Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

**Dates:** 20/05/2019 - 23/05/2019

**Medical Practitioner’s name:** Dr Stephen MACSHANE

**GMC reference number:** 6166932

**Primary medical qualification:** MB BS 2008 University of Newcastle upon Tyne

**Type of case**
New - Misconduct

**Outcome on impairment**
Impaired

**Summary of outcome**
Suspension, 4 months.
Review hearing directed
Immediate order imposed

**Tribunal:**

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<tr>
<th>Role</th>
<th>Name</th>
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<tr>
<td>Legally Qualified Chair</td>
<td>Mr Angus Macpherson</td>
</tr>
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<td>Lay Tribunal Member:</td>
<td>Mr John Kelly</td>
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<td>Medical Tribunal Member:</td>
<td>Dr Andy Cohen</td>
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| Tribunal Clerk:                    | Ms Keely Crabtree  |

**Attendance and Representation:**

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<th>Medical Practitioner:</th>
<th>Not present and not represented</th>
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<td>GMC Representative:</td>
<td>Mr Jeremy Lasker, Counsel</td>
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**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 - 21/05/2019

Background

1. Dr Macshane qualified in 2008 at the University of Newcastle Upon Tyne. Dr Macshane was employed as a locum middle grade doctor in the Emergency Department at Chesterfield Royal Hospital NHS Foundation Trust for two or three years before being appointed to a permanent role as an Associate Specialist in Emergency Medicine in May 2017.

2. Dr Macshane was on duty on 19 June 2017 when Patient A was brought into the Emergency Department having suffered a cardio-respiratory arrest. He died in hospital whilst under the care of Dr Macshane and his body was transferred to the mortuary. Patient A’s wife attended the hospital and spoke to Dr Macshane. Documentation was sent to the coroner concerning his death which the coroner found confusing. It contained two different dates of birth. The coroner had concerns as to whether the deceased patient had been correctly identified. Accordingly, Nurse B made enquiries of the nursing staff on duty on the relevant shifts to ascertain whether any formal identification had taken place. On 20 June 2017, she made further enquiries to Dr Macshane.

3. The allegation that has led to this hearing can be summarised as follows: on or around 20 June 2017, Dr Macshane made oral statements, which he knew to be untrue, to Nurse B and Dr C concerning the identification of Patient A’s body. It is further alleged Dr Macshane made a written statement on or around 20 June 2017 concerning the identification of Patient A, which he knew to be untrue, and initially maintained in a meeting with Dr D on 23 June 2017, a statement which he knew to be untrue. It is alleged that Dr Macshane’s actions in this regard were dishonest.

The Outcome of Applications Made during the Facts Stage

4. Dr Macshane did not attend the hearing nor was he represented in his absence. The Tribunal acceded to an application made by Mr Jeremy Lasker, Counsel on behalf of the GMC, pursuant to Rule 15 and 40 of the General Medical Council (Fitness to Practise Rules) 2004 as amended (‘the Rules’), that service had been properly effected on Dr Macshane and that, pursuant to Rule 31, it should
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proceed with this hearing in his absence. The Tribunal’s full decision on the application is included at Annex A.

5. The Tribunal granted Mr Lasker’s application, made pursuant to Rule 17(6) of ('the Rules'), to amend paragraph 2 (a) of the allegation. The Tribunal’s full decision on the application is included at Annex B.

The Allegation and the Doctor’s Response

6. The Allegation made against Dr Macshane is as follows:

1. On or around 20 June 2017, during a telephone call with Nurse B, you stated words to the effect of, you had:
   a. done the identification of Patient A; To be determined
   b. taken Patient A’s wife to the mortuary to identify the body. To be determined

2. On or around 20 June 2017, during a meeting with Dr C and Nurse B, you stated words to the effect of:
   a. Patient A’s wife had come to the hospital at after 21:00 hours with a friend; To be determined
   b. you had taken Patient A’s wife to the mortuary between 21:30 hours and 22:00 hours; To be determined
   c. there was a porter present during the identification; To be determined
   d. the porter unwrapped the body and Patient A’s wife made a positive identification; To be determined
   e. you would be on CCTV footage in the mortuary at the relevant time. To be determined

3. On or around 20 June 2017, you made a written statement in which you stated words to the effect of you had attended the mortuary with Patient A’s wife to identify Patient A. To be determined

4. During a meeting with Dr D on the 23 June 2017, you initially maintained that Patient A had been identified by his wife in your presence. To be determined
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5. You knew that:
   a. you had not attended the mortuary with Patient A’s wife to identify Patient A’s body; **To be determined**
   b. Patient A’s wife had not identified Patient A’s body. **To be determined**

6. Your actions as described at paragraphs 1 – 5 above were dishonest. **To be determined**

Factual Witness Evidence

7. The Tribunal received evidence on behalf of the GMC from the following witness:
   
   • Dr D Medical Director and Responsible Officer for Chesterfield Royal Hospital NHS Foundation Trust, by telephone link.

8. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:
   
   • Nurse B, Matron based in Emergency Department at Chesterfield Royal Hospital NHS Foundation Trust;
   • Ms E, Director of Nursing and Patient Care at Chesterfield Royal Hospital NHS Foundation Trust;
   • Dr C, Consultant in Emergency Medicine at Chesterfield Royal Hospital NHS Foundation Trust.

9. Dr Macshane did not challenge the evidence relied on by the GMC in support of the paragraphs of the allegation. Accordingly, the Tribunal had uncontested evidence from several GMC witnesses as to the assertions and explanations advanced by Dr Macshane when considering those paragraphs.

Documentary Evidence

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

   • Letter from Coroner to NHS dated 20/06/2017
   • Email from Mr F to Ms E dated 20/06/2017
   • Statement prepared by Dr Macshane dated 20/06/2017
   • Email from Mr F to Ms E dated 21/06/2017
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- Meeting notes from meeting between Dr D and Dr Macshane dated 23/06/17
- Statement prepared by Mr F dated 25/06/2017
- Meeting notes from meeting between Dr D and Dr Macshane dated 26/06/2017
- Letter from Dr D to Dr Macshane dated 26/06/2017
- Letter from Ms E to the Coroner dated 28/06/2017
- Meeting notes from meeting between Mr F and trust dated 04/07/2017
- Meeting notes from meeting between Dr C and the Trust dated 07/07/2017
- Meeting notes from meeting between Nurse B and the Trust dated 17/07/2017

The Tribunal’s Approach

11. 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 Macshane 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.

The Tribunal’s Analysis of the Evidence and Findings

12. 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 (a)

On or around 20 June 2017, during a telephone call with Nurse B, you stated words to the effect of, you had:

a. done the identification of Patient A;

13. Found proved. The Tribunal noted the witness statement of Nurse B in which she stated that, when Dr Macshane rang her back in answer to her initial call relating to the patient, he said: “he had done the viewing”. This reflected what she had said in a meeting on 17 July 2017 with the Trust’s Case Investigator, appointed by Dr D. She stated that Dr Macshane said in the telephone call that “he’d done the identification”. 
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Paragraph 1(b)

b. taken Patient A’s wife to the mortuary to identify the body.

14. Found not proved. There was no evidence that words to the effect that Dr Macshane had taken Patient A’s wife to the mortuary to identify the body were spoken by him in the telephone call with Nurse B on 20 June 2017.

Paragraph 2(a)

On or around 20 June 2017, during a meeting with Dr C and Nurse B, you stated words to the effect of:

a. Patient A’s wife had come to the hospital at 21:00 hours with a friend;

15. Found proved as amended. The Tribunal noted the witness statement of Dr C, in which she stated that in a meeting in the matron’s office on 20 June 2017, attended by Nurse B and Dr Macshane, Dr Macshane advised that the deceased’s wife had come into the Hospital later that evening along with a different friend of the deceased’s and was taken by himself and a porter to the mortuary. This reflected what she had said in a meeting on 7 July 2017 with the Trust’s Case Investigator. During that meeting she stated Dr Macshane had said at the meeting on 20 June 2017: “Patient’s wife came in after 21.00 with a friend”.

Paragraph 2(b)

b. you had taken Patient A’s wife to the mortuary between 21:30 hours and 22:00 hours; To be determined

16. Found proved. The Tribunal noted the witness statement of Nurse B in which she said that Dr Macshane had said that the Patient’s wife had completed the identification. In addition it had regard to the note of the meeting held by the Trust’s Case Investigator on 7 July 2017 in which Dr C stated that Dr Macshane had said at the meeting on 20 June 2017 that he had taken the patient’s wife to the mortuary between 21:30 and 22:00.

Paragraph 2(c) and Paragraph 2(d)

c. there was a porter present during the identification;

d. the porter unwrapped the body and Patient A’s wife made a positive identification;

17. Found proved. The Tribunal noted the witness statement of Nurse B who said that at the meeting on 20 June 2017, Dr Macshane had said that one of the porters got the body out of the mortuary. It also noted Dr C’s witness statement in which she stated that, at the meeting on 20 June 2017, Dr Macshane stated that, although
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he could not recall the name of the porter, the porter unwrapped the body and the deceased’s wife made a positive identification. In addition it had regard to the note of the meeting held by the Trust’s Case Investigator on 7 July 2017 in which Dr C stated that Dr Macshane had insisted at the meeting on 20 June 2017 that there was a porter, as well as the patient’s wife who identified the body and that he (the porter) unwrapped the body and put it away.

Paragraph 2(e)

18. Found proved. The Tribunal noted the witness statement of Dr C in which she recalled that, at the meeting on 20 June 2017, Dr Macshane, in answer to her observation that he (Dr Macshane) could not be seen on the CCTV in the mortuary, responded by saying that he must be visible on the CCTV. In addition, it had regard to the note of the meeting held by the Trust’s Case Investigator on 7 July 2017 in which Dr C stated that Dr Macshane had stated at the meeting on 20 June 2017 that he must have been visible on CCTV.

Paragraph 3

On or around 20 June 2017, you made a written statement in which you stated words to the effect of you had attended the mortuary with Patient A’s wife to identify Patient A.

19. Found proved. The Tribunal had regard to the written statement made by Dr Macshane in which he stated that he had arranged for Patient A’s wife to be taken to the mortuary to identify her spouse. He said “We were taken by a porter to mortuary at approximately 21.40…. In the mortuary, I unwrapped the body and allowed her to view it and she identified to me that this was her (husband).”

Paragraph 4

During a meeting with Dr D on the 23 June 2017, you initially maintained that Patient A had been identified by his wife in your presence.

20. Found proved. The Tribunal had regard to the notes of the meeting held by Dr D on 23 June 2017. In the early part of that meeting, Dr Macshane stated: “Yes, the body was there and I unwrapped him and asked is this (your husband) and she (Patient A’s wife) said yes.”
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Paragraph 5(a) and Paragraph 5(b)

You knew that:

b. you had not attended the mortuary with Patient A’s wife to identify Patient A’s body;

c. Patient A’s wife had not identified Patient A’s body.

21. Found proved. In the meeting on 23 June 2017 held by Dr D, after a short adjournment, Dr Macshane explained that Patient A’s wife did not want to go and see the body – it was too distressing for her. He acknowledged that he did not go to the mortuary and that the identification was in the department by reference to distinguishing marks on Patient A’s body.

Paragraph 6

Your actions as described at paragraphs 1 – 5 above were dishonest.

22. Found proved. The Tribunal noted by reference to the admissions which Dr Macshane made at the meeting with Dr D on 23 June 2017 that the information which he had provided to Nurse B in the telephone call on 20 June 2017, to Dr C and Nurse B in the meeting on 20 June 2017, by his written statement dated 20 June 2017 and initially in the meeting with Dr D on 23 June 2017 was not true.

23. The Tribunal recognised that, when considering dishonesty, the issue which it had to determine was Dr Macshane’s state of mind when he gave the assertions and provided answers on the occasions set out in paragraphs 1-5 of the allegation. The Tribunal finds that by the objective standard which it must apply pursuant to the case of Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67, Dr Macshane was dishonest on these occasions.

The Tribunal’s Overall Determination on the Facts

24. The Tribunal has determined the facts as follows:

1. On or around 20 June 2017, during a telephone call with Nurse B, you stated words to the effect of, you had:

   a. done the identification of Patient A; Determined and found proved

   b. taken Patient A’s wife to the mortuary to identify the body. Found not proved
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2. On or around 20 June 2017, during a meeting with Dr C and Nurse B, you stated words to the effect of:

a. Patient A’s wife had come to the hospital at after 21:00 hours with a friend; Determined and found proved

b. you had taken Patient A’s wife to the mortuary between 21:30 hours and 22:00 hours; Determined and found proved

c. there was a porter present during the identification; Determined and found proved

d. the porter unwrapped the body and Patient A’s wife made a positive identification; Determined and found proved

e. you would be on CCTV footage in the mortuary at the relevant time. Determined and found proved

3. On or around 20 June 2017, you made a written statement in which you stated words to the effect of you had attended the mortuary with Patient A’s wife to identify Patient A. Determined and found proved

4. During a meeting with Dr D on the 23 June 2017, you initially maintained that Patient A had been identified by his wife in your presence. Determined and found proved

5. You knew that:

a. you had not attended the mortuary with Patient A’s wife to identify Patient A’s body; Determined and found proved

b. Patient A’s wife had not identified Patient A’s body. Determined and found proved

6. Your actions as described at paragraphs 1 – 5 above were dishonest. Determined and found proved

Determination on Impairment - 22/05/2019

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

2. 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 a further witness statement from Dr D.

Submissions

3. On behalf of the GMC, Mr Lasker submitted that the facts found proved amount to serious misconduct, and that Dr Macshane’s fitness to practise is currently impaired by reason of that misconduct.

4. Mr Lasker directed the Tribunal to Good Medical Practice (2013) ('GMP') as follows:

'1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.

4. You must use your judgement in applying the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise, whatever field of medicine you work in, and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.

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

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

   a. You must take reasonable steps to check the information is correct.
   b. ‘You must not deliberately leave out relevant information.’

5. Mr Lasker submitted that any form of dishonesty by a member of the medical profession is likely to be considered serious, particularly when committed within the context of their practice, when the dishonesty is repeated and when attempts are made to cover it up. This is particularly so in this case as Dr Macshane lied repeatedly to colleagues who were seeking to establish the facts concerning the identity of Patient A, as well as in a written statement.
6. Mr Lasker further submitted that the overarching objective to maintain professional standards and the lack of full insight or remediation from Dr Macshane necessitated a finding of impairment in order to uphold professional standards and public confidence in the profession. He submitted that the public interest would not be met if a finding of impairment was not made.

**The Relevant Legal Principles**

7. 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.

8. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first, whether the facts as found proved amount to misconduct which is serious and, if so, whether the finding of that misconduct should lead to a finding of impairment.

9. The Tribunal must determine whether Dr Macshane’s fitness to practise is impaired today, taking into account Dr Macshane’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**

10. The Tribunal noted that the GMC recognised Dr Macshane’s benevolent motive for carrying out the identification of Patient A in the way he did. That identification was based on his knowledge of the distinguishing marks on Patient A’s body which were confirmed by Patient A’s widow and her confirmation that the possessions on his person were his own. The motivation for that identification was to spare Patient A’s widow from having to view the body. When inquiries were made by Nurse B on 20 June 2017 by telephone he did not tell the truth and stated that he had done the viewing. Thereafter it should have become increasingly apparent to Dr Macshane that the circumstances of the identification were of importance since he was asked to attend a meeting about them with Dr C and Nurse B later that day and indeed to write a statement as to what happened. In the meeting on 20 June 2017 and in the written statement on the same day he elaborated his account of what had happened. Meanwhile, it had been ascertained from Patient A’s widow that she had not attended a viewing of Patient A with Dr Macshane or at all. Moreover there was no CCTV footage of their having done so, and the mortuary confirmed that there was no evidence that the viewing had ever occurred. In the final interview on 23 June 2017 it became apparent that Dr Macshane was unfamiliar with the layout of the mortuary.
11. By the time Dr Macshane admitted that he had been untruthful during the second part of the meeting held on 23 June 2017, he had lied in the telephone call with Nurse B and in the subsequent meeting with Nurse B and Dr C on 20 June 2017 and in his written statement made later that day. He maintained his untruthful account during the first part of the meeting on 23 June 2017 with Dr D, only admitting his lies after it became apparent that the Trust had sufficient information to unseat his account.

12. By his actions, the Tribunal accept that he breached paragraphs 1, 65 and 71 of GMP.

13. In the light of the foregoing, the Tribunal finds that Dr Macshane’s conduct as found proved in paragraphs 1-6 of the Allegation amounts to serious misconduct.

Impairment

14. In the latter part of the meeting on 23 June 2017 with Dr D, Dr Macshane acknowledged his mistake and dishonesty. He recognised the seriousness of his behaviour for he feared losing his job. He said that he had brought matters on his own head and that it was “a shame”. On another occasion, he apologised to Dr C, the head of his department. It is apparent that he had, at a very early stage, developed a degree of insight into his behaviour and was expressing remorse and contrition. In fact, he was excluded from the Hospital on 23 June 2017, but allowed to return albeit in a non-clinical role on 7 July 2017. Then, when the internal inquiry was completed at some stage later in 2017 and he was given a written warning, to remain on his record for a year, he returned to his role as an Associate Specialist in Emergency Medicine. He continued in that role until about January 2019 when his contract was terminated for an unrelated incident. The Tribunal does not know the circumstances of that termination, but it is apparent that the Trust had sufficient confidence in Dr Macshane to allow him to continue in his role as an Associate Specialist until about January 2019.

15. The Tribunal noted the observation by Dr D in her witness statement dated 2 January 2019 that Dr Macshane had reflected on this incident and expressed regret for his actions. Dr D added that she believes that he would now seek support from a member of the nursing team or wider Emergency Care team should a similar situation arise.

16. Dr Macshane did not attend this hearing, nor did he submit a written statement as to these matters. Moreover, he did not formally admit any of them. Notwithstanding the confidence which Dr D has expressed in Dr Macshane, the Tribunal was disappointed that he did not submit any material to assure it that his remediation of these matters is complete and that it is very unlikely that there would be any repetition. The Tribunal does however consider that the matters the subject
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of this case are remediable. Although there was persistence in Dr Macshane’s dishonesty, essentially it all related to his continuing to maintain an original lie, which he told to cover up an arrangement which he made with Patient A’s widow to absolve her from identifying her husband’s body.

17. These matters do not go to the protection and promotion of the health, safety and wellbeing of the public. Instead they go to the maintenance of public confidence in the medical profession and the need to promote and maintain proper professional standards and conduct for members of the profession. In the view of the Tribunal, by his misconduct Dr Macshane has brought the profession into disrepute and breached a fundamental tenet of the profession, namely the requirement to act at all times with honesty and integrity. In these circumstances the Tribunal has reached the conclusion that a finding of impairment of fitness to practise is required.

18. The Tribunal has therefore determined that Dr Macshane’s fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 23/05/2019

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

The Evidence

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

Submissions

3. On behalf of the GMC, Mr Lasker submitted that the appropriate and proportionate sanction in this case is that of erasure. He also directed the Tribunal’s attention to the relevant sections of the Sanctions Guidance (‘SG’) when making its determination, in particular paragraphs 108, 109 (a)(b)(d), 124 and 128.

4. Mr Lasker conceded that a finding of impairment does not automatically mean that the Tribunal must impose a sanction upon Dr Macshane and that it has discretion, in appropriate cases, to take no action following a finding of impairment. However, Mr Lasker submitted that, given the facts found proved by the Tribunal, a decision to take no action in this case would not be appropriate. He further submitted that this was not a case that is suited to the imposition of conditions.

5. With regard to suspension, he stated that suspension has a deterrent effect and could be used to send out a signal regarding behaviour which is unbefitting of a doctor. However, a period of suspension is not, on analysis, sufficient.
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6. Mr Lasker submitted that it was the first time Dr Macshane has come to attention of the GMC and that his competence as a doctor is not in dispute. He submitted that the GMC is concerned with Dr Macshane’s probity and that his dishonesty was serious and persistent.

7. Mr Lasker submitted that erasure was the appropriate sanction to impose in order 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.

The Tribunal’s Determination on Sanction

8. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal alone, exercising its own judgement. In so doing, it has given consideration to its findings of fact, its findings of misconduct and impaired fitness to practise and the submissions made by Mr Lasker on behalf of the GMC. The Tribunal also paid particular attention to the ‘Sanctions Guidance’ and relevant paragraphs contained therein.

9. Throughout its deliberations the Tribunal has borne in mind that the purpose of sanctions is not to be punitive, but to protect the public interest. In making its decision, the Tribunal also had regard to the principle of proportionality, and it weighed Dr Macshane’s interests with those of the public. It also considered and balanced the mitigating and aggravating factors in this case.

The Tribunal’s Determination on Sanction

10. The Tribunal considered the following to be mitigating factors in this case:

   • The context of Dr Macshane’s dishonesty was that he always believed that he had made an accurate identification of Patient A. It was based on information with which he had been provided by Patient A’s wife.
   • He carried out his identification to spare Patient A’s wife the trauma of viewing the body of her late husband.
   • In the interview on 23 June 2017 with Dr D, Dr Macshane:
     (i) acknowledged his dishonesty;
     (ii) recognised that it was serious and could have implications for his career;
     (iii) recognised that he was responsible for it, and said it was a shame.
   • Dr Macshane apologised for his behaviour to Dr C, and to Dr D who also acted as his Responsible Officer.
   • Dr Macshane has no previous fitness to practise history.
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11. The Tribunal also noted that the Trust imposed a written warning to remain on his record for a year. This enabled Dr Macshane to return to his role as an Associate Specialist in Emergency Medicine at the Trust until January 2019. In the course of that period he earned the confidence of Dr D who was his Responsible Officer, as maybe discerned from her witness statement, dated 2 January 2019, to which reference was made in the Tribunal’s determination on Impairment.

12. The Tribunal balanced the mitigating factors against what it considered to be the aggravating factors in this case:

- Dr Macshane’s dishonesty persisted over a period of some 4 days, in the course of which, on 20 June 2017, he provided a dishonest account to Nurse B on the telephone, to Nurse B and Dr C at a meeting and in a written statement, and he confirmed that account initially when interviewed by Dr D at a further meeting on 23 June 2017;
- Dr Macshane only admitted his dishonesty when it became clear to him during the interview on 23 June 2017 with Dr D that the Trust did not accept his account.

No action

13. The Tribunal first considered whether to conclude the case by taking no action. Although it accepted that there is evidence that Dr Macshane has achieved a degree of remediation for his behaviour and earned the confidence of the Trust, it does not consider that this or any other factors in this case amount to exceptional circumstances warranting no action to be taken. This was misconduct relating to a significant issue, namely the identification of a deceased patient in accordance with proper procedure. The consequences of an incorrect identification could have been very serious. Dr Macshane’s dishonest account was a serious breach of GMP. By behaving as he did, he failed to promote and maintain public confidence in the medical profession, and he failed to promote and maintain proper standards and conduct for members of the profession. In the circumstances the Tribunal did not consider that it would be sufficient, proportionate or in the public interest to conclude the case by taking no action.

Conditions

14. The Tribunal next considered whether to impose conditions on Dr Macshane’s registration. In so doing, it bore in mind that any conditions imposed would need to be appropriate, proportionate, workable, and measurable. In the light of its findings, the Tribunal determined that it would not be possible to formulate a set of appropriate or workable conditions which could adequately address Dr Macshane’s misconduct, namely his dishonesty. In any event, the Tribunal concluded that a period of conditional registration would not be a sufficient, appropriate, or proportionate sanction to satisfy the public interest.
Suspension

15. The Tribunal next considered whether it would be appropriate and proportionate to suspend Dr Macshane’s registration. The Tribunal acknowledged that a sanction of suspension does have a deterrent effect and can be used to send a signal to Dr Macshane, the profession, and the public about what is regarded as behaviour unbefitting a registered doctor. It also acknowledged that suspension is an appropriate response to conduct which is sufficiently serious that action is required, in order to maintain public confidence in the profession, but which is not fundamentally incompatible with continued registration.

16. The Tribunal first considered whether, although these were serious breaches of GMP, Doctor Macshane’s misconduct was not fundamentally incompatible with his continued registration. It noted the context of the breaches of GMP, namely that the identification he had carried out was to relieve Patient A’s wife of the need to view the body of her late husband and that he did not have cause to believe that his identification was inaccurate. Although Dr Macshane’s conduct involved an abuse of trust and he disregarded principles set out in GMP, his dishonesty persisted over a relatively short period of time. Beyond maintaining his untrue account, Dr Macshane did not take any active steps, nor involve any other person in an attempt to cover up his actions. Moreover he did not do harm to others. He did not violate a patient’s rights, nor exploit vulnerable persons. These were not offences of a sexual nature, nor did they involve violence. He did not put his own interests before those of his patients. He has demonstrated insight into the seriousness of his actions and the consequences.

17. The Tribunal also noted that there was no evidence which demonstrated that remediation is unlikely to be successful, nor any evidence that there has been a repetition of similar behaviour since the incident. Indeed the witness statement of Dr D suggests the reverse. There is evidence of insight but the extent of this could not be explored due to Dr Macshane’s absence from this hearing.

18. The Tribunal has determined that action is required to uphold proper professional standards and conduct for members of the profession and to promote and maintain confidence in the profession. It considered that the proportionate measure to achieve that is to impose a suspension order for a period of 4 months. That period of time should serve to demonstrate to Dr Macshane and to the wider profession that this misconduct is not acceptable. The Tribunal also determined to direct a review of Dr Macshane’s case. That review will convene shortly before the end of the period of suspension, unless an early review is sought. The period of suspension should be sufficient time for Dr Macshane to demonstrate at the review hearing that he has been able to maintain the remediation which he has started. It may therefore assist the reviewing Tribunal if Dr Macshane:
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- Attends the review;
- Submits a reflective piece demonstrating the level of his insight into the impact his actions had on public confidence on the medical profession and his colleagues;
- Provides evidence that he has kept his medical skills and knowledge up to date;
- Submits testimonials and references;
- Submits any other evidence he considers may be of assistance to the reviewing Tribunal.

Determination on Immediate Order - 23/05/2019

1. Having determined that Dr Macshane’s registration should be suspended for a period of four months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Macshane’s registration should be subject to an immediate order.

2. The Tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor.

Submissions

3. On behalf of the GMC, Mr Lasker invited the Tribunal to impose an immediate order. He submitted that an immediate order was necessary given the circumstances of this case.

The Tribunal’s Determination

4. In reaching its decision the tribunal referred to the relevant paragraphs of the SG. It exercised its own judgement and had regard to the principle of proportionality.

5. The Tribunal considered the circumstances of Dr Macshane’s case. The Tribunal bore in mind the fact that Dr Macshane has not provided to this hearing any evidence or submissions concerning the matters in issue, which would have served to reassure it as to his current insight and reflection. He did not attend. The Tribunal considered that it was appropriate to order a review of the four month suspension order in order for Dr Macshane to provide to the reviewing Tribunal material concerning his professional practice and continuing reflection. In these circumstances, the Tribunal concluded that an immediate order was in the public interest.

6. This means that Dr Macshane’s registration will be suspended from when notification is deemed to have been served. The substantive direction, as already announced, will take effect 28 days from when written notice of this determination has
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been served upon Dr Macshane, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

7. There is no interim order to revoke.

8. That concludes this case.

Confirmed
Date 23 May 2019  Mr Angus Macpherson, Chair
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ANNEX A – 23/05/2019

Service and Proceeding in Absence

Service

1. Dr Macshane is not present nor represented at this hearing. The Tribunal has considered whether notice of this hearing has been properly served upon Dr Macshane in accordance with Rules 15 and 40 and Schedule 4, Paragraph 8 of the Medical Act 1983 (as amended). In so doing, the Tribunal has taken into account all the information placed before it, together with submissions made by Mr Jeremy Lasker, Counsel, on behalf of the GMC.

2. The Tribunal had regard to the Notice of Allegation letter from the GMC which was sent to Dr Macshane’s registered address via special delivery on 8 April 2019. The letter included the dates, time and location of this hearing. The Tribunal noted the Royal Mail delivery notification which confirms that the letter was signed for by ‘MACSHANE’ on 9 April 2019.

3. The Tribunal also had regard to the Notice of Hearing letter, dated 12 April 2019, which was sent via special delivery to Dr Macshane’s registered address by the Medical Practitioners Tribunal Service (‘MPTS’). This letter included the dates, time and location of this hearing. The Tribunal took note of the Royal Mail delivery notification which confirms that the letter was signed for by ‘MCSHANE’ on 13 April 2019.

4. Mr Lasker submitted that this evidence demonstrates that the notice of hearing has been served upon Dr Macshane.

5. Having considered all the evidence, the tribunal is satisfied that the Notice was drafted in proper form and that delivery was effected no later than 28 days before today’s date. Accordingly the tribunal is satisfied that notice of this hearing has been properly served upon Dr Macshane.

Proceeding in Absence

6. The Tribunal went on to consider whether to proceed in Dr Macshane’s absence in accordance with Rule 31. It bore in mind that the Tribunal’s discretion to proceed in the practitioner’s absence must be exercised with caution and with regard to the overall fairness of the proceedings. The Tribunal has balanced the interests of the practitioner, including fairness to him, against the public interest, including the need to protect patients.

7. Mr Lasker drew the Tribunal’s attention to the 18 April 2019 e-mail from Dr Macshane to the GMC which stated:
‘With regard to the upcoming tribunal. I took the decision in January to retire from practicing medicine. I informed the MPS of this with a view to having my name removed from the register. I can understand if there is a continued desire for the tribunal however, you would be wasting money, I have no desire to attend and regard my career in medicine as at an end.’

8. Mr Lasker also drew the Tribunal to the 26 April 2019 e-mail from Mr Macshane to the MPTS which stated:

‘I will not be attending as I have retired from medical practice for numerous reasons. I have no desire to ever revisit medicine in any way shape or form. I would be grateful if you could stop informing of these actions. I have no interest in them or their outcome. As far as I concerned the issue is closed and I regret ever having decided to serve the people of Chesterfield or its trust.’

9. Mr Lasker invited the Tribunal to proceed in the absence of Dr Macshane. He submitted that Dr Macshane has made no request for an adjournment or postponement of today’s hearing. He submitted that he has voluntarily absented himself from today’s proceedings and no purpose would be served by adjourning today’s hearing. Dr Macshane has given no indication that he would attend a future hearing. Mr Lasker submitted that it would be fair and in the public interest for the Tribunal to proceed in the doctor’s absence.

10. The Tribunal determined that Dr Macshane’s e-mails dated 18 April 2019 and 26 April 2019 demonstrate a deliberate and voluntary waiver of his right to appear and that an adjournment would not result in him attending a subsequent hearing.

11. The Tribunal has determined that it is appropriate to proceed with the hearing in Dr Macshane’s absence. In reaching its decision the Tribunal had regard to the issue of fairness to Dr Macshane, and its duty to ensure the proper and expeditious discharge of its regulatory function in the public interest.
Application to Amend the Allegation

1. In the course of its deliberations at the close of the GMC’s case on facts, the Tribunal considered paragraph 2(a) of the Allegation which alleges:

2. On or about 20 June 2017, during a meeting with Dr C and Nurse B, you stated words to the effect of:

   a. Patient A’s wife had come to the hospital at 21:00 hours with a friend;

2. The Tribunal noted there was no evidence that Dr Macshane said at the meeting on 20 June 2017 that Patient A’s wife had come to the hospital at 21:00 with a friend. There was evidence that he had said at the meeting that she had come in after 21:00 with a friend. The difference is of no consequence. In those circumstances, the Tribunal invited the GMC to make an application to amend paragraph 2(a) of the allegation.

3. Mr Lasker, Counsel, made an application, on behalf of the General Medical Council (GMC) under Rule 17(6) of the Rules, to amend paragraphs 2 (a) of the Allegation in the following terms:

4. Paragraph 2 (a)

   2. On or around 20 June 2017, during a meeting with Dr C and Nurse B, you stated words to the effect of:

      a. Patient A’s wife had come to the hospital at after 21:00 hours with a friend;

5. Mr Lasker submitted that the amendment could be made without injustice to Dr Macshane.

6. The Tribunal has considered Rule 17(6) of the Rules which states:

   "Where, at any time, it appears to the Medical Practitioners Tribunal that—

   (a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and

   (b) the amendment can be made without injustice,

   it may, after hearing the parties, amend the allegation in appropriate terms.”
7. The Tribunal accepted that the amendment in relation to paragraph 2 (a) could be made without injustice. It therefore determined to allow the application.