred to as a 'miraculous event', but he accepted that he told Patient B about another female patient who he had encouraged to pray at home. This female patient told Dr Scott that she saw a bright light in the window and felt the presence of Jesus. Dr Scott said this was a sign that she was connected with God and as a result she had given up drugs, drink and lost some weight.

84. The Tribunal also took into account Dr A telephone interview notes with Patient B, dated 30 March 2022. The Tribunal noted this interview took place two months after Patient B's consultation with Dr Scott. Dr A recorded that *"Dr Scott also told patient [B] that because he attended a Church of England school but then moved to a secular school he had 'disconnected from God' and was suffering from this."* Patient B informed Dr A that he felt very uncomfortable when he heard this and *"was taken aback"* and did not know how to respond.

85. In his oral evidence, Patient B said that Dr Scott said that his *"disconnection with God was the reason for my misfortune."* Patient B stated that he *"vividly"* remembers a conversation whereby Dr Scott shared his own experiences with God and how Christianity had helped him in the past. He stated that Dr Scott had told him that "by coming closer to God he would become a better person". Patient B said that Dr Scott also told him that when he was young, he was at a party and feeling low, God had spoken to him that he had 'gone away from him'.

86. The Tribunal bore in mind that Dr Scott accepted in his oral evidence that he told this personal anecdote to Patient B, and he said he usually would tell stories like this to encourage patients and to build rapport with them. He accepted that he told Patient B how the Christian faith has helped patients in the past. He denied saying to Patient B that *"his disconnection with God was the reason for his misfortune"* rather he said that Patient B would benefit from connecting with God. Dr Scott said that he personally found being disconnected from God to be harmful. He accepted that after explaining how faith might help Patient B's mental health, he suggested that he consider attending XXX Church.

87. In determining whether or not Dr Scott made the comments alleged, the Tribunal considered Dr Scott oral evidence. He stated that he encouraged patients by *"telling him his story to convince them that this is a God that changes lives"* and that when he was at a low point in his life God said to him *"you have gone away from me".* He stated he had received training in preaching. He stated that the Good Medical Practice enabled him to open up a conversation about faith and take account of a patient's spiritual beliefs. In cross examination, Dr Scott stated he accepted he may have been surprised by this conversation. The Tribunal considered that in general the accounts of Patient B and Dr Scott as to the nature of the discussion were similar. In determining whether Dr Scott said what is alleged, it considered the impact the words had on Patient B, both in his oral testimony and his written evidence. He stated he *'was taken aback'* and felt *'shock'* and a *'sinking feeling'* and felt that Dr Scott was blaming his misfortunes on something external. He felt that when Dr Scott used these words his trust in him had been broken. Dr Scott denies using these words but accepts he was encouraging Patient B to reconnect with God.

88. In chief examination, Patient B reiterated his statement, namely that Dr Scott informed him that *"the reason for his misfortune was his disconnection with God*", mainly because he did not attend a CoE school. In cross examination Patient B stated that Dr Scott recommended that he apologise to God, this is also mentioned in Dr A interview notes in what Patient B had relayed to him:

> *"Dr Scott also told patient [B] that because he attended a Church of England school but then moved to a secular school he had "disconnected from God" and was suffering from this. Patient [B] informed me that he felt very uncomfortable when he heard this and "was taken aback" and did not know how to respond."*

89. The Tribunal noted that none of Dr Scott's statements address whether he made these statements. His oral evidence was that he wanted to encourage Patient B in the spirit discussion, but he denied using these words or saying to Patient B to ask God for forgiveness.

90. Dr Scott also accepted he could not recall the words he used in prayer. Dr Scott accepted that he said *"[Patient B] would benefit to reconnect with God".*

91. Dr Scott also denied in his oral evidence that he said to Patient B the words "cleanse his mind" or "coming closer to God would make him a better person." He accepted that he told Patient B reconnecting with God would help his mental health. He denied saying disconnecting from God was the reason for his misfortune and that was Patient B's interpretation.

92. Dr Scott was asked if he asked or told Patient B "to apologise to God for leaving him and God would be by your side" or words to that effect to Patient B. In his oral evidence, Dr Scott said his own experience was such that he found making an apology to God was very beneficial and he recommended an apology to God. Dr Scott said that *"I found disconnection from God really harmful."*

93. After considering both Dr Scott's and Patient B's account regarding Dr Scott's statements, on balance it determined that Dr Scott did use words to that effect when speaking of his own spiritual beliefs and experiences.

94. In view of the evidence of Dr Scott and Patient B, the found there was evidence that Dr Scott discussed his own religious and/or spiritual beliefs with Patient B. Namely, the Tribunal considered that Dr Scott shared his own personal experiences and beliefs in the Christian faith.

95. Therefore the Tribunal found paragraph 2(b) of the allegation proved.

Paragraph 2(c)

96. The Tribunal considered whether on 25 January 2022 Dr Scott consulted with Patient B, he clasped Patient B's hands.

97. The Tribunal bore in mind that in Patient B's witness statement, dated 22 August 2022, he said that during the consultation, Dr Scott asked him if he practised any kind of prayer, and he told Dr Scott no he did not. To Patient B's recollection, Dr Scott said *"why not now?"* or words to that effect. Patient B then described how Dr Scott *"told me to put my hands in front of me and clasped my hands firmly, so that I would have to struggle to release my hands from his, and I was uneasy that he clasped my hands so tightly."*

98. Patient B insisted during his oral evidence that he was told to put his hands out and he was forced to pray by having his hands clasped. He said that his hands were extended out and Dr Scott held his hands together. Patient B clarified that when he stated he was made to pray, he meant that his hands were held together in prayer and that he did not pray out loud or in his head.

99. The Tribunal found that Patient B's account of the consultation was consistent with his complaint to NHSE. Dr A recorded in his telephone interview notes with Patient B, dated 30 March 2022, that Dr Scott *"asked patient [B] to put his hands out in front of him and clasped his hands tightly."*

100. The Tribunal also bore in mind that Dr Scott accepted in his oral evidence that Patient B had his hands on the desk, and he reached over and put his hands together. Albeit Dr Scott denied clasping Patient B's hands firmly, the Tribunal took into account Dr Scott's description of events in his statement, dated 15 September 2022, that on this occasion he *"gently held [Patient B's] hands, again my usual practice, to show the importance of physical touch which is well-known to be beneficial to patients".* He said that "*to state that I held his hands so tightly that he couldn't be released is simply nonsense".*

101. Dr Scott accepted when giving his oral evidence that he had clasped patient B's hand to pray but never pressed tightly, this was more of a gentle touch. He stated that Patient B's arms were under the table on his lap and when asked *'why not now?'* Patient B lifted his arms and placed them on the table and Dr Scott reached over to hold his hand. He further stated that would have asked if he could hold his hands in prayer but accepted that this is what he

would normally say rather than what was said to Patient B. The Tribunal determined that regardless of whether Dr Scott held Patient B's hands tightly/firmly as is Patient B's evidence, it was common ground that he had clasped Patient B's hands before praying.

102. The Tribunal bore in mind that Dr Scott did not mention clasping Patient B's hands in Patient B's medical record. However, despite a lack of contemporaneous record, in view of the evidence heard and considered, the Tribunal found that Dr Scott clasped Patient B's hands.

103. Therefore the Tribunal found paragraph 2(c) of the allegation proved.

Paragraph 2(d)

104. The Tribunal considered whether on 25 January 2022 when Dr Scott consulted with Patient B, he facilitated a prayer with Patient B.

105. In Patient B's witness statement, dated 22 August 2022, he said that during the consultation, Dr Scott asked him if he practised any kind of prayer, and he told Dr Scott no he did not. To Patient B's recollection, Dr Scott said *"why not now?"* or words to that effect. Patient B said he felt reluctant to do so but acknowledged he did not say this out loud. The Tribunal noted that Patient B recorded that prayer was given, *"He prayed for me; I don't remember what he said, I remember just hoping that it would be over and I would be able to go."*

106. In his oral evidence, the Tribunal noted that Patient B recalled that Dr Scott asked him if he would like to pray and *"would you like God to show compassion for your misfortunes*" or words to that effect. He said that from what he understood by Dr Scott saying, *"why not now?"*, he interpreted that to mean what have you got to lose by praying.

107. Patient B also said in oral evidence that there was a brief silence prior to Dr Scott praying aloud. He stated while he remembered the prayer was given, he could not recall the content. Patient B said he remembered that he wanted it to be over and the consultation to be at an end. He said he did not pray in his head and only Dr Scott was praying.

108. The Tribunal took into account Dr A telephone interview with Patient B, dated 10 March 2022. Dr A recorded that Patient B did *"not recall the exact words used by Dr Scott but understood this to be a prayer."* However, the Tribunal also bore in mind that Dr A recorded that Patient B did recall Dr Scott mentioning the word *"blessing"* and *"God forgive him for his*

sins". In his oral evidence, Patient B could not recall what words were used in the prayer as he was not paying attention to it.

109. In his witness statement, dated 15 September 2022, the Tribunal considered Dr Scott description of his usual practice of offering prayer to patients – *"I often ask whether it would be ok to pray with the patient",* stating that *"most patients agree, whether or not they pray themselves".*

110. In his oral evidence, Dr Scott stated he could not recall the exact words however he must have told him there now going to be a prayer.

111. The Tribunal bore in mind that Dr Scott accepted that he gave a positive prayer on Patient B's behalf, and he would say this aloud.

112. The Tribunal noted that Dr Scott may have referred to a prayer occurring in Patient B's medical record in his entry at 15:40:

"spirit discussion
has been to some Christian schools
discussed, prayed, GioGen suggested, Gideons"

113. In view of the evidence from Patient B, the acceptance of Dr Scott of a prayer occurring, and contemporaneous note of a prayer in Patient B's medical records, the Tribunal found that Dr Scott facilitated a prayer with Patient B.

114. Therefore it found paragraph 2(d) of the allegation proved.

Paragraph 2(e)(i)

115. The Tribunal then considered whether Dr Scott failed to ensure that Patient B welcomed one or more of his actions as described at paragraphs 2(a), 2(b), 2(c) and 2(d).

116. In order to reach a determination on this part of the allegation, the Tribunal needed to consider whether Patient B had consented to engaging with Dr Scott in this way. It considered this to be the starting point in relation this allegation. The Tribunal would then need to determine whether at any point consent was withdrawn. If it concluded that consent had been withdrawn or was no longer maintained, the Tribunal would need to assess the evidence to determine whether Dr Scott failed to ensure that consent was maintained so that Patient B welcomed those actions.

117. It would be necessary to assess the evidence with regard to implied and express consent and whether this was at any point withdrawn. If it was withdrawn, then the Tribunal would need to assess whether Dr Scott carried out checks to ensure it was maintained. The Tribunals finding in relation to allegation 2ei would also have an impact on the Tribunal's determination of allegation 2eii.

118. The Tribunal bore in mind the GMC guidance on Professional Standards and Ethics for doctors Decision making and Consent including the principles of consent and decision making outlined by the Legally Qualified Chair's advice.

119. The Tribunal also took into account GMC's guidance on Personal beliefs and medical practice (2013) when assessing consent.

> *29 In assessing a patient's conditions and taking a history, you should take account of spiritual, religious, social and cultural factors, as well as their clinical history and symptoms (see Good medical practice paragraph 15a). It may therefore be appropriate to ask a patient about their personal beliefs. However, you must not put pressure on a patient to discuss or justify their beliefs, or the absence of them.*
>
> *30 During a consultation, you should keep the discussion relevant to the patient's care and treatment. If you disclose any personal information to a patient, including talking to a patient about personal beliefs, you must be very careful not to breach the professional boundary that exists between you. These boundaries are essential to maintaining a relationship of trust between a doctor and a patient.*
>
> *31 You may talk about your own personal beliefs only if a patient asks you directly about them, or indicates they would welcome such a discussion. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them.*

120. While the Tribunal had found that Patient B was suffering with mental health issues, had an ADHD diagnosis and was vulnerable at the time of the Consultation, it did not consider that his vulnerability was such as to be incapable of providing consent.

121. The Tribunal bore in mind Ms Hill's, Counsel for GMC's closing submissions on facts regarding what was agreed and what was not agreed and whether Patient B clearly understood the nature of the discussion. She pointed out physical signs that should have led Dr Scott to realise that Patient B was uncomfortable with the discussions and which ought to have led to Dr Scott to check if Patient B was okay and happy to continue. She submitted that

the onus was on Dr Scott, in line with GMP, to ensure that Patient B welcomed the discussion, and he failed to do this.

122. The Tribunal also bore in mind Mr Phillips, counsel on behalf of Dr Scott's, closing submissions on facts, where he submitted a number of 'signs of consent' had been given by Patient B indicating he was happy for the discussion to take place. He submitted that provided patient B consented (implied or express) to the spiritual discussion in these ways, Dr Scott did not need to check further with Patient B and therefore could not have failed to ensure he welcomed his actions. He further submitted that Patient B displayed no verbal or physical signs to indicate he did not welcome the discussion.

123. The Tribunal addressed its mind to each of these when considering whether Patient B consented to each action in allegation 2(a),(b),(c) and (d). The Tribunal considered the evidence as a whole and considered each of these subparagraphs separately.

124. The same issue was at the core of each decision: whether consent was given and maintained. If not, was it necessary for Dr Scott to check in with Patient B during the discussion? In coming to its determination, the Tribunal would assess the evidence provided by Patient B, Dr Scott and the expert witnesses.

Consent form

125. The Tribunal first considered the *'Consent to Discuss Faith'* form. The Tribunal noted that Dr Scott had recorded under the Comments section of Patient B's medical record - "Spirit discussion – with permission". Further at 10.49a.m, Patient B's medical record shows that an 'administrative procedure' was used to attach a 'Consent to Discuss Faith' form.

126. The Tribunal had some concerns about the timing of the consent form being uploaded onto the system in the morning however accepted Dr Scott's account that the spiritual discussion was not pre-empted by him after the morning's consultation. Dr Scott explained as part of his oral evidence that due to the way EMIS (the Practice's Electronic Patient Record System) operates, the consent form was shown as being uploaded in the morning when this was not the case. Dr Scott explained that this record was in fact inserted later that afternoon after the consultation with Patient B. This was unchallenged by the GMC and was therefore accepted by the Tribunal as being correct.

127. Patient B could not recall the specific chronology of the spiritual conversation; however, he stated that the consent form was provided to him in the first part of the consultation. He described that Dr Scott *"he handed me a piece of paper, though I never got*

to read it. He just explained it to me and intentionally kept his hand over it. He never said what the document was explicitly, and I have not seen it since then. I was trying to engage with what he was saying at the same time as I had the paper".

128. Dr Scott responded to Patient B in his statement, he said *"With regard to the consent form that our practice has adopted, I firmly refute the suggestion that I was being secretive about it. It is a standard practice form and I am always open about the nature of spiritual conversations so have no need to be secretive, nor to hold my hand over the form."*

129. Patient B stated in oral evidence that he thought that Dr Scott was being evasive regarding the consent form because he did not explain what the document was explicitly. He stated he was asked to sign it and he believed it was a consent form of some description. Patient B said he did not feel that he was given enough time to read or understand the contents. He also maintained that the consent form was given at the beginning of the first consultation.

130. Dr Scott said he firmly refuted the suggestion he was being secretive and Patient B was aware of the content, which he signed at the end of the second part of the consultation. Dr Scott stated in his oral evidence that he had no reason to hide the form from him and he believed Patient B had read and understood it before signing it. Dr Scott maintains that signing the consent form at the end of the consultation constituted express consent to the faith consultation to take place.

131. Dr Scott's oral account was that this was done at the end of the second consultation in line with the Practice's Faith discussion Protocol. He stated that this served to confirm that the patient was agreeable to the faith discussion that had taken place, would assist for auditing purposes and would also enable Patient B to receive a questionnaire about the faith discussion.

132. Patient B was candid to the Tribunal that his recollection in relation to the duration and some content of the second consultation was unclear. He insisted that the consent form was handed to him in the first consultation and that the spiritual discussion also occurred in the first consultation. However, Patient B was able to recall specific details of the spiritual discussion.

133. Having reviewed the medical records and the separate entry for the spiritual discussion, together with Patient B and Dr Scott's oral account of the nature of the discussion, the Tribunal concluded that although Patient B had given honest evidence, he was perhaps mistaken about when the form was given to him and when the spiritual discussion

took place. The Tribunal considered the documentary evidence and Dr Scott's evidence. It accepted that on balance, the consent form was more likely than not to have been given to Patient B at the end of the second consultation and that the spiritual discussion took place at this time.

134. Both Dr Scott and Patient B's accounts indicate that the brief reasons as to the nature of the form was explained to Patient B. Patient B recalled that Dr Scott briefly explained why he needed to sign the form and understood that this was a World Health Organisation recommendation. It then follows whether the Tribunal could conclude that this was express consent given from Patient B to engage in such a discussion. The wording of the form states, 'I am happy and agree to discuss my faith and my belief when addressing my health concerns with Dr Richard Scott'. If the form was given at the end of the discussion, which the Tribunal determined it was, then asking for consent after the act had occurred seemed counter-intuitive. It was of the view that even if the consent form accompanied a brief explanation as to why it was required, it could not be relied upon as express consent as Patient B had signed this after the discussion had taken place. The Tribunal therefore determined this could not amount to informed consent.

135. The Tribunal accepted that Patient B stated that he was willing to hear all options that would help him in his recovery. It accepted that Patient B was also willing to move forward with the spiritual discussion, albeit his interpretation of what a spiritual conversation would involve was around meditation and breathing exercises at first.

136. The Tribunal took into account the Practice's 'Protocol to discuss faith form' that was in place at the time (implemented December 2020, reviewed December 2021 and January 2022):

> *If any patient indicates that they would welcome a discussion around faith as part of their consultation the following steps should be taken:*
>
> *1. Ask the patient to return to the waiting area to consider whether they would welcome a faith discussion,*
> *2. Patient to let the receptionist know they are keen to proceed.*
> *3. GP to call patient back into room*
> *4. the clinician should ask the patient to read and sign the consent to discuss faith form,*
> *5. The clinician should make an entry on Emis that consent has been sought and given by the patient to discuss faith.*

6. The completed consent form should be given to the admin team to scan onto the patients notes.

137. The protocol indicated that the consent form should be provided at the beginning of the faith consultation. The clinician should ask the patient to read and sign the 'Consent to Discuss Faith' form after the patient has gone back into the room.

138. As a matter of logic, the Tribunal considered that it is more appropriate for consent to be given prior to an act happening. This was supported by Dr C who opined that "*Dr Scott's comments about Patient [B] being asked to sign a 'Consent to Discuss Faith' form at the end of the 'spiritual discussion' does undermine Dr Scott's rationale for using the consent form, in that consent given after a process has been undertaken is not, even in principle, valid consent.*"

139. The Tribunal accepted the consent form was not required by the GMC and this was the Practice's own way of ensuring a patient was on board with the faith discussion. However, the Tribunal determined that as Patient B could not have properly consented to such a faith discussion after it had taken place. Therefore, the Tribunal was of the view that the consent form on its own did not suggest that informed consent was given by Patient B to discuss actions at 2(a), 2(b), 2(c) and 2(d).

140. Mr Phillips further submitted that in asking Patient B to sign the form at the end, which he did, Patient B was at that point fully aware of what the spiritual discussion involved and therefore consent was given retrospectively to the whole discussion. The Tribunal was thus invited to conclude that a consent form signed at the end amounted to implied consent of the whole consultation including Dr Scott sharing his beliefs with Patient B, clasping of his hand and facilitating in prayer. The Tribunal considered that while this might be true in respect of the initial discussion element of the consultation, this could not, be said to extend to cover Dr Scott's subsequent sharing of beliefs, clasping of hands or facilitating in prayer as this was not specified on the form. In absence of this information being contained on the form and without Dr Scott expressly making it clear what Patient B was consenting to before he signed the form, it could not amount to express consent of all the actions in the allegation.

141. The Tribunal determined therefore that the consent form, albeit signed at the end, could imply that Patient B agreed for the spiritual discussion to take place, as per allegation 2(a) however this could not extend to consenting to 2(b), 2(c) or 2(d) in absence of this being mentioned on the form as something that may take place during the discussion.

Re-entering the Consultation room.

142. The Tribunal accepted that both parties agreed that Patient B walked back into the room for the second part of the consultation without delay. Dr Scott asserted that because Patient B returned into the room, this was implied consent to engage in the spiritual discussion and therefore he did not need to check whether Patient B was happy to proceed. Dr Scott stated in his NHSE response, *"I briefly introduced the Christian faith as having helped patients in the past and asked whether he would welcome a discussion. He agreed and signified this agreement by complying with our practice policy of leaving the room and asking to be readmitted for this spiritual discussion. Naturally, he was free to walk away at this point if he did not want this conversation…".* The Tribunal noted that Dr Scott, accepted in his oral evidence that he did not expressly inform Patient B that was free to leave if he so wished when he got outside. Patient B stated that he was told to go outside for two seconds and come back in where upon a new consultation started. He stated he did not understand why this was happening but was being *"obedient".*

143. The Tribunal has already accepted that this must have occurred after the first consultation, bearing in mind the contemporaneous medical record and Dr A notes which mention Patient B re-entering the room before the spiritual part of discussion took place. On that basis, Patient B would have been made aware at the end of the first consultation that he would need to step outside and re-enter.

144. In his oral evidence, Dr Scott stated that he did not know which way the discussion was going to go. He himself highlighted the importance of checking consent all the way through and stated that Patient B returning for the second consultation was implied consent and this ended with express consent by virtue of the consent form which Patient signed at the end. Dr Scott pointed out that this method was not required by the GMC however it ensured consent was given from start to end.

145. The Tribunal bore in mind that this was an agreed internal Protocol and not required by the GMC. It further noted however that Dr Scott had not followed the surgery's own protocol in following steps one or two and instead asked Patient B to step outside the door. Dr Scott stated that it was unfair for patients to queue again at reception, and this impacted the Practice's resources. He therefore suggested that steps two and three were taken out of the protocol to simplify the process. He accepted however that this had not yet been done and when consulting with Patient B he did not follow steps two and three. Dr Scott accepted that the protocol was not shown or outlined to Patient B.

146. The protocol states that a patient should be given time in the waiting room to consider whether they would welcome a faith discussion, and the Tribunal found that Patient

B was not given that opportunity. Being away from the consultation room would have afforded Patient B additional time to appropriately consider and reflect on whether he wanted to proceed.

147. Dr Scott stated in his oral evidence that he would normally tell the patient that there is a protocol in place and if they would like a spiritual discussion, he was going to ask them to do something strange and ask them to leave and re-enter. He stated he would ask the patients to take time to think and to knock on the door only if they are happy to come back in to take part in the discussion. He stated that he would have explained this to Patient B and Patient B would have entered if he was happy to proceed. He stated that normally, then seconds was sufficient for a patient to consider the option when outside. Dr Scott stated that he partially complied with step one of the protocol by asking Patient B to step outside the room. However, Dr Scott stated he did not inform Patient B that if he was unhappy to proceed, he was free to leave the surgery upon leaving the room.

148. Dr D described this process as a 'cooling off period', where patients would benefit from time away to consider their options. He stated that Patient B seemed to have been given a reasonable time to reflect. Dr D pointed out that this was not required by the GMC however acknowledged it was a cautious step for Dr Scott to take.

149. In view of the medical records and Dr Scott's account, the Tribunal accepted that some mention of a spiritual conversation was made at the end of the first consultation, albeit it was not explained to Patient B that he would be free to leave at any time. By re-entering the room, it would therefore have been reasonable for Patient B to expect a further spiritual conversation to take place, or his interpretation of what a spiritual conversation would look like. Therefore, by returning to the room, the Tribunal determined that Patient B gave implied consent for the spiritual discussion to take place.

150. The Tribunal found that although it was not explained to Patient B exactly what the spiritual discussion would entail, nevertheless, as the discussion progressed, both Patient B and Dr Scott' s account indicate that patient B answered Dr Scott questions about the Christian faith, and this led to Dr Scott sharing his beliefs and personal experiences with him.

151. Patient B accepted he did not ask Dr Scott to stop at this point. However, the Tribunal concluded that Patient B could not have known the full extent of what he was consenting to when he re-entered the room. The Tribunal found therefore that by re-entering the room, Patient B gave implied consent to the initial discussion however not in relation to Dr Scott sharing his beliefs, clasping of hands or facilitating prayer as this was not made clear to him before he re-entered the room or immediately afterwards.

152. The Tribunal therefore determined that Patient B re-entering the room implied consent in relation to 2(a) however not in relation to 2(b),(c) or (d).

Verbal objection

153. In the absence of any verbal objection, Mr Phillips submitted it would be reasonable to determine that Patient B was giving implied consent at the time in relation to 2(a),(b),(c),(d) and therefore Dr Scott did not need to check that his actions were welcome. Mr Phillips also submitted that it would be contrived for Dr Scott to *"check every 30 seconds"* with Patient B if he was consenting to a spiritual conversation. The Tribunal accepted that checking every 30 seconds was not a reasonable expectation, however, it considered it would be reasonable for a competent GP to check at each significant stage of the discussion that a Patient was content to procced. The Tribunal acknowledged that Patient B did not verbally express his thoughts at the time, but it considered that it was the doctor's responsibility to gage any signs of discomfort, in line with paragraph 31 of GMC's guidance on Personal beliefs and medical practice (2013).

154. It considered the oral evidence of Dr C, who stated that in his experience as a GP, it would be 'harder for a younger person to say something should stop during a consultation than someone in their 40s who would be more comfortable to object'.

155. The Tribunal rejected Mr Phillips submission that a lack of sarcasm or rudeness from Patient B indicated consent. It considered that it is not for the Tribunal to comment on Patient B's personality or level of politeness. It could not reasonably determine that Patient B not becoming short with Dr Scott or abruptly telling him to stop could suggest any sort of implied consent.

156. The Tribunal was of the view that an absence of verbal objections in this case does not itself automatically provide signs of consent. Patient B stated in his oral and written evidence that he was *"taken aback"* and he did not know what to say or do. The Tribunal therefore concluded that lack of verbal objection on behalf of Patient B could not assist with its determination whether implied consent was given in respect of 2(a),(b),(c),(d).

Physical signs

157. The Tribunal bore in mind that Patient B said in oral evidence that during the spiritual conversation his *"body narrowed,/fidgeting/looking away from the Doctor and looking up and down at the floor and ceiling."* It acknowledged that Patient B was never asked what a

physical manifestation would look like until the GMC's evidence in chief and therefore did not address this in his witness statement. Patient B, in his oral evidence and written evidence stated that Dr Scott should have been able to see physical signs that he was uncomfortable. Dr Scott stated that Patient B did not present any physical manifestations of discomfort at any stage during the consultation and Patient B has only mentioned his physical manifestations in the current proceedings. The Tribunal noted that Patient B was honest about events he could not recall and therefore did not place too much weight on the fact that Patient B did not describe his physical manifestations in his witness statement or his account to Dr A.

158. In his witness statement Dr Scott stated that if Patient B '*did feel uncomfortable at any stage during the consultation, which was certainly not apparent from his actions' then I shall be happy to apologise, but he gave no such indication in during the consultation'.*

159. Dr C stated that as an experienced doctor, Dr Scott should use his skill to observe a patient's body language and ask if the patient is comfortable, allowing the patient to pause and respond. Dr C described non verbal signs that Dr Scott ought to have looked out for, such as changes in eye contact, changes in posture, the appearance of being distracted or fidgeting with his hands

160. He stated in this case, as the conversation because more intense, Dr Scott should have checked in with the patient. He stated that general consent to such a discussion would not be enough for all of the actions Dr Scott undertook and that for each of those actions, further consent would be required as the discussion became more intense. He stated that checking questions such as ' how is this going?' would enable Dr Scott to gage where the discussion was going and how the patient found it, enabling him to move on.

161. On balance, the Tribunal accepted that Patient B was feeling discomfort as the discussion progressed and showed some signs of physical manifestation which were not picked up by Dr Scott. Dr Scott ought to have checked with patient B that he was happy to proceed, particularly after he began to share his own beliefs and personal experiences to ensure Patient B was comfortable with the discussion progressing in this way.

162. The Tribunal therefore concluded that non verbal signs may not have been apparent at the end of actions in 2(a) and 2(b) and where Patient B was answering questions. However, after this, Dr Scott missed Patient B's non-verbal signs and should have checked with him before proceeding to clasp his hands or facilitate prayer. It therefore determined that by virtue of his non verbal signs, Patient B could not have consented to Dr Scott's actions in respect of 2(c) or 2(d).

Engaging in discussion

163. Patient B stated in his witness evidence that upon hearing the option of a spiritual discussion, he did not understand what this would entail and that he thought this would involve some type of mindfulness and breathing exercises. He stated that Dr Scott was not clear about where the conversation would be going, even though he did most of the talking. However, Patient B stated in his oral evidence, that he was asked questions about his faith and his schools, and he answered those questions. Patient B stated that when the consent form was given to him at the beginning and the reasons for the faith discussions were explained, he was still open to the treatment as he felt it would benefit him. This did not, at that stage 'ring any alarm bells' for patient B and he was happy to see where the conversation went. Patient B stated that he listened to Dr Scott about the Christian faith and answered his questions in relation to where he was with his own faith.

164. Dr Scott's record about Patient B's engagement in the second consultation is very limited. Dr Scott added in his oral account that Patient B was compliant and continued with the discussion. He accepted that he did most of the talking and demonstrated no signs that he was unwilling for the discussion to take place or to continue. Patient B stated that he felt he should be obedient even though he felt uncomfortable being told he had disconnected with God. He accepted that at no time did he use the word no to stop the consultation. Dr Scott stated Patient B did not disengage and continued with the conversation. He stated that Patient B did not express that he was not comfortable to proceed.

165. Patient B's oral evidence stated that he was open to discussion, and he listened to Dr Scott's account about his own beliefs and the miracle story. He said he then became shocked and had a *"sinking feeling"* when Dr Scott mentioned Patient B becoming disconnected with God and this being the reason for his misfortunes. This change in the way Patient B was feeling indicated that this was unexpected. However, Patient B stated that he was still willing to listen and proceed because he thought it would make sense later. He stated *'in the back of my mind, I thought maybe he has just phrased it wrong and there maybe some validity afterwards'*. He described himself as feeling uncomfortable but willing to hear what Dr Scott had to say. He agreed he did not say anything to stop him however stopped talking and listened to what Dr Scott had to say. He was no longer contributing to the discussion. Dr Scott said he did not observe any signs of distress however the Tribunal considered that he should have checked as is reasonable to expect from a reasonably competent doctor.

166. The Tribunal considered the evidence of Dr C who stated that the first half of the discussion where there was a back and forth between Patient B and Dr Scott,

notwithstanding that Patient B was contributing to the conversation, the onus was on Dr Scott to check he was comfortable. He stated in view of the length of the consultation, it was reasonable for Dr Scott to check Patient B felt comfortable to continue.

167. The Tribunal considered the initial two way discussion which took place, on all accounts and this suggested, that Patient B was consenting to participating in such a discussion as he was open minded about the help he could receive for his mental health. However, Patient B stated that after Dr Scott has made the comments about asking for forgiveness and his disconnection with God being the reason for his misfortunes, Patient B began to disengage and was shocked. There is no further evidence from Dr Scott or Patient B as to what he said in response to Dr Scott sharing those beliefs with him.

168. Dr D stated in his oral evidence that where a patient is silent during a consultation or looks ill at ease, it would be reasonable to ask questions such as 'are you ok' or 'how it is going'.

169. The Tribunal concluded that Patient B did pull back his engagement at this stage and was no longer speaking. The Tribunal opined that Dr Scott should have checked if he was ok and was happy to proceed.

170. Dr Scott, in his oral evidence and his response to NHSE stated that the onus was both on him and Patient B equally to ensure the discussion was welcome. In his oral evidence, he stated that he had taken implicit consent and if he saw that the patient was not happy to proceed or that he was not 'enjoying it' he would stop. He stated that as this was a two-way discussion, the onus would be on both the doctor and the patient. He stated that Patient B was in his 20s and was able to answer questions at this Tribunal and therefore he could not accept that he would be unable to speak up in the consultation and say no if he was unhappy to proceed.

171. The Tribunal therefore determined that although Patient B may have felt uncomfortable at the time, he continued to engage in the conversation and did not inform Dr Scott that he wished to stop. It concluded therefore that by continuing to engage in the discussion Patient B consented to Dr Scott's actions in respect of 2(a) and (b).

172. However, it could not be satisfied that continuing to engage in the discussion element of the consultation amounted to Patient B consenting to Dr Scott clasping his hands or facilitating prayer as per 2(c) and (d). This is explored further below.

Hands out to pray

173. The Tribunal bore in mind that on both accounts, there was no mention that contact of hands was about to take in the documentary evidence.

174. In his witness statement, Dr Scott stated *'I accept that at the end of a spiritual consultation, I often ask whether it would be ok to pray with the patient (paragraph 14). Most patients agree, whether or not they pray themselves, but the general position is that even those for whom this isn't their usual practice state that they are grateful for the time and trouble taken. [Patient B] claims to have been reluctant to pray, yet agreed to do so. I gently held his hands, again my usual practice, to show the importance of physical touch which is well-known to be beneficial to patients'.*

175. Dr Scott stated in his oral evidence that he asked if he could hold Patient B hands. He added that he would normally ask the patient if 'can we pray' or 'do you mind if we hold hands' however could not recall if these words were used with Patient B specifically on that day. Dr Scott did not make mention to this in his witness statement. Patient B denied being asked by Dr Scott if he could hold his hands and stated that he was only asked to put out his hands and was unclear why. The Tribunal had established that Patient B could have reasonably expected a prayer was about to happen in view of what the doctor has documented that he said in the moments before the prayer and Patient B's own account asking him whether he practiced any kind of prayer. Patient B stated that there was some mention of prayer and when Dr Scott stated 'why not now' he interpreted this to mean, what do you have to lose by praying.

176. He stated he was reluctant to pray but accepted he did not say anything about his reluctance however there was a brief pause between his request and the prayer. Patient B stated he did put out his hands when asked to do so and was surprised when his hands were clasped. He stated that this was *"invasive",* and he was not expecting that. He accepted that they were talking about prayer but did not think this was linked to Dr Scott's request to lift up his hands in front of him.

177. The Tribunal concluded that albeit Patient B knew that a prayer was going to ensue, separate consent would have been required to allow Dr Scott to clasp Patient B's hands and pray. This involved a physical touching which required further permission. On the evidence it had heard, the Tribunal concluded consent was not sought nor given. The Tribunal concluded that Dr Scott ought to have checked that consent to clasp Patient B's hand was given and the question 'why not know' was not sufficient for physical contact to take place. Dr Scott stated

that he closed his eyes during the prayer and therefore could not have been observant to any further signs that Patient B was not happy to proceed.

178. The Tribunal concluded that this marked a change in the intensity of the consultation and Dr Scott should have checked to see if Patient B was willing to proceed as consent could no longer have been implied and had not been expressly given for his hands being clasped.

179. Patient B accepted that he physically engaged in the prayer, however he did not actively participate in the prayer and was so shocked about his hands being clasped that he could not concentrate on what was being said. He stated that he was *"waiting for it to be over".* The Tribunal accepted that it was only Dr Scott who verbalised the prayer when patient B hands were clasped. As the Tribunal considered that fresh consent would have been required at that stage when Patient B's hands were clasped, it could therefore be reasonably concluded that Patient B did not consent to Dr Scott facilitating in prayer which was in the form of clasped hands.

180. Dr Scott stated in his oral evidence that during the prayer he had his eyes closed. The Tribunal concluded that he would been unable to look out for signs that Patient B was not happy to proceed. At this stage, the Tribunal considered a checking procedure should have been carried out by Dr Scott. It considered that reasonable questions could have been posed to Patient B such as *"are you comfortable to pray out loud/ are you comfortable to pray holding hands?".*

181. In reaching this determination, the Tribunal was mindful of Dr C's oral evidence when he stated that there needed to be an agreement to hold hands with the patient and engage in prayer. It therefore concluded that by raising his hands, Patient B could not have consented to Dr Scott's actions in respect of 2(c) or 2(d) and Dr Scott should have renewed consent before clasping Patient B's hands.

Taking the Bible

182. Patient B stated that Dr Scott insisted on giving him a Bible three times and he described taking the Bible "unwillingly". Dr Scott refuted Patient B's statement, stating that he would not have asked him three times as it would be clear Patient B was unwilling and so would not have read it. The Tribunal considered what Patient B had stated in his evidence, that he complied in order to be able to leave the consultation.

183. The Tribunal was of the view that the bible being given or taken by Patient B did not assist with its determination as to whether Dr Scott's actions in relation to 2(a),(b),(c) and (d) were welcomed as this was not formally part of the allegations before the Tribunal.

184. Having determined that consent could not have been given in respect of Dr Scott's action in relation to 2(c) or 2(d), the Tribunal next considered whether Dr Scott carried out checks to ensure Patient B was happy to for his hands to be clasped and engage in prayer during the consultation.

185. The Tribunal considered the evidence of Dr C who opined that it was imperative for Dr Scott to be alert to whether the conversation was welcome throughout and to be mindful of the stress on the patient. He stated, in view of the length of the consultation, it was important to carry out periodical checks. He also said he would expect Dr Scott to recognise that this was an unusual conversation and to describe the actions necessary. He stated that there needed to be an agreement to hold hands with a patient and to engage in prayer. The Tribunal accepted that what appears unusual to Dr C may be a normal spiritual discussion for Dr Scott, and indeed the contents of the discussion did not raise any concerns from Dr D who stated Dr Scott's consultation notes seemed reasonable. The Tribunal also noted that Dr Scott stated he had additional training in theology and claimed therefore he was perhaps in a better position than other doctors to engage in such discussions.

186. Dr D stated that it was not necessary to continuously ask the patient if they were happy to proceed, as this would make a patient 'hyper vigilant'. He added that as there was no outward sign of difficulty, it would have been helpful to check however this could risk adding artificial restraints to the ongoing rapport and could impact the flow of the consultation. He stated however, if the patient seems ill at ease or if the patient is not making eye contact or there is some moving around, then some checking questions would be required.

187. Both Dr D and Dr E agreed that the spiritual discussion needed to be patient centred.

188. The Tribunal took into account Dr E's oral evidence when assessing consent. Dr E has had experience of incorporating spiritual assessments in his own practice where there is an identified spiritual need. He agreed that when a physician has completed a spiritual assessment and is satisfied that consent is given effectively to proceed, a doctor may listen to a patient elaborate on their spiritual or religious concerns.

189. Dr E described five boundaries to which doctors, in his opinion, should be aware of when assessing and addressing spiritual needs of a patient:

1. *Do not prescribe religion to non-religious patients;*
    - Dr E opined that if a doctor had, for example, a patient struggling with social isolation and was at one time involved in religion in some way, then he considered it would be appropriate to suggest to the patient getting back into their religious community where they might receive a little more support. He stated that prescribing of religion like this is done in a sensitive patient centred way.

2. *Do not force a spiritual assessment for a patient who is not religious;*
    - He stated that that prescribing of religion should be done in a sensitive patient centred way. If it is clear from the spiritual history that the patient is not religious, then the doctor should not force that any further. The doctor can acknowledge it and then move on to address more secular forms of support.

3. *Do not pray with a patient before taking a spiritual history and unless the patient asks;*
    - The doctor may let the patient know that prayer is an option. Dr E considered it was acceptable for a doctor to have some physical contact as an indication of compassion and care, such as a hand on the shoulder or possibility holding the persons hands.

4. *Do not spiritually counsel patients;*
    - If a patient has a complex spiritual issue or need, then the doctor should refer the patient to somebody with training and skills to address those areas. He acknowledged that most patients do not have complex spiritual issues. Patients tend to have more day-to-day 'stuff' to do with their functioning and their medical illness and how it is affecting their family. As such a little counsel would certainly not be harmful.

5. *Do not do any activity that is not patient centred and not patient directed.*
    - The activities that the doctor does needs to be patient centred and needs to be done by the consent or the direction of the patient. He described that in addressing spiritual issues, the scenario could be likened to a 'ballroom dance', whereby the doctor needs to be sensitive and not step on the toes of their 'partner' whom is the patient, and the patient leads.

    - Dr E stated that from the steps taken by Dr Scott it would be reasonable to infer consent from his actions. He stated that Patient B moving his hands would suggest he was on board with the prayer. He stated that by the patient

> just being there, looking for help and comfort would also imply consent. He stated that provided a patient is on board to pray, it would be ok for the Doctor to proceed however the doctor must not coerce the patient to do something they do not wish to do.

190. The Tribunal found that Dr Scott undertook a Christian spiritual discussion with overtly religious content which also involved a prayer. The Tribunal considered, in relation to the comments made by Dr Scott and the subsequent holding of hands, goes over and above the realms of a spiritual conversation that might generally occur. For this reason, Dr Scott should have recognised that Patient B, who was not expecting this, was getting anxious. It would be expected for a reasonably competent doctor to ensure that any activity was with Patient B's consent and check if it was welcome. The Tribunal concluded as the conversation became more intense and included emotionally loaded content, namely after a conversation about miracles or Dr Scott's own personal experiences, the onus was on Dr Scott to carry out positive checks that their patient was comfortable. It did not consider a patient to be passively engaging as explicit consent. The Tribunal considered there to be a number of times during the consultation where it would have been natural and appropriate to stop and check with Patient B that he was happy to continue and maintain appropriate levels of information. This, it determined would have been after Dr Scott spoke to Patient B about reconnecting with God and certainly before taking hold of Patient B's hands.

191. The Tribunal found that Patient B did consent to undertake a spiritual discussion, but the Tribunal was of the view that Dr Scott then overstepped the boundaries. This was supported by Dr C's opinion in his expert report dated 21 June 2022:

> *"it was not, in my opinion sufficient for Dr Scott to obtain general permission for a 'spiritual discussion' to take place and not explicitly ensure that Patient [B] remained comfortable when, for example, Patient [B] was asked to 'apologise to God for leaving him and confirm that he will now be by his side.' The extent of Dr Scott's reported engagement with spiritual matters goes well beyond what would reasonably be expected to constitute a spiritual discussion with a general practitioner."*

192. Patient B said he wasn't listening to the prayer as he was so *"taken aback",* and in the Tribunal's view was suggestive that he wasn't aware that it was coming. Therefore, if he wasn't aware, he could not have consented to the clasping of hands or a prayer. The Tribunal considered that Dr Scott needed to have asked the appropriate questions and provided the required information so Patient B would know he was going to be asked to pray and could have anticipated the act.

193. The Tribunal was of the view that because of the way the patient was feeling and signs of discomfort that he was demonstrating, Dr Scott should have renewed consent in order to proceed to clasping his hands and facilitating prayer. In failing to check in with Patient B, Dr Scott had failed to ensure that the consultation remained patient centred and in doing so failed to maintain that his actions were welcome.

194. Dr Scott accepted in his evidence that Patient B seemed a little surprised with the discussion which should have prompted him to check in with Patient B at each step, but particularly when the discussion was to become more intense and require physical touching which Patient B had not anticipated.

195. The Tribunal determined that even if Dr Scott could not see those signs or they were not present, Dr Scott should have properly explained to Patient B that he was about engage in prayer and was about to make contact with his hands in order to pray or provide him with suitable options. The Tribunal did not consider Dr Scott's comment "why not now" could reasonably have suggested to Patient B that Dr Scott was going to take his hands into his own hands to pray. In failing to read the signs and/or ask the proper questions, Dr Scott failed to ensure consent was maintained. As such, Dr Scott failed to ensure that Patient B welcomed his actions in respect of 2(c) and 2(d).

196. Taking into account the evidence, the Tribunal found paragraph 2(e)(i) proved in so far as it related to actions in 2(c) and 2(d).

Paragraph 2(e)(ii)

197. The Tribunal then considered whether if Dr Scott failed to ensure that Patient B did not feel pressurised into partaking in one or more of the actions described at paragraphs 2(a), 2(b), 2(c) and 2(d).

198. In relation to Dr Scott's actions in 2(a) and 2(b), the Tribunal determined that Patient B had consented to the spiritual discussion and the sharing of beliefs by virtue of engaging in the discussion and re-entering the room. The Tribunal determined that consent was not withdrawn in respect of 2(a) and 2(b) and therefore it found no evidence to support that Patient B felt pressurised or that Dr Scott failed to ensure that Patient B did not feel pressurised.

199. As the Tribunal concluded that consent was withdrawn after Dr Scott shared his personal beliefs, the Tribunal went on to consider whether Dr Scott failed to ensure the Patient B did not feel pressurised in relation to the clasping of hands and facilitating prayer.

200. The Tribunal noted that Patient B accepted in his oral evidence that there was no pressure on him to sign the consent form. He stated that Dr Scott had asked him three times to take the Bible and he then acquiesced. However, this was not mentioned in his witness statement. The Tribunal noted that when asked whether he felt under pressure to take the Bible, he a stated he did not. Again, this did not particularly assist the Tribunal as it did not fall within the specific allegations, however, in assessing the evidence, it noted Patient B's honesty when stating when he did or did not feel pressurised. It also noted that there was no evidence of Patient B being forced to come back in the consultation room, although he may not have been aware why he was coming back in.

201. Patient B said in his witness statement that during the spiritual discussion:

> *"I felt like he was the puppeteer, and I was the puppet.*
> *…*
> *"[Dr Scott] clasped my hands firmly, so that I would have to struggle to release my hands from his, and I was uneasy that he clasped my hands so tightly and the way the consultation was going."*

202. It noted that Patient B stated that *"the way [Dr Scott] spoke to me made me feel incarcerated and I could not get out, mainly this was mentally but also because of the prayer."*

203. In his witness statement Dr Scott stated, '*I did suggest a local church that is attended by people of [Patient B's] age, but there was never any suggestion of compulsion'.*

204. Dr Scott told the Tribunal that he does not pressurise anyone into a spiritual discussion, rather he offers and encourages. While the Tribunal accepted that Dr Scott is passionate about his faith, it considered that Patient B would have been shocked by the intense nature of the consultation which included a clasping of hands and facilitating a prayer. As the Tribunal concluded that further consent was needed at the stage when Dr Scott reached for Patient B hands and clasped this for prayer and Dr Scott failed to check if the patient was comfortable with this. The Tribunal therefore determined that as he held onto Patient B's hand to engage in prayer and did not check if he was comfortable, Dr Scott failed to ensure that Patient B did not feel pressured to continue.

205. The Tribunal therefore determined that Patient B felt pressured to partake in the clasping of hands and prayer.

206. The Tribunal found paragraph 2(e)(ii) of the allegation proved in so far as it relates to actions 2(c) and 2(d).

The Tribunal's Overall Determination on the Facts

207. The Tribunal has determined the facts as follows:

Patient B

1. At all material times, you knew that Patient B was vulnerable by reason of their mental health.
   Determined and found proved

2. On 25 January 2022 you consulted with Patient B and you:

   a. undertook a religious and/or spiritual discussion with Patient B;
      Determined and found proved

   b. discussed your own religious and/or spiritual beliefs with Patient B;
      Determined and found proved

   c. clasped Patient B's hands;
      Determined and found proved

   d. facilitated a prayer with Patient B;
      Determined and found proved

   e. failed to ensure that Patient B:
      ~~i. ensure that Patient B:~~

      i. ~~1.~~ welcomed one or more of your actions as described at paragraphs 2.a., 2.b., 2.c. and 2.d;
         Determined and found proved in respect of 2c and 2d

      ii. ~~2.~~ did not feel pressurised into partaking in one or more of the actions described at paragraphs 2.a., 2.b., 2.c., and 2.d..
         Determined and found proved in respect of 2c and 2d

Determination on Impairment - 01/09/2023

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

The Evidence

209. 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, this evidence included but was not limited to:

- Statement from Dr F, Dr Scott's Responsible Officer, dated 14 July 2023.
- Dr Scott's Warning letter, dated 15 June 2012.
- XXX.
- Certificate in Professional Boundaries in Practice, dated 3 November 2022.
- Record of reflection and learning from Professional Boundaries in Practice course.
- Testimonials in respect of Dr Scott from patients and other professionals, various dates 2020-2022.

Submissions

210. The following is a non-exhaustive summary of submissions made during the impairment stage.

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

211. Ms Hill submitted that the facts found proved amounted to serious misconduct because Dr Scott's conduct fell seriously short of what to expect from a doctor. She further submitted that Dr Scott's fitness to practice is impaired by reason of his misconduct. Ms Hill highlighted paragraphs from Good Medical Practice (2013 edition) ('GMP') and GMC's Guidance on Personal Beliefs and Medical Practice (2013)('GMC's Personal Beliefs guidance'), which she submitted were engaged in Dr Scott's case (listed below). She submitted that Dr Scott's care in relation to Patient B fell seriously below the standard expected of a reasonably competent practitioner.

*Paragraph **54** -* GMP

212. Ms Hill submitted that Dr Scott's conduct in expressing his religious beliefs to Patient B, clasping his hands and facilitating a prayer with him exploited his vulnerability and caused him distress.

*Paragraph **4** - **GMC's Personal Beliefs Guidance***

213. Ms Hill submitted that Patient B was caused distress in that he described feeling uncomfortable and felt "*taken aback*". He further described his confusion about what had happened during the consultation and said he was shocked by it. Patient B was distressed for some days after the consultation and was distracted by looking for signs of a miraculous event. He was anxious about meeting with Dr Scott again and the experience had such a negative impact on him that did not wish to consult with him in future. Patient B described being "*traumatised*" after the consultation and feeling "*betrayed*" by Dr Scott. He didn't seek to attribute all of his difficulties to the consultation with Dr Scott, but he felt that the consultation detracted him, and delayed the improvement of his mental health.

*Paragraph **29** - GMC's Personal Beliefs Guidance*

214. Ms Hill submitted that making enquiries of Patient B's religious and spiritual beliefs may well have been appropriate, given his presentation. She submitted, however, it was inappropriate, to put pressure on Patient B to hold hands and pray, particularly when no checking activities were conducted to ensure that those actions were welcomed.

*Paragraph **30** - GMC's Personal Beliefs Guidance*

215. Ms Hill submitted that while the Tribunal had determined that Patient B did consent to undertake a spiritual discussion, Dr Scott then overstepped the boundaries. Further, that because of the way Patient B was feeling and signs of discomfort that he was demonstrating, Dr Scott should have renewed consent in order to proceed to clasping hands and facilitating prayer. In failing to check in with Patient B, Dr Scott failed to ensure that the consultation remained patient centred and in doing so failed to maintain that his actions were welcomed. Dr Scott failed to ensure that Patient B welcomed his actions in respect of allegations 2(c) and 2(d). She submitted that Dr Scott failed to keep the discussion relevant to Patient B's care and treatment. Dr Scott breached the professional boundary that existed between him and Patient B. Further, he breached the relationship of trust between him and Patient B.

*Paragraph **31** - GMC's Personal Beliefs Guidance*

216. Ms Hill submitted that the Tribunal had determined that Patient B could not have known the full extent of what he was consenting to when he re-entered the consultation room. It further determined that Patient B gave implied consent to the initial discussion however not in relation to Dr Scott sharing his beliefs, clasping his hands or facilitating prayer as this was not made clear to him before he re-entered the room or immediately afterwards. The Tribunal acknowledged that Patient B did not verbally express his thoughts at the time but considered that it was Dr Scott's responsibility to gauge any signs of discomfort in the patient. The Tribunal further determined that by virtue of his non-verbal signs, Patient B could not have consented to Dr Scott's actions in respect of 2(c) or 2(d). She submitted that

Dr Scott by virtue of clasping Patient B's hands and then praying with him, imposed his beliefs and values on Patient B, and further caused him distress by the inappropriate and, it is submitted, insensitive expression of those beliefs and values.

217. Ms Hill reminded the Tribunal of the expert opinion of Dr C, in regard to allegation 2(e)(i) and 2(e)(ii), where he opined that if Patient B's statement was accepted then Dr Scott did not ensure that Patient B welcomed his actions and he did pressure Patient B into taking part in his actions, then this was not consistent with GMC Guidance and was seriously below the standard expected. Dr C maintained that Dr Scott's clasping of Patient B's hands and facilitating prayer when this was not welcome had the potential to undermine the doctor patient relationship.

218. Ms Hill also reminded the Tribunal of Dr D's expert opinion, he maintained that Dr Scott's conduct was not below the standard expected. However, she submitted that this opinion was not sustainable in the light of the facts found proved. Dr D opined that some checking questions would be required if the patient seemed ill at ease or if the patient was not making eye contact, or there is some moving around. Both he and Dr E agreed that the spiritual discussion needed to be patient centred.

219. Ms Hill submitted that the Tribunal must have regard for the way in which Dr Scott has acted, or failed to act, in the past, including the facts found proved by this Tribunal. Ms Hill drew the Tribunal's attention to a warning letter sent to Dr Scott on 15 June 2012 by the GMC. This related to complaint alleging Dr Scott had abused his position as a medical practitioner to push his religion upon a vulnerable patient. She added that it was alleged that Dr Scott belittled the patient's religion (which was not the same as his) and emphasised the importance of Christianity, stating that Jesus could cure him. The Investigation Committee determined that Dr Scott knew or ought to have been aware that the views expressed by him were not directly relevant to the patient's clinical case and could potentially distress the patient. It determined that Dr Scott went beyond the limit of such spiritual guidance and his actions caused distress to the patient which was foreseeable. The committee determined that Dr Scott's actions constituted a significant departure from Good Medical Practice and supplemental guidance but that, in the circumstances, his actions fell just below the threshold for a finding of impaired fitness to practise. The committee determined that it was appropriate, proportionate and in the public interest for the protection of the reputation of the profession to issue Dr Scott with a warning. The warning was in place for a period of five years, to 2017.

220. Ms Hill also referred the Tribunal to XXX

221. Turning to the issue of impairment, Ms Hill referred to Dame Janet Smith in the Fifth Shipman Report, which discussed four examples where impairment may arise. She submitted that Dr Scott's fitness to practise is impaired with reference to limbs *a, b* and *c.*

222. Ms Hill submitted that there is no evidence of remediation in Dr Scott's case, although matters might be remediable. She submitted that Dr Scott did not accept he should have behaved any differently with regards to the spiritual discussion, nor had he shown any empathy or understanding for Patient B's discomfort during the consultation or his distress after it. She submitted that Dr Scott had mentioned being 'sorry' in his response to the NHSE dated 10 June 2022 and being 'happy to apologise' in his witness statement. However, she stated that although an apology had been expressed, it could not be conceived as being true and sincere in light of the evidence heard.

223. Ms Hill noted the following factors below and submitted that Dr Scott has no insight into his behaviour or into the impact his behaviour may have on his patient.

a. Dr Scott failed to acknowledge that he was in a position of trust and authority in relation to Patient B and that the onus was on him to ensure that Patient B welcomed his actions and didn't feel pressurised into partaking in them.

b. Dr Scott failed to regard Patient B as vulnerable by reason of his mental health and described him as "needy", rather than "vulnerable".

c. Dr Scott was wrong to assume that Patient B would verbalise any discomfort he felt.

d. Dr Scott failed to recognise the non-verbal signs that Patient B was uncomfortable during the clasping of hands or praying.

e. Dr Scott failed to undertake checking activities as the spiritual conversation became more intense, and the onus was on him to do so.

224. Ms Hill submitted that taking the case as a whole and the lack of insight as stated above, the likelihood of repetition is high.

225. Ms Hill drew the Tribunal's attention to the testimonials from Dr Scott's patients who both welcomed and benefited from a faith discussion with him. She submitted that she did not wish to detract from the positive content of the testimonials, but noted that they all predate 12 April 2022, which is the date Patient B's complaint was reported to the GMC. She submitted that these related to the previous complaint and therefore could not address the issues in this case.

<u>On behalf of Dr Scott</u>

226. Mr Phillips submitted that Dr Scott's actions did not amount to serious misconduct and his fitness to practice is not impaired. He referred the Tribunal to the authority of *Cheatle v GMC [2009] EWHC 645 (admin)* which held that misconduct must be serious rather than mere misconduct.

227. He further cited the authority of *Schodlok v The General Medical Council (GMC)[2015] EWCA Civ 769* which held that non serious misconduct findings should not be rolled up to become a justification for a finding of current impaired fitness to practice, though it was (obiter) left open that this might be possible in some circumstances.

228. Mr Phillips also referred the Tribunal to the five principles set out in *Calhaem v GMC [2007] EWCH 2606 (Admin)* and the five guiding principles set therein.

229. Mr Phillips submitted that the allegations found proved did not amount to harmful conduct and the harm to Patient B was not great. He submitted that much of the consultation was not offensive to Patient B, as per his evidence. He submitted that the turning point for Patient B was a suggestion he had disconnected from God and the subsequent prayer, which formed a minority in the consultation.

230. He submitted that there was an element whereby the Tribunal would have to take Patient B's evidence 'with a pinch of salt', as Patient B was not always accurate. For example, there were inaccuracies in his evidence as to when the consent form was signed and whether the Bible was forced on him or not.

231. Mr Phillips referred to Dr E's expert opinion, who stated that if a patient is open to prayer and is of the same faith as the doctor, (and Patient B said that he was of the Christian faith tradition) it can be very beneficial to those with mental health issues. He submitted that there has never been a case where a patient was harmed by prayer. Therefore, in Mr Phillips submission, even though it seemed that prayer was the most offensive part to Patient B, when considering the wider evidence, the academic evidence, and the expert evidence, there was no long-term harm to Patient B.

232. Mr Phillips submitted that Dr Scott's intention was to always help Patient B and there is strong evidence that Dr Scott was attuned to Patient B's needs because he listened carefully and made extensive notes. He submitted that Dr Scott did this because he wanted to help the next doctor treating Patient B.

233. Mr Phillips submitted that the evidence that consent was lost was not the strongest, there was nothing in written evidence of any suggestion of a change in body language and the first time the Tribunal heard this was during oral evidence. He submitted that although

the Tribunal had accepted this evidence, Dr Scott could be forgiven that maybe he missed the signs of Patient B on that particular day.

234. Mr Phillips invited the Tribunal to consider Dr Scott's NHSE response, dated 10 June 2022, whereby he submitted that there is an element of sorrow and remorse from Dr Scott, "*if Patient B did feel uncomfortable at any stage during the consultation, which was certainly not apparent from his actions, then I shall be happy to apologize, but he gave no such indication during the consultation."* He submitted that Dr Scott does not wish to cause distress to anybody, and he is sorry that the Tribunal have found that this was the case.

235. Mr Phillips referred to Dr Scott's previous warning from 10 years ago. He submitted that the facts were different, and the complainant was from a different faith. He submitted that that warning, with arguably more serious allegations still did not meet the threshold of misconduct. XXX. He submitted that following these allegations, Dr Scott has attended a professional boundaries course and has since improved his practice.

236. Mr Phillips submitted that Dr Scott has improved his practice and will do so going forward. He submitted that in future, Dr Scott will ask patients specifically whether they want to pray together and whether they are content with him holding their hands. He stated that Dr Scott will also change the form of the Consent Form to make it clear that the spiritual conversation is to be about the Christian faith. Mr Phillips also submitted that the presence of a consent form in itself, showed the Tribunal that Dr Scott wishes to comply with the GMC Guidelines. Dr Scott has accepted that the onus is on him to ensure that consent is ongoing. He stated that from now on, Dr Scott will provide the Consent Form at the start of the process.

237. Mr Phillips also submitted that there is little guidance of what is or is not acceptable in a spiritual conversation and there is no exact guidance from the NHS or the GMC. Dr E opined that in general, there is a strong desire from patients to have their doctor pray with them. He submitted that Dr Scott did try to follow Dr E's five boundary rules. He further drew the Tribunal's attention to Dr D's evidence, who opined that Dr Scott's actions did not fall seriously below the standards expected of a reasonably competent GP and Dr C who opined that Dr Scott did go 'over and above the realms of a spiritual conversation that might generally occur.' However, Mr Phillips submitted that Dr D could arguably be in a better position to opine on this case, as he has had more experience of spiritual conversations.

238. Turning to insight, Mr Phillips submitted that Dr Scott has shown insight by accepting he will carry out his consultations differently, he has apologised at an early stage before the hearing, and he has demonstrated timely development of insight during the investigation and hearing.

239. Whilst Mr Phillips respected the Tribunals decision in relation to vulnerability, he submitted that there is an element whereby Dr Scott saw events differently in relation to Patient B's ADHD and mental health issues. Dr Scott accepted that he failed to recognise the non-verbal signs that Patient B was uncomfortable during the clasping of hands and praying, but Mr Phillips submitted that the Tribunal's findings should be seen in the light of the fact these were not the strongest signals/signs that one might expect from someone with ADHD. He submitted that Dr Scott has said he will now in future double-check with patients that they are content to pray.

240. Concerning risk of repetition, Mr Phillips submitted that Dr Scott is prepared to modify his practice as he has done over the last 10 years. He submitted that in terms of percentages, this case was one example where Dr Scott went slightly over the line. He submitted that Dr Scott has learned from this experience and undertook a professional boundary course in November 2022. Mr Phillips submitted that it was important to remember that Dr Scott has conducted an estimated 3000 spiritual conversations, and this case represented only a fraction of a percentage. Therefore, he submitted that this case must be seen in the light of the good character references provided on behalf of Dr Scott.

241. Therefore, Mr Phillips submitted that there is no unwarranted risk of harm to the public, Dr Scott has not brought the medical profession into disrepute, and he has not breached fundamental tenets of the profession. He submitted that this case was a one-off episode and did not constitute serious misconduct and as such Dr Scott is not impaired for the above reasons.

The Relevant Legal Principles

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

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

244. With regard to misconduct, the Tribunal reminded itself of the decision of the High Court in *Roylance v General Medical Council (No.2) [2000] 1 AC 311*:

> *"'Misconduct' is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may*

often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First it is qualified by the word professional which links the misconduct to the profession of medicine, Secondly the misconduct is qualified by the word serious. It is not any misconduct which would qualify. The professional misconduct must be serious"

245. It also took account of the case of *Nandi v GMC ([2004] EWHC (Admin))* as to seriousness where it was referred to as "*conduct which would be regarded as deplorable by fellow practitioners.*"

246. The Tribunal bore in mind that misconduct it is a high threshold and that to amount to serious misconduct, the conduct in question must be reprehensible, morally culpable or disgraceful.

247. In determining whether the proven facts establish misconduct, the tribunal should consider whether Dr Scott has breached any of the relevant provisions of GMP as well as the GMC guidance on Personal Beliefs and Medical Practice. The Tribunal should not only consider whether there has been a breach of good medical practise, but also the extent of any breach and the circumstances or context in which the breach occurred.

248. When, as here, a Tribunal is assessing an Allegation comprising several proven facts, it should consider whether – in relation to each of them - they separately amount to behaviour that can be defined as serious misconduct. Where this is not so in relation to one or more of the facts, consideration can be given to whether separate incidents of non-serious misconduct can be accumulated to amount to a finding of serious misconduct. The authority usually given for this proposition is the case of *Schodlok v General Medical Council ([2015] EWCA Civ 769, paragraph 72).* However, as Mr Justice Kerr has said in the more recent case *of Sowida v GMC ([2021] EWHC 3466 (Admin))* the view expressed in Schodlok was 'tentative' and 'very' preliminary. Therefore, the approach usually taken – and the approach this Tribunal has taken - is to recognise the need to consider both

a. the volume of the findings of non-serious misconduct, and
b. the similarity of the findings of non-serious misconduct,

before deciding whether a series of non-serious misconduct could amount to a finding of serious misconduct.

249. When looking at impairment, the Tribunal must have regard to the overarching objective, namely protecting and promoting the health, safety and well-being of the public, promoting and maintaining public confidence in the medical profession and promoting and maintaining proper professional standards and conduct for the members of the profession.

250. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *CHRE v NMC & Grant (2011) EWHC 927.* In particular, the Tribunal considered whether its findings of fact showed that Dr Scott's fitness to practise is impaired in the sense that he:

a. *'Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
b. *Has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
c. *Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; […]*

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

252. In determining whether Dr Scott's fitness to practise is currently impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amounted to misconduct which was serious.

253. The Tribunal analysed the evidence provided by both parties in the context of submissions by both counsel and the principles in relevant legal authorities.

254. The Tribunal had regard to the relevant paragraphs of GMP and GMC's Personal Beliefs Guidance which had been referred to by Ms Hill in her submissions.

255. The Tribunal was mindful that there were distinctions to be drawn as to the seriousness of breaches, and some instances where a doctor may have fallen below and in others seriously below. It appeared to the Tribunal that it should be very cautious before aggregating the misconduct under consideration.

256. Accordingly, the Tribunal determined that it was appropriate to consider the behaviour towards each allegation individually and where appropriate, collectively.

Paragraph 1(a)

257. The Tribunal had found it proved that at all material times, Dr Scott knew that Patient B was vulnerable by reason of their mental health. The Tribunal took into consideration that paragraph 1(a) was a factual allegation. This does not constitute any action on behalf of Dr Scott.

258. The Tribunal was of the view that although paragraph 1(a) could not amount to misconduct in itself, it went on to consider misconduct in respect of the remaining allegations bearing in mind that Patient B was vulnerable, and that Dr Scott was aware of this.

259. Accordingly, the Tribunal concluded that there was no misconduct in relation to its finding in respect of paragraph 1(a).

Paragraph 2(a)

260. In respect of paragraph 2(a) of the allegation, Dr Scott was found to have undertaken a religious and/or spiritual discussion with Patient B in the consultation.

261. The Tribunal bore in mind its own findings in the fact's determination and found that Patient B did initially consent to undertake a spiritual discussion by virtue of re-entering the room and engaging with Dr Scott, albeit it concluded that Dr Scott subsequently overstepped the boundaries.

262. The Tribunal had regard to the evidence of both expert witnesses. Dr C and Dr D were in agreement that a spiritual discussion was "*in principle, consistent with GMC Guidance for such a discussion to take place and that for Dr Scott to undertake such a discussion was, in itself, acceptable and not below the standard expected.*"

263. The Tribunal accepted the expert witness evidence, therefore in relation to this allegation in itself, the Tribunal determined that Dr Scott's actions were acceptable and did not fall standards below expected of a doctor and therefore did not amount to misconduct.

Paragraph 2(b)

264. The Tribunal bore in mind its own findings at facts in respect of paragraph 2(b).

265. The Tribunal had found that Dr Scott shared with Patient B his personal anecdotes and beliefs. Dr Scott stated that he normally does this to encourage patients and to build a rapport with them.

266. The Tribunal had determined at the facts stage that Dr Scott used the following phrases, or words to that effect, when speaking of his own spiritual beliefs and experiences to Patient B:

"disconnection with God was the reason for my misfortune."
"by coming closer to God he would become a better person"
"to apologise to God for leaving him and God would be by your side"
"Miraculous event"

267. The Tribunal also bore in mind that it did not find that Dr Scott failed to ensure that Patient B welcomed the sharing of spiritual beliefs nor that he failed to ensure Patient B felt pressurised by the sharing of beliefs. However, the Tribunal went on to consider the impact that sharing these words would have on Patient B.

268. The Tribunal accepted Patient B's account of events and it was entitled to consider the impact these comments had on Patient B. Patient B stated he *'was taken aback'* and felt '*shock*' and a *'sinking feeling'*. The Tribunal considered that Dr Scott's comments would have caused Patient B to feel distress and he felt that trust was broken. It had also found that it was after Dr Scott shared his personal anecdotes, beliefs and the story about a miraculous event, that Patient B began to exhibit physical manifestations of distress. It also noted that for several days after Patient B experienced intrusive thoughts on looking for signs of a reconnection with God. However, it was mindful it had received no evidence of the long-term effects that Dr Scott's actions had on Patient B.

269. The Tribunal had regard to the fact that Dr D and Dr C agreed that *"it was, in principle, consistent with GMC Guidance for such a discussion to take place and that for Dr Scott to undertake such a discussion was, in itself, acceptable and not below the standard expected."*

270. It also accepted Dr E's expert opinion that a spiritual discussion can be very useful to patients, but it must be patient centred.

271. The Tribunal accepted the expert evidence. While the Tribunal considered it acceptable for Dr Scott to discuss his own personal religious beliefs, it was of the view that Dr

Scott should have recognised his personal anecdotes went beyond that which is expected in a GP consultation and the impact it had on Patient B.

272. In light of this, the Tribunal considered that Dr Scott, *to some extent,* breached paragraphs 54 of GMP and 4 and 31 of GMC's Personal Beliefs Guidance.

GMP

> ***54*** *You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.*

GMC's Personal Beliefs Guidance.

> ***4*** *Doctors may practise medicine in accordance with their beliefs, provided that they act in accordance with relevant legislation and:*
> *• do not cause patients distress.*
> *If any of these circumstances is likely to arise, we expect doctors to provide effective patient care, advice or support in line with Good medical practice, whatever their personal beliefs.*
>
> ***31*** *You may talk about your own personal beliefs only if a patient asks you directly about them, or indicates they would welcome such a discussion. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them.*

273. The Tribunal bore in mind however that not every departure from GMP and GMC Guidance will necessarily amount to serious misconduct. Actions had to be sufficiently serious to amount to serious misconduct.

274. The Tribunal determined that Dr Scott's actions in respect of 2(b) amounted to misconduct, but it did not consider these to be such that fellow practitioners would regard as deplorable in the circumstances. Accordingly, it did not consider his behaviour in relation to 2(b) to be sufficiently serious so as to amount to serious misconduct.

<u>Paragraph 2(c), 2(e)(i) and 2(e)(ii) – clasping of hands</u>

275. The Tribunal found that during the consultation Dr Scott clasped Patient B's hands. It accepted that both Dr D and Dr C agreed that *"it was, in principle, consistent with GMC Guidance for Dr Scott to clasp Patient B's hands during a consultation and that for Dr Scott to act in this way was, in itself, acceptable and not below the standard expected."* However, as

the Tribunal found that this should have been with Patient's B's renewed consent, and as it was not, it concluded that this did amount to misconduct.

276. The Tribunal considered paragraph 2(c) in the context that 2(e)(i) and 2(e)(ii) was also determined and found proved. Namely that Dr Scott failed to ensure that Patient B welcomed his actions, and he did not feel pressurised to partake it in the clasping of hands.

277. The Tribunal bore in mind its findings at the facts stage. It found that Dr Scott should have properly explained that he was about to make contact with Patient B's hands, and he failed to read the signs and/or ask the proper questions to ensure that consent was maintained. It concluded that consent was needed before Dr Scott reached for Patient B's hands. It determined that Dr Scott did not check if Patient B was comfortable, and as such Dr Scott failed to ensure that consent was maintained, and that Patient B did not feel pressured to continue.

278. The Tribunal considered that the clasping of hands, goes beyond the realms of what might generally occur in a GP consultation concerning any patient's mental health. It considered that holding of hands intensified the consultation generally and touch would not have been reasonably anticipated with the words he used namely *"why not now?".*

279. For this reason, Dr Scott should have recognised that Patient B, who was not expecting this, was becoming anxious. It bore in mind that Patient B described that he felt like *"[Dr Scott] was the puppeteer, and I was the puppet."* It would be expected for a reasonably competent doctor to ensure that such activity was with Patient B's knowledge and express consent and check if it was welcome.

280. As per Dr E's five boundaries, the Tribunal considered that Dr Scott should have kept patient focussed as he proceeded with the spiritual discussions. Specifically, he should have been mindful and extra vigilant to a vulnerable patient such as Patient B. A specific and more detailed consent form should have been provided to Patient B and at the appropriate time. Patient B should have been given adequate time to consider the consent form and Dr Scott should have continued to check in regularly that consent was ongoing. Furthermore, Dr Scott should have taken a more detailed contemporaneous note of the spiritual discussion and included this in the patient's medical records.

281. The Tribunal had regard to the joint report from Dr C and Dr D. It was aware that they did not reach an agreed opinion if Patient B's statement was accepted in respect of paragraph 4eii, however, they were in agreement that Dr Scott's actions were below the standard expected.

282. In Dr C's opinion, Dr Scott's conduct was 'seriously below' the expected standard.

283. Taking the allegation 2(c) in the context that it was not welcome and Patient B felt pressurised to partake, the Tribunal determined that Dr Scott breached paragraphs 54 of GMP and 4, 29 and 30 of GMC's Personal Beliefs Guidance.

GMP

> *54 You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.*

GMC's Personal Beliefs Guidance.

> *4 Doctors may practise medicine in accordance with their beliefs, provided that they act in accordance with relevant legislation and:*
> *• do not cause patients distress.*
> *If any of these circumstances is likely to arise, we expect doctors to provide effective patient care, advice or support in line with Good medical practice, whatever their personal beliefs.*
>
> *29 In assessing a patient's conditions and taking a history, you should take account of spiritual, religious, social and cultural factors, as well as their clinical history and symptoms (see Good medical practice paragraph 15a). It may therefore be appropriate to ask a patient about their personal beliefs. However, you must not put pressure on a patient to discuss or justify their beliefs, or the absence of them.*
>
> *30 During a consultation, you should keep the discussion relevant to the patient's care and treatment. If you disclose any personal information to a patient, including talking to a patient about personal beliefs, you must be very careful not to breach the professional boundary that exists between you. These boundaries are essential to maintaining a relationship of trust between a doctor and a patient.*

284. The Tribunal determined that Dr Scott's conduct fell below standards expected of a reasonably competent doctor and he crossed professional boundaries such that it constituted misconduct. However, it did not find that Dr Scott's conduct could be considered *deplorable*. Therefore, it concluded that, although misconduct, Dr Scott's actions did not cross the high threshold for this misconduct to be considered as reprehensible, morally culpable or disgraceful so to amount to serious misconduct.

Paragraph 2(d), 2(e)(i) and 2(e)(ii) – facilitating prayer

285. The Tribunal found that during the consultation, Dr Scott facilitated a prayer with Patient B. It accepted that Dr D and Dr C agreed that it was, in principle, consistent with GMC Guidance for prayer to take place during a consultation and that for Dr Scott to facilitate such a prayer was, in itself, acceptable and not below the standard expected. However, as the Tribunal found that this should have been with Patient's B's renewed consent, it concluded that this did amount to misconduct.

286. The Tribunal considered paragraph 2(d) in the context that 2(e)(i) and 2(e)(ii) was also determined and found proved. Namely that Dr Scott failed to ensure that Patient B welcomed his actions, and he did not feel pressurised to partake it in the prayer.

287. The Tribunal bore in mind its findings at facts stage. The Tribunal had determined that although Patient B may have expected a prayer to take place in context of the conversation that preceded the act. The mere indication to raise his hands was not enough. Dr Scott needed to have asked the appropriate questions and provided the required information so Patient B would know he was going to be asked to pray in the form of clasped hands so that he could have anticipated the act. As Patient B was feeling and exhibiting signs of discomfort, Dr Scott should have renewed consent in order to facilitate prayer. The Tribunal determined that even if Dr Scott could not see those signs, either because his eyes were closed or they were not obvious to him, Dr Scott should have properly explained to Patient B that he was about engage in prayer in the way he intended to and provide him with suitable options. In not doing so, Dr Scott did not check if Patient B was comfortable, and as such, Dr Scott failed to ensure that consent was maintained, and that Patient B did not feel pressured to continue.

288. Much like its consideration above to paragraph 2c, 2ei and 2eii of the allegation, the Tribunal considered whether in relation to the prayer in the form of clasped hands went over and above the realms of what might generally be expected to occur in a GP consultation concerning any patient's mental health. It considered that the prayer further intensified the consultation and for this reason, Dr Scott should have been alert to Patient B becoming anxious. It would be expected for a reasonably competent doctor to ensure that any activity was with Patient B's consent, check if it was welcome and ensure Patient B did not feel pressured.

289. Again, in relation to this allegation, the Tribunal arrived at the same conclusion with reference to Dr E's five boundaries, paragraph 73.

290. The Tribunal took into account Dr C and D opinion, in respect of 2(e)(i) and 2(e)(ii).

291. Dr D stated that *"Dr Scott is recorded by Patient B as having asked, and gained permission to do so with the words to the effect of "why not now?", and with the patient then putting his hands out at Dr Scott's request; this could reasonably have been assumed by Dr Scott as Patient B having given his consent for prayer",* and as such he opined that Dr Scott's actions were not below the standard expected of a reasonably competent GP. The Tribunal was mindful that this opinion was given with the assumption that consent was given. However, the Tribunal at the facts stage, found that consent had already been withdrawn and further consent would have been necessary to proceed.

292. Dr C however maintained his original opinion that Dr Scott's actions of facilitating a prayer, in relation to 2(e)(i) and 2(e)(ii) fell seriously below the standards expected.

293. The Tribunal bore in mind Dr Scott's account that it was a 'positive prayer', however there was evidence to suggest that the prayer was about his personal beliefs. It was his belief that Patient B had disconnected with God and should ask for forgiveness. As such, the Tribunal determined to some extent, Dr Scott was imposing his beliefs on Patient B. It had also accepted Patient B's account that he was not engaging, and he had signalled signs of distress and discomfort. Thus, the Tribunal concluded that facilitating a prayer did cross boundaries because it was carried out without consent.

294. Taking the allegation 2(d) in the context that it was not welcome and Patient B felt pressurised to partake, Dr Scott breached paragraphs 54 of GMP and 4, 29, 30 and 31 of GMC's Personal Beliefs Guidance.

GMP

> ***54*** *You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.*

GMC's Personal Beliefs Guidance.

> ***4*** *Doctors may practise medicine in accordance with their beliefs, provided that they act in accordance with relevant legislation and:*
> *• do not cause patients distress.*
> *If any of these circumstances is likely to arise, we expect doctors to provide effective patient care, advice or support in line with Good medical practice, whatever their personal beliefs.*

29 In assessing a patient's conditions and taking a history, you should take account of spiritual, religious, social and cultural factors, as well as their clinical history and symptoms (see Good medical practice paragraph 15a). It may therefore be appropriate to ask a patient about their personal beliefs. However, you must not put pressure on a patient to discuss or justify their beliefs, or the absence of them.

30 During a consultation, you should keep the discussion relevant to the patient's care and treatment. If you disclose any personal information to a patient, including talking to a patient about personal beliefs, you must be very careful not to breach the professional boundary that exists between you. These boundaries are essential to maintaining a relationship of trust between a doctor and a patient.

31 You may talk about your own personal beliefs only if a patient asks you directly about them, or indicates they would welcome such a discussion. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them.

295. The Tribunal determined that Dr Scott's conduct fell below standards expected of a reasonably competent doctor and he crossed professional boundaries that it constituted misconduct. However, in the context of these events, it did not find that Dr Scott's conduct could be considered deplorable or disgraceful. Therefore, it concluded that, although this amounted to misconduct, Dr Scott's actions did not cross the high threshold required to be considered serious misconduct.

296. The Tribunal recognised that Dr Scott's care may have been negligent in regard to Patient B, bearing in mind he was vulnerable. The Tribunal was also mindful that the allegation before it concerned a single incident involving multiple acts. It considered this in the light of *Calhaem* where it was held that a single negligent act, is less likely to amount to serious misconduct.

Conclusion

297. Although the Tribunal considered that Dr Scott actions fell below what is expected of a reasonably competent GP and that he should have carried out the necessary checks particularly in this case because Patient B was vulnerable and had an ADHD diagnosis. The Tribunal concluded however that, whilst there is a spectrum of seriousness, Dr Scott's conduct did not reach the level to be classified as serious misconduct, for the reasons set out above.

298. The Tribunal considered the paragraphs of GMP and GMC's Personal Beliefs Guidance set out above. Although it acknowledged there to be a significant breach of the principles set out in the paragraphs above, the particular breaches which it had found were not of the level that could amount to serious professional misconduct.

299. In considering misconduct in these particular set of allegations, the Tribunal applied the relevant case law, and it was not satisfied that a member of the profession or member of the public would not describe Dr Scott's actions as deplorable behaviour.

300. The Tribunal had concluded that Dr Scott's conduct did not amount to serious professional misconduct. Accordingly, there was no ground for going on to consider impairment. The Tribunal therefore determined that Dr Scott's fitness to practise is not impaired.

Determination on Warning - 04/09/2023

301. As the Tribunal determined that Dr Scott's fitness to practise was not impaired it considered whether in accordance with S35D(3) of the 1983 Act, a warning was required.

Submissions

302. The following is a non-exhaustive summary of submissions made.

On behalf of the GMC

303. Ms Hill referred the Tribunal to the relevant paragraphs of the GMC's Guidance on Warnings (March 2021) ('Warnings Guidance') and the Sanctions Guidance.

304. She reminded the Tribunal of its findings at the impairment stage. It found that Dr Scott's conduct breached various paragraphs of GMP, and GMC's Personal Beliefs Guidance and he fell below the standards expected of a reasonably competent doctor. It found that Dr Scott's conduct amounted to misconduct, but it was not sufficiently serious as to amount to serious misconduct.

305. Ms Hill submitted that Dr Scott's conduct had significantly departed from the guidance in GMP and in GMC's Personal Beliefs Guidance. She further submitted that Dr Scott's conduct, whilst determined not to be deplorable, did have the potential to impact the reputation of the profession.

306. Referencing paragraph 32 of the Warnings Guidance, Ms Hill invited the Tribunal to consider the following factors when determining whether issuing a warning is appropriate:

a. the level of insight into the failings.

307. Ms Hill submitted that the GMC maintained that Dr Scott has minimal or no insight into his behaviour. She submitted that Dr Scott does not accept that he should have behaved any differently with regards to the spiritual discussion with Patient B. He has not shown any empathy or understanding for Patient B's discomfort during the consultation (he doesn't accept that it should have been apparent to him), or his distress after it. She reminded the Tribunal of the statement of Dr Scott's Responsible Officer. She stated *"NHS England has not seen any expression of regret or apology made by Dr Scott in relation to the allegations being referred to the MPTS hearing."*

308. In terms of demonstrating the timely development of insight during the investigation and hearing, Ms Hill submitted the following factors:

- Dr Scott failed to acknowledge that he was in a position of trust and authority in relation to Patient B and that the onus was on him to ensure that Patient B welcomed his actions and didn't feel pressurised into partaking in them.
- Dr Scott failed to regard Patient B as vulnerable by reason of his mental health and described him as "needy", rather than "vulnerable".
- Dr Scott was wrong to assume that Patient B would verbalise any discomfort he felt.
- Dr Scott failed to recognise the non-verbal signs that Patient B was uncomfortable during the clasping of hands or praying.
- Dr Scott failed to undertake checking activities as the spiritual conversation became more intense, and the onus was on him to do so.

b. genuine expression of regret/apology

309. In his letter to NHS England dated 10 June 2022, Dr Scott noted: *"[Patient B] finishes by stating that I pressurised him with my beliefs, causing him to feel very uncomfortable and that he felt worse after he consultation. I am sorry that he felt that way".* Further, Dr Scott noted the following in his witness statement dated 15 September 2022 "*If [Patient B] did feel uncomfortable at any stage during the consultation, which was certainly not apparent from his actions, then I shall be happy to apologise, but he gave no such indication during the consultation".* She submitted that whilst Dr Scott has, therefore, expressed an apology to Patient B, it is difficult to conceive that his apology is true or sincere in the light of his evidence.

c. Previous good history

310. Ms Hill submitted that the Tribunal should have regard to the Warning issued to Dr Scott in 2012 (which was in place for five years) and the conduct which led to that Warning being issued. The 2012 Tribunal determined that Dr Scott's actions were in direct conflict with paragraph 19 of the GMC's Personal Beliefs Guidance:
"You must not impose your beliefs on patients, or cause distress by the inappropriate or insensitive expression of religious, political or other beliefs or views".

311. She further submitted that Dr Scott's actions also contravened Paragraph 33 of Good Medical Practice:
"You must not express to your patients your personal beliefs including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress".

312. The 2012 Tribunal determined that Dr Scott's actions constituted a significant departure from GMP but that his actions fell just below the threshold for a finding of impaired fitness to practise.

d. Whether the incident was isolated or whether there has been any repetition

313. Ms Hill submitted that this incident is not an isolated one, it represents the repetition of similar conduct, albeit that the warning was issued over ten years ago.

e. Any indicators as to the likelihood of the concerns being repeated

314. In relation to the likelihood of the concerns being repeated, she submitted that, taking the evidence in the case as a whole, including the evidence Dr Scott gave before the Tribunal, the likelihood of repetition in this case is high.

315. Ms Hill highlighted, when asked by his counsel whether Dr Scott thought that informing Patient B about a "*miraculous event"* was reckless, he replied: *"in the current climate, it is certainly risky".* Dr Scott also stated that paragraph 31 of the GMC Personal Beliefs Guidance is "*a very thorny paragraph. I think it needs rephrasing".* When cross-examined as to whether he performed regular checking activities, Dr Scott stated: *"I think to be hauled over the coals is extraordinary".*

316. Ms Hill brought the Tribunal's attention to the interview provided by Dr Scott and posted on the Christian Concern website. In that interview, Dr Scott stated the following with regards to XXX, and the warning in 2012: *"Having had no sanction applied at all, my practice remains unchanged, to be honest even after my first case it made no difference to me whatsoever…"*

f. Any rehabilitative/corrective steps taken

317. Ms Hill acknowledged that Dr Scott attended a professional boundaries course in November 2022 and that he had submitted his reflections for the Tribunal's consideration. She submitted that the focus of any corrective steps taken only appears to be on the wording and the timing the consent form is issued.

g. Relevant and appropriate references and testimonials

318. Ms Hill acknowledged that Dr Scott has provided testimonials from patients who both welcomed and benefitted from a faith discussion with him. Again, the GMC reiterated its observation that those testimonials predate Patient B's complaint.

319. Ms Hill concluded by submitting that it was appropriate, proportionate and in the public interest to issue Dr Scott with a warning. Further, she submitted that a warning would be appropriate because the concerns about Dr Scott's conduct are sufficiently serious. If the conduct was to be repeated this would arguably result in a finding of impaired fitness to practise.

On behalf of Dr Scott

320. Mr Phillips submitted a warning should only be imposed if a doctor's behaviour or performance is significantly below the standards expected of doctors and should not be repeated, but restricting a doctor's practice is not necessary. Therefore, he submitted it was not necessary to issue Dr Scott with a warning.

321. Mr Phillips referred to the Tribunal's findings on impairment and the relevant paragraphs of the Warnings Guidance. He accepted that the Tribunal had found that Dr Scott's conduct amounted to clear and specific breaches of GMP, and supplementary guidance. He acknowledged that Dr Scott's conduct fell short of the threshold as for his fitness to practice to be found impaired. Mr Phillips did not accept that these particular concerns were sufficiently serious that, if there were a repetition, they would likely to result in a finding of impaired fitness to practice. Therefore he submitted that a warning would not be appropriate in this case. Further Mr Phillips did not accept that there was a need to formally record these particular concerns.

322. Mr Phillips turned to the GMC's submissions on warning and submitted the following:

Minimal or no insight

323. Mr Phillips submitted that Dr Scott has offered an apology and he does accept that he should have acted differently, hence the changes in his practice with the consent form. He rejected the GMC's submission that Dr Scott lacked empathy or understanding, as he submitted that the reason Dr Scott engaged in a spiritual conversation is because he has empathy, and he wants to help patients. He further rejected the GMC's assertion that Dr Scott acted for his own benefit. He submitted that Dr Scott had stated that his spiritual practice is risky, and he only does so for the benefit of his patients because he seeks to do what is best for them holistically.

Failed to acknowledge position of trust and authority

324. Mr Phillips submitted that the very presence of a consent form, and Dr Scott sending patients out and waiting to come back in the consultation room, demonstrates that Dr Scott acknowledged that the onus is on him to obtain consent. He reminded the Tribunal that Dr Scott has now adapted and changed his practice and the consent form to make it clear that the spiritual conversation is to be about the Christian faith, and he will provide the form at the start of the process going forward.

325. In respect of vulnerability, Mr Phillips submitted that it was established it was a difficult concept to define and as such Dr Scott could be forgiven for not accepting Patient B's vulnerability. He submitted that Dr Scott will act accordingly if he is in a similar set of circumstances in the future. He also submitted that in future Dr Scott will double check with patients that they are content to pray.

Regret and apology

326. Mr Phillips submitted that there were expressions of apology in witness statement and response from Dr Scott. However, he submitted in light that Dr Scott was *"facing a raft of allegations"* of which he had to defend himself and that Patient B had made a number of mistakes in his evidence, then Dr Scott could be forgiven for not being as apologetic as he might be otherwise. He submitted that Dr Scott is now sorry for the fact that Patient B was distressed but that was not his intention.

Previous history – warning in 2012.

327. Mr Phillips submitted that there is a reason why a warning gets expunged from the doctor's record after 10 years because it would be unfair for this to continue to be held against him. He submitted that Dr Scott has learned from this occasion and since improved his practice. He submitted that Dr Scott now abides by GMC guidelines and Dr E's five boundary rules.

Repetition

328. Mr Phillips refused the GMC's submission that the likelihood of repetition is high. He submitted that Dr Scott wishes to do the best for his patients and will in the future speak to them about faith, which is permitted by GMC guidelines. He submitted that there is a small risk of a patient who may become uncomfortable halfway through a spiritual consultation with Dr Scott as the intensity increases. Mr Phillips submitted that Dr Scott gets it right 99% of the time and by putting in place the following: the change of the consent form, the change of the timing of consent form, making it clear that it is a spiritual conversation about Christian faith, and obtaining specific consent regarding prayer, he will reduce the chance of repetition to almost 0%.

Rehabilitation

329. Mr Phillips submitted that the Professional Boundaries course was clear evidence that Dr Scott has undergone appropriate rehabilitation. He submitted that not only was this course beneficial to Dr Scott but also his patients.

330. Mr Phillips submitted it is accepted that the testimonials predate the current proceedings, but the previous complaint was live at the time and part of the NHSE investigation. Therefore, he submitted that issues raised in the testimonials were highly analogous for the Tribunal today.

331. Mr Phillips concluded it was not appropriate or proportionate to issue a warning.

The Tribunal's Approach

332. The decision whether to issue a warning is a matter for the Tribunal making an evaluative judgment, taking account of all the circumstances of this particular case and having regard to the submissions of the parties. In deciding whether to issue a warning the Tribunal has taken account of the Guidance and whether a warning is necessary, appropriate and proportionate in this case.

333. The Tribunal had regard to paragraphs 13, 14 and 16 of the Guidance, which provide:

> *'13 Although warnings do not restrict a doctor's practice, they should nonetheless be viewed as a serious response, appropriate for those concerns that fall just below the threshold for a finding of impaired fitness to practise.*
>
> *14 Warnings should be viewed as a deterrent. They are intended to remind the doctor that their conduct or behaviour fell significantly below the standard expected and that a repetition is likely to result in a finding of impaired fitness to practise. Warnings may also have the effect of highlighting to the wider profession that certain conduct or behaviour is unacceptable.*
> *…*
>
> *16 A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following*
> *circumstances:*
>
> *• there has been a significant departure from Good medical practice, or*
> *• there is a significant cause for concern following an assessment of the doctor's performance.'*

334. In considering whether to issue a warning, the Tribunal also took into consideration the factors outlined at paragraph 20 of the Guidance:

> *'20 The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.*
>
> > *a There has been a clear and specific breach of Good medical practice or our supplementary guidance.*
> >
> > *b The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor's fitness to practise has not been found to be impaired.*
> >
> > *c A warning will be appropriate when the concerns are sufficiently*

serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely relating to a doctor's health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.

d There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).'

The Tribunal's Determination on Warning

335. Throughout its deliberations, the Tribunal had regard to the statutory overarching objective. In that regard, it bore in mind that its power to issue a warning is an important feature of its role in protecting the public, which includes protecting the safety of patients, maintaining public confidence in the profession, and declaring and upholding proper standards of conduct and behaviour.

336. The Tribunal applied the principle of proportionality and has sought to balance the public interest with the interests of Dr Scott when approaching its determination on whether to issue a warning. The Tribunal was mindful that issuing a warning to a doctor is a serious step and not one which is to be undertaken lightly. It was also conscious that a warning would remain on Dr Scott's record.

337. In considering whether a warning was necessary and proportionate the Tribunal took into account factors outlined in the Warning Guidance.

338. The Tribunal bore in mind the apology that Dr Scott had expressed in his witness statement and his initial response to NHSE, however it considered this a conditional apology which did not reflect genuine insight or remorse. It also noted the Responsible Officer's statement, dated 14 July 2023, which stated that Dr Scott had not provided any expression of regret or apology. No subsequent evidence had been provided to the Tribunal of any direct apology given to Patient B.

339. The Tribunal determined that Dr Scott had completed the professional boundaries course, and this was done after the consultation with Patient B. It noted Dr Scott's reflections, which demonstrated some learning, reflection and empathy, however, did appear at times to be conditional on other factors. It noted that Dr Scott considered God's own laws to supersede professional boundaries which he considered to be restrictive and unhelpful. It also acknowledged, that in relation to engaging in touch, Dr Scott accepted that assumptions should not be made and there is a danger of getting this wrong. This therefore demonstrated, to some extent, that Dr Scott understood the importance of obtaining permission before touching a patient.

340. The Tribunal considered the previous Warning issued by the GMC in 2012. It noted that the circumstances that gave rise to the Warning were similar however not analogous. This is because the patient in the previous case was not of the same faith as Dr Scott and also the language used in that consultation, in the Tribunal's view was wholly inappropriate and different to the current matter. However, the Tribunal concluded that in both cases, Dr Scott had overstepped the boundaries, his care was not patient centred and the manner in which the consultation took place was inappropriate. The Tribunal acknowledged that this dated back 10 years however in light of the similarity between the two cases, the Tribunal concluded that it ought to take this into account when considering whether a warning should be imposed.

341. The Tribunal further considered that the previous warning was a relevant consideration and took into account the threshold that needed to have been crossed for the GMC to proceed with the complaint of this type in 2012. It also concluded that this warning would have been relevant when referring the current matter to the MPTS.

342. The Tribunal considered submission, both at the conclusion of the impairment stage and during Mr Phillip's submissions on a warning, that Dr Scott has since shown some change. He has since changed the wording of the consent form however no evidence of this has been provided. It also bore in mind that Dr Scott had accepted that he had not complied with the Practice protocol when carrying out a faith discussion. The Tribunal was mindful that this was not a requirement under GMP however it raised some concerns about Dr Scott's tendency to follow GMP and other guidance currently in place.

343. The Tribunal went on to consider the risk of repetition and whether this was likely in this case. The Tribunal considered the video that Dr Scott had posted online in which he stated that notwithstanding the warning, he would continue to operate as normal, suggesting that he dismissed the warning and rejected the need to change. Dr Scott further referred to the warning as 'disgraceful' in 2019 XXX. The Tribunal concluded that this demonstrated a lack of acceptance by Dr Scott that he had done wrong. It went on to determine that where there is a failure to acknowledge a wrongdoing that the risk of repetition would remain. The Tribunal concluded that this risk would remain until Dr Scott addresses his approach on reading the signs during the spiritual conversation, carrying out regular checks at each reasonable stage.

344. The Tribunal accepted submissions made by Mr Phillips about how Dr Scott has since adapted his practice and will continue to adapt this so that it is in line with this tribunal's finding. However, in absence of evidence to confirm what has changed, the Tribunal could not be sure how Dr Scott has changed his approach to such spiritual discussions, particularly when dealing with vulnerable patients. Mr Phillips submitted that Dr Scott 'gets it right 99% of the time' however the Tribunal had not seen any evidence to support this.

345. The Tribunal also considered the numerous testimonials that had been submitted by Dr Scott. It acknowledged that many patients valued engaging in spiritual discussions with Dr Scott. It however

noted that these predated the date of his consultation with Patient B and as such were made without the knowledge of a further complaint being made.

346. Notwithstanding the changes that Dr Scott states he will make to his spiritual discussions, the Tribunal was of the view that there was a risk of repetition, and a warning would appropriate ensure that its concerns were enshrined. It therefore determined that a warning was necessary, appropriate and proportionate in this case.

347. Dr Scott's conduct was such a significant departure from paragraphs 54 of the GMP and paragraphs 4, 29, 30 and 31 of the GMC's Personal Beliefs Guidance and also contrary to the GMC's over-arching statutory objective, that a failure to mark his conduct without a warning would undermine public confidence in the medical profession and the regulatory system.

348. The Tribunal took into account the public interest and balanced this with the interests of Dr Scott. The Tribunal noted the potential damage to the reputation of the profession and the need to maintain professional standards, which warranted a form of action being taken in the form of a warning. The Tribunal determined that it was important to communicate the message to the public and the wider medical profession that his conduct was unacceptable and is taken seriously.

349. The Tribunal therefore determined it was necessary and proportionate to impose a warning on Dr Scott, in accordance with Section 35D(3) of the Medical Act 1983 and Rule 17(2)(n) of the Rules. The following warning will therefore appear on Dr Scott's registration:

> "On 25 January 2022, Dr Scott conducted a spiritual discussion with Patient B, a vulnerable person. He discussed his own spiritual beliefs with Patient B to the extent it was not patient centered, and which caused him distress. Dr Scott also failed to establish Patient B's consent to having his hands clasped and to Dr Scott facilitating a prayer which was not welcome. This conduct led to Patient B feeling pressurized which caused him further distress. In doing so Dr Scott breached paragraph 54 of Good Medical Practice and paragraphs 4, 29, 30 and 31 of the GMC's Personal Belief and Medical Practice Guidance.
>
> This conduct does not meet with the standards required of a doctor and his actions have undermined public confidence and the public's trust in the medical profession. It risks bringing the profession into disrepute, and it must not be repeated. The required standards are set out in Good Medical Practice and associated guidance. In this case paragraphs 54 of Good Medical Practice and paragraphs 4, 29, 30 and 31 of the GMC's Personal Beliefs and Medical Practice Guidance are particularly relevant.
>
> <u>Good Medical Practice</u>
>
> > ***54*** *You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.*

GMC's Personal Beliefs and Medical Practice Guidance

4 Doctors may practise medicine in accordance with their beliefs, provided that they act in accordance with relevant legislation and:

- *do not treat patients unfairly*
- *do not deny patients access to appropriate medical treatment or services*
- *do not cause patients distress.*

If any of these circumstances is likely to arise, we expect doctors to provide effective patient care, advice or support in line with Good medical practice, whatever their personal beliefs.

29 In assessing a patient's conditions and taking a history, you should take account of spiritual, religious, social and cultural factors, as well as their clinical history and symptoms (see Good medical practice paragraph 15a). It may therefore be appropriate to ask a patient about their personal beliefs. However, you must not put pressure on a patient to discuss or justify their beliefs, or the absence of them.

30 During a consultation, you should keep the discussion relevant to the patient's care and treatment. If you disclose any personal information to a patient, including talking to a patient about personal beliefs, you must be very careful not to breach the professional boundary that exists between you. These boundaries are essential to maintaining a relationship of trust between a doctor and a patient.

31 You may talk about your own personal beliefs only if a patient asks you directly about them, or indicates they would welcome such a discussion. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them.

Whilst the conduct in itself is not so serious as to require any restriction on Dr Scott's registration, it is necessary in response to his misconduct to issue this formal warning."

350. This warning will be published on the medical register in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy

351. That concludes this case.

ANNEX A – 22/08/2023
Rule 34(1) Application – Application to adduce further evidence

Submissions

352. On 22 August 2023, during the facts stage of proceedings, Ms Hill made an application on behalf of the GMC to admit further evidence, pursuant to Rule 34(1) of the Rules.

353. The document in question is a previous warning from 2012 in relation to Dr Scott.

354. Ms Hill submitted the GMC application should be granted on the grounds that is fair and relevant to do so, based on the questions asked of Patient B by Mr Phillips during his oral evidence. She submitted that the GMC wished to provide the Tribunal with the terms of the warning that was given and did not seek to put in any further detail, unless Mr Phillips wished to do so.

355. Ms Hill stated that during Mr Phillips' cross examination of Patient B, he asked him if he had researched Dr Scott, how long he had spent researching and if his research had made him more resolute to making a complaint against Dr Scott. Patient B responded that he did a little research on Dr Scott, for maybe an hour and he saw another case about Dr Scott. Patient B also said *"it didn't give me a stronger feeling of wanting to go forward with the complaint at all... it didn't discourage me either."*

356. Ms Hill submitted that the defence had referred to previous cases in cross-examination of Patient B. She argued that if Mr Phillips wished to refer to specific cases, then he should have done so.

357. Ms Hill argued that by virtue of Mr Phillips adducing evidence about previous matters not proceeded by the GMC would be unfair. She elaborated that it would be unfair for the more recent matters to be included in evidence but not for the warning to be admitted. She stated that it was up to Defence to raise Dr A notes earlier and to suggest redaction to this part of the evidence.

358. Mr Phillips, counsel on behalf of Dr Scott, opposed the application. He submitted it would be inappropriate and unfair to admit a matter from 10 years ago before the Tribunal. He submitted that those questions posed to Patient B were necessary in order to deal with the motivation behind his complaint. As such, these do not give rise to a previous warning being adduced as evidence before the Tribunal.

359. Mr Phillips stated that it was necessary to ask these questions to test Patient B genuine motivation and this was due to previous references being found in the GMC's evidence, namely Dr A telephone notes with Patient B, dated 30 March 2022. Dr A noted that Patient B had found previous references of Dr Scott and his use of religion in consultations. Mr Phillips stated that it was therefore pertinent for him to ask the question as to whether this influenced his decision to pursue the complaint. He stated if this was not contained within the GMC bundle then he would not have asked the question. He pointed out that he had asked Patient B what he had 'researched' and it was in fact Patient B that responded with the information about other GMC matters.

360. Mr Phillips stated that he did not pursue particular details of the matters that Patient B had then researched, or what Patient B was talking about when he gave his evidence.

361. Mr Phillips maintained that this was information already available to the Tribunal within the bundle. He added that Dr Scott would give evidence about more recent matter not proceeded with by the GMC.

362. Mr Phillips He re-iterated that it would be unfair for general questions such as these to give rise to a 10-year-old matter being introduced in evidence. Mr Phillips argued that this was neither fair or relevant and should not be admitted as this would impact Dr Scott's right to a fair hearing.

363. Both Ms Hill and Mr Phillips were agreeable at this stage for the Tribunal to reach a determination as to whether it was fair to admit the evidence. Both parties conceded that the matter of relevance could only be assessed if the Tribunal had full sight of the warning. However, both parties agreed for the Tribunal not to see this evidence at this stage and to reach a determination on fairness alone before proceeding further.

The Tribunal's decision

364. In reaching its decision, the Tribunal had regard to Rule 34(1) and had sight of the relevant document at this stage, namely Dr A notes contained within the GMC bundle.

365. The Tribunal noted that in order to accept further evidence at this stage, it must consider the fairness of doing so and the relevance of the evidence, and only admit the evidence where it is considered to be both fair and relevant to the case before it.

366. In response to the parties application, the Tribunal considered fairness first.

367. The Tribunal bore in mind the nature of the warning that the GMC seek to adduce is of historical nature dating back 10 years.

368. The Tribunal took into account the evidence of Dr A telephone notes with Patient B, dated 30 March 2022, it noted the words 'references' that is used.

> *"Patient A shared with me that he had searched the internet after the consultation and had found many references to Dr Scott and his use of religion in consultations. He told me that he didn't want anyone else to experience what he had been through."*

369. The Tribunal bore in mind Patient B's oral evidence where he stated that he read that Dr Scott had acted similarly on multiple occasions, but it did not give him a stronger feeling about complaining.

370. It also noted that it was Patient B who mentioned previous GMC cases, and this was not in fact put forward by Mr Phillips, in his cross examination of him. The word used by Mr Phillips during cross-examination of Patient B was 'research' rather than 'reference' to previous matters. It also noted that Mr Phillips did not pursue particular details of what Patient B stated in response.

371. It noted the reasoning behind Mr Phillips questioning, namely that this was to test Patient B's motivation for pursing the complaint and putting forward previous research as a reason for proceeding with this matter.

372. The Tribunal was not itself aware what case(s) Patient B was referring when he responded.

373. The Tribunal bore it mind it is correct that information that Dr A included in his statement could have been redacted from the onset.

374. It considered that to correct evidence that should or could have been redacted should not be a reason not to ask a relevant question about Patient B's motivation. How Patient B responded was again, at this stage, not in itself a fair gateway to admit a warning of 10 years of age.

375. Therefore, the Tribunal determined to refuse the GMC's application as it was unfair to Dr Scott for this document to be admitted as evidence at this stage in the proceedings and therefore put it out of its mind.

376. Accordingly, the Tribunal did not need to go on to consider the issue of relevance.

377. The Tribunal was of the view that its refusal of the GMC application to admit the previous warning does not preclude Miss Hill to pursue a further application of this nature if she submitted it was fair and relevant to do so later in proceedings.