Record of Determinations – Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 05/08/2019 - 08/08/2019

Medical Practitioner’s name: Dr David SMITH

GMC reference number: 4120331

Primary medical qualification: BM BCh 1994 Oxford University

Type of case 
New - Misconduct

Outcome on impairment 
Impaired

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

Tribunal:

<table>
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<tr>
<th>Legally Qualified Chair</th>
<th>Mr Kenneth Hamer</th>
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<tr>
<td>Medical Tribunal Member:</td>
<td>Dr Tushar Vince</td>
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<td>Medical Tribunal Member:</td>
<td>Dr John Moriarty</td>
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Tribunal Clerk: Ms Jeanette Close 5-7 August 2019
Ms Jean Gleeson 8 August 2019

Attendance and Representation:

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<th>Medical Practitioner:</th>
<th>Present and represented</th>
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<td>Medical Practitioner’s Representative:</td>
<td>Ms Alexandria Felix, Counsel, instructed by the Medical Defence Union</td>
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<tr>
<td>GMC Representative:</td>
<td>Mr Carlo Breen, Counsel, instructed by GMC Legal</td>
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Attendance of Press / Public
In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly in private.
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 and Impairment - 07/08/2019

Background

1. Dr Smith qualified in 1994 from Oxford University, obtaining full registration with the General Medical Council (GMC) in 1995. In January 1999, Dr Smith joined the Locking Hill Surgery (the practice) as a full time GP partner.

2. The Allegation that has led to Dr Smith’s hearing can be summarised as that between 30 July 2014 and 28 July 2017, Dr Smith pursued an improper emotional relationship with Patient A whilst she was a patient at the surgery, which continued after she had left the practice and had registered with another surgery.

3. It is also alleged that on 29 October 2017, Dr Smith issued a private prescription to Patient A for Diazepam.

4. It is further alleged that on 30 October 2017, Dr Smith attempted to inappropriately access Patient A’s medical records when she was no longer in his clinical care, whilst all the while knowing Patient A was vulnerable due to a mental health condition.

5. Initial concerns were raised by Dr B, Patient A’s GP, who sought advice from a Local Medical Committee (LMC) in November 2017. The LMC subsequently held a meeting with Dr Smith and Dr B to discuss Dr Smith breaching professional boundaries when Patient A was under his care. Following the meeting, on 19 January 2018, Dr Smith informed NHS England that he was self-referring to the GMC due to concerns raised, and his own reflection on his interactions with Patient A. In a letter dated 26 January 2018, Dr Smith subsequently referred himself to the GMC.

The Allegation and the Doctor’s Response

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

   1. Between 30 July 2014 and 28 July 2017 you provided clinical care to Patient A at Lockinghill Surgery, Stroud (‘the Surgery’) and you pursued an improper emotional relationship with her in that:
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a. you provided Patient A with your mobile telephone number;
   Admitted and found proved

b. on one or more occasion you engaged in text message conversations
   with Patient A;
   Admitted and found proved

c. you accepted Patient A as a ‘friend’ on social media;
   Admitted and found proved

d. you shared personal details and concerns with Patient A.
   Admitted and found proved

2. You continued to pursue an improper emotional relationship with Patient A
   when she was no longer registered as your patient at the Surgery, in that
   on one or more occasion you:

   a. met with Patient A in a non-medical setting;
      Admitted and found proved

   b. engaged in conversations with Patient A by way of:

      i. text messages;
         Admitted and found proved

      ii. Facebook messages;
          Admitted and found proved

      iii. telephone calls;
           Admitted and found proved

   c. made unsustainable promises to Patient A that you ‘would never leave’
      her and ‘would always be there’ for her, or words to that effect;
      Admitted and found proved

   d. shared personal details and concerns with Patient A;
      Admitted and found proved

   e. used affectionate language in your conversations with Patient A.
      Admitted and found proved

3. On 29 October 2017 you issued a private prescription for Patient A for
   diazepam.
   Admitted and found proved
4. On 30 October 2017 you inappropriately attempted to access Patient A’s medical records.

Admitted and found proved

5. You undertook the actions as described in paragraphs 3 and 4 when:
   a. Patient A was registered with another GP;
      Admitted and found proved
   b. Patient A was no longer in your clinical care;
      Admitted and found proved
   c. you had a personal relationship with Patient A.
      Admitted and found proved

6. At all material times, Patient A was vulnerable due to a mental health condition.

Admitted and found proved

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

The Admitted Facts

7. At the outset of these proceedings Dr Smith, through his counsel Ms Felix, admitted the entirety 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.

Determination on Impairment

8. In light of Dr Smith’s response to the Allegation against him, there are no facts to be determined. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules, whether or not Dr Smith’s fitness to practise is impaired by reason of his misconduct.

The Evidence

9. The Tribunal has taken into account all the evidence received during the hearing, both oral and documentary, as summarised below.

Witness Evidence
10. Dr Smith gave oral evidence on day one of the proceedings. The Tribunal was satisfied that Dr Smith is a caring and dedicated doctor and throughout his treatment of Patient A genuinely believed that he was acting in her best interests. The Tribunal considered that Dr Smith has fully cooperated with the investigation and these proceedings and has at all times sought to assist the process. In addition, the Tribunal received oral evidence from the following witness on day two on Dr Smith’s behalf:

- Dr C, Senior Partner at the practice and Dr Smith’s workplace supervisor.

Documentary Evidence

11. The Tribunal considered and analysed all documentary evidence adduced by the parties. The evidence included, but was not limited to:

- Extract from Audit trail - accessing Patient A’s records in October 2017;
- Private prescription dated 29 October 2017
- Doctor Smith’s Letter to LMC/reflective statement dated, 22 December 2017;
- Certificate of Attendance and Course information – Introduction to Professional Boundaries, dated 11 January 2018;
- Notes of facilitated LMC Meeting held on 18 January 2018;
- Dr Smith’s self-referral letter to the GMC, dated 26 January 2018;
- Certificate of Attendance – Maintaining Professional Ethics, dated 26-28 February 2018;
- Personal statement of Dr Smith, dated 20 March 2018;
- Patient A’s statement to NHS England, dated March 2018
- XXX
- XXX
- Certificate of Attendance – Coaching Programmes, dated June – September 2018;
- Notes from Dr Smith’s Telephone coaching sessions, dated June – September 2018;
- Dr Smith’s NHS England South (South Central) Voluntary Undertakings Agreement, dated 9 October 2018;
- Summary of Colleague feedback, dated 28 March 2019;
- Summary of Patient feedback, dated 18 April 2019;
- Dr Smith’s supplemental statements, dated 27 June 2019 and 12 July 2019 respectively.
- Dr C’s statement, dated 11 July 2019

12. The Tribunal also received evidence on behalf of Dr Smith in the form of testimonials from the following witnesses who were not called to give oral evidence:
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- Mrs F, Practice Manager at the practice, dated 8 July 2019;
- Dr G, GP Partner at the practice, dated 9 July 2019;
- Mrs H, Senior Practice Nurse at the practice, dated 2 July 2019;
- Dr I, former GP Partner at the practice, dated 6 July 2019;
- Dr J, Senior Partner at Rowcroft Medical Centre, dated 3 July 2019;
- Dr K, GP Partner at Minchinhampton Surgery, dated 1 July 2019;
- Dr L, Consultant Psychiatrist and Deputy Medical Director of 2gether NHS Foundation Trust, dated 12 July 2019;

Submissions

On behalf of the GMC

13. Mr Breen, Counsel on behalf of the GMC, submitted that Dr Smith’s fitness to practise is currently impaired by reason of Dr Smith’s misconduct. Mr Breen stated that the facts were aggravated by Patient A being a vulnerable patient and that the crossing of professional boundaries was not one isolated incident but was repeated behaviour over a 3 year period.

14. Mr Breen submitted that the excuses proffered by Dr Smith that he had received no training on professional boundaries, knew nothing of the principles of GMP and that he could not confide in anyone at the practice because of ‘friction’ were unacceptable, feeble and lame.

15. Mr Breen stated that there was evidence that Dr Smith was remorseful, and that he had provided examples of remediation. Nevertheless, Mr Breen submitted that Dr Smith’s behaviour was in direct breach of the overarching objective and brought the medical profession into disrepute. He stated that despite Dr Smith’s remediation, the public would be horrified if a finding of impairment was not made in this case, bearing in mind the prolonged nature of his behaviour and the vulnerability of Patient A.

On behalf of Dr Smith

16. On behalf of Dr Smith, Ms Felix said that she did not suggest that Dr Smith’s conduct did not amount to misconduct. However she submitted that Dr Smith’s fitness to practise was not currently impaired. She submitted that Dr Smith had always had the best motive and had made full admission to all the charges at the outset. She invited the Tribunal to view Dr Smith’s actions as having begun with providing his mobile number at a time when Patient A was particularly anxious and vulnerable due to her previous history. She stated that the events following this initial act could be compared to a snowball effect, one that continued over a period of time and which gradually crossed professional boundaries.
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17. She submitted that Dr Smith was a good and caring doctor, who would go the ‘extra mile’ for his patients and that when he saw Patient A was not receiving the treatment he thought she needed, he kept on trying to help. Ms Felix submitted that in all of his communications with Patient A, Dr Smith had no ulterior motive, his desire was to be a good doctor and to support Patient A.

18. Ms Felix submitted that Dr Smith had taken inordinate steps to learn from his mistakes and to never repeat them. She stated that Dr Smith has received lots of assistance and support in order for him to continue his practice and that NHS England have recently concluded he was no longer a risk to patients and lifted the restriction on his practice.

19. Ms Felix invited the Tribunal to have regard to all of the evidence before it in respect of Dr Smith’s remediation and asked what else could Dr Smith be expected to do to demonstrate the extent of his remorse and his remediation. She therefore invited the Tribunal to find Dr Smith’s practice not currently impaired.

The Relevant Legal Principles

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

21. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts found proved amounted to misconduct, including whether the misconduct was serious; and second whether Dr Smith’s fitness to practise is currently impaired by reason of misconduct.

22. The Tribunal must determine whether or not Dr Smith’s fitness to practise is impaired today, taking into account his 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.

23. Throughout its deliberations, the Tribunal was mindful of its responsibility to uphold the overarching objective as set out in the Medical Act 1983 (as amended). That objective is:

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

The Tribunal’s Determination on Impairment
Misconduct

24. The Tribunal has concluded that Dr Smith’s conduct fell far short of the standards of conduct reasonably expected of a doctor such as to amount to serious misconduct.

25. The Tribunal had regard to the meeting on 18 January 2018 attended by the LMC Chairman and others, where Dr Smith admitted that he had crossed the boundaries of professional conduct with Patient A. He agreed that whilst Patient A was his patient he:

- Provided her with his mobile number – he has since ‘blocked’ her and all other patients who are mere acquaintances (e.g. parents of children’s school friends);
- Accepted her as a ‘Friend’ on social media – he has since closed down all his social media accounts;
- Regularly engaged in text message conversations with her (even when he was on holiday);
- Offered to ring her when she sent distressed text messages;
- Used familiar language to her;
- Usually arranged for her to be the last patient of the day so that time was not a factor. Such interviews often lasted half an hour by which time few members of staff would be on the premises;
- Responded to [Patient A’s] occasional requests for a hug at the end of such consultations;
- Shared many personal details and concerns with her, which he now recognises were inappropriate; Replied with inappropriate and unsustainable promises in response to her concerns that she sometimes voiced e.g. “I’ll always be there for you;”
- Agreed to read a complimentary blog post that she had written about him;
- Accepted gifts from her (cakes etc).

26. Additionally, the Tribunal was deeply concerned at the tone, frequency and content of many of the text messages sent by Dr Smith to Patient A which appear in the bundle before it.
The Tribunal also noted that NHS England (NHSE) in its Investigation Report dated March 2018, stated that:

"6.2.1 During the time that patient A was registered with Dr S there was gradual erosion of professional neutrality as demonstrated by increasing socialisation of sessions, clear indications that Dr Smith treated (Patient A) as 'special' and Dr S beginning to make more personal disclosures.

6.2.4 Dr S crossed professional boundaries and pursued an inappropriate emotional relationship with patient A after she left his care. Those boundaries had begun to move whilst she was under his professional care, hitherto unrecognised by Dr S who therefore did not consider resetting these.

6.2.5 There were opportunities to recalibrate those boundaries (notably discussions between Dr S, patient A concerning boundaries in May and August 2017), but these were not taken until November 2017 when Dr S recognised himself that he needed to seek advice from colleagues.

6.2.6 This is a significant departure from the standards expected of a doctor (GMC, Good Medical Practice, 2013).”

NHSE also concluded that Patient A did suffer harm as a consequence of the relationship ending.

The Tribunal has also borne in mind (as did NHSE) the GMC’s guidance "Maintaining a professional boundary between you and your patient,” dated 2013.

The Tribunal view all these matters as serious breaches of Good Medical Practice ('GMP') (2013 version), over a lengthy period of time. In particular the Tribunal had regard to paragraphs 22b and 53:

"22 You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:

b regularly reflecting on your standards of practice and the care you provide

53 You must not use your professional position to pursue... [an] improper emotional relationship with a patient or someone close to them.”

The Tribunal determined that Dr Smith failed to reflect appropriately on the standards of care he provided to Patient A and that he did not take opportunities when they arose to remedy his course of action. The NHSE Investigation Report and
the text messages indicate that in May/June and in August 2017, Patient A’s therapist raised concerns with Patient A about the relationship with Dr Smith, who recalled this being discussed with Patient A.

32. The Tribunal also considered that Dr Smith failed to reflect on his actions which took place over an extended period of time, from late 2014 until July 2017 whilst Patient A remained Dr Smith’s patient, and continued after she left the practice until December 2017.

33. At the time of these events Dr Smith was an experienced GP and the Tribunal agree with Mr Breen that he ought not to have needed any particular training to understand that he was crossing professional boundaries. The Tribunal considered that Dr Smith’s relationship with Patient A was not wholly reactive at all times as evidenced by the frequency and content of the text messages he sent her. Additionally in his oral evidence Dr Smith admitted that he had made the suggestion of a private prescription of diazepam.

34. The Tribunal noted that on 29 October 2017 Dr Smith accessed Patient A’s medical records and issued her with a private prescription for diazepam. This was inappropriate. Then, Dr Smith failed to notify Patient A’s new GP of what he had done, which he should have, and left it to Patient A to destroy the prescription if it was not used.

35. In short, the Tribunal determined that Dr Smith failed to appreciate the professional boundaries that he had breached, which he ought to have appreciated and should have recognised when he breached them. In addition this was particularly important in the case of a vulnerable patient who was fragile and at a risk of dependency. The Tribunal was concerned that as a consequence of the relationship ending Patient A suffered harm.

36. The Tribunal is in no doubt that Dr Smith’s conduct fell well below the standards of conduct expected by fellow practitioners and that his actions amounted to misconduct.

Impairment

37. The Tribunal having found that the facts admitted and found proved amounted to misconduct went on to consider whether, as a result of that misconduct, Dr Smith’s fitness to practise is currently impaired.

38. In reaching its decision the Tribunal paid particular attention to the tests laid down by Dame Janet Smith in the fifth report to the Shipman Inquiry relating to findings of impairment and adopted by the High Court in a number of cases and to Mrs Justice Cox in CHRE v NMC & Grant [2011] EWHC 927 (Admin), paragraph 76:
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76. “I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor’s fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes.

“Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practice is impaired in the sense that s/he:

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

39. The Tribunal was satisfied that Dr Smith’s conduct put Patient A at unwarranted risk of harm, has brought the medical profession into disrepute and was a breach of a fundamental tenet of the profession. Dishonesty does not arise in this case.

40. The Tribunal has given all due allowance for the pressures Dr Smith may have been under at the practice, his lack of experience of managing patients with attachment issues, that he was guided throughout by a strong desire to help Patient A and believed that what he was doing was in her best interests, that he felt isolated at work, and the other difficulties Dr Smith mentioned occurring in his professional and family life at the time of these events.

41. However, these events took place over a three year period during which Dr Smith inappropriately and progressively exceeded the boundaries of his professional duties. Dr Smith admitted in evidence that if he had been approached by a fellow practitioner with the list of matters mentioned above at paragraph 25 he would have realised that the doctor was “in difficulty” and he would “not have thought this is OK.”

42. XXX. Dr Smith remained under agreed undertakings with NHS England until May 2019, XXX. Additionally, Dr Smith also continues to receive support from his workplace supervisor Dr C, and his mentor Dr M.
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43. Although Dr C gave evidence of the ‘huge change’ in Dr Smith’s practice and that he did not perceive any ongoing risk by Dr Smith, he recognised that with increased pressure of work it would be ‘all too easy for old habits to return’ and that monitoring and workplace supervision meetings should continue in order to ‘look out for problems early’. He stated that he did not feel workplace supervision needed to continue as frequently as it had been up to this point.

44. The Tribunal had regard to the various testimonials on behalf of Dr Smith where his colleagues and peers described him as a good and caring doctor who provided his patients with a high level of care.

45. The Tribunal determined that despite Dr Smith’s genuine remorse, contrition and his level of insight, which it accepts is substantial, together with the XXX testimonial evidence before it, there still remains some risk of repetition. Dr Smith has only recently returned to work against a backdrop of a lengthy period and catalogue of breaches of professional boundaries. The Tribunal was not satisfied that sufficient time has elapsed to say that Dr Smith’s fitness to practise is not impaired.

46. The Tribunal was mindful of the overarching statutory objective of the GMC in sections 1A and 1B of the Medical Act 1983, of the need to uphold proper professional standards and maintain public confidence in the medical profession. The Tribunal considers that public confidence in the profession would indeed be undermined if a finding of impairment were not made in this case at this point in time, in circumstances where these events are still relatively recent and where Dr Smith is rightly continuing to receive support.

47. Accordingly, the Tribunal find that Dr Smith’s fitness to practise is currently impaired by reason of his misconduct.

Determination on Sanction - 08/08/2019

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

2. Having determined that Dr Smith’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

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

On behalf of the GMC

4. On behalf of the GMC, Mr Breen referred the Tribunal to the overarching objective and the relevant paragraphs of the Sanctions Guidance (February 2018) (“SG”). He submitted that having regard to its findings on facts and the reasoning as set out in the Tribunal’s determination on impairment, there was still some risk that Dr Smith could repeat his behaviour. As such suspension was the only appropriate sanction and would send a message to the profession and the public and would have a deterrent effect.

5. Mr Breen submitted that taking no action was not appropriate in this case because there were no exceptional circumstances to consider.

6. Mr Breen further stated that Dr Smith’s practice had previously been subject to a period of conditions imposed by NHSE and conditions were not a proportionate response to the gravity of Dr Smith’s conduct in the particular circumstances of this case.

7. Mr Breen submitted that for these reasons the only appropriate and proportionate sanction in this case was one of suspension.

On behalf of Dr Smith

8. On behalf of Dr Smith, Ms Felix submitted that suspension would be neither appropriate nor proportionate in this case. She reminded the Tribunal that Dr Smith had been subject to conditions imposed by NHSE for approximately 13 months, XXX. The NHSE restrictions had continued until July 2019. She submitted that suspension at this point in time would interrupt the embedding of the considerable knowledge and insight he had developed.

9. She further submitted that the appropriate and proportionate sanction in this case was one of conditions. She stated that conditions in Dr Smith’s case were workable and reminded the Tribunal of the agreed voluntary undertakings and that there had been no problem with Dr Smith adhering to them.

10. Ms Felix submitted that Dr Smith had taken steps to correct his behaviour, had shown considerable remorse and a substantial amount of remediation. She stated that Dr Smith’s intentions and motives towards Patient A were always that she should achieve a good outcome and he had a strong desire to help Patient A.

11. Ms Felix further submitted that a sanction of suspension in this case would be utterly disproportionate and invited the Tribunal to consider a sanction of conditions for a period of six months.
The Tribunal’s Determination on Sanction

12. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal alone, exercising its independent judgement. The Tribunal has given consideration to its findings of fact, its findings of misconduct and impaired fitness to practise as well as the submissions made by Mr Breen on behalf of the GMC, and Ms Felix on behalf of Dr Smith. The Tribunal also had regard to the SG as set out below.

13. Throughout its deliberations the Tribunal bore in mind that the purpose of sanctions is not to be punitive, but to protect the public. That includes protecting the health, safety and wellbeing of the public, maintaining public confidence in the profession, and declaring and upholding proper standards of conduct and behaviour. In making its decision, the Tribunal also had regard to the principle of proportionality, and it considered Dr Smith’s interests as well as those of the public. It also considered and balanced the mitigating and aggravating factors in this case.

Mitigating Factors

14. The Tribunal found the following mitigating factors:

- Dr Smith’s behaviour involved a single patient and at all times he believed that he was acting in her best interests
- Dr Smith has shown a considerable amount of insight and remorse and has taken steps to avoid a repetition of his misconduct
- Dr Smith made an early admission of the facts
- Dr Smith’s previous good character and the testimonial evidence.

Aggravating Factors

15. The Tribunal next considered the aggravating factors of this case:

- Dr Smith’s misconduct continued over an uninterrupted period of 3 years
- The nature of Dr Smith’s misconduct escalated during this time
- Dr Smith seriously abused his professional position (paragraphs 142-144 of SG)
- Patient A was a vulnerable patient (paragraphs 145-146 of SG).

No action

16. Before reaching its decision as to an appropriate sanction to impose in Dr Smith’s case, the Tribunal first considered whether to conclude the case by taking no action.

17. The Tribunal considered paragraphs 68-70 of SG:
'68 Where a doctor’s fitness to practise is impaired, it will usually be necessary to take action to protect the public (see paragraphs 14–16). But there may be exceptional circumstances to justify a tribunal taking no action.

69 To find that a doctor’s fitness to practise is impaired, the tribunal will have taken account of the doctor’s level of insight and any remediation, and therefore these mitigating factors are unlikely on their own to justify a tribunal taking no action.

70 Exceptional circumstances are unusual, special or uncommon, so such cases are likely to be very rare. The tribunal’s determination must fully and clearly explain:

a what the exceptional circumstances are
b why the circumstances are exceptional
c how the exceptional circumstances justify taking no further action.’

18. The Tribunal determined that there were no exceptional circumstances to justify taking no action against Dr Smith’s registration. The Tribunal also determined that taking no action would be neither sufficient, proportionate, nor in the public interest.

Conditions

19. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Smith’s registration. It determined that conditions were better suited to the particular circumstances of this case.

20. XXX. As such conditions would allow Dr Smith further time to reflect and demonstrate the embedding of his reflection, learning and insight into his everyday practice.

21. The Tribunal reminded itself that conditions should be appropriate, proportionate, workable, and measurable whilst still at the same time maintaining public confidence in the profession. It had regard to paragraphs 81 and 82 of SG:

‘81 Conditions might be most appropriate in cases:

...  

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

...’
82 Conditions are likely to be workable where:

- a the doctor has insight
- b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings
- c the tribunal is satisfied the doctor will comply with them
- d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised’.

22. The Tribunal has given careful consideration to a sanction of suspension. There is no doubt that this is a serious case that could well justify suspension. The Tribunal rejects the suggestion that suspension would be ‘utterly disproportionate’. Dr Smith’s misconduct involved very serious transgressions of professional boundaries over a lengthy period of time and Patient A suffered harm. The Tribunal has re-read paragraphs 91-98 of the SG but in the end has drawn back from imposing a sanction of suspension. There are a number of reasons (in no particular order) which include:

(a) Dr Smith was throughout guided by a mistaken though genuine belief that he was doing his best for Patient A and to assist her. Nevertheless his misconduct did undoubtedly cause her distress and harm.

(b) Dr Smith was subject to voluntary undertakings with NHSE from May 2018 to July 2019 which he was ‘diligent in complying with’.

(c) Dr Smith is a good and caring doctor working in a busy practice where his skills and experience are needed.

(d) Dr Smith has learnt much from the experience of this case and appropriate conditions, including continuing supervision, should minimise the risk of repetition. To suspend his registration now may well interrupt and hinder the progress he has already made.

(e) It is not necessary or required to direct that Dr Smith’s registration be suspended in order to satisfy the matters mentioned in sections 1A and 1B of the Medical Act 1983. The statutory objective can be satisfied with conditions in this particular case.

23. The Tribunal considered that conditions are appropriate in this case and that it is possible to formulate appropriate and workable conditions which adequately address Dr Smith’s misconduct and the concerns of the Tribunal whilst at the same
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time maintaining public confidence in the profession consistent with the GMC’s
statutory overarching objective.

24. However, the Tribunal concluded that the length of time for conditions to be
imposed would need to be a substantial period in order to satisfy the requirement
for it to be an appropriate and proportionate sanction.

25. The following conditions are public and will be published:

1  He must personally ensure the GMC is notified of the following
information within seven calendar days of the date these conditions
become effective:

   a  The details of his current post, including:
    i  his job title
    ii his job location
    iii his responsible officer (or their nominated deputy)

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

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

   d  any training programmes he is in

   e  of the organisation on whose medical performers list he is
   included

   f  of the contact details of any locum agency or out of hours
   service he is registered with.

2  He must personally ensure the GMC is notified:

   a  of any post he accepts, before starting it

   b  that all relevant people have been notified of his conditions, in
   accordance with condition 10

   c  if any formal disciplinary proceedings against him are started by
   his employer and/or contracting body, within seven calendar
days of being formally notified of such proceedings
d if any of his posts, practising privileges, or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination.

e if he applies for a post outside the UK.

3 He must allow the GMC to exchange information with any person involved in monitoring his compliance with his conditions.

4 a He must have a workplace reporter appointed by his responsible officer (or their nominated deputy).

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his workplace reporter.

ii he has personally ensured that the GMC has been notified of the name and contact details of his workplace reporter.

5 a He must design a Personal Development Plan (PDP), with specific aims to address the deficiencies in the following areas of his practice:

- maintaining professional boundaries
- managing patients with attachment, personality or similar disorders
- dealing with vulnerable patients

b His PDP must be approved by his responsible officer (or their nominated deputy).

c He must give the GMC a copy of his approved PDP within three months of these substantive conditions becoming effective.

d He must give the GMC a copy of his approved PDP on request.

e He must meet with his responsible officer (or their nominated deputy), as required, to discuss his achievements against the aims of his PDP.
6 He must only work in a group practice setting where there is a minimum of two GP partners or employed GPs (excluding himself). The GPs must be partners or permanently employed GPs who are on the GP register (this excludes locum staff).

7 a He must be supervised in all of his posts by his workplace/clinical supervisor, as defined in paragraph 7(c) below. His workplace/clinical supervisor must be appointed by his responsible officer (or their nominated deputy).

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his workplace/clinical supervisor and approved his supervision arrangements

ii he has personally ensured that the GMC has been notified of the name and contact details of his workplace/clinical and his supervision arrangements.

c He must have a workplace/clinical supervisor approved by the GMC who is on site for 40% of Dr Smith’s clinical time. The approved workplace/clinical supervisor must agree to provide detailed progress reports to the GMC every six months. If the supervisor is absent for more than two consecutive working weeks, the supervisor is required to notify the GMC and an alternative workplace/clinical supervisor must be identified and approved by the GMC.

8 a He must keep a log of any patients he carries out consultations with that have known attachment disorders, personality disorders or similar disorders.

b He must discuss this log with the workplace/clinical supervisor at the next available meeting.

c He must log his reflections and submit these to the GMC every six months.

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

10 He must personally ensure the following persons are notified of the conditions listed at 1 to 9:
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a  his responsible officer (or their nominated deputy)

b  the responsible officer of the following organisations:

i  his place(s) of work, and any prospective place of work (at the time of application)

ii  all of his contracting bodies and any prospective contracting body (prior to entering a contract)

iii  any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application)

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

v  if any of the organisations listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within that organisation. If he is unable to identify that person, he must contact the GMC for advice before working for that organisation.

c  the responsible officer for the medical performers list on which he is included or seeking inclusion (at the time of application)

d  his immediate line manager and senior clinician (where there is one) at his place of work, at least 24 hours before starting work (for current and new posts, including locum posts).

26.  XXX

27.  The Tribunal direct in accordance with Section 35D (2)(c) of the Medical Act that Dr Smith’s registration be conditional on compliance with the above conditions for a period of 18 months for the protection of the members of the public and in his interests. A period of six months suggested by Ms Felix is unrealistically short.

28.  The Tribunal determined to direct a review of Dr Smith’s case. A review hearing will convene shortly before the end of the period of conditional registration, unless an early review is sought. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Smith to demonstrate how he has maintained professional boundaries with all patients; managed any patients with attachment, personality or similar disorders; and managed any vulnerable patients. This may show the review Tribunal how Dr Smith has continued to develop his insight and embed his reflections
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and learning into his everyday practice. This would assist any reviewing Tribunal to understand whether Dr Smith is safe and fit to practise without restrictions. It therefore may assist the reviewing Tribunal if Dr Smith provided the following information:

- a log of his reflections
- examples of meeting notes with his workplace/clinical supervisor
- evidence of engagement with his mentor
- XXX
- evidence of his PDP and subsequent completion/achievement of those objectives.

29. Dr Smith will also be able to provide any other information that he considers will assist.

Determination on Supplementary Sanction - 08/08/2019

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

2. The Tribunal has been invited by Ms Felix to make amendments to conditions 6, 7 and 11. Mr Breen made no submission on behalf of the GMC and stated that this is a matter for the Tribunal.

Condition 6

3. Ms Felix submitted that condition 6 as presently worded would prevent Dr Smith from continuing his work as a football club doctor. It is not the Tribunal’s intention to do this. Condition 6 is directed to Dr Smith’s work as a general practitioner. The Tribunal is content for condition 6 to be amended to read:

‘6. Save in relation to his work as a football club doctor he must only work in a group practice setting where there is a minimum of two GP partners or employed GPs (excluding himself). The GPs must be partners or permanently employed GPs who are on the GP register (this excludes locum staff)’.

Condition 7

4. Ms Felix invited the Tribunal to insert ‘NHS’ in condition 7a before the word ‘posts’. The Tribunal amends condition 7a to read:

‘He must be supervised in all of his NHS posts…’

5. The Tribunal wishes to make clear that conditions 5 and 8 and any log of reflections and evidence of PDP achievements mentioned in paragraph 28 of the
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Tribunal’s determination on sanction should encompass the entire scope of Dr Smith’s practice, including any non-NHS work. The Tribunal is mindful of the patient safety aspects of this case and the need to ensure that the whole range of Dr Smith’s medical work is available to any reviewing Tribunal.

XXX

7. A copy of the conditions as amended is below:

8. The following conditions are public and will be published:

   1 He must personally ensure the GMC is notified of the following information within seven calendar days of the date these conditions become effective:

       a The details of his current post, including:

          i his job title

          ii his job location

          iii his responsible officer (or their nominated deputy)

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

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

       d any training programmes he is in

       e of the organisation on whose medical performers list he is included

       f of the contact details of any locum agency or out of hours service he is registered with.

   2 He must personally ensure the GMC is notified:

       a of any post he accepts, before starting it

       b that all relevant people have been notified of his conditions, in accordance with condition 10
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c if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings

d if any of his posts, practising privileges, or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination

e if he applies for a post outside the UK.

3 He must allow the GMC to exchange information with any person involved in monitoring his compliance with his conditions.

4 a He must have a workplace reporter appointed by his responsible officer (or their nominated deputy).

b He must not work until:

   i his responsible officer (or their nominated deputy) has appointed his workplace reporter

   ii he has personally ensured that the GMC has been notified of the name and contact details of his workplace reporter.

5 a He must design a Personal Development Plan (PDP), with specific aims to address the deficiencies in the following areas of his practice:

   • maintaining professional boundaries
   • managing patients with attachment, personality or similar disorders
   • dealing with vulnerable patients

b His PDP must be approved by his responsible officer (or their nominated deputy).

c He must give the GMC a copy of his approved PDP within three months of these substantive conditions becoming effective.

d He must give the GMC a copy of his approved PDP on request.
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e  He must meet with his responsible officer (or their nominated deputy), as required, to discuss his achievements against the aims of his PDP.

6  Save in relation to his work as a football club doctor he must only work in a group practice setting where there is a minimum of two GP partners or employed GPs (excluding himself). The GPs must be partners or permanently employed GPs who are on the GP register (this excludes locum staff).

7  a  He must be supervised in all of his NHS posts by his workplace/clinical supervisor, as defined in paragraph 7(c) below. His workplace/clinical supervisor must be appointed by his responsible officer (or their nominated deputy).

    b  He must not work until:

        i  his responsible officer (or their nominated deputy) has appointed his workplace/clinical supervisor and approved his supervision arrangements

        ii  he has personally ensured that the GMC has been notified of the name and contact details of his workplace/clinical and his supervision arrangements.

    c  He must have a workplace/clinical supervisor approved by the GMC who is on site for 40% of Dr Smith’s clinical time. The approved workplace/clinical supervisor must agree to provide detailed progress reports to the GMC every six months. If the supervisor is absent for more than two consecutive working weeks, the supervisor is required to notify the GMC and an alternative workplace/clinical supervisor must be identified and approved by the GMC.

8  a  He must keep a log of any patients he carries out consultations with that have known attachment disorders, personality disorders or similar disorders.

    b  He must discuss this log with the workplace/clinical supervisor at the next available meeting.

    c  He must log his reflections and submit these to the GMC every six months.

9  He must have a mentor who is approved by his responsible officer (or their nominated deputy).
10. He must personally ensure the following persons are notified of the conditions listed at 1 to 9:
   a. his responsible officer (or their nominated deputy)
   b. the responsible officer of the following organisations:
      i. his place(s) of work, and any prospective place of work (at the time of application)
      ii. all of his contracting bodies and any prospective contracting body (prior to entering a contract)
      iii. any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application)
      iv. any locum agency or out of hours service he is registered with
      v. if any of the organisations listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within that organisation. If he is unable to identify that person, he must contact the GMC for advice before working for that organisation.
   c. the responsible officer for the medical performers list on which he is included or seeking inclusion (at the time of application)
   d. his immediate line manager and senior clinician (where there is one) at his place of work, at least 24 hours before starting work (for current and new posts, including locum posts).

9. XXX

**Determination on Immediate Order - 08/08/2019**

1. Having determined to impose conditions on Dr Smith’s registration, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Smith’s registration should be subject to an immediate order.

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2. On behalf of the GMC, Mr Breen submitted that there is no application from the GMC for an immediate order.

3. On behalf of Dr Smith, Ms Felix submitted that given the Tribunal’s findings an immediate order should be made.

The Tribunal’s Determination

4. The Tribunal has borne in mind the paragraphs of the Sanctions Guidance (February 2018) which deal with immediate orders namely, 172-178 and in particular paragraphs 173 and 178:

‘173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor’s special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.’

‘178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.’

5. As is apparent from the Tribunal’s determinations on impairment and sanction, this case raises issues of patient safety and public trust in the form of abuse of a professional relationship and the crossing of boundaries involving a vulnerable patient.

6. The Tribunal is satisfied that an immediate order is appropriate, proportionate and in accordance with the overarching objective. The Tribunal considers that each of the three limbs of section 38(2) of the Medical Act 1983 are satisfied namely that an immediate order is necessary for the protection of members of the public or is otherwise in the public interest, or is in the best interests of Dr Smith.

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

8. There is no interim order to revoke.

9. That concludes this case.
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Confirmed
Date 08 August 2019

Mr Kenneth Hamer, Chair