PUBLIC RECORD

Dates: 08/04/2024 - 01/05/2024

Medical Practitioner's name:	Mr Anthony LAMBERT
GMC reference number:	3095506
Primary medical qualification:	MB BS 1985 University of London

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

Summary of outcome

Suspension, 6 months
Review hearing directed

Tribunal:

Legally Qualified Chair	Mr Gerry Wareham
Lay Tribunal Member:	Mr Paul Hepworth
Medical Tribunal Member:	Dr Frances Burnett

Tribunal Clerk:	Ms Jemine Pemu (08/04/2024 – 29/04/2024) Mr Matt O'Reilly (30/04/2024 – 01/05/2024)

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr James Leonard KC, instructed by Weightmans Solicitors
GMC Representative:	Mr Paul Williams, 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 - 25/04/2024

Background

1. Mr Lambert qualified in 1985 with MB BS from the University of London. In 1992, Mr Lambert became a Fellow of the Royal College of Surgeons of England and then went on to undertake a Diploma in Sports Medicine in 1996 at the Royal College of Surgeons of Edinburgh, Royal College of Physicians of Edinburgh. He became a Master of Surgery at the University of Bath in 1998 and passed the Intercollegiate Speciality Examination in General Surgery with a sub-speciality in Vascular Surgery in 1998. In 2008, Mr Lambert completed a Master of Science at the University of Bath. Prior to the events which are the subject of the hearing, Mr Lambert served for 36 years in the Royal Navy and reached the rank of Surgeon Commander. Mr Lambert commenced surgical training at Royal Navy Hospital Hasler in Gosport in 1992 and became an Honorary Consultant General Surgeon at Derriford Hospital Plymouth in May 2000, having previously spent two years at the hospital as a Trainee.

2. At the time of the events Mr Lambert was practising in General Surgery and General Paediatric Surgery at Derriford Hospital, part of University Hospitals Plymouth NHS Trust ('UHP').

Nature of complaint

3. The allegation that has led to Mr Lambert's hearing can be summarised as, on 20 April 2016 whilst working at UHP Mr Lambert performed an umbilical hernia repair on Patient A, a child, who was unconscious under general anaesthetic, and undertook a freeing of preputial

adhesions on Patient A's penis without the knowledge or consent of either Patient A or his parents, and that his language when informing them of what he had done was inappropriate. It is also alleged that Mr Lambert responded to questions asked during an interview as part of a UHP investigation into his conduct on 20 April 2016 in a way which he knew to be untrue and therefore dishonest.

4. It is further alleged that there were a number of failings in relation to the standard of care and communication provided by Mr Lambert in the treatment of Patients G and I. There are also allegations of inappropriate comments made in the course of his clinical work in a professional setting. The full particulars are set out below.

Notification of complaint

5. On 23 April 2016, Mrs B, the mother of Patient A, submitted a complaint to University Hospital Plymouth NHS Trust regarding Mr Lambert by email. Mr Lambert was consultant to Patient A (Mrs B's son) for the treatment of his umbilical hernia. During an operation on Patient A at Derriford Hospital performed on 20 April 2016, it is alleged that Mr Lambert performed an additional procedure to free his foreskin without Patient A, Mrs B or her husband's knowledge or consent.

6. A complaint was submitted to Derriford Hospital on 20 October 2018 by a Foundation Year 1 (FY1) trainee working with Mr Lambert in the general surgery department in relation to his conduct at the Trust.

7. The initial concerns were raised with the GMC on 10 June 2019 by Patient G via an online complaint made regarding the care provided to her by Mr Lambert. Patient G also submitted a copy of the complaint letter, dated 11 February 2019, that she had submitted to the Hospital regarding the treatment provided to her by Mr Lambert. The other matters of concern came to light during the subsequent investigation.

The Outcome of Applications Made during the Facts Stage

8. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise) Rule 2004 as amended ('the Rules'), to withdraw paragraphs 3a, 4a, 4b, 4c(i)(2-5), 5, 6a and 6c and amend paragraph 4 of the Allegation. The Tribunal's full decision on the application is included at Annex A.

9. On 19 April 2024, the Tribunal granted the GMC's application for the expert witness for the defence, Ms J, to make available to the GMC the research papers and materials which she had read after producing the Joint Expert Report with Mr K which had influenced her subsequent change of opinion from that as expressed in the Joint Expert Report.

10. On 22 April 2024, the Tribunal granted the GMC's application, made pursuant to Rule 35(3) of the Rules, to recall the expert witness for the GMC, Mr K, to deal with the specific issues that had arisen after he completed giving his evidence. Mr Williams, Counsel, wished to ask Mr K further questions restricted to the extent that the further documentation supplied by Ms J, following the GMC's successful application for disclosure of research materials, justified or supported that change of mind as exemplified in Ms J's second statement.

The Allegation and the Doctor's Response

11. The Allegation made against Mr Lambert is as follows:

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

Patient A

1. On 20 April 2016, whilst working at University Hospitals Plymouth NHS Trust ('UHP'), you:

    a. were performing an umbilical hernia repair on Patient A, a child, and whilst Patient A was unconscious under general anaesthetic you:

        a. examined Patient A's penis; **Admitted and Found Proved**

        b. undertook a freeing of preputial adhesions on Patient A's penis; **Admitted and Found Proved**

    b. failed to obtain consent from Patient A and/or Patient A's parents before carrying out the actions outlined at paragraph:

        a. 1. a. i. ; **Admitted and Found Proved**

        b. 1. a. ii. ; **Admitted and Found Proved**

    c. made an inappropriate comment to Patient A and his mother, Mrs B, that '*…because I am a bit of a nosey twat I noticed that [Patient A]'s penis did not look quite normal…*', or words to that effect.
    Admitted and Found Proved

UHP

2. On 17 June 2016, you were interviewed as part of a UHP investigation into your conduct on 20 April 2016 and:

   a. when discussing your comment set out at paragraph 1. c. you stated '*This is the first time in 16 years I've had a complaint…*', or words to that effect; Admitted and Found Proved

   b. when asked the question '*Have you ever had any complaints about language in the past?*' you stated '*No*', or words to that effect; Admitted and Found Proved

   c. you knew you had previously:

      a. received a letter dated 15 July 2014 from UHP informing you that UHP would be conducting an investigation into concerns about your conduct, including the allegation that '*On the 1st July, 2014 you used expletive language on the Children's High Dependency Unit in front of the nursing staff, the patients and the patients parents.*'; Admitted and Found Proved

      b. received a letter dated 25 September 2014 from UHP:

         i. informing you that the allegation outlined at paragraph 2. c. i. had been upheld; Admitted and Found Proved

         ii. proposing that a final written warning be issued to you; Admitted and Found Proved

      c. been excluded from working at UHP between 15 July 2014 and 6 October 2014 (inclusive) whilst the UHP investigation outlined in paragraph 2. c. i. took place; Admitted and Found Proved

   d. you knew that your statements were untrue as set out at paragraphs:

      a. 2. a. ; To be determined

      b. 2. b. ; To be determined

   e. your actions as described at paragraph 2.a and 2b were dishonest by reason of paragraphs 2. c. and 2. d.; To be determined

3. Between 1 June 2018 and 31 October 2018 (inclusive), whilst working at UHP, you made comments as set out in Schedule 1 which were inappropriate in that one or more of them:

   a. were:

i. foul and/or abusive; **Admitted and Found Proved**

ii. aggressive and/or intimidating; **Admitted and Found Proved**

iii. bullying in nature; **Admitted and Found Proved**

iv. derogatory towards:

1. patients; **Admitted and Found Proved**

2. other healthcare professionals; **Admitted and Found Proved**

3. women; **Admitted and Found Proved**

b. deterred other healthcare professionals from approaching you. **Admitted and Found Proved**

Patient G

4. Between 31 July 2018 and 2 August 2018 (inclusive), Patient G was admitted to UHP under your care, and you failed to: **Inserted under Rule 17(6)**

a. implement an appropriate treatment plan in that you did not continue the antibiotics given to Patient G in A&E and the Surgical Assessment Unit for a minimum of 5 days following the initial administration; **To be determined**

b. ~~you failed~~ to appropriately communicate with Patient G: **Amended under Rule 17(6)**

i. on 1 August 2018 in that you:

1. were stern in your history taking; **To be determined**

2. were disbelieving and/or aggressive in respect of their previous diagnosis of Campylobacter related problems; **To be determined**

ii. on 2 August 2018 in that you:

1. told Patient G that you did not know what the cause of her symptoms were~~as~~ but nevertheless discharged her; **To be determined Amended under Rule 17(6)**

2. seemed angry at Patient G for declining sigmoidoscopy; **To be determined**

3. never asked Patient G about her bowels,
To be determined

4. left Patient G with no clear management plan;
To be determined

5. adopted a poor attitude in speaking to Patient G.
To be determined

Patient I

5. Between 7 October 2018 and 13 October 2018 (inclusive), Patient I was admitted to UHP under your care and you failed to provide an adequate handover ~~communicate~~ to the on-call team, that before Patient I was discharged on 13 October 2018: Amended under Rule 17(6)

a. her bowels should have been functioning normally and flatus passed; To be determined

b. the results of the blood tests taken on 13 October 2018 should be checked; To be determined

c. you should be informed if the results of the bloods tests taken on 13 October 2018 were significantly abnormal; To be determined

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

The Admitted Facts

12. At the outset of these proceedings, through his counsel, Mr James Leonard KC, Mr Lambert made admissions to several paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

13. In light of Mr Lambert's response to the Allegation made against him, the Tribunal was required to determine the paragraphs and sub-paragraphs remaining.

Factual Witness Evidence

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

- Mrs B, mother of Patient A, by video link. Witness statement dated 21 October 2022;
- Patient G, by video link. Witness statement dated 20 August 2019.

15. 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:

- Dr L, former locum senior house Officer ('SHO') in general surgery, dated 05 November 2019;
- Dr M, Core Surgical Trainee in General Surgery Department at Derriford Hospital, dated 03 November 2019;
- Ms N, formerly employed within the Surgical Assessment Unit at Plymouth NHS Trust, dated 15 November 2019.

16. Mr Lambert provided his own witness statement, dated 6 April 2023 and also gave oral evidence at the hearing.

17. The Tribunal also received written evidence on behalf of Mr Lambert from the following witnesses who were not called to give oral evidence:

- Mr O, Professor of Organisational Ethnography at the University of Cambridge, undated;
- Mr P, Medical Director at Practice Plus Group Hospital, Plymouth, dated 06 April 2023;
- Mr Q, Foundation Year 2 doctor at Derriford Hospital, dated 04 April 2023.

Expert Witness Evidence

18. The Tribunal also received written reports and heard oral evidence from two expert witnesses aimed at assisting the Tribunal in understanding the standard of care expected of a reasonably competent general surgeon, particularly in relation to Patients A, I and G.

19. Mr K, Consultant Surgeon, was instructed on behalf of the GMC. He provided an Expert Report dated 31 October 2020. He also provided two supplemental Expert Reports dated 22 October 2021 and 19 May 2022.

20. Ms J, Consultant General and Colorectal Surgeon, was instructed on behalf of Mr Lambert. She provided two Expert Reports dated 18 December 2023.

21. A Joint Expert Report was also produced, dated 26 January 2024.

22. Ms J produced an additional report, dated 16 April 2024, in which she withdrew her agreed view as set out in the Joint Expert Report with regard to the failure to continue the administration of antibiotics to Patient G.

Documentary Evidence

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

- Documents relating to July 2014 UHP Investigation, dated 15 July 2014 to 25 September 2014;
- UHP Investigation Reports, dated April 2016 and 01 April 2019;
- UHP Final Written Warning, dated 22 July 2016;
- Summary of Police Interview, dated 11 May 2016;
- Various exhibits from the Witness Statement of Mrs B, dated 27 April 2016, 07 September 2016, 16 September 2016 and 20 April 2016;
- Parental signed consent form relating to Patient A signed by Patient A's father, dated 20 April 2016;
- Various exhibits from the Witness Statement of Patient G, dated 10 June 2019, 11 February 2019 and 24 May 2019;
- Abdominal and Chest X-Rays/images for Patient G provided by UHP, dated 31 July 2018 to 03 May 2019;
- UHP Medical Records provided by Patient G, various dates;
- Email from Royal Cornwall NHS Trust attaching Incident Initial Review document, timeline of treatment provided to Patient I, UHP's clinical detail and UHP's estimated timeline, dated 17 July 2019;
- UHP Root Cause Analysis Investigation Report, dated 03 April 2019;
- UHP Pharmacy TTA Guidance (Standard Operating Procedure), dated June 2018;
- Medical Records for Patient I provided by UHP, various dates;
- Post Mortem for Patient I, dated 23 October 2018;
- Cornwall and Isles of Scilly Coroner's Inquest Statements Bundle - Witness Statement and Exhibits of Mr Lambert, dated 01 October 2019;

- Cornwall and Isles of Scilly Coroner's Record of Inquest, dated 12 May 2021;
- Partial Transcript of Cornwall Coroner's Court Inquest - Evidence of Mr Lambert, dated 12 May 2021;
- Partial Transcript of Cornwall Coroner's Court Inquest -The Coroner's narrative and summing-up, dated 14 May 2021;
- Various exhibits from the Witness Statement of Mr Lambert, dated December 2021, 29 and 30 July 2019 and 5 October 2018.

The Tribunal's Approach

24. 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. Mr Lambert 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.

25. The Tribunal also bore in mind that while balance of probabilities is an unvarying standard, the judgment of Re H (Minors) [1996] AC 563 stated that it is expected that the more serious the allegation, the more cogent the evidence must be. It accepted that if Mr Lambert's credibility was an issue, or there was a dispute between his evidence and that of others, evidence of his good character was relevant and admissible but the weight to be put on such evidence was a matter for the Tribunal.

26. In respect of the allegations that Mr Lambert acted dishonestly, the Tribunal applied the test laid down by the Supreme Court in *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67 *('Ivey'*), namely that the Tribunal should first ascertain subjectively the actual state of Mr Lambert's knowledge or belief as to the facts. Whether the belief is reasonable may be a matter of evidence, but reasonableness is not an additional requirement when considering whether the belief was genuinely held. The Tribunal should then ascertain whether his conduct was dishonest applying the objective standards of ordinary decent people.

27. The Tribunal accepted the Legally Qualified Chair's advice that when considering dishonesty, the Tribunal should consider the probability or improbability of dishonesty having occurred. The Tribunal also noted that Mr Lambert came before it as a person of good character. The Tribunal weighed this fact in his favour both when considering whether the evidence he had provided to the Tribunal was truthful, and in considering whether he was likely to have acted in the manner alleged.

28. In assessing a witness's credibility, the Tribunal reminds itself that it should not assess witness credibility exclusively on the demeanour of the witness when giving their evidence, but their veracity should be tested by reference to objective facts proved independently in their evidence, in particular by reference to the documents in the case. The Tribunal should make a rounded assessment of a witness's reliability, rather than approaching their reliability in respect of each charge in isolation from the others: R (on the application of Dutta) v GMC [2020] EWHC 1974 (Admin).

29. It is open to the Tribunal not to rule out the whole of a witness's evidence based on credibility; credibility could be divisible: Khan v The General Medical Council [2021] EWHC 374 (Admin).

30. The Tribunal note that, when considering the evidence of any witness in this case, it should also bear in mind the extent to which the passage of time may have affected the memory of a witness. The Tribunal would be aware from its own experience that memories can fade with the passage of time, and that recollections may change, or may become confused, as to what did or did not happen at a particular time. The Tribunal should make due allowance for the way in which the passage of time may have affected the recollections of any of the witnesses.

31. As to individual pieces of evidence, the Tribunal is entitled to draw proper inferences - to come to common sense conclusions based upon the evidence which it accepted as reliable; but it must not speculate. Similarly, the Tribunal should not speculate about what other evidence there might have been. The Tribunal should only draw an inference if it could safely exclude other possibilities: Soni v GMC [2015] EWAC 0364 Admin.

32. Expert evidence is permitted to provide the Tribunal with information and opinion, which is within the witness' expertise, but which is likely to be, or may be outside our experience and knowledge. It is important that the Tribunal should see it in its proper perspective, which is that it is part of the evidence as a whole to assist in regard to any particular aspect of the evidence to which it relates and to come to any conclusions on the basis of our own observations. The Tribunal should consider the experts' evidence and attach such weight to it as considered appropriate in being able to make a determination on the outstanding denied factual allegations.

The Tribunal's Analysis of the Evidence and Findings

33. 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.

UHP investigation

Paragraphs 2(d)(a) and 2(d)(b)

34. On 17 June 2016, Mr Lambert was interviewed as part of a UHP investigation into his conduct on 20 April 2016 including a comment he was alleged to have made to the parents of Patient A, as set out at paragraph 1c of the Allegation ('…*because I am a bit of a nosey twat I noticed that [Patient A]'s penis did not look quite normal*…').

35. In that interview he stated '*This is the first time in 16 years I've had a complaint*…', or words to that effect, and when asked 'Have you ever had any complaints about language in the past?' he answered 'No'. Mr Lambert had been subject to an earlier investigation and subsequent warning following a complaint regarding his language in 2014. He accepted the factual assertions in this paragraph of the Allegation but denied that he knew these comments were untrue when made and that he was thereby dishonest.

36. The Tribunal considered carefully the nature and context of the questions put to Mr Lambert during the investigation. Taken in isolation, the questions could be interpreted in the way alleged, but the context of the discussion and preceding questions were highly relevant to how they may have been perceived and understood by Mr Lambert. The Tribunal had no one before it from the interview other than Mr Lambert, and no direct evidence as to the intent of the question asked beyond his evidence.

37. The Tribunal sought to determine Mr Lambert's knowledge or belief as to the facts, in particular whether he understood the question to relate to a similar situation as the one he now faced, a complaint from a patient or relative, or of general application. In doing so the Tribunal bore in mind:

- Mr Lambert was aware that the previous complaint against him occurred at the same hospital and it was a matter of record. A member of Human Resources department was present at the interview and would have had access to the record of the complaints made against him. Mr Lambert stated that any attempt to deceive in such circumstances would have been reckless in the extreme;

- The context of the conversation to that point was such that it was not unreasonable that Mr Lambert may have been focused on similar circumstances specifically involving patient complaints. The first comment he made, "This is the first time in 16 years I've had a complaint" was immediately followed by "I have had compliments on the way I handle patients.". The question as to whether he had been subject of complaints in the past was immediately preceded by comments about patients and minors;
- Mr Lambert was presented with notes of the meeting after it occurred and did not see fit to change them. There is no evidence anyone else present challenged these assertions at that time;
- The Tribunal also considered Mr Lambert's previous good character. It was of the view that this also made it less likely that he would seek to deliberately mislead in such circumstances rather than seek to distinguish the previous complaint as not of the same nature.

38. The Tribunal noted the manner in which Mr Lambert responded to questions put to him by both Counsel and the Tribunal during the hearing. It noted that Counsel would often have to draw Mr Lambert back to the question that was being asked of him as he would often not answer the specific point raised but give information he felt relevant. Taking into account its experience of how Mr Lambert had answered questions during the current hearing and the points set out above the Tribunal found that on the balance of probabilities Mr Lambert believed the questions asked during the 2016 investigation related to complaints from a patient and not general complaints regarding his language.

39. As the Tribunal had determined that Mr Lambert, at the time of the interview, did not believe the statement that he was making was untrue, the Tribunal therefore found paragraph 2(d)(a) and 2(d)(b) of the Allegation not proved.

Paragraph 2(e)

40. The Tribunal set out to determine whether Mr Lambert's actions as described at paragraph 2.a and 2b were dishonest by reason of paragraphs 2. c. and 2. d

41. As the Tribunal had determined as a matter of fact that Mr Lambert did not believe his statements to be untrue when he made them, the Tribunal also found that an ordinary and decent person under those circumstances would not find his actions to be dishonest.

42. The Tribunal therefore found paragraph 2(e) of the Allegation not proved.

Patient G

Paragraph 4(a)

43. The Tribunal set out to determine whether whilst Patient G was under Mr Lambert's care he failed to implement an appropriate treatment plan in that he did not continue antibiotics given to Patient G in A&E for a minimum of 5 days following the initial administration.

44. The Tribunal had sight of the *'Time critical conditions: Sepsis'* flow chart ('the flow chart'), which is used in UHP for adult patients when sepsis is clinically suspected. It was completed for Patient G following her admission to the hospital on 31 July 2018 and it was concluded by the clinician undertaking the assessment at that time that she did not have symptoms and signs meeting the criteria for severe sepsis, although she did meet the criteria for uncomplicated sepsis. Both experts agreed that Patient G did not have 'severe sepsis' as defined by the flow chart which is UHP accepted guidance for clinicians when determining whether it is necessary to administer antibiotics. The Tribunal found the evidence of Mr K to be reliable and cogent. He was clearly of the view that on the basis of the indications he had taken from the records, it was the correct and prudent course to prescribe antibiotics. However, he offered the Tribunal no reference to any guidance which may have mandated such a course. On occasion he referred to Patient G as displaying 'severe sepsis' but did accept it was not 'severe' as defined by the flow chart. He also referred to it as serious or significant sepsis and stated that there were clear indications that Patient G was unwell.

45. The Tribunal also heard evidence that although Patient G had a raised temperature and other symptoms, she was not presenting as a patient who was acutely clinically unwell to nurses and doctors. The Tribunal noted that a doctor reviewed Patient G's case before Mr Lambert and did not prescribe antibiotics, and even considered discharging Patient G. It also heard evidence that there is current national guidance for prescribers discouraging the use of broad spectrum antibiotics in the absence of an identified source of infection as indiscriminate prescription of antibiotics is contrary to the public health as it could lead to acquired immunity, and that 'watch and wait' is an accepted strategy for managing uncomplicated sepsis or infection.

46. Mr Lambert was an extremely senior and respected practitioner who had frequently dealt with issues of infection of undiagnosed source, and was of excellent professional

character. It would have been an easy option for him to have prescribed antibiotics if he felt that such a course was merited. The Tribunal accepted Ms J's opinion that many doctors would not prescribe antibiotics in these circumstances. Ms J stated in her evidence that Patient G was not displaying signs of severe sepsis. She had been assessed three times on the Glasgow Coma Scale without concern, her temperature was high but not of itself an indication of severe sepsis, and was falling, and there were no other indications that Patient G was at significant risk. Even taking into account the swinging pyrexia which both experts agreed was evident on 2 August, she did not ever meet the clinical criteria for severe sepsis during her period of hospital admission.

47. The Tribunal determined that in the absence of any evidence of established guidance or requirement that antibiotics must be given, it was a matter of clinical judgement whether or not to prescribe them. Whilst the Tribunal was persuaded by the evidence of Mr K that many doctors would have prescribed antibiotics in these circumstances, on the balance of probabilities it was satisfied that it was a decision within the discretion of Mr Lambert, as the treating clinician, and was within the bounds of an appropriate course of action. It was therefore not a 'failure' for him to choose to withhold antibiotics rather than prescribe without an identified source of infection.

48. The Tribunal therefore found paragraph 4(a) of the Allegation not proved.

Paragraph 4(b)(i)(1)

49. The Tribunal set out to determine whether between 31 July 2018 and 2 August 2018 (inclusive), whilst Patient G was admitted to UHP under Mr Lambert's care, he failed to appropriately communicate with Patient G on 1 August 2018 in that he was stern in his history taking.

50. The Tribunal considered all the evidence heard, including admissions from Mr Lambert that he can occasionally be direct or short. The evidence from Patient G was general and not detailed as to the reasons why she formed this perception. In her letter of complaint submitted to UHP, dated 11 February 2019, some six months after the incident, she stated, '*He was quite stern in his approach and history taking…*'. When asked in evidence what Mr Lambert had said or done to make her feel this way, Patient G was unable to provide further details or offer examples. The Tribunal was satisfied that she may have perceived Mr Lambert's style of communication and behaviour as being stern, but on the balance of probabilities found insufficient evidence that his behaviour or communication was

inappropriate or unprofessional in the circumstances of a busy ward round. The Tribunal found no evidence to prove that Mr Lambert's interactions with Patient G were inappropriate.

51. The Tribunal therefore found paragraph 4(b)(i)(1) of the Allegation not proved.

Paragraph 4(b)(i)(2)

52. The Tribunal set out to determine whether between 31 July 2018 and 2 August 2018 (inclusive), whilst Patient G was admitted to UHP under Mr Lambert's care, he failed to appropriately communicate with Patient G on 1 August 2018 in that he was disbelieving and/or aggressive in respect of their previous diagnosis of Campylobacter related problems.

53. The Tribunal considered the letter of complaint submitted by Patient G to UHP, dated 11 February 2019, which stated, '*He …questioned how I knew that I had had Campylobacter 2 months previously in quite an aggressive and disbelieving way (I had it confirmed through my GP).*'

54. The Tribunal bore in mind the evidence given by Mr Lambert and supported by the records, that campylobacter was already at that time a significant element of his differential diagnosis based on his acceptance of her history in that regard. Mr Lambert had no recollection of the discussion but stated that any such question would have been to secure further information and confirmation, and would not have been by way of challenge, much less disbelief. When giving evidence, Patient G was asked why she thought Mr Lambert was quite aggressive and disbelieving and she said that Mr Lambert asked her how she knew it was Campylobacter. There was nothing further that Patient G could add to assist the Tribunal as to why this apparently reasonable question was aggressive or disbelieving.

55. The Tribunal determined that there was insufficient evidence prove this sub-paragraph of the allegation on the balance of probabilities.

56. The Tribunal therefore found paragraph 4(b)(i)(2) of the Allegation not proved.

Paragraph 4(b)(ii)(1)

57. The Tribunal set out to determine whether between 31 July 2018 and 2 August 2018 (inclusive), whilst Patient G was admitted to UHP under Mr Lambert's care, he failed to

appropriately communicate with Patient G on 2 August 2018 in that he told Patient G that he did not know what the cause of her symptoms were but nevertheless discharged her.

58. The Tribunal, having considered the evidence before it, deemed it entirely appropriate for Mr Lambert to inform Patient G that he did not know the cause of her symptoms at the time of her discharge. It agreed with the opinions of both experts who stated that doctors cannot keep patients in hospital indefinitely whilst searching for the cause of their symptoms. It was not alleged that Mr Lambert should not have discharged her. The Tribunal therefore did not find it proved that Mr Lambert's communication in this regard was inappropriate.

59. The Tribunal therefore found paragraph 4(b)(ii)(1) of the Allegation not proved.

Paragraph 4(b)(ii)(2)

60. The Tribunal set out to determine whether between 31 July 2018 and 2 August 2018 (inclusive), whilst Patient G was admitted to UHP under Mr Lambert's care, he failed to appropriately communicate with Patient G on 2 August 2018 in that he seemed angry at Patient G for declining sigmoidoscopy.

61. Within the letter of complaint, Patient G stated, '*That morning of the 2nd August, Mr Lambert saw me again. He said he didn't know what was wrong with me and seemed quite angry that I had declined a sigmoidoscopy. He said it could be a Colitis causing the problem, I said I would accept one then, as all other tests were inconclusive. I was never asked about any bowel symptoms, of which there were none…*'

62. The Tribunal was presented with no further evidence to show that Mr Lambert seemed angry, and in evidence patient G could not add further detail as to how this was demonstrated and how his behaviour was inappropriate. The Tribunal accepted that this may have been Patient G's perception of Mr Lambert at the time of the complaint, but that there was not sufficient evidence on the balance of probabilities to show that his communication with Patient G was inappropriate. Furthermore, the Tribunal bore in mind Mr Lambert's evidence that he was not present when the sigmoidoscopy was declined.

63. The Tribunal determined that there was insufficient evidence to prove this sub-paragraph of the allegation on the balance of probabilities.

64. The Tribunal therefore found paragraph 4(b)(ii)(2) of the Allegation not proved.

Paragraph 4(b)(ii)(3)

65. The Tribunal set out to determine whether between 31 July 2018 and 2 August 2018 (inclusive), whilst Patient G was admitted to UHP under Mr Lambert's care, he failed to appropriately communicate with Patient G on 2 August 2018 in that he never asked Patient G about her bowels.

66. The Tribunal relied on the history taken at the hospital and the clinical notes of Patient G, dated 01 August 2018 at 6.10am which stated that her bowels had opened. Furthermore, a timeline within Patient G's clinical notes showed that her bowels opened normally again that same day. The Tribunal noted that there were two mentions of Patient G's bowels within her clinical notes and history. It therefore follows that Mr Lambert, having relied on Patient G's history, would not have needed to ask her about her bowels.

67. The Tribunal determined that since the information was already available to Mr Lambert it could not be an 'inappropriate communication' not to ask the question, and that accordingly there was insufficient evidence provided to prove this sub-paragraph of the allegation on the balance of probabilities.

68. The Tribunal therefore found paragraph 4(b)(ii)(3) of the Allegation not proved.

Paragraph 4(b)(ii)(4)

69. The Tribunal set out to determine whether between 31 July 2018 and 2 August 2018 (inclusive), whilst Patient G was admitted to UHP under Mr Lambert's care, he failed to appropriately communicate with Patient G on 2 August 2018 in that he left Patient G with no clear management plan.

70. The Tribunal had regard to Patient G's clinical notes, dated 02 August 2018 at 16:33 which stated, '*patient has agreed to go home*'. The Tribunal noted that the allegation related only to communication of an action plan and did not allege that the decision to discharge was flawed. It heard evidence that discharge was normally left with other team members to arrange in the basis of the notes and comments of the consultant and was not a consultant specific responsibility. The Tribunal also accepted the submissions of Mr Leonard KC on behalf of Mr Lambert that Patient G had access to a GP and A&E should they be required and

there was nothing inappropriate about this information being given at discharge by a Junior Doctor. The Tribunal had sight of Patient G's discharge letter, dated 02 August 2018, which included a clear management plan which was, primarily, the need for an outpatient clinic and colonoscopy.

71. The Tribunal therefore found paragraph 4(b)(ii)(4) of the Allegation not proved.

Paragraph 4(b)(ii)(5)

72. The Tribunal set out to determine whether between 31 July 2018 and 2 August 2018 (inclusive), whilst Patient G was admitted to UHP under Mr Lambert's care, he failed to appropriately communicate with Patient G on 2 August 2018 in that he adopted a poor attitude in speaking to Patient G.

73. The Tribunal had regard to Patient G's letter of complaint in which she stated, 'Does he feel it is OK to speak to patients and his team with such a poor attitude?' It accepted that Patient G's perception and memory of the interaction was as she relates, however in the absence of specific examples and evidence to show that Mr Lambert adopted a poor attitude the mere assertion was not sufficient evidence, on the balance of probabilities, to establish that Mr Lambert's communication was inappropriate.

74. The Tribunal therefore found paragraph 4(b)(ii)(5) of the Allegation not proved.

Patient I

Paragraph 5(a), (b) and (c)

75. The Tribunal set out to determine whether between 7 October 2018 and 13 October 2018 (inclusive), Patient I was admitted to UHP under Mr Lambert's care and he failed to provide an adequate handover to the on-call team, that before Patient I was discharged on 13 October 2018 her bowels should have been functioning normally and flatus passed; the results of the blood tests taken on 13 October 2018 should be checked; and he should be informed if the results of the bloods tests taken on 13 October 2018 were significantly abnormal.

76. The Tribunal was satisfied on the basis of the evidence of both experts that a safe handover was vitally important, and that checking the functioning of the bowels and passing

of flatus and consideration of the blood results were key elements of a safe discharge. The matter of where responsibility for ensuring that this occurred was less clear.

77. The Tribunal noted that the GMC had called no witnesses to establish the background to this paragraph of the Allegation and relied on Patient I's clinical record sheet, handover notes and the expert evidence of Mr K. There was no evidence as to any handover system or practice which may have been in operation at the hospital. The Tribunal noted that following the inquest, UHP conceded that there were inadequacies in the handover procedure and continuity of care in operation in the hospital at the time and that subsequently changes have been made to mitigate risk.

78. The Tribunal considered the records available. It noted in particular an entry on 09 October 2018 at 10:30 which stated 'HPB taken over care today'. Mr Leonard KC referred the Tribunal to the notes which showed that same HPB Senior Clinical Fellow saw Patient I on 9 and 12 October 2018, which indicates some continuity of care, and also that the HPB team had taken over and maintained control of Patient I's care. Patient I was seen by another HPB Registrar on 10 October 2018.

79. The Tribunal noted that Mr Lambert attended Patient I on 11 October 2018 with the Senior Clinical Fellow from HPB and on again on 12 October 2018 with the FY1 Doctor who was due to be on the ward on 13 October 2018 when Mr Lambert would not be in the hospital. Mr Lambert states that these attendances on Patient I were out of care and concern and not a matter of requirement or responsibility. There was no evidence present in the records to show that he had taken over the care of Patient I from the HPB team. The HPB team had seen Patient I on the morning of the 12th and determined that Patient I would go home in the morning with bloods being taken before she did.

80. It was the agreed view of the experts that the checks required were essential before discharge. Ms J was of the view that they were so evidently required that it would not be necessary to stipulate them, and that she would not do so. Mr K agreed that any competent practitioner would ensure this was done before discharge, but stated that he believed that as a matter of prudence the need should be noted. As stated, the Tribunal did not hear evidence from any doctors or others working on the ward as to any established procedure or any form of handover system in place. The Tribunal took the view that in such circumstances, where doctors and nurses change constantly and there is no guarantee of continuity, the ultimate responsibility for safe discharge must rest with the doctor conducting the discharge. The Tribunal heard that patient discharge from hospital can only take place after review by a

senior doctor at specialist trainee level or above, as happened in Patient G's case. It considered that the discharging clinician in this type of busy hospital setting must be capable of making decisions on whether it is safe to discharge a patient, and should make whatever reasonable enquiries that may require.

81. The Tribunal determined that on the evidence available it could not be satisfied on the balance of probabilities that Mr Lambert was still the supervising doctor at the time of Patient I's discharge. In any event it is also satisfied that it has not been established to the necessary standard that there was a requirement to specifically bring the issues the subject of the allegation, the bowel function and the blood tests, to the attention of the discharging clinician.

82. Mr Lambert was not scheduled to work on the ward on Saturday 13 October 2018. In such circumstances, and in the absence of any specific evidence of local practise or requirement, the Tribunal found that the evidence did not establish any requirement that Mr Lambert be personally contacted regarding the blood results, rather than a duty consultant who would be much more easily located and better placed to assist.

83. The Tribunal therefore found paragraph 5 of the Allegation not proved in its entirety.

The Tribunal's Overall Determination on the Facts

84. The Tribunal has determined the facts as follows:

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

Patient A

1. On 20 April 2016, whilst working at University Hospitals Plymouth NHS Trust ('UHP'), you:

    a. were performing an umbilical hernia repair on Patient A, a child, and whilst Patient A was unconscious under general anaesthetic you:

        a. examined Patient A's penis; **Admitted and Found Proved**

        b. undertook a freeing of preputial adhesions on Patient A's penis; **Admitted and Found Proved**

    b. failed to obtain consent from Patient A and/or Patient A's parents before carrying out the actions outlined at paragraph:

a. 1. a. i. ; Admitted and Found Proved

b. 1. a. ii. ; Admitted and Found Proved

c. made an inappropriate comment to Patient A and his mother, Mrs B, that '*…because I am a bit of a nosey twat I noticed that [Patient A]'s penis did not look quite normal…*', or words to that effect.
Admitted and Found Proved

UHP

2. On 17 June 2016, you were interviewed as part of a UHP investigation into your conduct on 20 April 2016 and:

a. when discussing your comment set out at paragraph 1. c. you stated '*This is the first time in 16 years I've had a complaint…*', or words to that effect; Admitted and Found Proved

b. when asked the question '*Have you ever had any complaints about language in the past?*' you stated '*No*', or words to that effect;
Admitted and Found Proved

c. you knew you had previously:

a. received a letter dated 15 July 2014 from UHP informing you that UHP would be conducting an investigation into concerns about your conduct, including the allegation that '*On the 1st July, 2014 you used expletive language on the Children's High Dependency Unit in front of the nursing staff, the patients and the patients parents.*'; Admitted and Found Proved

b. received a letter dated 25 September 2014 from UHP:

i. informing you that the allegation outlined at paragraph 2. c. i. had been upheld; Admitted and Found Proved

ii. proposing that a final written warning be issued to you;
Admitted and Found Proved

c. been excluded from working at UHP between 15 July 2014 and 6 October 2014 (inclusive) whilst the UHP investigation outlined in paragraph 2. c. i. took place; Admitted and Found Proved

d. you knew that your statements were untrue as set out at paragraphs:

a. 2. a. ; Not proved

b. 2. b. ; Not proved

e. your actions as described at paragraph 2.a and 2b were dishonest by reason of paragraphs 2. c. and 2. d.; **Not proved**

3. Between 1 June 2018 and 31 October 2018 (inclusive), whilst working at UHP, you made comments as set out in Schedule 1 which were inappropriate in that one or more of them:

a. were:

i. foul and/or abusive; **Admitted and Found Proved**

ii. aggressive and/or intimidating; **Admitted and Found Proved**

iii. bullying in nature; **Admitted and Found Proved**

iv. derogatory towards:

1. patients; **Admitted and Found Proved**

2. other healthcare professionals; **Admitted and Found Proved**

3. women; **Admitted and Found Proved**

b. deterred other healthcare professionals from approaching you. **Admitted and Found Proved**

Patient G

4. Between 31 July 2018 and 2 August 2018 (inclusive), Patient G was admitted to UHP under your care, and you failed to: **Inserted under Rule 17(6)**

a. implement an appropriate treatment plan in that you did not continue the antibiotics given to Patient G in A&E and the Surgical Assessment Unit for a minimum of 5 days following the initial administration; **Not proved**

b. ~~you failed~~ to appropriately communicate with Patient G: **Amended under Rule 17(6)**

i. on 1 August 2018 in that you:

1. were stern in your history taking; **Not proved**

2. were disbelieving and/or aggressive in respect of their previous diagnosis of Campylobacter related problems; **Not proved**

ii. on 2 August 2018 in that you:

1. told Patient G that you did not know what the cause of her symptoms were~~as~~ but nevertheless discharged her; Amended under Rule 17(6) Not proved

2. seemed angry at Patient G for declining sigmoidoscopy; Not proved

3. never asked Patient G about her bowels, Not proved

4. left Patient G with no clear management plan; Not proved

5. adopted a poor attitude in speaking to Patient G. Not proved

Patient I

5. Between 7 October 2018 and 13 October 2018 (inclusive), Patient I was admitted to UHP under your care and you failed to provide an adequate handover ~~communicate~~ to the on-call team, that before Patient I was discharged on 13 October 2018: Amended under Rule 17(6)

    a. her bowels should have been functioning normally and flatus passed; Not proved

    b. the results of the blood tests taken on 13 October 2018 should be checked; Not proved

    c. you should be informed if the results of the bloods tests taken on 13 October 2018 were significantly abnormal; Not proved

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

Determination on Impairment - 30/04/2024

85. 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, Mr Lambert's fitness to practise is impaired by reason of misconduct.

The Evidence

86. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition the Tribunal received further documentary evidence in the form of fifteen testimonials from Mr Lambert's previous colleagues, and a Stage 2 defence bundle on behalf of Mr Lambert which included, but was not limited to:

- Mr Lambert's Appraisal documentation for the year ending April 2021;
- Various Continual Professional Development ('CPD') evidence and certificates;
- Mr Lambert's CV, dated July 2022;
- Various feedback reports from Patients and Colleagues.

Submissions

On behalf of the GMC

87. Mr Paul Williams, Counsel, submitted Mr Lambert's fitness to practise is impaired by reason of misconduct. He reminded the Tribunal of the relevant legal principles when considering misconduct and that the question of impairment was a matter for its own judgment. He said that the word *misconduct* in the Medical Act denotes a serious breach of the accepted standards, such that a doctor's fitness to practise is impaired. Mr Williams accepted that the Tribunal will take into account the apology that the doctor made, his character and the testimonial evidence provided.

88. Mr Williams submitted, in relation to Patient A, that the admitted facts amount to an 'incredibly serious' instance of misconduct. He submitted that patient consent is a fundamental part of clinical practice and that, legally, conducting a procedure or examination without consent could be an assault. He submitted that the need for consent is a necessary consequence of the autonomy of the patient and patients have the right to consent or not consent to any procedure. Mr Williams submitted that to ignore that right is to ignore the patient's autonomy.

89. Mr Williams submitted that Patient A's age, he was 12 at the time, is an aggravating feature. He was old enough to express his own view on consent which should have been taken into account and respected, and that view was also explicitly supported by his parents. Mr Williams submitted that Mr Lambert should have listened to the patient and his parents asking him not to undertake the examination or the procedure, and that he had the

opportunity to back out, having made the examination without consent and identified the issue, and seek consent at this stage, but did not.

90. Mr Williams noted that Mr Lambert apologised for his actions but stated that he was not able to express full insight or an understanding of why he did it. He therefore submitted that Mr Lambert's insight is not fully developed. Mr Williams submitted that the Tribunal should be assisted by the expert report of Mr K, in which he set out clear reasons why Mr Lambert should not have conducted the procedure and that his actions fell seriously below the expected standard. Mr Williams submitted that it cannot be claimed on Mr Lambert's behalf that because Patient A may well have needed this procedure done eventually, it was somehow to his benefit that Mr Lambert carried it out when he did. He submitted that to accept this would be to totally disregard the psychological effect on Patient A. Mr Williams reminded the Tribunal of the powerful evidence of Mrs B as to the impact of this incident on Patient A. He submitted that the incident had affected him during the time of his A- Level exams and still impacts him now. The psychological effects have been such that it has damaged his trust in the medical profession.

91. Mr Williams submitted that using the phrase 'because I'm a bit of a nosey twat' when speaking to Patient A and his parents after the procedure, combined with the lack of consent, was an aggravating feature as it trivialises what he had done. He submitted that this language is inappropriate in any medical context, but it was particularly inappropriate in these circumstances as Mr Lambert knew that he had gone against an express refusal of consent, and it was used in front of a child.

92. Mr Williams submitted that there are numerous examples of Mr Lambert using deeply inappropriate language to both colleagues and patients in many different settings and under many different circumstances. He submitted that this use of language and Mr Lambert's attitude to his language is not a one-off aberration but part and parcel of how the doctor behaved whilst in clinical practice. Mr Williams acknowledged the character references provided on behalf of Mr Lambert, in which many positive things were said about him. However, he invited the Tribunal to balance this against the elements of foul and abusive language repeatedly used by Mr Lambert, which he had admitted could be described as aggressive, intimidating, bullying and derogatory. This language had the potential to deter healthcare professionals from approaching him, as set out in the Allegation.

93. Mr Williams submitted that it was contrary to Good Medical Practice in terms of his duty to respect colleagues, and the fact that Mr Lambert states that he did not intend them

to be as the Allegation described them, may give the impression that he is passing off some responsibility onto the person receiving those words. He submitted that, if this is the case, then that is quite wrong as the words and phrases used by Mr Lambert are deeply inappropriate on any objective basis. Mr Williams submitted that there is clear evidence that this is the way in which Mr Lambert regularly spoke and behaved. He also reminded the Tribunal that Mr Lambert used inappropriate language under cross examination. Mr Williams submitted that perhaps Mr Lambert was stressed or frustrated whilst being cross examined, and perhaps there is a theme in that he reverts to using foul language when stressed. He submitted that there are clear grounds for the Tribunal to find that Mr Lambert has not entirely learned his lesson and that his use of inappropriate language is still not under control. He stated that Mr Lambert has not been able to fully explain why he behaved in the way that he did, or indicate changes he has made so that he will not behave in a similar way in the future.

94. Mr Williams submitted that Mr Lambert's actions would be viewed as deplorable by fellow members of the profession both in relation to Patient A and the schedule 1 allegations. He submitted that members of the public would be shocked to learn of such behaviour and that Mr Lambert's actions have brought the medical profession into disrepute and therefore amount to serious misconduct.

95. In terms of impairment, Mr Williams submitted that the mere passage of time does not remediate the seriousness of the allegations and that it was fair comment to suggest that his insight was still not fully developed, that he is not rehabilitated, has not fully remediated his actions and there remains a risk of repetition if he is in a clinical setting. Mr Williams noted that Mr Lambert is now retired, for the most part. He submitted, however, that there remains a risk that Mr Lambert can choose to return to practice, and the risk of repetition arising from his incomplete insight and reflection should lead the Tribunal to conclude that Mr Lambert is currently impaired.

96. Mr Williams submitted that the Tribunal should consider the need to uphold the overarching objective and send a clear message, to Patient A, to the public and all medical practitioners about the importance of consent. He submitted that the public needs to feel confident that practitioners understand the gravity of proceeding not only in the absence of consent, but in the face of a clear refusal of consent. Mr Williams submitted that the Tribunal should also consider the importance of upholding standards in relation to how doctors deal with their colleagues and how they present to patients.

On behalf of Mr Lambert

97. Mr James Leonard KC submitted that it is accepted that the public interest is engaged in relation to the issues raised in relation to Patient A. He submitted that the Tribunal should ask itself whether or not the conduct complained of is of a sufficiently immoral or outrageous or disgraceful character such as would be deplored by fellow members of the profession. Mr Leonard accepted that the Tribunal would be troubled by what Patient A's mother told it about the subsequent impact on Patient A. He submitted that this was certainly not foreseen, perhaps not foreseeable, and most definitely not intended. Mr Leonard submitted that there is no suggestion that freeing the adhesions was other than clinically indicated. He submitted that even Patient A's mother accepts that Mr Lambert was intending to act in Patient A's best interest. Mr Leonard submitted that, against this background, the Tribunal should consider whether Mr Lambert's actions can be said to be sufficiently 'immoral, outrageous or disgraceful conduct' such as would be deplored by members of the medical profession.

98. Mr Leonard asked the Tribunal to bear in mind that all of the theatre staff present were aware that consent had not been obtained (including two anaesthetists, one of whom was a consultant) and yet they were party to what Mr Lambert then did. He accepted that the fact remains that Mr Lambert should not have dealt with the adhesions on Patient A's penis in the way that he did, and that, in the absence of consent an outpatient appointment should have been arranged. Mr Leonard invited the Tribunal to conclude, however, that Mr Lambert is devastated by the consequences of his actions even though they were clinically indicated and carried out with the best of intentions. He reminded the Tribunal that this incident is now eight years old, and the GMC were aware of what had happened and what was admitted in 2016 but took no action. Mr Leonard submitted that the Tribunal should regard this as a completely isolated incident without precedent and without repetition. He submitted that Mr Lambert apologised at the time and sought to put it right as far as he could via a meeting, and deeply regrets not having had the opportunity to do so at the time. Mr Leonard submitted that the Tribunal will form its own view of seriousness against that background, and it is not necessarily the case that every situation in which consent has not been given will give rise automatically to misconduct.

99. In relation to the allegations surrounding Mr Lambert's use of language and behaviour towards patients and colleagues, Mr Leonard submitted that Mr Lambert recognises that those who complained of his conduct had the right to do so and he remains mortified that he caused the individuals concerned to feel as they did. This was not his intention. He submitted that Mr Lambert has only ever sought to teach, encourage learning and strive for excellence

in his clinical practice. He submitted that Mr Lambert remains very distressed that his actions have discouraged any of those things based on the way his behaviour was perceived.

100. Mr Leonard reminded the Tribunal of the circumstances and context in relation to each allegation and submitted that whilst there may not be an excuse for poor behaviour, there can be an explanation which impacts on culpability. He submitted that the matters in the Schedule cover a period of 5 months and relate to three individuals, one of whom speaks to her interactions with Mr Lambert over the course of 3 days in July 2018 as an FYI (Dr C), and Nurse E whose complaints relate to Patient F, a single patient on the one day of 6 October 2018. This was a day when there was considerable pressure as regards availability of beds and senior staff. Mr Leonard submitted that the complaints cover a narrow compass of time at Derriford, and it was significant that no such allegations arose during Mr Lambert's time working at Nuffield.

101. Mr Leonard reminded the Tribunal that the accepted background to this intemperate behaviour was the stress suffered by Mr Lambert as part of his deployment to combat zones. He submitted that Mr Lambert did not re-assimilate back into the NHS well, and to some extent took his frustrations out on colleagues despite not having any intention to do so. Mr Leonard invited the Tribunal to recognise the different approaches that working in the military as opposed to the NHS might entail, by way of an explanation for Mr Lambert's behaviour, though not as an excuse. He submitted that the Tribunal has heard from Mr Lambert about the impact of not having a team around him and acting as a stand-alone surgeon gave rise to considerable frustrations. Mr Leonard invited the Tribunal to make its own assessment as to whether these matters amount to serious misconduct.

102. Mr Leonard submitted that the failings admitted here were clearly capable of remediation. He reminded the Tribunal that Mr Lambert has greatly curtailed his duties and last worked at the Derriford, the only location of issues identified in Schedule 1, in October 2018 and last worked at the Nuffield in November 2021. He reminded the Tribunal of the vast array of Charges originally brought by the GMC which have been hanging over Mr Lambert's head up until the beginning of this hearing, when they were greatly abridged to what now falls for consideration.

103. Mr Leonard reminded the Tribunal of Mr Lambert's considerable public service through his Naval career and its impact on him as relevant to consideration of impairment. He submitted that Mr Lambert has made an outstanding contribution to the lives of too many to number in the most challenging of situations, and it has taken its toll on him. He

submitted that this deserves considerable recognition. He informed the Tribunal that Mr Lambert now works as a trainer for the Royal College of Surgeons' Trauma Surgery course and as an examiner for the MRCS course again for the Royal College of Surgeons. He submitted that the Tribunal may regard Mr Lambert's contribution in this regard as positively in the public interest, bearing in mind his experience of active military service.

104. Mr Leonard submitted that Mr Lambert has complete insight into the allegations he has admitted and therefore it would be open for the Tribunal to conclude that Mr Lambert's fitness to practice is not currently impaired.

The Relevant Legal Principles

105. 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.

106. 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 as a result of that finding of serious misconduct, Mr Lambert's fitness to practice is currently impaired.

107. The Tribunal must determine whether Mr Lambert's fitness to practise is impaired today, taking into account Mr Lambert'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. It should also consider whether a finding of impairment is warranted taking into account the wider public interest.

108. The Tribunal considered the overall risk to public safety and the impact of its findings on all three elements of the overarching objective. It also considered whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of current impairment was not made.

109. The LQC highlighted the case of *Roylance v GMC (no2) (2000) 1 AC 311* in which 'misconduct' was defined as 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'. In the case *Nandi v GMC [2004] EWHC*

2317 (Admin), it was said that serious misconduct is sometimes described as misconduct which would be considered deplorable by fellow practitioners.

110. The LQC further referred the Tribunal to the principle set out in *Cheatle v GMC [2009] EWHC 645 (Admin): 'The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct.'*

111. The LQC drew the Tribunal's attention to the case of *Yeong v GMC [2009] EWHC 1923 (Admin),* which states that '*where a FTPP considers that fitness to practise is impaired for such reasons, and that a firm declaration of professional standards so as to promote public confidence in that medical practitioner and the profession generally is required, the efforts made by the practitioner to address his problems and to reduce the risk of recurrence of such misconduct in the future may be of far less significance than in other cases, such as those involving clinical errors or incompetence'*.

The Tribunal's Determination on Impairment

Misconduct

112. In determining whether Mr Lambert's fitness to practise is impaired by reason of misconduct, the Tribunal first considered whether the facts admitted amount to misconduct and that misconduct is serious.

113. The Tribunal had regard to Good Medical Practice (2013), in particular paragraphs 1, 31, 36, 37 and 65, which provide:

> *'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.*
>
> *...*
>
> *31 You must listen to patients, take account of their views, and respond*

honestly to their questions.

…

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.'*

Patient A

114. The Tribunal noted that it was agreed by both parties that there was strong evidence that no consent was obtained by Mr Lambert from Patient A and his parents. Indeed, there was uncontested evidence that the lack of consent was made explicit and in clear terms on two separate occasions, by both the patient and his parents. The Tribunal took the view that the decision to complete the examination and procedure contrary to the clear expressions of no consent was aggravated by Patient A's young age.

115. The Tribunal reminded itself of the oral evidence of Patient A's mother in relation to the psychological impact of the incident resulting in his unwillingness to seek further medical intervention and how this had delayed the follow up treatment he needed. It noted the psychological impact there had been on Patient A, such that it was still a factor at the time of his A-Levels. The Tribunal also reminded itself of the evidence of Mr Lambert that he believed he was acting in Patient A's best interest in carrying out the procedure, despite his failure to obtain consent from Patient A's parents. However it noted that he made very limited attempts to find Patient A's parents after he noticed the abnormality of his penis, and although he entered the waiting room, he did not call their name.

116. The Tribunal considered the submissions of Mr Leonard KC that members of the theatre team went ahead with the procedure knowing that Mr Lambert had not obtained consent. However, it concluded that Mr Lambert was the surgeon in charge of the procedure and as such was responsible. The Tribunal noted that this was a single incident in a long and distinguished career.

117. The Tribunal considered that members of the medical profession would find the act of a doctor operating on a child without any form of consent, or following an express refusal of consent to be deplorable. It determined that such actions would bring the medical profession into disrepute. It was of the view that the impact it had on Patient A, or some similar adverse outcome, was a foreseeable potential result of an open breach of trust. The Tribunal concluded that this misconduct was serious. Obtaining consent before carrying out a procedure or physical investigation on a patient is a fundamental tenet of the medical profession. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice. The Tribunal reminded itself that Mr Lambert was refused consent by Patient A and his parents on two separate occasions. It noted that the procedure was not urgent and Mr Lambert could have waited to ensure that he obtained parental consent without posing any risk to the patient.

118. The Tribunal reminded itself of Mr Lambert's oral evidence given at the facts stage when he stated, '*I have stopped looking',* explaining that he did not want to see any abnormality in a patient for which he did not have explicit consent to treat. It was concerned this indicated that Mr Lambert still does not trust himself to not act in a similar manner if he found himself in the same position again. The Tribunal considered that most doctors in similar circumstances would understand the imperative not to carry out the procedure, and would view his actions as a deplorable breach of trust fundamental to the medical profession to obtain consent before operating on a patient.

119. Therefore, the Tribunal determined that Dr Lambert's actions in relation to the procedure carried out on Patient A without consent amounted to misconduct, which was serious.

<u>Language and behaviour in regard to Patient A</u>

120. The Tribunal considered the language and behaviour of Mr Lambert in relation to Patient A and his parents. When Mr Lambert spoke to Patient A's parents to tell them he had carried out the unauthorised procedure he accepts he said '…because I am a bit of a nosey twat I noticed that [Patient A]'s penis did not look quite normal…', or words to that effect. He accepts that this was inappropriate, but it is for the Tribunal to determine whether it constitutes serious misconduct.

121. Mr Williams, on behalf of the GMC submitted that using such inappropriate language indicates a lack of insight regarding the seriousness of the failure to stay within the clear permissions set down, and in effect treats Patient A as 'a piece of meat', showing that his and his parents' consent were not valued. Mr Leonard on behalf of Mr Lambert took considerable exception to this terminology and submits that whilst the wording employed was unfortunate and inappropriate, it displayed no intention of disrespect. The crude word was employed by Mr Lambert against himself, and was an example of his casual approach to formality from his background in the forces.

122. The Tribunal is in no doubt that the language used in such circumstances was entirely inappropriate. It determined that it showed that Mr Lambert lacked full understanding of the consequences and seriousness of what he had done, and as such was relevant to his insight in that regard at that time. It considered, however, that as for the use of the language per se, the fact that the crude term was addressed by Mr Lambert against himself was significant. The word was of itself offensive, and thereby inappropriate, but was not employed as an insult against Patient A or his parents. It considered the assistance given in *Roylance v GMC (no2) (2000) 1 AC 311 and Nandi v GMC [2004] EWHC 2317 (Admin)* as regards what should be considered serious misconduct. In *Roylance* it was described as "*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*" and that "*serious professional misconduct may arise where the conduct is quite removed from the practice of medicine but is of a sufficiently immoral or outrageous or disgraceful character*". In *Nandi* it was said that serious misconduct is sometimes described as misconduct which would be considered deplorable by fellow practitioners.

123. The Tribunal considered the language used by Mr Lambert to be clearly inappropriate, ill-judged and far beyond any form of 'informal banter' that you may see between doctors and patients. The Tribunal considered Mr Lambert's language in relation to Patient A and his parents to be something that deserves an apology, but not a formal sanction. It took the view that most colleagues would not consider this to be serious misconduct capable of bringing the medical profession into disrepute and deserving of a sanction, but rather inappropriate language which shows poor judgement, but it would not be regarded as deplorable in isolation.

124. The Tribunal was of the view that in such circumstances fellow practitioners may well find the use of this term by Mr Lambert to be unwise or unprofessional and below the

standards to be expected in the circumstances. However it was not satisfied on the balance of probabilities that they would consider it 'deplorable', 'immoral' or 'of outrageous character'. The Tribunal concluded that in this regard Mr Lambert's use of language was unfortunate and unprofessional, but did not constitute serious misconduct such as may lead to a finding of impairment.

125. As regards the comments admitted within schedule 1 of paragraph 3 of the Allegation, the Tribunal first considered the nature and extent of the comments, both individually and cumulatively. The GMC characterised these as numerous examples of deeply inappropriate comments in many different settings and circumstances and illustrated how he behaved in clinical practice. It was submitted that whilst he may not have had the intent ascribed by the descriptors in paragraph 3 of the Allegation, that was their effect and they were deeply inappropriate and contrary to GMP. Whilst accepting his lack of intent, the GMP suggested this could be seen as ascribing responsibility to the person receiving the words, which would be wrong.

126. Mr Lambert through his counsel strongly contested this, stating that to claim a lack of intention was not to blame the recipient, but was putting the comments in context and explaining how they came to be made, not excusing them. He also contested that they demonstrated a significant course of conduct or were indicative of his interactions with colleagues. The comments within the schedule related to 3 individuals and covered a discrete 5 month time period. Indeed, the last 3 were within a very short time on the same day, all in interactions with one nurse.

127. The Tribunal considered carefully the language employed within all the comments listed in the schedule and the context in which it was deployed. It considered the tests set out in Roylance and Nandi, as above, and bore in mind all the circumstances which had been put before it. It accepted that Mr Lambert had a professional experience and background which differed greatly from that of many doctors employed within hospital settings. He had worked at the cutting edge in military environments and had been accustomed to what may be termed a less nuanced approach to communication in front line work. He also admitted that some of his experiences had left him vulnerable to allowing his frustration to spill over. Whilst the Tribunal felt that such matters did not of themselves excuse the use of inappropriate language, they were relevant factors to be considered when assessing the seriousness.

128. The Tribunal bore in mind that it was presented with a host of positive testimonial evidence from other colleagues who had worked with him for longer periods of time in less stressful environments such as Nuffield. It also heard positive testimonial evidence from nurses in general surgery speaking to Mr Lambert's skills as a surgeon, however some of these testimonials did allude to Mr Lambert's directness if things are not carried out correctly.

129. The Tribunal was of the view that none of the comments made, separately or cumulatively, were such that they were 'deplorable', 'immoral' or 'of outrageous character'. Again, they constituted behaviour which Mr Lambert accepted was not to his credit, but they were not serious misconduct such as may lead to a finding of impairment.

Impairment

130. The Tribunal having found that the facts found proved in relation to the procedure carried out on Patient A without consent amounted to serious misconduct went on to consider whether, as a result of that misconduct Mr Lambert's fitness to practise is currently impaired.

131. The Tribunal considered whether Mr Lambert's misconduct was capable of being remediated, has been remediated, and whether it was highly unlikely to be repeated. It looked for evidence of insight and remediation and balanced those against the three limbs of the statutory overarching objective, namely to:

- protect and promote the health, safety and wellbeing of the public;
- promote and maintain public confidence in the medical profession; and
- promote and maintain proper professional standards and conduct for the members of the profession.

132. The Tribunal had regard to the guidance provided by Dame Janet Smith in the *Fifth Shipman report* as adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin*. It considered that factors (a), (b) and (c) in the test of *Grant* were engaged in this case:

> *'Do our findings of fact in respect of the doctor's misconduct, show that his fitness to practise is impaired in the sense that he:*

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

133. The Tribunal concluded that Mr Lambert's misconduct breached fundamental tenets of the profession as he had been explicitly refused consent by Patient A and his parents on more than one occasion. The Tribunal was presented with no clear explanation as to why he had conducted the procedure in the face of the lack of consent. It noted his comments that he had stopped looking at patients beyond the matter for which he had consent. It saw this as potentially detrimental to the overall care of his patients and indicating a lack of self trust to act within the scope of the consent given. This suggested that his insight into the importance of consent, and following the patient's expressed wishes, was incomplete and therefore raised the real risk of repetition should he ever be in the same position again.

134. The Tribunal took into account the statutory overarching objective and was of the view that all three limbs were engaged. The Tribunal concluded that a finding of current impairment was justified since the fear of repetition identified was a risk to public safety. It was also of the view that the breach of trust inherent in the misconduct was such that a finding of impairment was required to promote and maintain public confidence in the profession, and to promote and maintain proper professional standards. It was necessary to reaffirm clear standards of professional conduct, and importance of obtaining consent from patients prior to carrying out medical procedures.

Determination on Sanction - 01/05/2024

135. Having determined that Mr Lambert'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

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

Submissions on behalf of the GMC

137. Mr Paul Williams, Counsel, referred the Tribunal to its findings at Stage 2, namely, that it considered members of the medical profession would find the act of a doctor carrying out a medical procedure on a child without consent, and with an explicit refusal of consent, to be deplorable. Further, that the Tribunal had determined that such actions were a breach of trust which would bring the medical profession into disrepute, and that an adverse impact on Patient A was a foreseeable potential result. He said that the misconduct damaged the reputation of the medical profession, confidence in fellow medical practitioners, and had an adverse impact on Patient A.

138. Mr Williams said that the Tribunal concluded that this serious misconduct was a breach of a fundamental tenet of the medical profession. He said that the principle of patient consent reflects their right to determine what happens to their own bodies and is an essential element fundamental part of Good Medical Practice. He noted that the Tribunal had reminded itself that Mr Lambert was refused consent by Patient A and his parents on two separate occasions, and that the procedure was not urgent. He said that Mr Lambert could have waited to ensure that he obtained parental consent without posing any risk to the patient.

139. Mr Williams also reminded the Tribunal that Mr Lambert said in oral evidence at Stage 1 he had stopped looking for any abnormalities in patients, as he did not want to see clinical issues in a patient which he did not have explicit consent to treat. Mr Williams reminded the Tribunal that it found this to be of concern as a potential indicator that Mr Lambert still did not trust himself to not act in a similar manner If he found himself in the same position again. He said that this perhaps illustrated the limited nature of the development of Mr Lambert's insight.

140. Mr Williams submitted that the Tribunal was provided with no clear explanation as to why Mr Lambert had conducted the procedure in the face of a lack of consent. He reminded the Tribunal that it had determined this also suggested that Mr Lambert's insight was incomplete and that there was consequently a risk of repetition. Mr Williams reminded the Tribunal that it had found all three limbs of the overarching objective engaged and he submitted that the gravity of the Tribunal's findings means that it would be inappropriate to take no action regarding sanction.

141. Mr Williams submitted that the starting point would therefore be the consideration of conditions, and whether such a sanction would be workable, and would reflect the gravity of the misconduct. He submitted that it would be difficult to see how conditions could be

imposed so as to address the concerns identified by the Tribunal, and referred the Tribunal to the relevant paragraphs of the Sanctions Guidance (5 February 2024) ('SG'). He referred the Tribunal in particular to paragraph 82 as regards the applicability of sanctions. He accepted that Mr Lambert exhibited some insight, which paragraph 82(a) indicated was likely to be needed for conditions to be suitable, but that it still required development. Paragraph 82(b) referenced retraining as a focus for conditions. Mr Williams submitted that although perhaps conditions could be drafted with an aim to ensure Mr Lambert continued to develop his insight and reflection, that was not within the usual ambit of 'retraining'. He submitted that it was difficult to construct conditions that would be appropriate and effective, and that the imposition of conditions would not in any event reflect the gravity of the misconduct and wider issues of public concern.

142. Mr Williams submitted that Mr Lambert required a period of time to develop his insight, reflect and consider why he acted as he did and how he could amend that going forward. He submitted that conditions were not therefore appropriate, particularly where there is a risk of repetition.

143. Mr Williams submitted that a period of suspension would meet the gravity of the seriousness and extent of the misconduct in this case. Mr Williams submitted that the length of the period of suspension was a matter for the Tribunal, but that suspension would satisfy the overarching objective in declaring and upholding proper standards and publicly marking the gravity of its findings, and would also allow Mr Lambert time to reflect. He also invited the Tribunal to consider directing a review to allow Mr Lambert the opportunity to demonstrate that he has developed his insight.

Submissions on behalf of Mr Lambert

144. Mr Leonard KC, reminded the Tribunal of Mr Lambert's overall service to the community, both military and civil. He said that Mr Lambert was humbled by the observations of the Tribunal. He referred to the finding of the Tribunal that it had heard no real explanation from Mr Lambert as to the reason he undertook the procedure without consent. He reminded the Tribunal of Mr Lambert's oral evidence at Stage 1 that preserving Patient A's foreskin for future reconstruction as early as possible was vital for any future procedure. Mr Leonard acknowledged however that Mr Lambert should not have undertaken the procedure without consent. He also said that the Tribunal's concern that Mr Lambert would stop seeking to identify medical issues in a way that compromised patient safety has struck him deeply. Mr Leonard said that Mr Lambert was anxious to ensure that the Tribunal understood that he has always treated his patients as best he could with the utmost care and that in the four years that followed this incident, up until Mr Lambert stopped practising, there were no issues of concern whatsoever.

145. Mr Leonard stressed that Mr Lambert accepted now and at the time that he was wrong to have done what he did, that he wrote a letter of apology, and sought a meeting with Patient A and his parents to apologise personally, but that offer was not taken up. Mr Leonard said that Mr Lambert has now stepped back from front line practise and is not undertaking patient facing work anymore. He submitted that the overwhelming impression of Mr Lambert is of someone who adheres to all the important facets of Good Medical Practice and is a champion of them. He referred the Tribunal to the testimonial evidence provided. Mr Leonard said that Mr Lambert is a public servant in the context of his military service and beyond that few would be able to equal, and that this Tribunal had acknowledged at Stage 1 Mr Lambert's excellence in surgery. He said that the allegation was some eight years old and that Mr Lambert has expressed regret and apology. He submitted that whilst he could not go behind the Tribunal's observations in relation to insight, Mr Lambert has apologised and made a big step towards insight and therefore submitted that even if it is not complete, it is significantly on its way.

146. Mr Leonard submitted that the finding of impairment itself at this stage in Mr Lambert's career, after so many years of outstanding service, was of significant impact on him, and a punishment in itself. He submitted that there was no prospect of Mr Lambert resuming clinical work in the future. He invited the Tribunal to consider that a finding of impairment would be a significant enough outcome, or that some form of conditional registration would reflect the public interest. He said that despite Mr Lambert having absolutely no prospect of resuming clinical work, attendance at remediation education, for example requiring Mr Lambert to undergo ethics and consent training, before undertaking any kind of practice in the future would be a proportionate response.

147. Mr Leonard said that if the Tribunal do not agree that a finding of impairment and conditions was not significant for somebody at the conclusion of their career, he acknowledged that taking no action would be unlikely to meet the Tribunal's expressed concerns, which leaves only suspension or a more serious outcome which the GMC have not sought and he would say is wholly inappropriate. He submitted that it would be for the Tribunal to determine a length of any suspension imposed, but invited it to make it as short as possible.

The Tribunal's Determination on Sanction

148. 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.

149. 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 Mr Lambert's interests with the public interest.

150. The Tribunal also reminded itself of the overarching objective as set out in Section 1 of the Medical Act 1983, which requires the Tribunal to:

a. Protect, promote, and maintain the health, safety, and well-being of the public,

b. Promote and maintain public confidence in the medical profession, and

c. Promote and maintain proper professional standards and conduct for members of that profession.

Aggravating and Mitigating Factors

151. 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 Mr Lambert's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

152. The Tribunal was of the view that Patient A's age at the time of the incident was an aggravating factor, as he was a twelve year old child. It also noted that consent had been explicitly refused by both Patient A and Patient A's parents on two occasions. The Tribunal had heard that Mr Lambert's actions in undertaking the procedure had an adverse impact on Patient A, causing him psychological harm, and had found that some adverse impact on him was a foreseeable potential result of Mr Lambert's actions. The Tribunal considered that this fundamental breach of trust and his incomplete insight into his actions were also aggravating factors.

153. In mitigation, the Tribunal considered that Mr Lambert had written an apology to Patient A's parents, apologised to Patient A's mother through his Counsel during these proceedings and has offered to meet Patient A's parents. It considered that Mr Lambert's expressions of apology, regret and remorse were genuine. Mr Lambert also made admissions at the earliest possible stage. The procedure he undertook without consent was clinically indicated and medically correct. The Tribunal considered that the passage of time since the incident, some eight years, was a relevant factor, and that this was a single incident in an

otherwise unblemished career and that Mr Lambert was of good character. The testimonials spoke strongly to Mr Lambert's good character and it was noteworthy that these testimonials were from across a broad spectrum of colleagues.

154. In respect of Mr Lambert's insight, the Tribunal bore in mind that there was not a pattern of behaviour, that this was a single one-off incident which did not suggest a fundamental lack of understanding of the principles of GMP. Whilst the Tribunal determined at Stage 2 that there was a risk of repetition, it considered this was significantly qualified by Mr Lambert's long and distinguished history of excellent clinical service. It considered that this breach whilst isolated, was attitudinal, in that although he knew that he did not have consent and that it was needed, he placed his view of the best interests of the patient before those of the patient and his parents. The risk of repetition is not significant, Mr Lambert has stressed he has learned from the incident, but not one which the Tribunal could entirely rule out.

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

No Action

156. The Tribunal first considered whether to conclude the case by taking no action. It was satisfied that there were no exceptional circumstances in this case that would justify taking no action. It considered concluding this case by taking no action would not be appropriate or proportionate given the serious nature of its findings. The Tribunal decided that taking no action would fail to uphold the statutory overarching objective.

Conditions

157. The Tribunal next considered whether it would be appropriate to impose conditions on Mr Lambert's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable, and measurable.

158. The Tribunal took account of relevant paragraphs of the SG, and in particular paragraphs 81a and b of the SG. It noted circumstances in which conditions can be imposed:

> *"81 Conditions might be most appropriate in cases:*
>
> ..

b involving issues around the doctor's performance

c where there is evidence of shortcomings in a specific area or areas of the doctor's practice…"

159. The Tribunal considered that as Mr Lambert does have some insight into his actions, there was the potential for him to respond to conditions. The Tribunal was of the view that the misconduct did not flow from lack of knowledge or understanding and that it could not identify effective conditions which would be practicable, workable or measurable in the circumstances.

160. The Tribunal was also of the view that conditions would not be commensurate with the seriousness of the misconduct. It determined that conditions would not be sufficient to address such a serious breach of patient trust, maintain public confidence in the profession and uphold proper professional standards. The Tribunal was therefore satisfied that the imposition of conditions would not be an appropriate or proportionate response.

Suspension

161. The Tribunal then went on to consider whether to impose a period of suspension on Mr Lambert's registration.

162. The Tribunal had regard to paragraphs 91, 92 and 93 of the SG:

"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…"

163. The Tribunal also considered paragraphs 97a, f and g of the SG to be engaged:

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

a A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.

…

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."

Erasure

164. Before determining if suspension was the appropriate sanction, it went on to consider whether the misconduct was so serious as to be fundamentally incompatible with continued registration, as required by paragraph 92 of SG. Whilst Mr Lambert's misconduct was a serious breach of the tenets of the medical profession and had the potential to seriously impact Patient A and other patients' trust in the profession, the Tribunal was satisfied that it was not fundamentally incompatible with continued registration. It noted that this was a one-off isolated incident, took into consideration Mr Lambert's otherwise unblemished career and excellent character and that the procedure carried out was clinically indicated, and medically correct. It felt that in all the circumstances a concerned member of the public would be satisfied that suspension was a significant sanction and a clear marker of the seriousness of the misconduct. It was therefore satisfied that erasure would not be appropriate in this case.

165. The Tribunal determined therefore that a period of suspension was the appropriate and proportionate response to mark the seriousness of Mr Lambert's misconduct. It

determined to suspend Mr Lambert's registration from the medical register for a period of 6 months. It was satisfied that such a period upheld the overarching objective to protect the public, maintain public confidence in the profession and uphold proper professional standards.

166. The Tribunal considered that whilst the first limb of the overarching objective was engaged, it was less of a cause for concern for the Tribunal given the limited nature of the risk of repetition it identified, as set out above. The Tribunal concluded that a suspension of this length would, however, provide Mr Lambert with an opportunity to further develop his insight and remediate appropriately.

167. The Tribunal determined to direct a review of Mr Lambert's case. A review hearing will convene shortly before the end of the period of suspension, unless an early review is sought. The Tribunal wished to clarify that at the review hearing, it will be Mr Lambert's responsibility to demonstrate how he has addressed this Tribunal's concerns. It therefore may assist the reviewing Tribunal if Mr Lambert provided evidence of his developed insight into the seriousness of his actions and the central importance of consent and trust in the doctor patient relationship. Mr Lambert may also provide evidence of any remediation he has undertaken to address the concerns of this Tribunal and any further evidence he considers will assist a reviewing Tribunal.

Determination on Immediate Order - 01/05/2024

168. Having determined to suspend Mr Lambert's registration, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

169. On behalf of the GMC, Mr Williams submitted that there was no application in respect of an immediate order.

170. On behalf of Mr Lambert, Mr Leonard made no submission given the GMC made no application.

The Tribunal's Determination

171. The Tribunal had regard to paragraphs 172 to 178 of the SG. It took account of the guidance, the submissions of both parties and the specific basis upon which the Tribunal reached its determination on sanction.

> *'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…'*

172. The Tribunal was satisfied that the substantive order properly marks the seriousness of Mr Lambert's misconduct and upholds the overarching objective. It determined that an immediate order was not necessary to protect members of the public, it is not in the public interest, and it is not in the best interests of the doctor.

173. In all the circumstances, the Tribunal determined not to impose an immediate order of suspension on Mr Lambert's registration.

174. This means that Mr Lambert's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal. If Mr Lambert does lodge an appeal, he will remain free to practise unrestricted until the outcome of any appeal is known.

175. There is no interim order to revoke.

176. That concludes the case.

ANNEX A – 25/04/2024

177. On behalf of the GMC, Mr Paul Williams, Counsel made an application pursuant to Rule 17(6) of the Rules to amend the Allegation.

Submissions

178. Mr Paul Williams applied to withdraw paragraphs 3a, 4a, 4b, 4c(i)(2-5), 5, 6a and 6c of the Allegation. He also applied to amend paragraph 4 as follows:

1. Between 1 June 2018 and 31 October 2018 (inclusive), whilst working at UHP, you:

~~a. refused to allow:~~

~~a. a Physicians Associate student to shadow you in the Surgical Assessment Unit ('SAU') as part of their planned educational programme;~~

~~b. Doctors Associates to carry out procedural duties, including:~~

~~i. taking bloods;~~

~~ii. fitting cannulas;~~

~~iii. carrying out electrocardiograms;~~

~~iv. fitting catheters;~~

b. made comments as set out in Schedule 1 which were inappropriate in that one or more of them:

a. were:

i. foul and/or abusive;

ii. aggressive and/or intimidating;

iii. bullying in nature;

iv. derogatory towards:

1. patients;

2. other healthcare professionals;

3. women;

b. deterred other healthcare professionals from approaching you.

Patient G

2. Between 31 July 2018 and 2 August 2018 (inclusive), Patient G was admitted to UHP under your care, and you failed to:

~~a. on 1 August 2018, you failed to arrange all appropriate investigations in that you cancelled the ultrasound and instigated sigmoidoscopy in the absence of bowel symptoms;~~

~~b. on 2 August 2018, you failed to:~~

~~a. appropriately diagnose Patient G as the diagnosis did not include:~~

~~i. right lung pleural effusion;~~

~~ii. right lung basal consolidation;~~

~~iii. the fluid collection in the pelvis with the impression of inflammation;~~

~~iv. the fluid collection in the abdomen with the impression of inflammation;~~

~~b. arrange all appropriate referrals in that you did not make a referral:~~

~~i. to the respiratory medical team to investigate Patient G's chest;~~

~~ii. to the gynaecological team to investigate Patient G's pelvis;~~

~~c. between 1 August 2018 and 2 August 2018 (inclusive), you failed to:~~

a. implement an appropriate treatment plan in that you did not:

i. continue the antibiotics given to Patient G in A&E and the Surgical Assessment Unit for a minimum of 5 days following the initial administration;

~~ii. await the resolution of Patient G's pyrexia prior to their discharge;~~

~~iii. await an improvement in Patient G's abdominal pain prior to their discharge;~~

~~iv. await the results of Patient G's blood cultures prior to their discharge;~~

~~v. act upon the CT result and ultrasound scan, which demonstrated a right lung basal consolidation and pleural effusion indicative of pneumonia;~~

d. ~~you failed~~ to appropriately communicate with Patient G:

a. on 1 August 2018 in that you:

i. were stern in your history taking;

ii. were disbelieving and/or aggressive in respect of their previous diagnosis of Campylobacter related problems;

b. on 2 August 2018 in that you:

i. told Patient G that you did not know what the cause of her symptoms were~~as~~ but nevertheless discharged her;

ii. seemed angry at Patient G for declining sigmoidoscopy;

iii. never asked Patient G about her bowels,

iv. left Patient G with no clear management plan;

v. adopted a poor attitude in speaking to Patient G.

~~Patient H~~

3. ~~On 6 October 2018, whilst working at UHP, you conducted an incision biopsy of the lymph node in the left groin on Patient H and you:~~

~~a. discharged Patient H directly from theatre;~~

~~b. failed to follow the:~~

~~a. standard operating procedure;~~

~~b. accepted procedure for patient discharge from recovery;~~

~~c. allowed Patient H to drive home;~~

~~d. failed to provide Patient H with:~~

~~a. discharge documents;~~

~~b. wound care advice;~~

~~c. written postoperative instructions;~~

Patient I

4. Between 7 October 2018 and 13 October 2018 (inclusive), Patient I was admitted to UHP under your care and:

~~a. you failed to provide adequate postoperative care in that you inappropriately allowed Patient I to be discharged from UHP on 13 October 2018 despite:~~

~~a. Patient I having not opened her bowels or passed flatus;~~

~~b. a significant finding of pus from the perforated appendix;~~

~~c. allowing insufficient time to monitor the effect of the additional antibiotic specific for pseudomonas;~~

~~d. abdominal pain;~~

~~e. generalised tenderness upon examination;~~

~~f. the abnormal blood test results on 10 October 2018 which had a high white blood cell count and CRP greater than 400;~~

~~g. the abnormal blood test results on 13 October 2018 which had elevated CRP and liver enzymes;~~

~~h. Patient I being at significant risk of developing post appendicectomy intra-abdominal sepsis;~~

b. you failed to provide an adequate handover ~~communicate~~ to the on-call team, that before Patient I was discharged on 13 October 2018:

a. her bowels should have been functioning normally and flatus passed;

b. the results of the blood tests taken on 13 October 2018 should be checked;

c. you should be informed if the results of the bloods tests taken on 13 October 2018 were significantly abnormal;

~~c. you failed to refer Patient I for urgent review by a:~~

~~i. gastroenterological consultant;~~

~~ii. senior anaesthetist;~~

179. Mr Williams submitted that following a meeting of experts, a joint report was created. He submitted that following conferences between the experts to consider whether the position had changed and whether it was proper to pursue the charges in the form that they were in or at all. Mr Williams submitted that it would be improper to pursue the charges which have been withdrawn and necessary and proper to make amendments to some paragraphs of the Allegation, particularly in relation to Patient I. He submitted that the focus in relation to Patient I has moved to the adequacy of the handover that was highlighted in the joint report.

180. Mr Williams referred the Tribunal to the joint expert report which stated that on more than one occasion in relation to Patient I, both experts highlight the importance of the electronic handover document and what it could provide. He submitted that the email chain within the supplementary bundle describes how the document was obtained.

181. Mr Williams submitted that there would be no prejudice to Dr Lambert in granting the application to withdraw and amend these paragraphs of the Allegation.

182. On behalf of Dr Lambert, Mr James Leonard KC did not oppose the application.

Tribunal's Decision

183. The Tribunal considered that the proposed amendments and withdrawals were fair and could be made without injustice to Dr Lambert. It considered that it would clarify and better reflect the GMC's case. Accordingly, it determined to grant the application to withdraw paragraphs 3a, 4a, 4b, 4c(i)(2-5), 5, 6a and 6c and amend paragraph 4 of the Allegation in accordance with Rule 17(6) of the Rules.

184. The Tribunal therefore determined to grant the GMC's application.

Schedule 1

1. When Dr C advised you that she was not comfortable placing a cannula in a patient's neck you stated '…*go and put a fucking cannula in his neck*…' or words to that effect;

2. Upon discovering a patient with a prescription for Oramorph during a ward round you stated '…*who the fuck did this*...' or words to that effect;

3. When Dr C informed you that she would be returning to her normal team you shouted '…*you are my junior, I need you here and so you will be here tomorrow*…' or words to that effect;

4. In reference to a female patient you stated '…*did you see her fanny*…' or words to that effect;

5. In reference to a female patient you stated '…*wasn't she fat*…' or words to that effect;

6. In reference to a female member of staff's trousers you stated '…*she shouldn't be wearing them*…' or words to that effect;

7. When speaking to another healthcare professional about Dr D's management of a patient you stated that Dr D's '…*management was shit*…' or words to that effect;

8. In response to Dr D referring a patient to the gynaecology team you stated '…*why the fuck did you do that*…' or words to that effect;

9. In reference to a female member of staff you stated that she '…*shouldn't be eating cake due to her size*…' or words to that effect;

10. On 6 October 2018, when referring to a patient who was alcohol dependent and attempting to get home you stated '…*if he didn't spend all of his fucking money on drink, then he could afford his own taxi*…' or words to that effect;

11. On 6 October 2018, when asked by Nurse E to prescribe something for a patient suspected to be sceptic, Patient F, you stated '…*Go away. Who are you to tell me to do my job? This patient will have to wait like everyone else…'* or words to that effect;

12. On 6 October 2018, when asked by Nurse E whether you would like her to start the septic pathway for Patient F you stated '…*the patient will literally have to wait like everyone else*…' or words to that effect;

13. On 6 October 2018, when asked by Nurse E whether you would like her to take bloods from Patient F you stated '…*your lot don't do that, my lot do that*…' or words to that effect.