PUBLIC RECORD

Dates: 06/06/2022 - 09/06/2022

Medical Practitioner's name:	Dr Venkata Sujana CHINTALA
GMC reference number:	6094662
Primary medical qualification:	MB BS 2003 NTR University of Health Sciences

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 2 months.

Tribunal:

Legally Qualified Chair	Miss Gillian Temple-Bone
Lay Tribunal Member:	Mrs Carol Jackson
Medical Tribunal Member:	Professor William Roche

Tribunal Clerk:	Ms Jemine Pemu

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Andrew Kennedy, QC, instructed by the Medical Defence Union
GMC Representative:	Mr Ian Brook, 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 & Impairment– 07/06/2022

Background

1. Dr Chintala qualified in 2003 from NTR University of Health Sciences, India. Prior to the events which are the subject of the hearing, Dr Chintala undertook specialist training in psychiatry between February 2006 and July 2009, followed by training in specialist adult psychiatry, including addiction in 2013. Between February 2018 and May 2019, Dr Chintala was a Consultant Psychiatrist in General Adult Psychiatry at the Southern Health Foundation NHS Trust. From July 2020 to April 2021 Dr Chintala worked for the NHS Sussex Trust in a locum position. In April 2021 Dr Chintala was employed as a Consultant Psychiatrist by the Solent NHS Trust as part of the Community Mental Health Recovery Team based at St Mary's Hospital, Portsmouth, and remains in their employ.

2. Dr Chintala was absent from work XXX from 13 to 17 May 2019. On 21 May 2019, Dr A, Dr Chintala's line manager, was informed that Dr Chintala had been doing Mental Health Assessments ('MHA') elsewhere, whilst on sick leave Dr Chintala conducted 7 assessments between 13 to 17 May. Dr A was later informed of another absence due to sickness between 8 and 11 January 2019, during which time Dr Chintala had worked elsewhere. The records showed that Dr Chintala had submitted 3 claims, for the period 8-11 January 2019, for MHA's carried out at 13:30 and 16:00 on 8 January and 00:30 on 9 January 2019. She claimed fees and received payment in March 2019. The matter was reported internally resulting in a referral to the Counter Fraud Service ('CFS'). On 6 June, Dr A informed Dr Chintala of the

concerns which were investigated by the CFS. Dr Chintala was apologetic and informed Dr A that she was having a difficult time.

3. Dr Chintala was interviewed under caution by the CFS on 18 July 2019. It was estimated that the sick pay for the 9 days was approximately £3000. Dr Chintala repaid that sum.

4. The allegation that has led to Dr Chintala's hearing can be summarised as, whilst employed by the Southern Health Foundation Trust, Dr Chintala completed ten mental health assessments during two periods when she was absent from work and in receipt of sick pay. It is alleged that Dr Chintala knew that she should not work for any other employer or Trust whilst on sick leave, and her actions were therefore dishonest.

The Allegation and the Doctor's Response

5. The Allegation made against Dr Chintala is as follows:

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

1. Whilst employed by the Southern Health Foundation Trust ('the Trust'), between 8 January 2019 and 17 May 2019 you completed the Mental Health Assessments as set out in Schedule 1, whilst you were absent on sick leave from:

   a. 8 to 11 January 2019;

      Admitted and found proved

   b. 13 to 17 May 2019.

      Admitted and found proved

2. You knew that you should not work for any other employer or the Trust whilst absent from the Trust on sick leave.

   Admitted and found proved

3. Your actions as set out at paragraph 1 were dishonest by reason of paragraph 2.

Admitted and found proved

The Admitted Facts

6. At the outset of these proceedings, through her counsel, Mr Andrew Kennedy QC, Dr Chintala admitted the facts of the Allegation in its entirety, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced the facts of the Allegation as admitted and found proved in full.

Factual Witness Evidence

7. The Tribunal 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:

- Dr A, former Consultant Psychiatrist and Clinical Service Director of East Area Adult Mental Health Service at Southern Health NHS Foundation Trust, dated 13 December 2019 & 11 July 2019
- Ms B, Finance Assistant at Southampton City Clinical Commissioning Group, dated 23 December 2019 and 14 July 2020;
- Ms C, Workforce Business Partner of Portsmouth and South East and Southampton divisions, dated 23 January 2020 and 17 June 2020;
- Ms D, Personal Assistant to the Head of Nursing and Head of Operations, dated 28 January 2020 & 24 June 2019, 9 July 2019
- Ms E, Lead Counter Fraud Specialist for Southern Health NHS Foundations Trust, dated 4 June 2020.

8. Dr Chintala provided a witness statement, dated 18 February 2022, but did not give oral evidence at the facts stage of the hearing.

Documentary Evidence

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

- A Trust statement from Dr A, dated 11 July 2019;
- Email from Dr A to Dr Chintala, dated 6 June 2019;
- Trust statement from Ms B, dated 27 June 2019;
- Supplemental Trust statement from Ms B, dated 9 October 2019;
- Mental Health Act Assessment Claim Forms, dated 8-11 January 2019 and 13-17 January 2019;
- Trust statement from C, dated 27 June 2019;
- Email from Dr A to C, dated 29 May 2019;
- Dr Chintala's absence Records, dated 24 June 2019;
- Dr Chintala's contract of employment, dated 14 June 2018;
- Trust statement from Ms D, dated 24 June 2019;
- Supplemental Trust statement from Ms D, dated 9 July 2019;
- Emails from Dr Chintala to Ms D, dated 13 May 2019 and 3 June 2019;
- Emails from Dr Chintala to Dr A, dated 8-14 January 2019;
- Statement of Mr F, dated 1 July 2019;
- Statement of Ms G, dated 3 July 2019;
- Interview Transcript – Dr Chintala, dated 18 July 2019;
- Southern Health NHS Foundation Trust – Investigation Report, dated July 2019;
- Rule 7 response on behalf of Dr Chintala, dated 14 October 2020.

Determination on Impairment

10. In light of the admissions made by Dr Chintala, the Tribunal 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, Dr Chintala's fitness to practise is impaired by reason of misconduct.

The Evidence

11. No witness evidence was called on behalf of the GMC. No further documentary evidence was provided by the GMC at this stage.

12. Dr Chintala gave oral evidence at the impairment stage of the hearing.

Documentary Evidence

13. The Tribunal had regard to the documentary evidence included in the bundle provided on behalf of Dr Chintala. This evidence included but was not limited to:

- Appraisal April 2018 - March 2019, dated 17 May 2022;
- Appraisal form July 2019 – September 2020, dated 17 May 2022;
- Appraisal form April 2022 - March 2021, dated 17 May 2022;
- Colleague feedback 30 October 2020, dated 17 May 2022;
- Patient feedback 2020
- Various training certificates of completion;
- Various certificates of appreciation, dated 17 May 2022;
- Reflective statement of Dr Chintala, dated 06 June 2022.

Submissions

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

14. Mr Ian Brook, Counsel, submitted that Dr Chintala's fitness to practise is impaired by reason of misconduct. He reminded the Tribunal of the overarching objective and of the two-stage process when considering misconduct. He referred the Tribunal to relevant case law which he submitted was engaged in this case.

15. The cases cited by Mr Brook included *Cheatle v General Medical Council. [2009] EWHC 645 (Admin); Aga v General Medical Council [2012] EWHC 782 (Admin); Mallon v General Medical Council 2007 SC 426; Roylance v General Medical Council [1999] Lloyds Rep.Med. 139; Meadows v General Medical Council (2007) Q.B. 466; PSA v GMC & Uppal [2015] EWHC 1304; The Queen (on the application of Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin); Council for Healthcare Regulatory Excellence v. NMC and Paula Grant [2011] EWHC 927 (Admin) and Cohen v GMC [2008] EWHC 581 Admin.*

16. Mr Brook submitted that while Dr Chintala's actions had not posed any direct risk to patients, her actions, in her dishonest conduct, brought the profession into disrepute. He reminded the Tribunal that honesty and integrity are fundamental tenets of the medical profession and that Dr Chintala's conduct and actions had breached these tenets. Mr Brook acknowledged that Dr Chintala had made full admissions to the allegations and had fully engaged with these proceedings. However, Mr Brook submitted that, taken as a whole, Dr Chintala's actions were unacceptable for a member of the profession and must be marked by a finding of impairment.

17. Mr Brook submitted that looking at Dr Chintala's otherwise unblemished record, the Tribunal could conclude that the doctor is not impaired. However, he reminded the Tribunal that its overarching concern should be that of the public interest and not that of an individual practitioner. He also submitted that there are cases where a finding of no impairment may have an adverse impact on public confidence in the profession. Mr Brook submitted that, in this case, public confidence in the profession would be undermined if a finding of impairment was not made.

18. Mr Brook concluded by asserting that a finding of impairment was necessary in order to mark the unacceptable nature of Dr Chintala's dishonesty and to uphold the overarching objective.

On behalf of Dr Chintala

19. Mr Andrew Kennedy, QC, submitted that Dr Chintala had made admissions as to her misconduct and accepted that her fitness to practise is currently impaired. He submitted that the impairment stage involves a 2-stage test which looks backwards to determine misconduct, and then forward to assess any current impairment. Mr Kennedy QC also reminded the Tribunal that a finding of dishonesty does not necessarily trigger a finding of misconduct or impairment. He submitted that any determination on current impairment is a matter for the Tribunal to determine.

20. He reminded the Tribunal that the Medical Act does not recognise 'serious misconduct'. He therefore submitted that there is no requirement for the Tribunal to determine whether her misconduct amounts to serious misconduct because misconduct by its definition is serious. He reminded the Tribunal that misconduct requires conduct which falls far below that which is expected of a medical practitioner.

21. Mr Kennedy QC submitted that the conduct in this case fell far below the conduct expected of a medical practitioner. He referred the Tribunal to Dame Janet Smith's 5th Shipman Report in which she set out four reasons why a doctor's fitness to practise may be impaired. He submitted that three of the elements under this test for impairment are engaged in this case.

22. These are:

> *'(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; and/or

(d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

23. Mr Kennedy QC submitted that he accepts on Dr Chintala's behalf that her admitted misconduct impairs her fitness to practice on the grounds of maintaining public confidence and upholding proper professional standards. Therefore, he submitted that Dr Chintala's fitness to practice is currently impaired.

The Relevant Legal Principles and the Tribunal's Approach

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

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

26. In relation to the question of misconduct, the Tribunal had regard to the case of *Roylance v General Medical Council (No.2) [2000] 1 AC 311* in which it was held:

"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.'

27. The Tribunal reminded itself of the judgement of *Auld LJ in Meadows v General Medical Council (2007) Q.B. 466* where it was stated:

"[Misconduct] must be linked to the practise of medicine, or conduct that otherwise brings the profession into disrepute, and it must be serious; the sort of conduct which would be regarded as deplorable by fellow practitioners."

28. The Tribunal relied on further guidance on the issue of misconduct has been provided in the judgment of Elias LJ in *The Queen (on the application of Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin),* in which his Lordship concluded that a number of principles could be derived from an overview of the existing authorities, including:

"Misconduct is of two principal kinds.

(1) First, it may involve sufficiently serious misconduct in the exercise of professional practise such that it can properly be described as misconduct going to fitness to practise.

(2) Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outside the course of professional practise itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession…"

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

30. In considering the dishonesty in this case, the Tribunal was mindful that it can be difficult to demonstrate remediation where a finding of dishonesty has been made. It also was aware that there were degrees of dishonesty and it should carefully consider the context of the dishonesty in this case.

31. The Tribunal relied upon further guidance of *PSA v GMC & Uppal [2015] EWHC 1304:*

> *"A finding of impairment does not necessarily follow upon a finding of dishonesty. If misconduct is established, the tribunal must consider as a separate and discrete exercise whether the practitioner's fitness to practise has been impaired."*

32. *Yeong v GMC [2009] EWHC 1923 per Sales J* at paras 50 & 51:

> *"The overarching concern is the public interest in protecting the public and maintaining confidence in the practitioner and medical profession when considering whether the misconduct in question impairs fitness to practise"*

33. The Tribunal reminded itself of the statutory overarching objective which is 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.

The Tribunal's Determination on Impairment

Misconduct

34. The Tribunal first considered whether the facts found proved in the Allegation are a sufficiently serious departure from the standards of conduct reasonably expected of Dr Chintala as a registered medical practitioner to amount to misconduct, which was serious.

35. The Tribunal acknowledged that Dr Chintala had admitted misconduct and impairment but was aware that the decision on misconduct and impairment was for the Tribunal to determine.

36. The Tribunal noted that the dishonesty occurred over a period of time from January to May 2019. The Tribunal recognised that, aside from the misconduct relating to this case, Dr Chintala has an unblemished record. The Tribunal considered that Dr Chintala's dishonest conduct is compounded by the fact that she was a senior medical practitioner.

37. The Tribunal determined that Dr Chintala's behaviour would be regarded as deplorable by fellow colleagues. This view was confirmed by the fact that Dr Chintala's misconduct was reported by a colleague. That doctor reported feeling betrayed by the Registrant.

38. The Tribunal had regard to paragraphs 1, 36, 37, 65, 68 and 77 of Good Medical Practice *("GMP"),* they state:

'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.

36 You must treat colleagues fairly and with respect.

37 You must be aware of how your behaviour may influence others within and outside the team.

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

68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

77 *You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.'*

39. The Tribunal considered that Dr Chintala had breached those paragraphs of GMP. In behaving dishonestly at work, she had breached a fundamental tenet of the medical profession.

40. The Tribunal concluded that Dr Chintala's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

Impairment by reason of misconduct

41. The Tribunal having found that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct Dr Chintala's fitness to practise is currently impaired.

42. The Tribunal had regard to paragraph 76 of the judgment in the case of *CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin)*, in which Mrs Justice Cox set out the helpful and comprehensive approach of Dame Janet Smith in her 5th Shipman Report to determining issues of impairment. At paragraph 25.67 of the Shipman Report, Dame Janet identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise.

'Do our findings of fact in respect of the doctor's misconduct…show that his/her fitness to practise is impaired in the sense that s/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; and/or…

d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

43. The Tribunal accepted Mr Kennedy QC's submission that three aspects of the test set out in the 5th Shipman Report by Dame Janet Smith are engaged. The key issue in relation to impairment is whether Dr Chintala's fitness to practise is impaired today. However, in order to form a view as to Dr Chintala's current fitness to practise, the Tribunal has taken into account the way in which she has acted in the past and may be expected to act in the future.

44. Dr Chintala gave oral evidence to the Tribunal in which she explained her misconduct as arising from her poor management of her work life balance and her inclination to deal with XXX by seeking more work. She expressed her remorse, acknowledging her dishonesty, and the effects of her actions on other people. Asked in evidence in chief to describe the effects of her misconduct she said '*I am really sorry – I should not have attended the call and should have declined the call. My actions were dishonest. My peers would've been really annoyed, angry it would have added to their workload*.' Asked how she felt now she replied : '*sad, disappointed with myself. I let down my family, other people, my peers, my regulator. I'm really sorry. I've lived with this and don't know what will happen and how I will live with myself. I feel worried, scared. I don't know.'*

45. As a witness the Tribunal found her to have some insight, but to be at times evasive, and not entirely forthright. In particular the tribunal noted that her appraisal was signed off by her on 26th July 2019. It referred to a single matter being investigated concerning a patient of hers whom she had assessed during absence from work XXX. Dr Chintala explained her

motivation in that appraisal as '*she knew the patient well and wanted to help'.* On 18th July 2019, Dr Chintala was interviewed by the CFS and although not legally represented at that interview, was asked questions about the three instances of January 2019 and the seven occasions of MHA assessments in May 2019. Dr Chintala had not informed her appraiser correctly of the extent of the matters being investigated. During the interview, she also gave the impression that she did not claim for some MHA assessments for patients that were known to her. In oral evidence, when asked, Dr Chintala did not remedy these inaccuracies. The Tribunal found some of her responses to be misleading.

46. The Tribunal was concerned by the gravity of her misconduct. It noted that she emailed the secretary to her line manager on 8 January 2019 at 08.37 hrs stating she was '*unable to come to work today and tomorrow as I am not feeling well with flu like symptoms.*' Later, she attended assessments for three different patients, at 13.30 hrs and 16.00 hrs, on 8 January 2019, and in the early hours of the following day, 9 January at 00.30 hrs. She claimed and was paid for each assessment in addition to receiving sick pay from Southern Health. The sums of money claimed and paid to her for those assessments including travel costs totalled £596.75. In oral evidence Dr Chintala accepted that at that time of her sick leave, her department at Southern Health was understaffed. In May 2019 her misconduct was repeated with seven MHA assessments whilst on sick leave. Subsequently, having been informed of an investigation, she did not make claims for payment for those assessments.

47. In her evidence, Dr Chintala expressed that she felt deep shame and regret at her 'mistake'. However, the Tribunal bore in mind that many of her reflections centred around the impact of her misconduct upon herself. The Tribunal was mindful of the emphasis Dr Chintala had placed on external circumstances such as work life balance and her struggle to XXX at the times when she took sick leave.

48. The Tribunal noted that Dr Chintala had attended a three-day ethics course in May 2021 to remediate and reflect upon her misconduct. She was able to provide examples of what she had learned from that course, including some recognition of what her peers must

have felt. However, the Tribunal considered she was not entirely open in her explanation for the reasoning behind her actions. It noted that Dr Chintala did not deny that her actions were motivated in part by financial gain. Dr Chintala, in her evidence, mentioned some motivation to care for patients who were at risk to not only themselves but also others, but did little to persuade the Tribunal that her actions, in her misconduct were ultimately for her patients' benefit. The Tribunal therefore took the view that Dr Chintala has shown partial insight into the factors that contributed to her behaviour.

49. The Tribunal bore in mind that whilst dishonesty is difficult to remediate, it is not impossible. In this case, the Tribunal considered that Dr Chintala has shown evidence of insight as she has admitted her misconduct and has accepted her fitness to practice is currently impaired. The Tribunal considered that her misconduct is remediable but has not yet been remedied. It determined that Dr Chintala is part way along her journey of remediation. The Tribunal took into consideration the absence of misconduct by Dr Chintala before January 2019 or since May 2019. Regarding a likelihood of repetition, the Tribunal considered there remains a risk until she gains full insight but regards the risk as low.

50. In respect of insight, the Tribunal was satisfied that Dr Chintala recognises her wrongdoing for which she is remorseful. Whilst she may not yet fully appreciate the potential impact of her conduct on the profession and the wider public, the Tribunal was satisfied that Dr Chintala is determined that the same mistakes will not be repeated. The Tribunal noted her failure to explain her understanding of honesty as a fundamental tenet during her evidence and took the view that Dr Chintala was not forthcoming in her declarations to the CFS and her appraiser.

51. The Tribunal considered that a reasonable and well-informed member of the public would expect a finding of impairment to be made in this case to mark the seriousness of the misconduct. It considered that a finding of impairment is necessary in this case to maintain public confidence and to uphold and maintain standards for members of the profession.

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

Determination on Sanction - 09/06/2022

53. Having determined that Dr Chintala'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

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

55. The Tribunal received further evidence on behalf of Dr Chintala in the form of a Testimonial bundle and oral evidence which included:

- Testimonial evidence from Dr H, consultant clinician in the Community Mental Health Team, by video link;
- Written statement of Dr H, dated 13 May 2022;
- Testimonial evidence from Dr I, Consultant Psychiatrist and Lead Clinician in Older Persons Mental Health Service in Solent NHS Trust, by video link;
- Written statement of Dr I, dated 19 May 2022;
- Further Testimonials in support of Dr Chintala from colleagues;
- Letter to Dr I from the MDU, dated 06 May 2022.

Submissions

On behalf of the GMC

56. Mr Ian Brook, Counsel, submitted that sanctions are not designed to punish a doctor but may have a punitive effect. The primary purpose of a sanction is to uphold the overarching objective. He submitted that patients must be able to trust doctors, and that a doctor's conduct must justify this trust.

57. Mr Brook submitted that the appropriate sanction in this case would be one of suspension. He submitted that whilst there is repeated dishonesty, involving a number of MHA assessments, over the course of two distinct periods, that they took place over relatively short periods of time.

58. Mr Brook submitted that Dr Chintala's conduct falls short of being incompatible with continued registration. Mr Brook referred to criticisms of Dr Chintala's candour and openness arising from the oral evidence of character witnesses who indicated that they were not aware of the full details of the incidents.

59. Mr Brook referred to the Sanctions Guidance (16 November 2020) ('the SG'). In particular, he referred to paragraphs 91, 92, 93 and 97(a) and (f) regarding suspension:

> '***91*** *Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*

92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration…

93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions…

97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.'

…

f No evidence of repetition of similar behaviour since incident

60. Mr Brook submitted that it is in the public's interest for Dr Chintala to remain on the medical register. He reminded the Tribunal of the testimonial evidence it received regarding the difficulty in obtaining doctors to fulfil face to face MHA Assessments. Mr Brook submitted that there has been no evidence of repetition of similar behaviour by Dr Chintala since the incidents.

61. Mr Brook submitted that a review should be ordered following the period of suspension to reassure the public and the regulator that Dr Chintala is fit to return to practise. He referred to paragraphs 49 and 50 of the impairment determination in which the Tribunal determined that Dr Chintala is still on her journey of remediation. He submitted that in these circumstances a review should be ordered to ensure Dr Chintala is able to remediate fully.

On behalf of Dr Chintala

62. Mr Andrew Kennedy QC, submitted that as a clinician, Dr Chintala is highly competent, as a colleague she is reliable and aside from these matters she is somebody whom her colleagues and testimonial witnesses regard as honest. He submitted it might be said that these matters are out of character. Mr Kennedy QC also submitted that Dr Chintala is remorseful. He referred to various testimonials provided on behalf of Dr Chintala to support this. He made particular reference to the testimonial of Dr K who stated that Dr Chintala is very open and honest.

63. Mr Kennedy QC submitted that it would be unfair for the Tribunal to assume that witnesses are underplaying the gravity of matters when they have referred to isolated or single issues rather than multiple occurrences in their testimonials. Each witness had been given the allegations in full. He submitted that the themes of confidence, reliability, probity and expressions of remorse can be found throughout the testimonials provided on behalf of Dr Chintala.

64. Mr Kennedy QC directed the Tribunal to the helpful insight provided into the pressures that the MHA assessment system continues to face. He submitted that the Tribunal has had the evidence and statement of Dr I. The Approved Mental Health Professional Ms J in a written testimonial stated '*Please note it is challenging to find a doctor to attend a mental health act assessment additionally it is very rare to find a doctor with previous acquaintance to attend the MHAA. Most of the time approved doctors are difficult to find to attend*

assessment due to shortage of doctors. Sujana is a hard working consultant, when it comes to her patients or assessing the patients that she has previous Acquaintance Sujana will go out of her way to support the assessing teams …….'

65. Mr Kennedy QC reminded the Tribunal that Dr H in oral evidence had said it was much easier to fill a remote/virtual working role rather than a post for a section 12 approved doctor to work face to face with patients.

66. Mr Kennedy QC reminded the Tribunal of Dr Chintala's immediate apologies when confronted with matters. He submitted that although the dishonesty in this case was repeated, Dr Chintala made no attempts to cover up her misconduct. Mr Kennedy QC also referred the Tribunal to paragraph 44 onwards of the impairment determination in which the Tribunal acknowledged that Dr Chintala was in fact remorseful and recognised the impact of her actions on herself, her family and her colleagues. He reminded the Tribunal that in paragraph 46 of the Impairment Determination it had found that Dr Chintala had developed some insight. Mr Kennedy QC invited the Tribunal to view their impairment findings alongside paragraphs 42, 45 and 46 of the SG:

> *'42 When things go wrong and a patient under a doctor's care has suffered harm or distress, doctors should:*
>
> *a take steps to improve by learning from mistakes and preventing similar events recurring*
>
> *b be open and honest, and apologise.*
>
> *45 Expressing insight involves demonstrating reflection and remediation.*
>
> *46 A doctor is likely to have insight if they:*
>
> *a accept they should have behaved differently (showing empathy and understanding)*

b *take timely steps to remediate and apologise at an early stage before the hearing*

c *demonstrate the timely development of insight during the investigation and hearing.'*

67. Mr Kennedy QC invited the Tribunal to reflect on the cultural barriers which may have increased the criticisms it had made relating to Dr Chintala's insight. He reminded the Tribunal of the doctor's earlier evidence relating to English being her second language and the differences and difficulties she may face when orally articulating her remorse and insight. He took the Tribunal to paragraph 50 of the impairment determination which states '*The Tribunal noted her failure to explain her understanding of honesty as a fundamental tenet during her evidence'*. He reminded the Tribunal of Dr Chintala's difficulties speaking in a second language and directed the Tribunal to Dr Chintala's written reflective statement where she more clearly captured her understanding of honesty as a fundamental tenet. Mr Kennedy QC suggested some of the difficulty Dr Chintala faced trying to articulate why she was dishonest was because she inherently considers herself to be an honest person and was trying to articulate that in a second language.

68. Mr Kennedy QC directed the Tribunal to paragraph 49 of the impairment determination which states '*The Tribunal considered that her misconduct is remediable but has not yet been remedied'*. Mr Kennedy QC then referred to Mr Brook's submissions of the repeated nature of the dishonesty as an aggravating feature. He submitted that Dr Chintala declared the issues of her probity to her appraiser. He submitted that it may be unfair to attach too great a criticism to the doctor's involvement in the appraiser's failing to make further inquiries into the details surrounding Dr Chintala's misconduct.

69. Mr Kennedy QC submitted that Dr Chintala made full admissions of dishonesty from the outset and apologised to her line manager, Dr A, immediately. He submitted that this apology was repeated before the CFS. He submitted that Dr Chintala is a competent, valued

clinician as shown by the feedback received from her colleagues and patients, as well as the testimonials.

70. Mr Kennedy QC submitted that this was not a case in which taking no action or imposing conditions would be appropriate. He submitted that the appropriate sanction in this case would be one of suspension. In his submissions, Mr Kennedy QC made reference to the relevant paragraphs of the SG relating to suspension. In determining the appropriate length of the proposed suspension, Mr Kennedy QC reminded the Tribunal of the overarching objective and the punitive effect of suspension on the Practitioner. He informed the Tribunal that, if suspended, Dr Chintala is likely to lose her job as she will be unable to fulfil the terms of her employment contract by her inability to work.

71. Mr Kennedy QC reminded the Tribunal of the impact of the length of suspension on the provision of services. He submitted that if Dr Chintala is suspended for a lengthy period, and that results in her losing her job, she may be in a position where she is unable to work and provide services for an even lengthier period than the Tribunal originally imposed. Mr Kennedy QC submitted that a suspension for a period of 3 months would be appropriate. He submitted that this is not a case where a review should be necessary. However, he submitted that if a review is directed, it should be made clear to the doctor what she is expected to do in the meantime and what she should make available for the next hearing.

72. Mr Brook challenged the assertion of Mr Kennedy QC , that Dr Chintala would lose her job if suspended, in the absence of evidence to that effect. Mr Kennedy QC accepted there was no evidence before the Tribunal that she would lose her job.

The Relevant Legal Principles

73. This stage of the proceedings is governed by Rule 17(2)m of the Rules and the Tribunal's task now is to decide what sanction, if any, should be imposed upon the registration of the Doctor.

74. When considering sanction, the Tribunal must have particular regard to the statutory overarching objective:

a. To protect, promote and maintain the health, safety and wellbeing of the public;
b. To promote and maintain public confidence in the medical profession; and
c. To promote and maintain proper professional standards and conduct for members of that profession.

75. In reaching its decision, the Tribunal must take into account the SG. The purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it may have a punitive effect. If the Tribunal departs from the Guidance the relevant paragraph should be referenced, and reasons for departing from the Guidance given.

76. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal exercising its own judgement, taking account of the SG. It must consider the least restrictive sanction first and then, if necessary, consider the other sanctions, taking into account the submissions that have been heard. The Tribunal must consider its determination on impairment and take those matters into account during its deliberations on sanction.

77. The Tribunal is reminded of the familiar guidance given by Lord Bingham MR in *Bolton v The Law Society [1994] 1 WLR 512* to the effect that the reputation of a profession is more important than the fortunes of any individual member. Membership of a profession may bring many benefits, but membership comes at the price of liability to sanctions to maintain the reputation of the profession.

78. The public interest, which should be at the forefront of the Tribunal's mind, includes the public interest in enabling a suitable doctor to return to safe practice, but also the wider public interest of the protection of patients, the maintenance of confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

The Tribunal's Determination on Sanction

79. The decision as to the appropriate sanction, if any, to impose in this case is a matter for the Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken the SG into account and borne in mind the over-arching objective.

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

Aggravating and Mitigating Factors

81. The Tribunal has already set out its decision on the facts and impairment which it took into account during its deliberations on sanction. Before considering what action, if any, to take in respect of Dr Chintala's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

82. The Tribunal identified the following aggravating factors:

- The Tribunal noted that the dishonesty was repeated 10 times over 5 months;
- Dr Chintala defrauded her employer for financial gain;
- Dr Chintala left her colleagues to cover her NHS work within a service that was under pressure thus failing to work collaboratively with them;
- Dr Chintala was performing a serious statutory duty to determine whether to deprive a patient of their liberty. Patients and the public would expect a high level of probity in the discharge of that medical duty;
- Dr Chintala is a senior doctor in her profession;
- Dr Chintala, in her statement, accepted that her actions may have delayed appointments for patients.

83. Having identified aggravating factors in this case, the Tribunal identified the mitigating factors to be:

- Dr Chintala made full admissions when first challenged;
- Dr Chintala expressed genuine remorse then and since including in her recent written self-reflection;
- Dr Chintala has taken steps to develop her insight and remediate her misconduct through attendance on a 3 day ethics course with subsequent self-reflection;
- The Tribunal noted that Dr Chintala had no previous fitness to practise history;
- There are eleven positive testimonials from her places of work between 2018 and 2022 provided on behalf of Dr Chintala, in which she is described as a highly competent, reliable, capable clinician who is a good team player;
- Dr Chintala has positive feedback from patients and colleagues attesting to her competence, reliability, care and integrity in the workplace;
- Dr Chintala has begun to address issues in her lifestyle and work to avoid XXX;
- It has been 3 years since the incidents occurred and there has been no suggestion of any recurrent behaviour since that time;
- Dr Chintala repaid the sick pay.

84. The Tribunal accepted Mr Kennedy QC's submissions regarding the application of paragraph 48 of the SG concerning cross-cultural communication. In evidence in chief Dr Chintala explained that when she was worried she would translate her answers from her mother tongue into English. In particular, bearing that guidance in mind the Tribunal re-read Dr Chintala's reflective statement where she stated '*I should not have attended the assessments. I understand how this is against one of the most fundamental tenets of medical profession which is to be honest and my actions were dishonest*.' Further in her statement she stated '*I understand the effects on my colleagues who would have covered me in good faith. It would have added to their workload and in turn may have led to their burn out. They would be*

frustrated and annoyed as well when they knew about this. This may have indirect effect on their patient care, In addition to this, there would have been an impact on my employer in the current climate of staff shortages in the NHS as well as financial implications.'

85. The Tribunal bore in mind the oral evidence of Dr I and Dr H who spoke of the high regard in which they held Dr Chintala. Both stressed the remorse of Dr Chintala, and her willingness to discuss the details of her misconduct at her interview for her current position, and in her recent appraisal. Regrettably neither doctor had, in spite of receiving the Rule 15 allegation, appreciated the extent of the misconduct. That is not the failure of Dr Chintala, and, indeed, both doctors stated that in any event they would welcome her back to work, because they found her to be a good and competent clinician and valued member of their team. Neither had any reservations as to her probity.

86. The Tribunal balanced the aggravating and mitigating factors identified in this case, and considered each sanction in ascending order of severity, starting with the least restrictive.

No action

87. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances. The Tribunal determined that there are no exceptional circumstances in this case and that, given the seriousness of its findings, it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

88. The Tribunal next considered whether to impose conditions on Dr Chintala's registration. The Tribunal noted that conditions are appropriate and workable in certain

circumstances including where a doctor has been open and honest and has shown insight. It also noted that conditions may also be appropriate where a Tribunal is satisfied that the doctor will comply with them and has the potential to respond positively to their work being supervised.

89. The Tribunal noted that the SG provides that in cases of dishonesty, it is difficult to identify any conditions that could be appropriate, proportionate, workable, and measurable. In light of Dr Chintala's dishonest conduct and impairment, the Tribunal determined to accept the submissions of Mr Kennedy QC, that it would be difficult to formulate appropriate and workable conditions.

90. The Tribunal was also of the view that imposing conditions on Dr Chintala's registration would not sufficiently mark the seriousness of her dishonest conduct.

Suspension

91. The Tribunal then went on to consider whether suspending Dr Chintala's registration would be appropriate and proportionate. In this regard, The Tribunal considered paragraphs 91, 92, 93 and 97 (a), (e), (f) and (g) of SG to be relevant

> '91 *Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> 92 *Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for*

which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate
their actions…

97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a. A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors

…

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

f. No evidence of repetition of similar behaviour since incident

g. The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour'.

92. The Tribunal accepted that suspension does have a deterrent effect and would send a sufficiently robust signal to the profession, and the public about the gravity of transgressing proper standards of professional behaviour. The Tribunal was satisfied that Dr Chintala's misconduct was so serious that significant action had to be taken to maintain public confidence in the profession and to maintain proper professional standards, whilst acknowledging that there were no patient safety issues.

93. The Tribunal was of the view that while it had found that Dr Chintala's misconduct was serious and in breach of GMP it fell short of being fundamentally incompatible with continued registration.

94. The Tribunal did consider whether erasure would be appropriate but decided in view of the guidance at para 109 of the SG, it would be disproportionate, given the features of this case. The Tribunal determined that public confidence would be adequately served by a period of suspension. It did not consider it to be in the public interest to erase an otherwise competent doctor in the specific circumstances of this case.

95. Dishonesty whilst deplorable must be marked to maintain public confidence and to uphold professional standards. Taking all of the evidence, submissions and its own deliberations into account, the Tribunal was satisfied that the public would be content for a period of suspension to reflect the gravity of the misconduct and to send a clear message to the profession. The Tribunal was of the view that during a period of suspension, Dr Chintala would have the time and opportunity to continue to develop her insight further.

Length of suspension

96. Having considered the sanctions in ascending order of restrictiveness and having determined to suspend Dr Chintala's registration, the Tribunal went to on to consider the length of the period of suspension for her. The Tribunal determined to suspend Dr Chintala's registration from the medical register for a period of 2 months. The length was determined

by a recognition that a suspension would of itself mark the seriousness of Dr Chintala's misconduct, the need to maintain public confidence in the profession and to uphold proper professional standards. Additionally, the time period was not in order for Dr Chintala to fully remediate. Her journey began three years ago, was significantly progressed through this hearing and will continue for some time to come. Two months will reflect the need to uphold public confidence without depriving the public of a competent and much needed doctor.

97. This suspension will uphold the over-arching objective to protect the public, maintain public confidence in the profession and uphold proper professional standards. The Tribunal also reminded itself that this was not a case involving matters of patient safety, or one involving a doctor that is unable to admit their dishonesty.

98. The Tribunal further determined that it was not necessary to direct a review of Dr Chintala's case as it considered that the risk of repetition is very low. Further evidence of remediation would be unlikely to be established within the period of suspension of two months.

Determination on Immediate Order - 09/06/2022

99. Having determined that a two-month suspension was the appropriate sanction, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Chintala's registration should be subject to an immediate order.

Submissions

Submissions on behalf of the GMC

100. Mr Brook, Counsel, submitted that an immediate order was required in this case to protect public confidence in the medical profession.

Submissions on behalf of Dr Chintala

101. Mr Kennedy, QC, submitted that imposing an immediate order was neither necessary nor appropriate in this case and noted that this was not a case concerning issues relating to patient safety. He submitted that an immediate order should not be imposed as it is effectively punitive in a case such as this as it adds a month's suspension to the total suspension period. He also submitted that the Tribunal is not concerned with public or patient safety in this case and not imposing an immediate order does not dilute the message sent to the public.

102. Mr Kennedy, QC, submitted that there is a public interest in permitting competent doctors to practise, and not removing competent doctors from practice for longer than is absolutely necessary. It would not be appropriate to deprive Dr Chintala's patients of her services for longer than is required.

The Tribunal's Determination

103. 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.

104. The Tribunal considered paragraph 172 of the SG which states:

> *'172 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...'*

105. The Tribunal considered that no issues in relation to patient safety had been identified in this case.

106. Dr Chintala practices in a specialty in which there is an acknowledged shortage of consultants. The public confidence and the upholding of professional standards would be maintained by the order of the sanction of suspension without the imposition of an immediate order. The Tribunal determined that it was neither in the public interest nor in Dr Chintala's interest to impose an immediate order.

107. This means that Dr Chintala's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless she lodges

an appeal. If Dr Chintala does lodge an appeal she will remain free to practise unrestricted until the outcome of any appeal is known.

108. That concludes this case.

SCHEDULE A

Schedule 1

Date of Assessment	Time of Assessment
8 January 2019	13:30
8 January 2019	16:00
9 January 2019	00:30
14 May 2019	18:15
15 May 2019	14:00
15 May 2019	15:30
16 May 2019	14:00
16 May 2019	19:30
16 May 2019	21:00
17 May 2019	22:00