Public Record


Medical Practitioner’s name: Dr John BLEASDALE

GMC reference number: 3333422

Primary medical qualification: MB ChB 1990 University of Leeds

Type of Case

Outcome on impairment

New - Misconduct

Impaired

Summary of outcome

Suspension, 12 months

Review hearing directed

Immediate order imposed

Tribunal:

Legally Qualified Chair: Miss Rachel Birks

Lay Tribunal Member: Mr Martyn Green

Medical Tribunal Member: Dr Bridget Langham

Tribunal Clerk: Mr Matthew Rowbotham and Miss Emma Saunders

Attendance and Representation:

Medical Practitioner: Present and represented

Medical Practitioner’s Representative: Mr Marios Lambis, Counsel, instructed by RadcliffesLeBrasseur

GMC Representative: Mr Edward Morgan, Counsel

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
Determination on Facts - 19/09/2019

Background

1. Dr Bleasdale qualified in 1990 before undertaking his house officer training in hospitals in Leeds and Hull. He worked as a Senior House Officer in Hull before beginning his specialist anaesthetic training in Birmingham. Dr Bleasdale worked as a Registrar within the South Midlands Anaesthetic Registrar Training programme. He completed his specialist training in anaesthetics in 2000. Dr Bleasdale took a post as a Consultant in Intensive Care Medicine and Anaesthesia at the Sandwell and West Birmingham Hospitals NHS Trust (‘the Trust’) in May 2000, where he has worked continuously since then. Dr Bleasdale has held a number of additional posts including Clinical Lead for Critical Care Services from 2005 to 2010; Local Negotiating Committee Chair 2011 to 2014; Serious Incident Investigator 2012 to date; Chair of Never Events Assurance Committee, 2014 to 2016; MPTS Tribunal Member 2012 to 2018; Joint Clinical Lead between 2015 and 2018; and Multidisciplinary Team Lead for Critical Care from 2015 to 2019. He has also been involved in the training of junior doctors. Dr Bleasdale has undertaken a number of roles in private practice since 2002, including work at the BMI Priory Hospital (‘the Priory’).

2. The allegation that has led to Dr Bleasdale’s hearing relates to concerns that he worked on-call concurrently for the Trust and for the BMI Priory Hospital (‘the Priory’). It is alleged by the General Medical Council (GMC) that this took place on 33 separate occasions between March 2016 and December 2017. It is alleged that Dr Bleasdale knowingly agreed to work concurrently for the Trust and the Priory, failed to adequately notify the Trust of this and knew he should not have agreed to work concurrently for both the Trust and the Priory. The GMC allege that Dr Bleasdale’s actions were dishonest.

3. The initial concerns were raised with the GMC on 27 April 2018 by Mr B, Head of Medical Staffing at the Trust, in advance of a report being compiled as part of the Trust investigation. The Trust investigation began when concerns were raised by colleagues on 29/30 November 2017, with Dr A, Consultant Anaesthetist and Clinical Director for the Anaesthetics, Critical Care and Pain Management directorate at the Trust.

The Outcome of Application Made during the Facts Stage

4. The Tribunal granted Dr Bleasdale’s application, made pursuant to Rule 34(13) of the GMC (Fitness to Practise Rules) 2004 as amended (‘the Rules’), for the oral evidence of two witnesses to give evidence by telephone. The witnesses were Ms C, Leader and Trustee at Sutton Coldfield Adventure Unit, and Ms D, Deputy Director of Governance at
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the Trust. Mr Lambis submitted that both witnesses were unable to attend in person due to professional commitments and that they were testimonial witnesses. The application was unopposed. The Tribunal determined that it was fair to grant the application given the submissions from Mr Lambis. On Day 3 of the hearing, Mr Lambis indicated that the Tribunal would hear from Ms C but that oral evidence was no longer required from Ms D given timing difficulties.

The Allegation and the Doctor’s Response

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

1. Between on or around 1 March 2016 and 1 December 2017 you carried out on-call work on dates set out on in Schedule 1 for:

   a. Sandwell and West Birmingham Hospitals NHS Trust (‘the Trust’);
      Admitted and found proved

   b. BMI Priory Hospital (‘the Priory’).
      Admitted and found proved

2. You:

   a. knowingly agreed to work concurrently for the Trust and the Priory on one or more of the dates set out in Schedule 1;
      Admitted and found proved

   b. failed to adequately notify the Trust that you had agreed to work concurrently for the Trust and the Priory on one or more of the dates set out in Schedule 1;
      Admitted and found proved

   c. knew that you should not have agreed to work concurrently for the Trust and the Priory.
      To be determined

3. Your actions as described at paragraph 1 were dishonest by reason of paragraphs 2a-2c.
   To be determined

The Admitted Facts

6. At the outset of these proceedings, through his counsel Mr Lambis, Dr Bleasdale made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In
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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.

The Facts to be Determined

7. In light of Dr Bleasdale’s response to the Allegation made against him the Tribunal is required to determine whether Dr Bleasdale knew that he should not have agreed to work concurrently for the Trust and the Priory and whether his actions in carrying out the on-call work, as set out in Schedule 1, were dishonest.

Factual Witness Evidence

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

   • In person from Dr A, who also provided a witness statement dated 28 May 2019;
   • In person from Dr E, Consultant Anaesthetist at the Trust and previously a Clinical Director at the Trust from 2011 to 2015, who also provided a witness statement dated 31 May 2019;
   • In person from Dr F, Consultant Anaesthetist at the Trust, who also provided a witness statement dated 24 May 2019.

9. 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 H, Manager at Midland Intensive Care and an Independent Consultant Intensivist and Anaesthetist, whose witness statements were dated 22 March 2019 and 3 June 2019;
   • Dr G, Consultant Radiologist at the Trust and Group Director for the Imaging Group, whose witness statement was dated 6 June 2019;
   • Mr B, whose witness statement was dated 17 June 2019.

10. Dr Bleasdale provided his own witness statement dated 7 August 2019 and also gave oral evidence at the hearing. In addition, the Tribunal received oral evidence from the following witnesses on Dr Bleasdale’s behalf:

   • In person from Dr I, Consultant Anaesthetist at the Trust and Clinical Lead for the Trust Critical Care Service, who also provided a witness statement dated 7 August 2019;
   • In person from Dr J, who worked as a Consultant Gynaecologist at the Trust prior to retirement from NHS practice in October 2018 and currently has practising privileges at the Priory, who also provided a witness statement dated 12 August 2019;
Documentary Evidence

11. The Tribunal had regard to all of the documentary evidence provided by the parties. This evidence included, but was not limited to, the Trust’s Management Report dated 19 July 2018 with enclosures; Dr Bleasdale’s Work Details Form dated 12 June 2018; Letter from the Trust confirming the outcome of a disciplinary hearing dated 7 September 2018; Dr Bleasdale’s Job Plans for 2014 to 2017; Dr Bleasdale’s Input and Output Forms relating to his Trust appraisals from 2014 - 2018; a template Consultant contract from the Trust; the Trust’s Job Planning Policy dated June 2013 to June 2017; Code of Conduct for Private Practice (2004) and the Trust’s Consultant contract Terms & Conditions from the NHS Employer website dated 2003.

12. The Tribunal also had regard to email correspondence between Dr Bleasdale and Dr H, relating to Dr Bleasdale’s rota and availability for on-call sessions at the Priory between 2016 and 2017.

13. The Tribunal also took account of a number of documents such as Dr Bleasdale’s Curriculum Vitae, and the testimonials and feedback provided about Dr Bleasdale’s practice.

The Tribunal’s Approach

14. In reaching its decision on the facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Bleasdale 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.

15. The Tribunal was reminded of the test in relation to dishonesty as set out in the case of Ivey v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] that:

“When dishonesty is in question the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual’s knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.”
16. The Tribunal was told that Dr Bleasdale is of good character and that he has no previous fitness to practise history. The Legally Qualified Chair reminded the Tribunal that Dr Bleasdale’s character and history is not a defence to these allegations but that it might be relevant to the credibility of his evidence or his propensity to do what is alleged.

The Tribunal’s Analysis of the Evidence and Findings

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

Paragraph 2(c)

18. The Tribunal first considered the Code of Conduct for Private Practice (2004), published by the Department of Health, applicable to Dr Bleasdale. Section 2.4 of the code stated:

"Consultants should ensure in particular that:
Private commitments, including on-call duties, are not scheduled during times at which they are scheduled to be working for the NHS"

Section 2.6 of the code stated:

"There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on-call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments."

19. The Tribunal heard from Dr Bleasdale that he believed that his work at the Priory constituted a form of ‘critical care cover’, rather than being ‘on-call’. The Tribunal had regard to the detail that Dr Bleasdale submitted to the Trust about his work at the Priory. Within Dr Bleasdale’s appraisals from 2015 to 2018 he described his work as "private practice general intensive care cover’. In oral evidence he described that cover as "seven days per week, 24 hours a day on-call", and stated that he had told his appraisers and job planners that.

20. Dr Bleasdale also gave evidence of a typical day when working on the intensive care unit (ICU) on-call cover at the Priory, which included a ward round at the Priory starting at around 7:15am, then working at the Trust between 8am and 6pm whilst being available to the Priory for support. He then went back to the Priory for a ward round before commencing telephone support for the Priory throughout the night. When on call for the Trust he would commence duties at 5:30pm and be on site till 9pm when he would then be available on the telephone until 8am. Dr
Bleasdale said that when on-call for either the Trust or the Priory he needed to be able to physically attend either hospital within 30 minutes should he be required to do so.

21. The Tribunal has concluded that the 33 instances of concurrent on-call work do not arise in circumstances envisaged by section 2.6 of the Code of Conduct for Private Practice.

22. In his written statement dated 7 August 2019, Dr Bleasdale stated that the patients at the Priory intensive care unit were admitted under a “lower threshold” than those at the Trust, meaning that they usually required less critical or urgent care.

23. When looking at the ‘Terms and Conditions - consultants (England) 2003’ document that Dr Bleasdale had been working under as a consultant, the Tribunal noted that in schedule 9, it states that

"2. The consultant is responsible for ensuring that the provision of Private Professional Services or Fee Paying Services for other organisations does not:

• result in detriment of NHS patients or services;

• diminish the public resources that are available for the NHS.

Disclosure of information about private commitments

3. The consultant will inform his or her clinical manager of any regular commitments in respect of Private Professional Services or Fee Paying Services. This information will include the planned location, timing and broad type of work involved.

4. The consultant will disclose this information at least annually as part of the Job Plan Review. The consultant will provide information in advance about any significant changes to this information.

Scheduling of work and job planning

5. Where there would otherwise be a conflict or potential conflict of interest, NHS commitments must take precedence over private work. [...] the consultant is responsible for ensuring that private commitments do not conflict with Programmed Activities."

24. The Tribunal heard from Dr F, Dr E and Dr A, that they were aware that Dr Bleasdale worked in private practice, but were not aware of how this interacted with his NHS work until the issue was raised in November 2017. The Tribunal found that
this might partly be due to the way appraisals and job plans were carried out, with little cross-referencing between the two. The Tribunal heard that the consultant (appraisee) was expected to include details of their private practice in the scope of work of the appraisal input form, which was populated by them, prior to the appraisal meeting. The Tribunal also heard that the private practice in section 8 of the job planning form was completed by the consultant before or just after the job planning meeting with their job planner. The Tribunal heard that there was a culture of limited interaction between job planning and appraisal. However, even if there were more interaction between the two, any knowledge of the fact that the work at the Priory would involve on-call work depended upon Dr Bleasdale being open with either his appraiser or person carrying out the job planning. The Tribunal was satisfied that Dr Bleasdale had not disclosed the full details of his work in his job plans or in his appraisal input documents. This information would potentially have alerted his appraisers or job planners to conflicts in his availability and ended the concurrent on-call work.

25. Dr Bleasdale should not have been working in the manner set out in the allegations as he could not comply with the Terms and Conditions nor the Code of Conduct for Private Practice. The Tribunal was satisfied that Dr Bleasdale’s on-call work at the Priory did result in the detriment of both private and NHS patients as there was potential for him to be unable to respond within 30 minutes to an urgent call at one site if he was already in attendance at an urgent situation at the other.

26. As the Tribunal has now established there was clear guidance available to, and a contractual requirement on, Dr Bleasdale that he should not have worked in this manner, it next went on to consider if Dr Bleasdale would have been aware of this guidance.

27. The Tribunal noted that Dr Bleasdale had held prominent professional roles, including being a member and Chair of the Local Negotiating Committee, a group that scrutinises NHS policies and works with the British Medical Association to ensure NHS staff have clear and fair contracts, amongst other work. Dr Bleasdale was also a rota master at the Trust, meaning he played a part in the rostering of staff. He was also a serious incident investigator. Due to Dr Bleasdale holding these roles, and his status at the Trust, the Tribunal found it improbable that he would not have been familiar with NHS guidance and contractual requirements. In addition, he was a consultant at the time when the new contract was negotiated and implemented, and the Tribunal has heard and accepted evidence from various witnesses who confirmed heightened awareness, by the consultant body, of the contents of the contract and their significance. He would have been issued a new contract and would have been aware of his obligations when it was introduced.

28. The Tribunal were mindful that all witnesses had highlighted how "trustworthy and reliable" Dr Bleasdale was. Dr J told the Tribunal that she would go to Dr Bleasdale if she needed any professional advice. The Tribunal considered that
these endorsements show that Dr Bleasdale appears to be a well-informed member of staff, and a person sought out by colleagues for professional guidance.

29. The Tribunal noted the difficulties faced by Dr Bleasdale following a bereavement in 2014 and evidence that he was not the sort of person who would ever say no when asked to do something. It did not consider that these factors helped evidence any lack of knowledge of, or consideration of, the need to ensure he was not committed to working on-call for two organisations concurrently.

30. Taking into account that there was clear guidance available to Dr Bleasdale, and that he would have known that this guidance existed, the Tribunal concluded that on the balance of probabilities Dr Bleasdale must have known that he should not have agreed to work concurrently at both the Trust and the Priory. Even if not explicitly set out in the guidance or Code of Conduct, it was a matter of common sense, for an experienced doctor, that concurrent on-call work could result in patient safety risks. It was also a matter of common sense that the concurrent on-call involved double payments for time that each organisation would have expected to be set aside exclusively for them. He was an experienced clinician who had been doing private work for some time and had been involved in governance within the Trust. Accordingly, the Tribunal found this sub-paragraph of the Allegation proved.

Paragraph 3

31. The Tribunal had regard to the test in relation to dishonesty as set out in Ivey, firstly identifying (subjectively) what Dr Bleasdale’s knowledge or belief as to the facts was and then, secondly whether Dr Bleasdale’s conduct was honest or dishonest by applying the (objective) standards of ordinary decent people. The Tribunal noted that there was no requirement that Dr Bleasdale must appreciate that what he has done, by those standards, was dishonest.

32. The Tribunal took account of the paragraphs of the Allegation that have been admitted or found proved by the Tribunal. As a result, the Tribunal considered that Dr Bleasdale knowingly agreed to work concurrently at the Trust and the Priory on the dates set out in Schedule 1, failed to adequately notify the Trust of this agreement and knew that he should not have agreed to work concurrently at both places. The Tribunal has found that Dr Bleasdale knew that he should not have agreed to work concurrently, given his experience and the clear patient safety issues when undertaking both posts at the same time. He would also have been paid twice by different organisations for the same period of time. The Tribunal considered that this was key to it determining what Dr Bleasdale’s knowledge or belief as to the facts was.

33. Consultants within the NHS have a high degree of autonomy. Dr Bleasdale therefore had a high level of discretion as to how he carried out his job. The Trust therefore would have high expectations that he would provide accurate information
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for his job plan which set out the requirements of his role and associated expectations and reward.

34. The Tribunal noted that Dr Bleasdale is of good character and has no previous fitness to practise history. It had regard to the various positive testimonials who have all said that Dr Bleasdale is a highly regarded clinician and that the alleged conduct is totally out of character for him. His testimonial evidence speaks highly of his honesty and integrity.

35. The Tribunal had regard to Dr Bleasdale’s written statement dated 7 August 2019:

"With hindsight, it is now very clear to me that I should never have agreed to work on-calls for the Trust and the Hospital ICU concurrently without first discussing it with my employers. I agree that it was wrong of me to do so, but that was not my thinking at the time. Had I considered, and therefore known, that my actions were wrong either on a principled or contractual basis, I would never have agreed to work concurrent on-calls.

... Prior to starting at the Hospital, I did consider what I would do if I was called to both the Hospital and the Trust simultaneously and whether there might be any patient safety implications. However I thought about it on the basis of feasibility – whether I thought it was feasible for me to cover both locations or not. Since the merger of the City and Sandwell Hospitals into the Trust, and more recently with the new hospital plan, there have been proposals on restricting services in Intensive Care. One of the proposals offered on more than one occasion has been for the consultants to consider a single consultant covering the two sites as in several other specialities. It has always been my view that this is feasible, given adequate cover, but it was rejected for economic rather than clinical concerns, because there would not actually have been any saving to the Trust. I think that this belief that two-site cover was feasible and safe influenced by decision with regard to covering the Hospital when on-call at the Trust.”

36. Given this evidence, the Tribunal was of the view that Dr Bleasdale had given thought as to whether it was feasible to work on-call at both the Trust and the Priory at the same time. This evidence suggests he was focused on it being a contractual matter.

37. However, the Tribunal identified a clear patient safety risk in Dr Bleasdale working on-call for the Trust and the Priory at the same time, which would be apparent to any doctor and indeed any ordinary member of the public. It was of the view that Dr Bleasdale could easily have put alternative arrangements in place. He could have stopped doing on-call shifts for one or both places; he could have given more accurate availability to the Priory to prevent conflicts; if there was a clash
when he got a rota then he could have asked it to be swapped; and/or if his shift could not be swapped then he could have sought someone to cover a shift. The Tribunal was concerned that this happened on 33 occasions throughout 2016 and 2017.

38. Although no patient safety incidents arose during this time and Dr Bleasdale was not required to be at the Trust and the Priory simultaneously, the Tribunal was conscious that this could not have been guaranteed, and someone else might not have been able to cover any emergencies. It was clear that patient safety could have been compromised and whilst this might have been a low probability, if it did occur, the likelihood of serious harm was high. Dr Bleasdale would have known that this risk existed. The Tribunal was of the view that Dr Bleasdale did know what his contract said about the work he was undertaking and it did not accept his rationale that he worked at both places to ensure patient care at the Trust and the Priory was not compromised.

39. The Tribunal was of the view that Dr Bleasdale could have put the information about him being on-call at the Priory in his job plan for the Trust. On looking at the four job plans provided in the evidence it is noted that on two occasions the gynaecology and eye lists were detailed, and on two occasions it stated ‘for JB to complete’. The Priory on-call ICU work was not mentioned in section 8 in any of these forms. The Tribunal noted that in each of the appraisal forms, under the scope of work section, the Priory ICU was described as ‘cover’. The Tribunal noted that Dr Bleasdale had acted as an appraiser for other colleagues and that, given his experience, he would have known about the need to be transparent and flag up any competing interests or at least have given accurate availability to avoid instances of concurrent working.

40. The Tribunal concluded that Dr Bleasdale had a number of opportunities to avoid a situation where he was working on-call at both the Trust and the Priory. It has no evidence before it that Dr Bleasdale had a sufficient back up plan should anything go wrong and he had been unable to attend either the Trust of the Priory at a certain point. The fact that none of the steps highlighted above were actioned is clear evidence to the Tribunal of an attempt by Dr Bleasdale to ensure that his concurrent on-call working was kept under the radar.

41. This is supported by the fact that the concerns were discovered when two of Dr Bleasdale’s Consultant colleagues reported his actions to Dr A as they knew that the concurrent working was wrong. The Tribunal determined that Dr Bleasdale knew at the time that he should not have worked concurrently as set out in paragraphs 1 and 2 of the Allegation. All of the professional witnesses who gave evidence agreed that it would be wrong to work on-call concurrently for two employers.

42. The Tribunal considered whether Dr Bleasdale’s actions were due to financial motivation. Whilst the retainer payments for working on-call at the Priory during
2014 and 2015 were around £500 per week this then increased in 2015 and 2016 to £600 per day, resulting in significant financial remuneration. The Tribunal noted that the payments that Dr Bleasdale received for the 33 shifts identified in Schedule 1 were around £19,000 in extra payments. It noted that this amount had been paid back to the Trust by Dr Bleasdale. Having regard to all of the evidence before it, the Tribunal was unable to conclude on the balance of probabilities that Dr Bleasdale’s actions were for monetary gain. It concluded that it was perhaps more of a disregard for what he knew to be wrong for his own convenience, but not necessarily for financial reasons.

43. The Tribunal had regard to the second part of the test as set out in Ivey as to whether Dr Bleasdale’s actions were dishonest by applying the (objective) standards of ordinary decent people. The Tribunal took account of a number of factors, including Dr Bleasdale’s knowledge of contracts and policies given the roles he undertook, and that he took part in gathering the availability of his colleagues for the on-call rotas for the critical care department at the Trust for a number of years, such that he would know about the rationale and logistics of on-call arrangements. The Tribunal was conscious of the limited information contained with the appraisals and job plans that Dr Bleasdale provided to the Trust about his work at the Priory and that there was an absence of any formal arrangement for swapping to ensure cover for his on-call work at the Priory. The Tribunal balanced these factors against the positive submissions and testimonials it received about Dr Bleasdale’s character.

44. The Tribunal considered that, applying the objective standards of an ordinary decent person, Dr Bleasdale’s actions were dishonest. It determined that Dr Bleasdale allowed a situation to develop where he was doing something he should not have been doing. He failed to adequately notify the Trust about this and only stopped when colleagues raised concerns about his actions.

45. The Tribunal has found that Dr Bleasdale’s actions as described at paragraph 1 of the Allegation were dishonest by reason of paragraphs 2a-2c. The Tribunal found this paragraph of the Allegation proved.

The Tribunal’s Overall Determination on the Facts

46. The Tribunal has determined the facts as follows:

1. Between on or around 1 March 2016 and 1 December 2017 you carried out on-call work on dates set out on in Schedule 1 for:

   a. Sandwell and West Birmingham Hospitals NHS Trust (‘the Trust’);
      **Admitted and found proved**

   b. BMI Priory Hospital (‘the Priory’).
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Admitted and found proved

2. You:

a. knowingly agreed to work concurrently for the Trust and the Priory on one or more of the dates set out in Schedule 1;
   Admitted and found proved

b. failed to adequately notify the Trust that you had agreed to work concurrently for the Trust and the Priory on one or more of the dates set out in Schedule 1;
   Admitted and found proved

c. knew that you should not have agreed to work concurrently for the Trust and the Priory.
   Determined and found proved

3. Your actions as described at paragraph 1 were dishonest by reason of paragraphs 2a-2c.
   Determined and found proved

Determination on Impairment - 23/09/2019

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

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

3. In addition, the Tribunal received a statement dated 17 June 2019 from Mr K, Dr Bleasdale’s Responsible Officer at the Trust. Mr K stated that Dr Bleasdale had cooperated with the Trust’s investigation "fully and whole-heartedly" and was keen to pay back monies "even before it was asked of him". He stated that it was clear that Dr Bleasdale deeply regretted the situation and was apologetic. Mr K stated that Dr Bleasdale had taken steps to address the concerns by looking at the hours he worked, reflecting on his workload and resigning from his on-call work at the Priory.

GMC Submissions
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4. Mr Morgan submitted that there was cogent evidence upon which the Tribunal can and should be satisfied that Dr Bleasdale’s fitness to practise is impaired.

5. Mr Morgan made a number of references to case law, including to the case of Cheatle v GMC [2009] EWHC 645 (Admin) as to the approach to be taken by the Tribunal in its consideration of impairment. In Cheatle:

   "a finding that fitness to practise is impaired is a two step process. First, there must be a finding of serious misconduct. Secondly, the Panel must conclude that, as a result, the doctor's fitness to practise is impaired. In coming to a conclusion on impairment, the authorities make clear that the Panel must look forward. It must consider whether, in the light of what happened, and of evidence as to the doctor's conduct and ability demonstrated both before and after the misconduct, fitness to practise is impaired by the particular events."

6. Mr Morgan also referred to the case of GMC v Meadow [2006] EWCA Civ 1390, that the Tribunal’s task is to consider the position looking forward not back, albeit keeping in view the conduct of the past. In Meadow:

   "the purpose of [Fitness to Practise] proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The [Fitness to Practise Tribunal] thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past..."

7. Mr Morgan made reference to a number of the standards set out in the current edition of Good Medical Practice (2013) ("GMP") as to the obligations upon all doctors. He stated that doctors should "act with probity, honesty and integrity" and, with reference to paragraph 57 of GMP, that a doctor should "make sure that conduct justifies patient trust and the public trust in the profession".

8. Mr Morgan stated that the Tribunal has found that Dr Bleasdale knowingly agreed to work concurrently for the Trust and the Priory. He stated that notice of this arrangement was not given to the Trust and that the employer's knowledge of the interaction between the NHS and private practice was dependent upon Dr Bleasdale's openness. Dr Bleasdale did not disclose the full details of his work to the Trust.

9. Mr Morgan submitted that Dr Bleasdale’s work at both the Trust and the Priory resulted in potential detriment to patients in that it undermined Dr Bleasdale’s ability to respond at one site or the other. Mr Morgan stated that it was a matter of common sense that concurrent working could result in patient safety risks. He stated
that there was no evidence of a sufficient back up plan. Mr Morgan submitted there was clear evidence of an attempt to keep the concurrent on-call working ‘under the radar’.

10. Mr Morgan submitted that, in the interests of fairness, Dr Bleasdale fully and properly cooperated in disciplinary proceedings; he disengaged from the practice of concurrent on-call working; and effected restitution by payment of £19,000 to his employing Trust. Mr Morgan submitted that it would be wrong to overlook these factors when considering the issue of public confidence in the profession.

11. Mr Morgan submitted that Dr Bleasdale’s actions were dishonest and, given the above factors, there was ample evidence of material departures from the standards of GMP. He stated that paragraph 124 of the Sanctions Guidance (6 February 2018) (‘the SG’) was informative:

"Although it may not result in direct harm to patients, dishonesty related to matters outside the doctor’s clinical responsibility (eg providing false statements or fraudulent claims for monies) is particularly serious. This is because it can undermine the trust the public place in the medical profession. Health authorities should be able to trust the integrity of doctors, and where a doctor undermines that trust there is a risk to public confidence in the profession. Evidence of clinical competence cannot mitigate serious and/or persistent dishonesty."

Submissions on Dr Bleasdale’s behalf

12. Mr Lambis stated that he had no submissions to make on impairment and agreed that it was a matter for the judgment of the Tribunal.

The Relevant Legal Principles

13. 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 judgment alone.

14. 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 that was serious, and then whether the finding of that misconduct could lead to a finding of impairment.

15. The Tribunal must determine whether Dr Bleasdale’s fitness to practise is impaired today, taking into account Dr Bleasdale’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.
16. The Legally Qualified Chair reminded the Tribunal of the criteria set out by Dame Janet Smith in the Fifth Shipman Report, as referred to in the case of CHRE v NMC and Grant [2011] EWHC 927 (Admin), as follows:

"Do our findings of fact in respect of the doctor’s misconduct... show that his/her fitness to practise is impaired in the sense that s/he:

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

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

17. The Legally Qualified Chair also reminded the Tribunal of a principle set out in the case of Cohen v GMC [2008] EWHC 581 (Admin), that:

"The Merrison Report stated that 'the GMC should be able to take action in relation to the registration of a doctor ... in the interests of the public', and that the public interest had 'two closely woven strands', namely the particular need to protect the individual patient, and the collective need to maintain confidence of the public in their doctors.”

The Tribunal’s Determination on Impairment

Misconduct

18. The Tribunal first considered whether Dr Bleasdale’s actions amount to misconduct.

19. The Tribunal considered that Dr Bleasdale knowingly agreed to work concurrently at the Trust and the Priory on the dates set out in Schedule 1, failed to adequately notify the Trust of this agreement and knew that he should not have agreed to work concurrently at both places. The Tribunal has found that Dr Bleasdale knew that he should not have agreed to work concurrently and that his actions were dishonest.

20. The Tribunal considered that the following paragraphs of GMP were engaged as follows:

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

34. When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.

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

66. You must always be honest about your experience, qualifications and current role.

68. You must be honest and trustworthy in all your communication with patients and colleagues...

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

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

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

21. In relation to paragraph 71, the Tribunal has heard from witnesses that they saw the job plan and appraisal documents completed by Dr Bleasdale but that they did not realise there were work commitments that conflicted. The Tribunal was of the view that Dr Bleasdale could have put information about working on-call at the Priory in his job plans for the Trust and his input forms for his appraisal. Instead, his only reference to his ICU work was as “cover” in his appraisal document. The Tribunal considered that it was an attempt by Dr Bleasdale to ensure that the concurrent on-call working was kept under the radar. In line with GMP, Dr Bleasdale should have checked that the information in the job plans was correct and ensured that he did not deliberately leave out relevant information about his on-call arrangements. This is also a breach of paragraph 66 which required honesty when providing information about a current role.

22. With regard to paragraph 34 of GMP, the Tribunal considered the issue to be that Dr Bleasdale had allowed the concurrent on-call shifts to be scheduled and made no arrangements to change this. The Tribunal was conscious that this put patients at risk as Dr Bleasdale might not have been available in person for colleagues or patients who required his support whilst on-call.
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23. The Tribunal determined that paragraph 77 of GMP was relevant in that Dr Bleasdale was working in two places at once and that he knew he was being paid by both employers for work completed at the same time. Whilst not necessarily motivated by monetary gain, the Tribunal was of the view that Dr Bleasdale had not been honest in his financial dealings with the Trust.

24. The Tribunal questioned whether Dr Bleasdale’s actions were serious such as to amount to misconduct. It had regard to the departures from the standards set out in GMP that it has identified, including that the finding of dishonesty is against the fundamental principles of honesty and integrity. The Tribunal was mindful that Dr Bleasdale worked concurrent on-call shifts at the Trust and the Priory on 33 occasions in a two-year period. It was not a ‘one off’ and there had been a number of opportunities for Dr Bleasdale to have made alternative arrangements to avoid such clashes but this did not happen. Whilst the Tribunal has not concluded that such decisions were for monetary gain, it does find that Dr Bleasdale made a conscious decision not to make alternative arrangements thereby benefitting financially.

25. The Tribunal noted that if Dr Bleasdale had not been able to attend in person at either the Trust or the Priory when required and last-minute cover was unavailable then there was a clear risk to patient safety. The likelihood of any such issue arising was low but it was still a possibility, especially as Dr Bleasdale had no effective back up plan in place. If an issue did occur there was the risk of significant patient harm.

26. The requirement to act with honesty and integrity appears throughout GMP and is a fundamental tenet of the profession. The Tribunal has found a breach of this requirement and, when linked with patients being put at risk, this is serious.

27. For all of the reason above, the Tribunal concluded that Dr Bleasdale’s conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

Impairment by reason of misconduct

28. The Tribunal, having found that the facts found proved amounted to misconduct, went on to consider whether Dr Bleasdale’s fitness to practise is currently impaired by reason of his misconduct.

29. The Tribunal had regard to Dr Bleasdale’s past actions in relation to the criteria set out in Grant as to whether his fitness to practise was impaired in the sense that he:

"a. has in the past acted so as to put a patient or patients at unwarranted risk of harm"
30. The Tribunal referred to its previous comments about the risk to patient safety given Dr Bleasdale was working two on-call shifts concurrently. Whilst the probability of Dr Bleasdale being called out to both the Trust and the Priory at the same time was low, the likelihood of serious harm if this did happen was high such that there could have been a loss of life. The concurrent on-call work occurred on 33 occasions throughout 2016 and 2017 when Dr Bleasdale could have put alternative arrangements in place.

"b. has in the past brought the medical profession into disrepute”

31. The Tribunal noted that a number of Dr Bleasdale’s colleagues were shocked when they found out about the allegations and that Dr Bleasdale had been horrified himself when he realised what he had done. The Tribunal was mindful that a member of the public would expect that safety of patients by way of the on-call arrangements at a hospital would not deliberately be placed in jeopardy. It took into account the public perception of the double payment that Dr Bleasdale received, to the sum of £19,000, which was a considerable amount. The Tribunal concluded that the public and members of the profession alike would consider the concurrent on-call work and associated receipt of double payment to be unacceptable. The Tribunal was of the view that Dr Bleasdale’s actions had in the past brought the medical profession into disrepute.

"c. has in the past breached one of the fundamental tenets of the medical profession”

32. The Tribunal determined that Dr Bleasdale has breached a fundamental tenet of the profession in the past. It referred to the inside front cover of GMP which sets out:

"Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.

... Domain 4: Maintaining trust
• Be honest and open and act with integrity."

"d. has in the past acted dishonestly”

33. The Tribunal has found that Dr Bleasdale acted dishonestly in the past.
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34. In accordance with the approach set out in Grant, the Tribunal then had regard as to what Dr Bleasdale might be liable to do in the future, whether Dr Bleasdale’s conduct is remediable and if it has been remedied.

Insight

35. The Tribunal took account of Dr Bleasdale’s actions immediately after the concerns were raised when he admitted what he had done, stopped doing the on-call work at the Priory and repaid the monies owed to the Trust. The Tribunal determined that, whilst Dr Bleasdale did not accept that his actions were dishonest, he did accept that they were wrong given the patient safety concerns. The Tribunal has found that Dr Bleasdale has previously expressed genuine remorse and apologised for his actions and that he was helpful, open and remorseful when giving evidence to the Tribunal. It was of the view that Dr Bleasdale’s answers to questions in cross-examination involved many concessions on his part.

36. The Tribunal concluded that Dr Bleasdale has undertaken reflection on all matters apart from an acceptance of dishonesty and that he does realise the effect and impact of his actions.

37. In relation to Dr Bleasdale’s insight, the Tribunal concluded that the views of the people that know him are of relevance to its deliberations.

- Dr F
  Witness statement dated 24 May 2019:
  "Dr Bleasdale was very honest and open with me about what had happened... Dr Bleasdale is an outstanding doctor... He is a well-respected Consultant Anaesthetist at the Trust and a lot of junior anaesthetists look up to him. He has undertaken many leadership roles within the Trust... he is hardworking and dependable and puts patient safety first. He has always been a reliable and trustworthy colleague."

- Dr A
  Oral evidence in cross examination on 16 September 2019:
  "I have a lot of respect for Dr Bleasdale... he is professional and honest."

- Dr I
  Witness statement dated 7 August 2019
  "He was not upset that people had raised concerns about the double on-calls, but rather that his actions might have potentially impacted on patient safety... He was upset that people might think that he was greedy, or that he was putting his private work before his NHS work... For my part, I have never thought of Dr Bleasdale as greedy or putting his private work first. Dr Bleasdale has always put his NHS commitments first, and he is extremely dedicated."
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Oral evidence on 18 September 2019
"Utterly dependable, hardworking, clinically outstanding... Could not have asked for a better colleague clinically or managerially... Well respected and sensible counsel."

- Dr J
  Witness statement dated 12 August 2019
  "Dr Bleasdale told me that he had been extremely stupid... Dr Bleasdale is motivated by his wish to help people and he finds it very difficult to say 'no'.”
  Oral evidence on 18 September 2019
  "Dr Bleasdale is reflective, kind and ethical.”

- Ms K
  In a testimonial letter dated 20 August 2019, she referred to Dr Bleasdale as a "Trusted leader" who had the "highest standards of honesty and integrity".

38. The Tribunal has made various serious findings in relation to Dr Bleasdale’s conduct in the past but considered that this appeared to be out of character for him given everything else the Tribunal has heard from witnesses called both on behalf of the GMC and on Dr Bleasdale’s behalf.

39. The Tribunal also had regard to the steps that Dr Bleasdale has taken to address the issues that he identified were a problem, including his inability to say ‘no’, taking on too much work and his response to any personal difficulties he has previously faced. The Tribunal was of the view that Dr Bleasdale has reflected on what has happened and what led him to make the wrong decisions that he did. He has put mechanisms in place to stop him making those wrong decisions again but further reflection is needed in terms of the Tribunal’s findings that his actions were dishonest, not simply poor judgment.

Risk of repetition in the future

40. The Tribunal noted that dishonesty is difficult to remediate but it is possible. It determined that Dr Bleasdale has shown genuine remorse for his actions and has told the Tribunal that he is ashamed of his actions and realises how stupid he had been. The Tribunal has found that Dr Bleasdale has admitted that his actions were wrong however he did not admit that his actions were dishonest. The Tribunal determined that it was extremely unlikely that Dr Bleasdale would repeat his actions in the future. It was unable to say that it would never happen again, given the remaining reflection required in relation to Dr Bleasdale’s insight, but had regard to the positive steps taken by Dr Bleasdale and the reflections he has undertaken so far.

41. The Tribunal had regard to the need to protect and promote the health, safety and wellbeing of the public; to maintain public confidence in the profession;
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and to maintain proper professional standards and conduct for members of the profession. The Tribunal has found that in the past Dr Bleasdale has put patients at unwarranted risk of harm, has brought the profession into disrepute and has breached a fundamental tenet of the profession, namely by acting dishonestly. These findings together with the Tribunal’s conclusions in relation to incomplete insight and therefore a residual risk of repetition, lead the Tribunal to determine that Dr Bleasdale’s fitness to practise is impaired by reason of misconduct. It was of the view that public confidence in the profession would be undermined if such a finding was not made. It is also necessary to make such a finding in order to protect the public by maintaining the integrity of on-call arrangements which are designed to ensure the wellbeing and safety of patients. A finding of impairment is also necessary to promote and maintain proper professional standards and conduct for members of the profession.

Determination on Sanction - 24/09/2019

Hearing in Private

1. At the outset of the sanction stage, the Tribunal determined, in accordance with Rule 41XXX of the Rules, that parts of this hearing be heard in private where the matters under consideration are confidential, namely where they relate to XXX. As such this determination will be read in private but a redacted version will be published following the conclusion of this hearing, with those matters relating to XXX removed.

Sanction

2. Having determined that Dr Bleasdale’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.

4. The Tribunal received further evidence on behalf of Dr Bleasdale including XXX. The Tribunal also received an email dated 23 September 2019 from Dr A, outlining the serious issues he believed the Trust would face if Dr Bleasdale were unable to return to his post.

GMC Submissions
5. Mr Morgan provided written submissions to the Tribunal which he outlined during his oral submissions. Mr Morgan reminded the Tribunal that it is their decision alone what sanction, if any, to impose. He submitted that the Tribunal should consider the facts of the case and the character of the impairment when deciding on the most appropriate sanction, starting with the least restrictive. Mr Morgan submitted that, when looking at the SG and the overarching objective, a key responsibility of the Tribunal was to consider the interests of both Dr Bleasdale and the public.

6. Mr Morgan submitted that the Tribunal has heard witnesses speak with a single voice about the honesty of Dr Bleasdale and commitment to his professional work. Mr Morgan also submitted that the Tribunal has heard that Dr Bleasdale paid back the money to the Trust, complied fully with the investigations into the concerns and demonstrated remorse for his actions. Mr Morgan submitted that it was the Tribunal’s decision as to how much weight to give to this evidence.

7. However, Mr Morgan submitted that, given the serious nature of Dr Bleasdale’s conduct, protection of the public interest can only lead to one conclusion, a sanction of erasure. Mr Morgan drew the Tribunal’s attention to paragraphs 125 and 128 of SG:

"125. Examples of dishonesty in professional practice could include:

a defrauding an employer

[...]

e failing to take reasonable steps to make sure that statements made in formal documents are accurate.

128. Dishonesty, if persistent and/or covered up, is likely to result in erasure."

8. Mr Morgan submitted that erasure of Dr Bleasdale’s name from the Medical Register communicates in clear unequivocal terms a commitment to maintain public confidence in the profession. He referred to paragraph 108 of the SG:

"Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor."

Mr Morgan stated that erasure affirms the maintenance and upholding of standards and represents a fair and proportionate regulatory response.

**Submissions on Dr Bleasdale’s behalf**
9. Mr Lambis submitted that Dr Bleasdale is an excellent clinician, who strives to do the best for his patients. Mr Lambis said that this could be seen in the positive testimonials provided by Dr Bleasdale’s colleagues and employers. Mr Lambis took the Tribunal through the three limbs of the overarching objective.

10. Mr Lambis submitted that Dr Bleasdale has been relied upon heavily by his employers and was trusted to do a good job. Mr Lambis suggested that it would be unfair to deprive the public of such a good and caring doctor, who has done nothing since the events which led to this hearing which would question his character or credibility. Mr Lambis submitted that it would put patient safety at risk if Dr Bleasdale were not to return to work due to the shortage of staff available to cover sessions at the Trust.

11. Mr Lambis submitted that Dr Bleasdale’s actions were not motivated by money and there was no intention on his part to put patients at risk. Mr Lambis submitted that, upon the commencement of both the Trust and the GMC’s investigations, Dr Bleasdale had participated fully in the process and repaid any money he had made through the concurrent working highlighted in the Allegation. Mr Lambis drew the Tribunal’s attention to the findings of The Professional Standards Authority v The Nursing and Midwifery Council’s decision dated 22 March 2016 [2017] CSIH 29. He drew an analogy between that case and this in that Dr Bleasdale has made prompt admissions to most of the Allegation during the investigatory process. He submitted that public confidence has been maintained by requiring Dr Bleasdale to undergo a thorough regulatory process and through the finding of impairment of fitness to practise.

12. Mr Lambis submitted that Dr Bleasdale has made good progress XXX. He is developing tools to ensure he maintains a good work/life balance.

13. Mr Lambis concluded his submissions by suggesting that erasure of Dr Bleasdale’s name from the Medical Register would be disproportionate and have a punitive effect on Dr Bleasdale. Mr Lambis accepted that Dr Bleasdale had put himself in a difficult position but that there was little likelihood of repetition. He submitted that a short period of suspension would be the most appropriate sanction.

The Tribunal’s Determination on Sanction

14. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgement.

15. In reaching its decision, the Tribunal has taken account of SG, in particular paragraphs 120-128, which cover dishonesty. It has borne in mind that the purpose of sanctions is not to be punitive, but to protect patients and the wider public interest, although they may have a punitive effect.
16. The Tribunal gave careful consideration to the aggravating and mitigating factors present in Dr Bleasdale’s case.

17. In mitigation the Tribunal had regard to the following factors:

- Dr Bleasdale was open and participated fully with both the Trust and GMC investigations.
- Dr Bleasdale was quick to respond when these allegations were drawn to his attention, ceasing private practice on-call work and repaying the money he had made through concurrent working. The Tribunal was satisfied that Dr Bleasdale’s actions were not motivated by financial gain.
- There has been immediate and genuine regret on the part of Dr Bleasdale and he has apologised for his actions.
- There is some indication that Dr Bleasdale has begun to gain insight into the importance of a good work/life balance and self-care, and the personal cost that can come from agreeing to work in such a manner as set out in the Allegation.
- Dr Bleasdale has been XXX, which may help him reduce the likelihood of repeating his actions and dishonesty.
- The Tribunal found that each witness spoke positively about Dr Bleasdale’s ability to act with honesty and integrity, including the witnesses called by the GMC. This was despite their knowledge of the Allegation.
- There is no indication that Dr Bleasdale has done anything since the events leading to the Allegation to further call into question his character. It appeared to the Tribunal that this incident is out of character for him.
- Dr Bleasdale was working in a pressured situation, due to staff shortages at both the Trust and the Priory. The on-call rota for the Priory originally had interest from 8-9 consultants but ended up with only 4 taking part. Dr Bleasdale was one of only 3 of the 15 consultants at the Trust who agreed to work more sessions in critical care to cover vacant sessions.

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

- Dr Bleasdale’s actions were carried out over a two-year period, with 33 incidents of concurrent working for which he received a significant amount of money. This was not a ‘one-off’ occurrence.
- Dr Bleasdale has not admitted that his actions were dishonest, but the Tribunal did note that Dr Bleasdale has admitted from the outset that what he did was wrong.
- The Tribunal could not completely rule out the risk of repetition. Dr Bleasdale’s insight into his dishonesty is incomplete. He still works in a pressured environment at the Trust where he takes on additional work that other colleagues decline.
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- The Tribunal was of the view that Dr Bleasdale’s actions meant that arrangements for on-call patient care were compromised, and this could have put patient safety at risk. He had no back-up plan if he could not attend an emergency at either hospital.
- Dr Bleasdale did not provide full details of his work with his appraisers and job planners at the Trust. However, no false information was provided.

No action

19. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Bleasdale’s case, the Tribunal first considered whether to conclude the case by taking no action.

20. The Tribunal determined that, in view of the serious nature of its findings on impairment, it would be neither sufficient, proportionate nor in the public interest to conclude this case by taking no action.

Conditions

21. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Bleasdale’s registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

22. The Tribunal was of the opinion that a period of conditional registration would not be workable or proportionate given the steps that Dr Bleasdale still needs to take in terms of his insight into his actions. The Tribunal was unable to formulate conditions that would adequately protect the public interest and maintain public confidence in the medical profession.

23. The Tribunal determined that it would not be appropriate or sufficient to direct the imposition of conditions on Dr Bleasdale’s registration.

Suspension

24. The Tribunal then went on to consider whether suspending Dr Bleasdale’s registration would be appropriate and proportionate.

25. The Tribunal had regard to its findings at the facts and impairment stages. It was of the view that Dr Bleasdale’s behaviour was "unbefitting of a doctor", in relation to paragraph 91 of the SG as his dishonest actions represented a serious breach of principles set out in GMP. The Tribunal also noted paragraph 124 of the SG which states that “Evidence of clinical competence cannot mitigate serious and/or persistent dishonesty".
26. The Tribunal had regard to paragraph 97 of the SG, as to a number of factors that might indicate that suspension might be appropriate, and determined that the following sub-paragraphs were engaged in this case:

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

... 

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

f. No evidence of repetition of similar behaviour since incident.

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

The Tribunal found that, whilst there has been some acknowledgement of his wrongdoing, Dr Bleasdale has yet to show insight into his dishonest actions. The Tribunal concluded that it is possible that Dr Bleasdale can remediate fully via XXX and that there was a low likelihood of a repetition of the behaviour. The Tribunal was of the view that Dr Bleasdale has progress to make and that he needs to have appropriate mechanisms and support systems in place to ensure a successful work/life balance.

27. Having borne in mind the above issues, the Tribunal went on to consider if a sanction of erasure of Dr Bleasdale’s name from the Medical Register would be more appropriate. The Tribunal had regard to paragraph 92 of SG:

"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).”

The Tribunal found that Dr Bleasdale actions were dishonest and represented a breach of expected standards but, whilst in some instances this might be considered incompatible with being a doctor, there were a number of clear and compelling mitigating factors in this case. The Tribunal had regard to the large number of
positive testimonials about Dr Bleasdale’s character and his admission of wrongdoing. It had regard to his full participation in XXX to address XXX, and to identify what it actually takes to be the best doctor he can be, together with his full cooperation with the Trust and GMC’s investigations. Whilst not a mitigating factor, the Tribunal was reassured that there was no evidence of deliberate attempts by Dr Bleasdale to schedule the on-call at the same time for both the Trust and the Priory. It noted that although the concurrent working occurred on 33 occasions there were other occasions when his on-call work was not carried out concurrently.

28. The Tribunal concluded that Dr Bleasdale appears to have acted totally out of character, possibly due to the stressful situation he found himself in and the need to be considered a good doctor by his peers by agreeing to take on work that others were unavailable to complete. The Tribunal concluded that Dr Bleasdale’s actions were not motivated by greed or self-interest. It found the evidence of Ms L to be compelling because it accorded with all of the other evidence heard by the Tribunal, namely that Dr Bleasdale is extremely hard working, is the person everyone turns to for profession help, and he does not find it easy to say no. However, she notes that this desire to be the best doctor he can be has come at a personal cost.

29. The Tribunal agreed with Mr Lambis’ submissions that it can select from sanctions other than erasure following a finding of dishonesty. Not every case of dishonesty has to result in erasure. The Tribunal acknowledged the seriousness of Dr Bleasdale’s actions but, in consideration of all of the various factors specific to this case, a sanction of erasure would be disproportionate as Dr Bleasdale’s actions are not fundamentally incompatible with continued registration. Erasure is not the only means of protecting the public, the reputation of the profession and proper standards of conduct, and so a sanction of erasure would be disproportionate. Sanctions or not intended to be punitive and if the three strands of the overarching objective can be met by a suspension, to impose a sanction of erasure would only be punitive.

30. The Tribunal therefore determined that a period of suspension was the most appropriate and proportionate response in this instance. It was of the view that suspension would indicate the seriousness of Dr Bleasdale’s actions and send a signal to him, the profession and the public about what is regarded as behaviour that is unbefitting of a registered doctor.

31. In determining the length of suspension, the Tribunal had regard to paragraph 100 of SG:

"The following factors will be relevant when determining the length of suspension:

a. the risk to patient safety/public protection"
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\[ b. \text{the seriousness of the findings and any mitigating or aggravating factors}\]

\[ c. \text{ensuring the doctor has adequate time to remediate.} \]

32. The Tribunal determined to suspend Dr Bleasdale’s registration for a period of 12 months given the seriousness of its findings in relation to dishonesty. It was of the view that this period would allow adequate time for Dr Bleasdale to remediate and further develop insight into his actions. The Tribunal determined that such a period was appropriate and proportionate, having regard to all of the mitigating and aggravating factors in this case.

Review hearing directed

33. The Tribunal determined to direct a review of Dr Bleasdale’s case. The fact that the Tribunal has the discretion to direct a review hearing in this way is a further reason why the 12 month suspension will meet the three strands of the overarching objective. Dr Bleasdale will not automatically be permitted to resume practice at the end of the 12 months. He will only be able to do so if he can satisfy a reviewing Tribunal that it is not necessary to restrict his practice further. The reviewing Tribunal will once again take into account the 3 strands of the overarching objective. Therefore, a proportionate response to the need to protect and promote the health, safety and wellbeing of the public, promote and maintain public confidence in the profession and promote and maintain proper professional standards and conduct for members of the profession. 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, the onus will be on Dr Bleasdale to demonstrate how he has continued to develop insight into his actions. It considered that a future Tribunal reviewing this matter would be assisted by:

- A reflective statement from Dr Bleasdale, relating to his dishonesty and the steps he has taken to ensure the risk of repetition in the future is further reduced;
- XXX;
- Evidence that Dr Bleasdale has kept his medical skills and knowledge up to date;
- Dr Bleasdale will also be able to provide any other information that he considers will assist.

Determination on Immediate Order - 24/09/2019

1. Having determined to suspend Dr Bleasdale’s registration for 12 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Bleasdale’s registration should be subject to an immediate order.
GMC Submissions

2. Mr Morgan submitted that an immediate order was necessary in this case. He referred to the Tribunal’s determination on sanction in terms of the incomplete insight shown by Dr Bleasdale. He stated that the Tribunal has found that Dr Bleasdale’s actions were out of character, although there was a need to restore public confidence in the profession as a result of the conduct found.

3. Mr Morgan submitted that the threshold for the imposition of an immediate order was met. He referred to paragraph 173 of the SG:

"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."

4. Mr Morgan stated that there was no interim order in place on Dr Bleasdale’s registration.

Submissions on Dr Bleasdale’s behalf

5. Mr Lambis stated that he had no submissions to make in respect of an immediate order.

The Tribunal’s Determination

6. In making its decision the Tribunal exercised its own judgment. It had regard to paragraph 172 - 178 of the SG, with particular reference to paragraphs 172, which repeats the test set out in Section 38 of The Medical Act 1983 (as amended) and 178:

"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. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, [...]"

... 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."
7. The Tribunal had regard to its findings, including that it was unable to rule out the risk of recurrence in the future. It determined that an immediate order should be imposed in order to maintain public confidence in the profession and for the protection of the public. The Tribunal has also not been made aware of any practical issues in relation to the protection of patients if an immediate order were made. It was aware that Dr Bleasdale will have been aware of the date of this hearing for some time and therefore he, and the Trust, will have had time to make any arrangements for the care of patients before this hearing arose.

8. In all the circumstances, the Tribunal determined to impose an immediate order of suspension on Dr Bleasdale’s registration. It was of the view that such an order would ensure that there is necessary restriction in place to cover the duration of any appeal period and that public confidence would be damaged if no such order was made.

9. This means that Dr Bleasdale’s registration will be suspended 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.

10. There is no interim order to revoke.

11. That concludes this case.

Confirmed Date 24 September 2019

Miss Rachel Birks, Chair
# Record of Determinations – Medical Practitioners Tribunal

**Schedule 1**

<table>
<thead>
<tr>
<th>Date</th>
<th>Hours worked for the Trust</th>
<th>Hours worked for Priory (24 hours on-call)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 March – 2 March 2016</td>
<td>17:30-08:00</td>
<td>08:00-08:00</td>
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<td>7 April - 8 April 2016</td>
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<td>3 June – 4 June 2016</td>
<td>17:30-08:00</td>
<td>08:00-08:00</td>
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