Primary Health Lists

Dr Sean Clarke
Appellant
V

Ashton Leigh and Wigan PCT
Respondent

[2011] PHL 15383

DECISION

Before:	**Judge Nancy Hillier** **Ms Jane Everitt – independent member** **Dr Sati Ariyanayagam – specialist member**
Hearing	**21- 25 November 2011**
Venue	**Liverpool Crown Court**
Representation	**Dr Clarke – Mr Counsell** **PCT- Mr Clarkson**

Appeal

1. Dr Sean Clarke appeals pursuant to Regulation 15 of the NHS (Performers Lists) Regulations 2004 (the Regs) against the decision of Ashton Leigh and Wigan PCT (the PCT) dated 29 March 2010 to remove him from their Medical Performers List
2. We heard the oral evidence of Ms Elaine Sharples, Practice manager and Dr Smith from the relevant surgery, from patients 3, 7, 8 and 11 and from staff members 1, 2 and 4 and also from Dr Clarke.

Preliminary matters

3. At the commencement of the hearing Mr Clarkson provided the panel with an amended schedule of allegations which set out the revised findings sought by the Respondent. Mr Counsell took us through the allegations and indicated that the factual matrix underpinning the allegations involving patients 2,3,5,7 10and 12 and Staff member 4 were admitted. Mr Clarkson indicated that no factual challenge was made to the testimonial evidence to be called on behalf of Dr Clarke and no expert evidence was to be called to contradict the evidence of Dr Crouch MB ChB FRCGP DObstRCOG.a medico legal expert who provided a report in respect of the allegations, instructed on behalf of Dr Clarke. Dr Crouch's cv demonstrates that between 1973 and 2008 he was a Principal in general practice, becoming a Senior Partner between 1990 and 2008. He had been an external assessor to the NHS Commissioner, Chairman of the Medical Protection Society Claims Advisory Committee and Deputy Director for Post Graduate General Practice Education in Yorkshire. Dr Crouch is a founding member of the Expert Witness Institute. His expertise to report on these matters was not challenged.
4. It was therefore agreed that the testimonial evidence, the evidence of patients 2, 4 and Patient 5's father and Dr Crouch would be read. It had already been agreed that in relation to patient 6, who is seriously ill, his evidence should be read.
5. During the course of the first day it became apparent that Staff member 3, who was the subject of a witness summons, had indicated that she was ill and could not attend to give evidence. A letter was handed to the panel from her GP which confirmed that she was too ill to attend the hearing. The parties were able to consider their positions overnight in relation to this witness' evidence. The PCT did not apply for an adjournment of the final hearing to await her recovery. Mr Counsell indicated that he did not seek to go behind the medical evidence and that the appellant took the pragmatic view that the evidence would be in written form and that he would make submissions in due course about the weight to be attached to it given the history of the matter. The panel agreed that it was not appropriate to adjourn the hearing.
6. A further witness, Patient 8, was due to give evidence on the afternoon of the first day. She did not attend and telephone calls to her went unanswered. Further enquiries were made overnight but she did not return the telephone calls made to her mobile or home telephone. The PCT applied for a witness summons, which was opposed by the appellant on the grounds that there was no evidence that the witness was unwilling to attend and the application was too late in the day. Mr Clarkson submitted that the summons should be granted as a last attempt to secure the attendance of the witness, who had stated that she was willing to attend in June. He stated that if the PCT were unable to serve the summons, or if the witness did not attend following service, the PCT would close its case without seeking an adjournment to pursue her attendance any further. The summons was issued under The First tier Tribunal (HESC) Rules 2008 (the Rules) Rule 16 and time for service was reduced under Rule 5 (3) on the grounds that no prejudice was caused to the appellant by this step

being taken and that it was fair for the PCT to be given the opportunity to secure the attendance of a witness. Patient 8 attended the following day.

7. During the course of case management the parties had identified an issue in relation to the allegation concerning patient 1. In respect of this allegation the respondent relied on the evidence of a note taken by Elaine Sharples of a telephone call made by patient 1 who could now not be traced concerning a consultation with Dr Clarke.
8. Mr Counsell objected to the evidence being admitted and submitted that the panel should exclude it under Rule 15 on the grounds of fairness. He submitted that the admission of the evidence was unfair because there was no statement of evidence from the man, no interview of him and no disclosed record of a discussion by the partners of the issues he raised in the telephone conversation. Further, the appellant would be prejudiced by the admission of this hearsay evidence because the panel would not be able to assess the contention by Dr Clarke that the man was large and intimidating because we would not see him and that the evidence would thus be unchallengeable. He cited the case of ***R on the application of Dr SS v Knowsley NHS Primary Care Trust and the Secretary of State for Health (and another application)*** **[2006] EWHC26 (Admin)**
9. Mr Clarkson submitted that the rules clearly allow hearsay evidence to be admitted, and conceded that the weight to be given to it was a matter for the panel. He said that the evidence was relevant, because the sole issue was whether Dr Clarke used the expletive "fucking" during the consultation. The PCT did not seek to rely on any other matter, such as the recorded feelings of the man, and he pointed out that the court recognised in ***Knowsley*** that there would be occasions when evidence would be taken into account even though the "complainant" was not present at the hearing.
10. The panel considered the submissions of both advocates and the case of ***Knowsley*** and the appropriate rules.
11. Rule 15(2)(a) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 provides that the tribunal may admit evidence whether or not the evidence would be admissible in a civil trial in England and Wales.
12. We concluded that the evidence was admissible hearsay evidence which was relevant to the finding sought by the PCT. We took into account the principle that fairness relates to both parties and the concerns raised by Mr Counsell that Dr Clarke could not directly challenge the evidence. We also took into account the fact that the note of the telephone conversation recorded that the man did not want to pursue a complaint, and that he simply requested that the matter be raised with the other partners. We put into the balance the fact that the allegation related to 2003 and was about a consultation when Dr Clarke had only recently joined the practice, that he may not have known the detail of the contents of the telephone recording at the time and that it may not be accurate.
13. We balanced those factors against the fact that Mrs Sharples was to give oral evidence and could be challenged about the note which she had taken and any conversations which had taken place subsequently. We concluded that the quality and strength of the evidence may not be sufficient to make a finding, as was conceded by the PCT, and that it was

very important to treat this hearsay evidence with caution, but that there was no inherent unfairness in the evidence being admitted and being assessed by the panel simply because it was hearsay. Mr Counsell could challenge Mrs Sharples on her recollection and note taking and the panel could weigh that evidence in due course with the very strong caveat that he could not challenge the man who made the call. We distinguished the case of ***Knowsley*** because it clearly envisages that on occasion there will be cases when it is appropriate to admit hearsay evidence.

14. Following our decision Mr Counsell produced a supplemental statement from Dr Clarke dealing with his recollection in respect of the allegation. No objection was taken to the admission of this statement, which was dated 3 October 2011 and we agreed to admit it.
15. Following the evidence of staff member 1 and upon reflection of that evidence, the PCT withdrew allegation 3 on day 3 of the hearing. The panel agreed that this was an appropriate course of action.
16. Following the evidence of staff member 2 and upon reflection of the evidence, the PCT withdrew allegation 7 on day 3 of the hearing. The panel agreed that this was an appropriate course of action.
17. During closing submissions Mr Clarkson withdrew allegation 6 (c) on behalf of the PCT. The panel agreed that this was an appropriate course of action since staff member 4 had given evidence that she believed his behaviour as set out in 6 (c) had been entirely appropriate in the circumstances.

Background

18. The Respondent PCT keeps a list of medically qualified practitioners called the Medical Performers List pursuant to Regulation 3 of the NHS (Performers Lists) Regulations 2004 (the Regulations),
19. The Appellant has been included in the Respondent PCT's Medical Performers List since it was started in April 2004.
20. On 17 February 2010 he was suspended from the list under Regulation 13(1)(a) of the Regulations. On 15 April 2010, the Interim Orders Panel of the General Medical Council suspended Dr Clarke's GMC registration for a period of 18 months. Dr Clarke remains suspended by the GMC.
21. The PCT conducted a hearing on 14, 15 and 29 March 2011, which Dr Clarke did not attend and was not represented on legal advice. The PCT Panel determined that the continued inclusion of the Appellant in the Medical Performers List was prejudicial to the efficiency of the provision of medical services in its area and that he was unsuitable to be included on that list. It therefore directed his removal from the Medical Performers List.
22. On 18 April 2011, the Appellant lodged an appeal against the decision to the First Tier Tribunal. The panel have not been asked to review the initial decision, nor have we been provided with a copy of the decision. We are not asked to attach any weight to the decision, and are aware that the factual assertions/ allegations before us are different in some respects from those the PCT panel considered.

The Allegation/ factual matters asserted by the PCT

23. The Allegation which the Appellant faces is contained in a document which was amended both before and during the hearing. The allegations which were pursued by the PCT in closing were as follows (with an indication where the factual basis of the allegation is admitted) :

<u>Number 1</u>
On or about the following dates, at the Sullivan Way Surgery, Dr Clarke acted towards the following patients in such a way as to cause complaints about his inconsiderate manner towards them -

(a) Patient 1, on 1 May 2003, who had attended the Surgery to obtain a MED4 form, by saying words to the effect that the DSS should "get their fucking act together",

(b) Patient 2, on 9 May 2003, by refusing to provide duplicate 'sick notes' (admitted),

(c) Patient 3, on 9 October 2003, by declining the patient's request for a 'sick note' (admitted),

(d) Patient 4, on 9 July 2004, by treating him as if he was wasting Dr Clarke's time, despite attending for an appointment as follow up after an Accident and Emergency attendance,

(e) Patient 5, on 4 October 2006, by declining to deal with a clinical matter raised by his father during a consultation (admitted),

(f) Patient 6, on 16 January 2008, by failing to adequately explain the reasons why a home visit would not be appropriate,

(g) Patient 7, on 30 April 2008, when she attended for a second opinion, by accusing her of 'slagging off' his colleagues (or words to the like effect) (admitted),

(h) Patient 8, on 9 July 2008, who had attended with a sore mouth, by -

(i) stating that he was having a "fucking bad morning",

(ii) telling her that she should tell her dentist to "fuck off";

<u>Number 4</u>

On or about 12 June 2006, in relation to Staff Member 2, a patient and staff member at the practice, Dr Clarke, after all other practice staff had departed Sullivan Way Surgery for the evening -

(a) asked her questions using words to the effect of "Are you getting any? Are you getting any sex?",

(b) held her against filing cabinets,

(c) restrained her physically by holding her waist,

(d) attempted to kiss her;

Number 5

In or around December 2007, in relation to Staff Member 3, a patient and staff member at the practice, Dr Clarke kissed her on the lips at the Sullivan Way Surgery, without invitation, when she attended him for the purposes of having a prescription signed;

Number 6

In relation to Staff Member 4, a staff member at the practice, Dr Clarke -

(a) attempted to put his arms around her on more than one occasion during 2008 when she asked him to sign repeat prescriptions (admitted),

(b) asked her about the state of her sex life on one occasion in 2008 or 2009 during her marriage (admitted),

Number 8.

On or about 26 October 2009, during the course of a consultation with Patient 10, regarding the issue of a 'back to work note', Dr Clarke asked her questions about how often she had sexual intercourse without making her aware of any reason for doing so (admitted),

Number 9.

On or about 31 October 2009, at the GUM clinic at the Sullivan Way Surgery, in relation to Patient 11 (a female patient over 18 years of age), Dr Clarke -

(a) sought to administer a Depo-Provera injection in a manner inconsistent with good practice, as described in:

(i) paragraphs 9, 14(d) and 15(c) of Maintaining Boundaries (General Medical Council, November 2006),

(ii) paragraphs 21(a) and 21(b) of Good Medical Practice (General Medical Council, March 2009),

and likely to cause embarrassment to her,

(b) asked her questions about how often she had sexual intercourse without making her aware of any reason for doing so;

Number 10.

In or around November 2009, while treating her as a patient, Dr Clarke carried on a friendship with Patient 12 (a female patient over 18 years of age) (admitted).

Issues

24. The essential issues were therefore whether the PCT could prove the factual assertions contained in the allegation which were denied by Dr Clarke, whether the factual matters in any event amounted to breaches of the relevant guidance on GP's conduct, and whether, in the light of any adverse findings in respect of Dr Clarke, those matters were sufficient to support removal from the PCT Performer's List on the grounds of suitability and/or efficiency.

Law

25. The appeal is brought to the Tribunal under Regulation 15(2)(a). Regulation 15 (3) provides that the Tribunal can make any decision the PCT could make under the Regulations.

26. Regulation 10.3 provides the conditions for removal on discretionary grounds :

The Primary Care Trust may remove a performer from its performers list where any of the conditions set out in paragraph (4) is satisfied.
(4) The conditions mentioned in paragraph (3) are that—
(a) his continued inclusion in its performers list would be prejudicial to the efficiency of the services which those included in the relevant performers list perform ("an efficiency case");
(b) he is involved in a fraud case in relation to any health scheme; or
(c) he is unsuitable to be included in that performers list ("an unsuitability case").

27. Regulation 11 outlines the mandatory criteria to be considered when taking the decision

Unsuitability:

11.—(1) Where a Primary Care Trust is considering whether to remove a performer from its performers list under regulation 10(3) and (4)(c) ("an unsuitability case"), it shall—
(a) consider any information relating to him which it has received in accordance with any provision of regulation 9;
(b) consider any information held by the Secretary of State as to any record about past or current investigations or proceedings involving or related to that performer, which information he shall supply if the Trust so requests; and
(c) in reaching its decision, take into consideration the matters set out in paragraph (2).
(2) The matters referred to in paragraph (1) are—
(a) the nature of any offence, investigation or incident;
(b) the length of time since any such offence, incident, conviction or investigation;
(c) whether there are other offences, incidents or investigations to be considered;
(d) any action taken or penalty imposed by any licensing or regulatory body, the police or the courts as a result of any such offence, incident or investigation;
(e) the relevance of any offence, incident or investigation to his performing relevant

primary services and any likely risk to any patients or to public finances;
(f) whether any offence was a sexual offence to which Part I of the Sexual Offences Act 1997(a) applies, or if it had been committed in England and Wales, would have applied;
(g) whether the performer has been refused admittance to, conditionally included in, removed, contingently removed or is currently suspended from any list or equivalent list, and if so, the facts relating to the matter which led to such action and the reasons given by the Primary Care Trust or equivalent body for such action; and
(h) whether he was at the time, has in the preceding six months been, or was at the time of the originating events a director of a body corporate, which was refused admission to, conditionally included in, removed or contingently removed from any list or equivalent list or is currently suspended from any such list, and if so, what the facts were in each such case and the reasons given by the Primary Care Trust or equivalent body in each case for such action.

Efficiency:

(5) Where a Primary Care Trust is considering removal of a performer from its performers list under regulation 10(3) and (4)(a) ("an efficiency case"), it shall—
(a) consider any information relating to him which it has received in accordance with any provision of regulation 9;
(b) consider any information held by the Secretary of State as to any record about past or current investigations or proceedings involving or related to that performer, which information he shall supply, if the Trust so requests; and
(c) in reaching its decision, take into account the matters referred to in paragraph (6).
(6) The matters referred to in paragraph (5)(c) are—
(a) the nature of any incident which was prejudicial to the efficiency of the services, which the performer performed;
(b) the length of time since the last incident occurred and since any investigation into it was concluded;
(c) any action taken by any licensing, regulatory or other body, the police or the courts as a result of any such incident;
(d) the nature of the incident and whether there is a likely risk to patients;
(e) whether the performer has ever failed to comply with a request to undertake an assessment by the NCAA;
(f) whether he has previously failed to supply information, make a declaration or comply with an undertaking required on inclusion in a list;
(g) whether he has been refused admittance to, conditionally included in, removed or contingently removed or is currently suspended from any list or equivalent list, and if so, the facts relating to the matter which led to such action and the reasons given by the Primary Care Trust or the equivalent body for such action; and
(h) whether he was at the time, has in the preceding six months been, or was at the time of the originating events a director of a body corporate, which was refused admission to, conditionally included in, removed or contingently removed from, any list or equivalent list, or is currently suspended from any such list, and if so, what the facts were in each such case and the reasons given by the Primary Care Trust or equivalent body in each case for such action.

28. In all cases it is important to consider the effect of Reg 11(7) which provides

(7) In making any decision under regulation 10, the Primary Care Trust shall take into account the overall effect of any relevant incidents and offences relating to the performer of which it is aware, whichever condition it relies on.

29. The standard of proof is the civil standard, namely the balance of probabilities. The burden is on the PCT to prove its case. The Tribunal takes an inquisitorial, or investigatory, approach, rather than a strictly

adversarial one. In essence, the hearing in relation to the allegation is a fact gathering exercise consistent with the overriding objective set out in Rule 2.

30. There is no sliding scale of standard of proof depending on how serious the allegation is.
    In ***In re B (Children) [2009] 1 AC 11.*** Baroness Hale concluded at [70-72]:
    "[the standard of proof] is the simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies. As to the seriousness of the allegation, there is no logical or necessary connection between seriousness and probability."
31. It is also appropriate for the Tribunal to consider relevant guidance, for example that contained in the "Primary Medical Performers Lists Delivering Quality in Primary Care Department of Health 2004" (DOH Guidance).
32. When making the decision the Tribunal should bear in mind he principle of proportionality at all stages.

Evidence

<u>1. Allegations concerning patients</u>

<u>A Treating patients in an inconsiderate manner</u>

Allegation 1 – that Dr Clarke acted in such a way towards patients 1 -8 as to cause complaints about his inconsiderate manner towards them

Patient 1

On May 1 2003 Dr Clarke said to a patient who had attended the surgery to obtain a MED4 (long term medical or "sick" note) that the DSS should "get their fucking act together".

33. Mrs Sharples gave evidence that the file note from which this allegation arose was a note of a telephone call from a patient who had seen Dr Clarke on May 1 2003. She said that she could vaguely remember the patient ringing and that she wrote the contents of the conversation down as they spoke. She said that other than the content of the note she could not now recall the conversation and that she could not remember discussing the matter with Dr Clarke. She thought the matter had been discussed at a practice meeting and thought she had seen the minutes of that meeting but she could not remember what had been said. She told us that in 2003 "unless they wanted to put it in writing, that was it" and was clear that the man had not wished to pursue the complaint.
34. The note itself records "f……." and Mrs Sharples was challenged on her

evidence that the full word had been used. She said that she could remember that the word “fucking” had been used, rather than “effing” which she would have recorded as such and said she would have written “f dot dot dot” if the man had used that expression. Mrs Sharples reiterated that she could not remember what she said to Dr Clarke and said “I would’ve given him a copy of the note.”

35. Dr Clarke gave evidence that at the time he had only recently started at Sullivan Way, and this was the only time he had seen Patient 1. He told us that it stuck in his mind that the man came in and said “I’ve come for a MED4”. Dr Clarke had reviewed the patient’s notes before he came in and said that he had not seen any detail of a long term problem which would warrant a MED4. The patient said he didn’t want treatment, he just wanted the note. Dr Clarke explained that the note would normally be considered by a GP who knew the patient, and the patient replied “I can’t see Dr Sutton, you’ll have to do.” The man was 39 and there was no obvious reason why he should have a long term note, but the man had been quite robust in his request. Dr Clarke had given him the benefit of the doubt and issued a MED3 for a short period which would allow him time to see Dr Sutton. He denied saying “fucking” and said that whilst he might use the word in a different social setting – for example at a Rugby match- he did not use it in a professional setting. He had used words at the surgery which he had later regretted, like “get stuffed” and “slag off” but he could not remember saying ”fucking” which was “quite offensive”.
36. Mr Clarkson suggested to Dr Clarke that he might swear if he were frustrated. Dr Clarke agreed. Mr Clarkson asked “If you are behind in the list and not watching your language is it possible you said something inappropriate?” to which Dr Clarke replied “It’s possible”. Mr Clarkson said the man had no motivation to complain because he got a sick note. Dr Clarke pointed out that the note was not for as long as the man had wanted.

Patient 2

The allegation of a refusal to provide duplicate sick notes for this patient is admitted.

37. Dr Clarke could remember the consultation “vaguely”. He told the panel that the patient had her foot in plaster and it was quite clear she needed a MED 3 (short term medical or “sick” note). She asked for two notes, one for each of her employers, and he was not sure this could be done. He had suggested that she photocopy one note but she was adamant that she have two. He had told her that he would check the position, which he did. He was not aware that she had been upset, other than disappointed that she did not get what she wanted.
38. When cross examined by Mr Clarkson, Dr Clarke accepted that the patient had had a previous sick note, probably issued by the hospital. Mr Clarkson said that Dr Clarke’s attitude had demonstrated that he did not care about the patient’s concerns, which Dr Clarke denied. Further, Mr Clarkson said that Dr Clarke should have told the patient that he would get back to her. Dr Clarke said he could not remember what was said exactly, but he did

say that if he was wrong he would happily issue a sick note. He said "I may be shooting myself in the foot here but to be honest I can't remember saying that I would get back to her".

39. Mr Counsell suggested to Mrs Sharples that Dr Clarke had asked her to find out whether it was possible to fill in two MED 3's as requested by this patient. She agreed and said that she had rung the DSSS and spoken to someone who "didn't give a straight answer" to her question. She still didn't know what the answer was.
40. This was the only occasion that Dr Clarke had ever come across the problem. Current guidance would suggest that only one note be issued. He had sent Patient 2 a written apology explaining the fact that he had "double checked" the position.

Patient 3

The allegation that he declined the patient's request for a "sick note" is admitted.

41. Patient 3 gave evidence that he had been a patient at the surgery for 3 or 4 years and had seen Dr Clarke before this day with "no problems". He said that he had gone to the job centre to "sign on" on that day and wasn't feeling too well, and that the woman where he signed on had told him to go to see the doctor. Coincidentally he had been at the surgery with his wife later that day and the receptionist had also said he didn't look too well and had made Patient 3 an appointment for the afternoon.
42. Patient 3 said that during the consultation "everything seemed fine" but that when he said he wanted "a week off" Dr Clarke "got really bothered…he had a full surgery…and he told me to get out in quite an aggressive voice." He added "It could've been a bit of a misunderstanding".
43. Patient 3 said that when the consultation had ended his wife had taken him by taxi to Wigan infirmary where he was seen straight away. He added that a few days later, when he was feeling better, he had sent a letter of complaint which had been responded to. When shown the letter of apology from the surgery by Mr Clarkson he said that that was not the letter he had received.
44. Mr Counsell pointed out that the notes showed that he was mistaken about the day of the week, and that in fact he had seen Dr Clarke on a Thursday. Patient A denied this. Mr Counsell showed Patient A the evidence that he had been to the hospital on the day before he had seen Dr Clarke. Again, Patient 3 denied that fact, and denied that he had, as the records suggested, seen a different GP, namely Dr Smith, on the Wednesday. Mr Counsell reminded Patient 3 that Dr Clarke had prescribed him amoxicillin when he saw him, but Patient 3 said that he couldn't recall that. Mr Counsell showed Patient 3 the letter of complaint, dated 9 October 2003, received on 10 October 2003 and pointed out that Patient 3 was incorrect in stating that he had waited 3 days, because the complaint was apparently made on the day of the alleged incident. Patient 3 denied that this was the case.
45. When cross examined about the consultation Patient 3 accepted that a

week's sick note would not have helped in any event since he wasn't due to sign on again for a fortnight, and when it was suggested to him that Dr Clarke had said that he did not qualify for a long term sick note he said "Yes, I think he did".

46. Mr Counsell pointed out to Patient 3 that he had not mentioned anything about being told to "get out" in his complaint. Patient 3 replied "I can't remember. He did say that he was very busy and said I'd got to get out".
47. During re-examination by Mr Clarkson Patient 3 volunteered that he had not gone to see Dr Clarke again. We allowed Mr Counsell to put to Patient 3 the patient records which demonstrated further visits/ consultation with Dr Clarke. Patient 3 said he was "100% sure I never saw him again".
48. Dr Clarke said that it was an unusual situation because he was on his own at the surgery conducting urgent appointments. He had seen 11 patients in the morning and 24 patients in the afternoon. The patient said he was breathless but on examination he seemed well and his heart rate was normal and his chest clear. Dr Clarke knew that the patient had seen Dr Smith the day before, and that Dr Smith had referred him for tests. Dr Smith had also noted that there was some chest rhonci, however Dr Clarke was concerned that the symptoms could be more anxiety based.
49. The patient reported symptoms which were worsening so Dr Clarke prescribed antibiotics, aware that blood tests and a chest x ray had been organised. At the end of the consultation the patient asked for a MED 4 so he wouldn't have to sign on any more. Dr Clarke gave evidence that he told patient 3 that the surgery was for urgent appointments and that in any event he did not believe there were grounds for a long term note. Dr Clarke denied being annoyed or angry, other than with the DSS. It was a theme of patients being sent for MED4s, maybe 8 or 9 of them in 6 months, and he had written to the DSS to complain about their practice.
50. Dr Clarke denied saying that he could not be bothered or that the patient had to "get out". He was unable to recall how the consultation had ended. The consultation had gone on longer than a normal "walk in" appointment. The patient had visited him and spoken with him on the telephone subsequently. Following receipt of the complaint he had written to Patient 3 stating that they had apparently been at cross purposes.
51. Dr Smith confirmed that the results of tests are entered on the computer system on the date of the test rather than the result. He confirmed that the entry for 8.10.2003 would be the date of the outpatient visit and that blood test results could be sent back on the day they were taken.

Patient 4

On 9 July 2004 treated patient 4 as if he was wasting Dr Clarke's time despite the patient attending for a follow up after an accident and Emergency attendance.

52. Patient 4 did not give oral evidence. His handwritten complaint states "General attitude intimating I was wasting his time. This was after going to A and E Thursday night with a burst varicose vein in my ankle, was given appointment on Fri 9/7/04 to see a consultant at A/E who told me to see

my GP for a further Reference on this matter".

53. Dr Clarke said that the patient was a 61 year old man who had had a burst varicose vein which had been treated as an outpatient. The man was a contingency patient who had come as he had been told to see his GP for a referral. Dr Clarke had completed the referral and although he had been "expedient" he did not feel that anything he said or did would be interpreted as giving the impression of an attitude that the man was wasting his time. He said that he had been business like because he had to get through the work with fewer "social niceties". Dr Clarke had discussed the matter with Dr Smith who said that the patient wants "everything done yesterday".
54. Dr Smith confirmed that this patient saw Dr Clarke because of a burst varicose vein. When asked if he had described the patient to Dr Clarke as "difficult" he said "This patient is quite an anxious patient who wants things to be explained".
55. Dr Clarke said that there was no need to deal with the referral urgently, but that the patient had asked for a referral and he had been given one. He denied that he had displayed any "negative attitude" during the consultation. He had sent a written apology to the patient stating that there had been 16 appointments that day –"Perhaps some of this came across to you during the consultation. If this is the case then I apologise".

Patient 5

The allegation of declining to deal with an additional clinical manner during a consultation is admitted.

56. The original allegation is found in a telephone note made by Mrs Sharples. She records that the father of patient 5 had telephoned on 4 October 2006. She records "He wished to bring the matter to my attention but does not wish to make the complaint formal" and that the problem was "The doctor said he had dealt with two things and would not deal with a third problem".
57. Dr Clarke gave evidence that the patient was a 13 year old boy who had come with his father. He had described bowel problems and Dr Clarke had examined him and then discussed the problem both with him and his father.
58. The boy's father had then said that the boy had a tight foreskin. Not wishing to leave the matter Dr Clarke had performed another examination and then discussed the problem with both of them. By this stage the consultation had lasted 18 minutes. The father then raised the issue of bite marks that the boy had. Dr Clarke knew there were patients waiting and said that the surgery had a one patient one problem policy and that there was insufficient time in this appointment to deal with anything further. The surgery were able to arrange for the boy to see another GP on the following day.
59. Dr Clarke said that was probably the only time that he had used the policy. He felt that you had to deal with as many problems as the patient had if there was a clinical need. In this case the man had seemed to accept the explanation that the bites would have to wait for another day. He did not

feel he said nor did anything which would give cause for complaint, and the young man had come to see him again a couple of times after this.

60. Mrs Sharples told the panel that there had been a problem with patients wanting to discuss multiple problems during a short appointment. At a meeting on 14 September 2005 the partners had resolved to put up notices that made it clear that if a patient had more than one problem to discuss then they should make that clear to reception. Notices had been put up shortly thereafter and the panel had copies of similar notices.
61. When cross examined by Mr Clarkson Dr Clarke repeated that he did not think the bites warranted a third examination, and could wait for a further appointment. He said that the boy's father had said the marks were flea bites or spots which had been there some time. He believed that it may be necessary to discuss acne and that that issue, which would be the third substantive issue for discussion, would be properly left for another day. His colleague had later seen the boy and recorded "cat bite" but the treatment given was of an anti inflammatory and anti – itch nature, which puzzled him.
62. Mr Clarkson asked "Surely it would have been possible to deal with it?" to which Dr Clarke replied "No, it could have taken much longer. I had patients waiting and had to move on". He denied being "bombastic", saying that he had not raised his voice "or anything like that" and did not accept that he was inconsiderate to the patient or his father.

Patient 6

On 16 January 2008 failed to adequately explain to the patient the reasons why a home visit would not be appropriate.

63. This complaint dated 22 January 2008 was before us in a handwritten form. It explained that the patient had been on holiday in Benidorm until 15 January. He and his wife had been ill with a virus. They had not sought treatment "has (sic) we only had a couple of days left. They had arrived home at 11.30pm on the 15 January and he had rung the surgery the following morning to request a home visit. He states that upon speaking to Dr Clarke Dr Clarke had said there was no need for a home visit because they had managed to undertake a journey from Spain. The man had explained that he and his wife were in their 70's and Dr Clarke had said that there are people in their 90's who walk to the surgery. The patient states that "I told him to forget it" and described Dr Clarke as "bombastic" and arrogant.
64. Dr Clarke said that he had given all the explanation he could to the patient as to why a home visit was not appropriate and had offered a contingency appointment. In the end he felt the only thing he could have said to satisfy the patient would have been to agree a home visit, but such a visit was not clinically appropriate. He had written to the patient following the complaint explaining the criteria for home visits and apologising if he had appeared to be uncaring or arrogant. Dr Clarke had taken the matter to the partners' meeting where it was confirmed there were no clinical grounds for a home visit.

Patient 7

On 30 April 2008 when the patient asked for a second opinion accused her of “slagging off” his colleagues.

65. Patient 7 wrote a letter of complaint following a consultation in April 2008. She said that she had had a knee operation and had gone to Dr Clarke to seek a referral for a second opinion. She wrote that Dr Clarke “…was abusive, aggressive and unprofessional right from the start. Stating I was trying to “Slag off his own colleagues”. She also wrote that he had dictated a letter stating” You probably would not want to see this patient” and said that she felt disappointed and let down.
66. Patient 7 gave oral evidence that she was a long standing patient of the surgery. She said that a nurse had told her to seek a second opinion following the knee surgery she had had as she was dissatisfied with it. She said when she had explained to Dr Clarke about the inadequacy of the knee surgery, and that the matter would not have happened as it did had she been referred for an x ray by one of his GP colleagues, Dr Clarke had said “You’ve come here slagging off my colleagues and slagging off the hospital”. She said she was quite shocked and that Dr Clarke had raised his voice.
67. Mr Counsell reminded Patient 7 that in fact the letter dictated by Dr Clarke did not say what she thought he had dictated and that in fact she “had got the wrong end of the stick”, which she denied. He suggested that Dr Clarke had said “Is there anyone else you want to slag off?”. Patient 7 stated “ I know he said ‘ You come here slagging them off”.
68. Dr Smith gave evidence that he knows this patient well. He had sent her a letter following the complaint which was available in the papers and which stated that Dr Clarke’s letter was “appropriate and accurate”.
69. Dr Clarke said that when he had said “Is there anyone else you’d like to slag off?” it was to lighten the mood and was not in any way offensive. He accepted that the comment was ill judged, but said he had not meant to be inconsiderate to the patient.

Patient 8

On 9 July 2008 said to the patient who had attended with a sore mouth that

1. he was having a “fucking bad morning”
2. telling her that she should tell her dentist to “fuck off”

70. Patient 8 had made a telephone complaint which she had then confirmed in writing. She attended to give oral evidence following service of a witness summons upon her.
71. Patient 8 explained that she had been in severe pain following a dental filling. She had attended the infirmary but had waited 3 hours and “didn’t get seen”. She had rung her dentist who had said it might not be a dental problem, so she had telephoned the GP’s surgery and had been offered a contingency appointment. She said that she didn’t really want to see Dr

Clarke, who said he'd had "an effing bad morning" and had banged her tooth. She said "He swore at me" and that he had rung the dentist and argued with them. She said that she had not complained straight away but had done so when she had been rung by someone from the practice. She said she thought it was Dr Smith.

72. When cross examined by Mr Counsell Patient 8 agreed that she had not wanted to see Dr Clarke, had been very on edge and was on medication for depression at the time. She agreed that the tooth tapping had hurt, and that Dr Clarke had said that the dentist was "Passing the buck". She denied that Dr Clarke had used words to the effect of "tell them to get stuffed".
73. When asked about her comment that Dr Clarke had sworn at her she stated that he had not sworn at her but that he had sworn.
74. Dr Clarke gave evidence that he refuted using the word fuck or fucking during the consultation. He denied being annoyed with the dentist, but did feel that his patient had been "fobbed off". He had qualified as a dentist and felt the patient needed dental treatment in the form of a temporary filling. He gave evidence that he had telephoned the dentist not to remonstrate with her but to ensure the best outcome for their joint patient. He accepted his actions were unprofessional.

B Communicating with and treating patients in an inappropriate manner

Allegation 8 regarding Patient 10

On or about 26 October 2009 during a consultation regarding a "back to work" note asked questions about how often she had sexual intercourse without making her aware of any reason for doing so.

75. This allegation is made by Patient 10, who is also staff member 3, in respect of a consultation with Dr Clarke. Patient 10/Staff member 3 did not attend to give evidence. In her written statement she states that she was about to return to work in the surgery following a hysterectomy. She states "During the appointment Dr Clarke asked me some questions regarding my relationship with my husband. He asked me whether I had resumed sexual relations and I confirmed that I had. He then went on to ask how often I had sex with my husband. I thought this was totally inappropriate and said it was nothing to do with him. He offered me no explanation as to why the information was relevant or might be important. " The complaint was raised in February 2010 shortly after the complaint made by Patient 11.
76. Dr Clarke's evidence was that Patient 10 explained that she was still feeling slightly tired and was not fully back to her normal self. She agreed that in accordance with her discussions with the practice manager, she would be able to return in a phased manner. He felt that it was appropriate to take a history including enquiries about the condition of the wound, any discharge and any functional problems which would have included questions about whether she had been able to resume sexual relations with her partner. As Patient 10 appeared low in mood, he considered that it was appropriate to take a brief sexual history and asked

whether there were any issues regarding her current sexual activity in comparison to her usual practice and frequency. He therefore asked whether she was having intercourse at a normal rate for her and her partner.

77. Dr Clarke accepts the allegation and that he did not "signpost" the reasons behind the questions. He states "In retrospect, I accept that it would have been helpful if I had given her an explanation of my reasoning for this line of questioning.". He did not think it was a good idea to have staff as patients as was the practice in this surgery.
78. Dr Crouch commented in his report: "The note made by Dr Clarke indicates that the patient is able to drive and that she has not lifted anything. It further records that there is no dryness. The issue of vaginal dryness could well indicate that questions were asked regarding any difficulties with intercourse. Whilst it would be unusual to ask a patient who had had an abdominal hysterectomy regarding problems with intercourse, this would depend on the previous complaints made by the patient prior to the operation." and "It may well have been appropriate to ask if she had had intercourse on more than one occasion and if this had been normal."

Allegation 9 regarding Patient 11

On or about 31 October 2009, at the GUM clinic at the Surgery, in relation to Patient 11 (a female patient over 18 years of age), Dr Clarke -

(a) sought to administer a Depo-Provera injection in a manner inconsistent with good practice, as described in:

(i) paragraphs 9, 14(d) and 15(c) of Maintaining Boundaries (General Medical Council, November 2006),

(ii) paragraphs 21(a) and 21(b) of Good Medical Practice (General Medical Council, March 2009),

and likely to cause embarrassment to her,

(b) asked her questions about how often she had sexual intercourse without making her aware of any reason for doing so;

79. Patient 11 explained that she normally saw a nurse for her contraceptive injection but they were running late so she agreed to see a GP. She had been expecting a female GP and only realised that she was seeing a man when she entered Dr Clarke's room. She said "I thought 'no'. I don't like Dr Clarke".
80. She told the panel that Dr Clarke had asked her how often she had sex, and she had told him it was none of his business. He "went on" about the side effects of the injection and she said she knew all about osteoporosis. Dr Clarke had made a comment about her not breaking a hip if she fell, which she had taken to mean he was saying she was fat. Mr Counsell suggested to her that Dr Clarke had explained to her about why he was

asking the questions because she had alluded to some explanation in her statement. She said “Right, fair enough but he should’ve said ‘You should use other contraception’ End of.” Patient 11 said nobody else had asked her questions like this before when she had her injection. They had said she could have an oral contraceptive but the injection suits her. She was worried Dr Clarke wouldn’t give it to her.

81. In respect of the administration of the injection patient 11 said that Dr Clarke had said “Right, come on, in your bum” and she had said it wasn’t in her bum it was in her back. She said she had just wiggled her jeans down. Dr Clarke had been sitting in his chair, and she had not been offered a chaperone or a curtain. She said that there was no couch in the room for her to lean on
82. Patient 11 explained that she did not make a complaint at the time. She said “I just thought a doctor might say that”. When she next attended for her injection on 16 January 2010 she had told the nurse how Dr Clarke had given her the injection and the nurse had said that that wasn’t the right way to give the injection. Patient 11 had then said that she wasn’t sure Dr Clarke should have asked her about sex, and the nurse had said “No, he shouldn’t have asked you” and that the other doctors needed to know. Dr Lewis had then rung her – “I hadn’t decided to complain. It was Dr Lewis who asked me to go in.”
83. When cross examined by Mr Clarkson Dr Clarke said that he had pulled the curtains for the patient’s privacy as far as they could go and that she had used the couch to lean on. He said that he had beckoned her over to the couch, not towards himself.
84. Dr Clarke said that sometimes patients ask for a GP at a GU clinic when they have issues to discuss. He said that the patient had been having the injection for many years and he would not offer a chaperone in those circumstances. If the patient had asked for one he would have asked her to wait to see the nurse since she was the only potential chaperone. He had reviewed the patient’s notes before she had come in and he wondered if there might be a sexually transmitted infection agenda, since she had had regular infections and had not had any full review of her Depo injections and contraceptive needs.
85. Dr Clarke said that he had realised that the patient appeared tense and had asked her about how long she had been having the injections and had tried to discuss the side effects. He told her that she should consider other forms of contraception and had asked whether she had a stable partner and how often she had sex in that context. He stated “She said it’s none of your business and it was clear she just wanted the injection”.
86. Dr Clarke said that he believed he had explained why he was asking her about sexual intercourse and that he had continued to explain why, and give further information until it became clear that the patient did not wish to have a discussion about it. At that point he had pulled a gap in the screens and had said that the injection would be ‘in her bum.’
87. When cross examined by Mr Clarkson Dr Clarke maintained this position and said “I could have done better but I think I gave her an adequate preface to the questions and gave her further information”. Mr Clarkson said “Neither before nor after did you make it clear to her” to which he replied “I believe I did make it clear what the questions were for.”

88. Dr Clarke drew a plan of his consulting room for the benefit of the panel. He explained that the patient had come to a position between the couch and the desk and he had administered the injection from his chair so that it would be horizontal. He had then turned to the sharps bin to allow her to pull her jeans up. The patient did not appear to be upset at any stage.
89. Dr Clarke said that the first time he had become aware of the allegation was at the partners' meeting where it was announced that he would be suspended. The complaint from Patient 10 came to light after this had occurred.

C Friendship with a patient

Allegation 10 regarding Patient 12

In or around November 2009, while treating her as a patient, carried on a friendship with the patient.

90. This allegation is admitted in that Dr Clarke accepts that he had a friendship with this female patient.

91. Dr Clarke agreed that he had had a platonic friendship with a woman who made deliveries to the practice and was a patient. He told the panel that he was aware that the guidance counsels against treating family members and those with whom one has a “close personal relationship”. He did not believe that he had given this person any preferential treatment, nor was any alleged. He did not feel that she came into the category of ‘close personal relationship’. He was aware that there were rumours that there was more to it than a friendship and had confirmed to his partners that there was not. They had agreed to tell staff that the relationship was not improper.
92. Patient 12 filed a statement which supported the fact that the friendship was platonic.

2. Allegations concerning staff

Allegation 4: Staff member 2

On or about 12 June 2006, in relation to Staff Member 2, a patient and staff member at the practice, Dr Clarke, after all other practice staff had departed Sullivan Way Surgery for the evening -

(a) asked her questions using words to the effect of "Are you getting any? Are you getting any sex?",

(b) held her against filing cabinets,

(c) restrained her physically by holding her waist,

(d) attempted to kiss her;

93. When giving evidence Staff member 2 said that on 12 June 2006 it was her husband's birthday. The other staff had gone home and Dr Clarke had spoken to her about a patient. She denied that she was upset that evening and said that although there had been a discussion about her husband's health she had not discussed her own health with Dr Clarke. When she had gone to leave she said Dr Clarke had followed her: "I felt he had to get it in that he was there if I needed him. I wasn't interested. I felt he abused me." She said it was not a "hug" that he gave her, and that she felt trapped against a cabinet. On the way home she had to stop the car because she felt humiliated and embarrassed. She had not wanted to pursue the matter because her husband was ill, and because she had to work at the practice. She had told Mrs Sharples and thought it would remain between themselves and another friend. Mrs Sharples had told Dr Smith.
94. Staff member 2 accepted that at the end of this incident she had said words to the effect of "Sean you've got it wrong. I didn't need this, but thanks for caring". She explained that she felt he cared about her husband, but that then when she was leaving he had asked her if she was getting any sex and had said he could "sort it out here and now". He had got hold of her and had kissed her. She was embarrassed because of what he had said.
95. Staff member 2 denied ever making a comment to the effect of "I bet he could show us a good time in bed" to Dr Clarke when he was walking through the car park and she was with Mrs Sharples.
96. Mrs Sharples gave evidence that she was aware of this complaint and the fact that the staff member did not wish to take the matter further. She could not recall a conversation in a partners meeting about alleged comments made to Dr Clarke by staff member 2 in her presence in a car park, namely that Dr Clarke could show them a good time, nor could she recall any comments of that nature being made at all.
97. Staff member 2 gave evidence that when she had told Dr Clarke that his actions on the evening of 12 June 2006 had made her feel humiliated he had said that he was not apologising, and said words to the effect that he didn't need to be liked, he just wanted respect. She had told him that but for her husband's illness she would have taken the matter further.
98. Staff member 2 told the panel that Dr Clarke has a caring side. She had been upset on another occasion and he had empathised and she had seen that side of him "plenty of times".
99. Dr Clarke accepted that this member of staff was not in the group of staff who engaged in banter and that proffering a hug on this occasion had been "unfortunate". Mr Clarkson said that it was an odd thing to do, and he agreed.
100. Dr Clarke said that he thought Staff member 2 had left the surgery. He saw her and she looked "fed up" so he asked her how things were. She told him that her husband had heart problems and they never got to go out much. She also said that she was drinking too much and had started to hide the bottles. Dr Clarke said he felt he was in a difficult position. He said he didn't know she was a patient at the surgery, and he felt he was in a difficult position. Staff member 2 had raised with him the fact that she "no longer had relations" with her husband. He had put his arm round her but

she had pulled back and said "No, it wouldn't be fair to [her husband]." "He said "I only meant to give you a hug, and she said sorry, I got it wrong". He stated he was more concerned about her alcohol use. He had tried at a future date to discuss the situation with her but it was clear that she did not want to discuss matters. When the incident was discussed at a partners meeting Dr Clarke said that he had given her a hug which had been misinterpreted. He had explained that he had been shocked by the fact that she had confided about the drink problem. Another partner confirmed that Staff member 2 was a patient and had recently disclosed her alcohol problem and pointed out that Dr Clarke could not have known this from any source other than Staff member 2. The partners had said the matter would be discussed with the staff member. Later, at a Christmas party, Dr Clarke's evidence was that Staff member 2 had apologised to him. He said he was flabbergasted that she was now saying that he had abused her and could not understand how she "has got to her current position".

Allegation 5: Staff member 3

In or around December 2007 kissed a staff member on the lips at the surgery without invitation when she attended him to have a prescription signed.

101. This witness did not attend to give evidence through illness. In her statement she alleged that Dr Clarke kissed her on the lips when she attended upon him on Christmas Eve to have a prescription signed and that she was her shocked and embarrassed.

102. Dr Clarke said he had been asked for Christmas kisses by the women who worked in reception, and when this staff member came in he had asked her for a kiss. He said she proffered a cheek and when he had given her a kiss she had left very quickly. He said he had felt embarrassed and had later apologised to her. He had reflected on his conduct and the following Christmas "There were no Christmas kisses".

103. Mr Clarkson challenged Dr Clarke on his version of events. Dr Clarke said that the kiss was on the cheek, not the lips and that the staff member had said ok when he had made the request.

Allegation 6 Staff member 4

Dr Clarke -

(a) attempted to put his arms around her on more than one occasion during 2008 when she asked him to sign repeat prescriptions,

(b) asked her about the state of her sex life on one occasion in 2008 or 2009 during her marriage,

(c) asked her about the state of her sex life on one occasion in 2009 when she had met a new partner. This limb of the allegation was not pursued by the PCT following her evidence.

104. This allegation is admitted; however the PCT called staff member 4 to give evidence as there were some factual differences as to the circumstances surrounding the admitted conduct

105. Staff member 4 gave evidence that she had worked with Dr Clarke for about 7 years and she agreed that she regarded him as a friend and a person in whom she confided personal matters. She was not a patient at the surgery and she discussed some very personal medical issues with him. She denied that she had ever been for a drink with Dr Clarke or that he had been to her home and that they had kissed when he left.

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106. Staff member 4 stated that in respect of the single comment about the state of her sex life early in her marriage in 2008 or 2009 that she had thought the question "odd" and said that it wasn't the sort of question she would have asked a recently married person. She accepted that it was in the course of a conversation about fertility treatment. Dr Clarke said the questions were not asked in any prurient way, and the staff member did not say anything at any stage which made him think she felt uncomfortable, although she had tapped her nose as if to say "Nosy"

107. Staff member 4 agreed that in respect of the single enquiry as to her sex life when she formed a new relationship in 2009 there were circumstances which had caused others to be concerned for her sexual health. She agreed that Dr Clarke's query was apparently made as a concerned friend and was not in any way prurient. In fact, the man was a friend rather than a sexual partner. The allegation was subsequently removed by the PCT.

108. Dr Clarke said he had met this staff member for a drink at lunchtime and had also been to her house. He said that he was not proud of the fact that he had kissed her and had subsequently told his wife about his conduct. He said that following that they had cuddled, at her request, in his room. Dr Clarke accepted that attempting to put his arms around this member of staff was unprofessional, whether invited or not. Staff member 4 denied that she had asked Dr Clarke for a cuddle and said such behaviour would be unprofessional

<u>Dr Clarke's circumstances.</u>

Dr Clarke gave evidence that when he joined the practice in 2003 it was very different from his previous surgery. The practice was busier, the patients were in a lower socio economic group and the problems were very different. He had not found it easy at first, especially dealing with patients who expected things which he didn't always feel were appropriate, particularly sick notes and antibiotic prescriptions.
Dr Smith gave evidence that he is the senior partner in the practice where Dr Clarke was a partner. He told the panel that in the mid 2000's Dr Clarke had

been instrumental in implementing a formal chaperone policy.
He explained that there are booked appointments and then as many as 30 “extras”. He said that Dr Clarke got on with his work and did not shirk his responsibilities. In 2008 Dr Clarke had been supported to have time out, seek counselling and see his own GP, with a gradual return to work. Following that there had been no complaints until the allegation by Patient 11

Submissions

Mr Clarkson made both written and oral submissions in respect of the alleged conduct.

Patient-related concerns (2003-2008)

109. Under this heading Mr Clarkson submitted that Dr Clarke had repeatedly breached the guidance. He submitted that in relation to the pre 2006 allegations the guidance on appropriate professional standards was published by the General Medical Council as "Good Medical Practice" (2001 edition) which provided that:

> *All patients are entitled to good standards of practice and care from their doctors. Essential elements of this are … good relationships with patients …* and *To fulfil your role in the doctor-patient partnership you must :be polite, considerate and honest respect patients' privacy and dignity …"*

110. Guidance on appropriate professional standards post 2006 was published in revised form by the General Medical Council as "Good Medical Practice" (2006 edition), which in particular provided that:.*Good doctors make the care of their patients their first concern: they … maintain good relationships with patients …To communicate effectively you must: listen to patients, ask for and respect their views about their health, and respond to their concerns and preferences …"*

111. In relation to Patient 7 Mr Clarkson submitted that the relevant guidance on appropriate professional standards was "Good Medical Practice" (2006 edition) which provided that:.*In providing care you must (e) respect the patient's right to a second opinion … To fulfil your role in the doctor-patient partnership you must:*
(a) be polite, considerate and honest
(b) treat patients with dignity …"
And in relation to Patient 7 Mr Clarkson submitted that the conduct was contrary to the guidance that *You must not make … unfounded criticisms of colleagues that may undermine patients' trust in the care or treatment they receive, or in the judgement of those treating them."*

Staff-related concerns (2005-2008/9)

112. Mr Clarkson submitted that in relation to Staff member 2 whose allegation related to a time before November 2006, the appropriate Guidance was the 2001 edition which in particular provided that:.
"1. All patients are entitled to good standards of practice and care

from their doctors. Essential elements of this are … good relationships with … colleagues …
34. You must always treat your colleagues fairly."

113. In respect of the subsequent allegations the 2006 edition applied which provided *… Good doctors make the care of their patients their first concern: they … maintain good relationships with … colleagues …You must treat your colleagues fairly and with respect."*
Mr Clarkson submitted that by his conduct in respect of Staff members 1-4 Dr Clarke compromised good working relationships and, at a time when he was a partner in the practice, failed to deal fairly with his colleagues.

114. Mr Clarkson submitted on behalf of the Respondent that Dr Clarke's communication with patients was at times inadequate .As an example of the standard required he cited the GMC guidance on Consent (2008) which states "For a relationship between doctor and patient to be effective, it should be a partnership based on openness, trust and good communication."

115. In respect of Patient 10 Mr Clarkson drew the panel's attention to the GMC publication of November 2006 "Maintaining Boundaries" where guidance is provided as follows: *It is particularly important to maintain a professional boundary when examining patients: intimate examinations can be embarrassing or distressing for patients. Whenever you examine a patient you should be sensitive to what they may perceive as intimate. This is likely to include examinations of breasts, genitalia and rectum, but could also include any examination where it is necessary to touch or even be close to the patient … Before conducting an intimate examination you should: …d. give the patient privacy to undress and dress and keep the patient covered as much as possible to maintain their dignity. … During the examination you should: a. explain what you are going to do before you do it and, if this differs from what you have already outlined to the patient, explain why and seek the patient's permission …"*

116. In respect of the allegation that Dr Clarke carried on a friendship with Patient 12 while she was a patient of the practice Mr Clarkson submitted that the relevant guidance on appropriate professional standards at this time was "Good Medical Practice" (2009 edition) which provides that:.
"5. Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship.

117. Mr Clarkson submitted on behalf of the PCT that "It is not suggested that Dr Clarke engaged in a sexual relationship with this patient; nor is it suggested that Dr Clarke exercised any improper emotional manipulation of the patient. This paragraph of the Allegation arises not out of any moral disapprobation in relation to a performer ….. but the very reason for the guidance in Good Medical Practice is to avoid any potential conflict in the care and treatment of a patient. The Allegation categorises the relationship between Dr Clarke and the patient as one of friendship and this is accepted by the Respondent…. Nonetheless, such a relationship must be

of concern because, at the time of the events in question, the patient was not only a patient of the practice but was also the subject of professional correspondence written by Dr Clarke.

Suitability and efficiency

118. It was submitted on behalf of the PCT that "Determination of whether the practitioner is unsuitable or whether continued inclusion would be prejudicial to the efficiency of services are matters of judgment to be exercised by the Tribunal taking into account all relevant factors (see ***Dr Vinod Moudgil v Wandsworth Primary Care Trust*** *[FHS/14671], October 2009* (at paragraph 113), applying the analysis and approach taken by the High Court in *CRHP v (1) GMC (2)* ***Dr Tarun Biswas*** *[2006] EWHC 464 Admin* (at paragraphs 42 to 44 of the judgment of Jackson J)."

119. Mr Clarkson submitted that the number, nature and frequency of deficiencies in the practice of the Appellant demonstrate a recurrent problem with his ability to adhere to the principles of good medical practice. He continued "Such matters can properly be categorised as matters of bad practice and as such would come within the category of issues impacting upon the *efficiency* of primary medical services. Such actions lead to difficulties within a practice, tend to diminish the reputation of the profession, and involve practice partners, staff and others unnecessarily in the resolution of such matters." Further, he submitted that on a straightforward interpretation of *unsuitability* the allegations if proved are sufficiently serious behaviour as to fall within this category, affecting as they do both doctor-patient and doctor-staff relationships.

120. Mr Counsell submitted that the allegations fall into two categories: Firstly, allegations of rudeness to eight patients going back nearly a decade. He stated that the PCT appears to have asked the practice manager, Ms Sharples to trawl back through the records and dig out a relatively small number of patient complaints to add to the other allegations which Dr Clarke faces. He reminded the panel that many of the complaints were addressed at the time (often by Dr Clarke writing to the patient concerned), the majority were discussed at partners' meetings and they were resolved or not pursued at the time. Mr Counsell submitted that Dr Clarke accepts that there have been moments when he has allowed himself to speak to patients in a less than wholly professional way, particularly when he has been very busy, but that he had discussed this with the other partners at a meeting in September 2008 and sought professional help. He concluded " It may be said that there must be very few GP's who have not faced allegations of abruptness or worse at some time or another during their career"

121. Secondly, Dr Clarke faces allegations from female members of staff and/or female patients that he behaved in an inappropriate way. Mr Counsell submitted that the case before us …" is rather different and, it may be said, significantly less serious, than the one which he faced at the PCT hearing".

122. Mr Counsell stressed the importance of the testimonial evidence which, he said "…speaks of a caring and conscientious doctor. Whatever one

makes of the factual allegations, if the Panel who removed Dr Clarke from the list had heard the evidence which this Tribunal will hear and if it had been dealing with the allegations in their present form, it would not have removed him from the list even if it had been correct to find any of the allegations proved. "

Tribunals' conclusion on findings of fact and allegations brought by the PCT.

1 A Treating patients in an inconsiderate manner

Allegation 1 – that Dr Clarke acted in such a way towards patients 1 -8 as to cause complaints about his inconsiderate manner towards them

Patient 1 – Not proved.

123. We are satisfied that Mrs Sharples took an accurate note of what this patient said, namely that Dr Clarke had said that the the DSS should "get their f…….. act together", and that the man had said "fucking" rather than "effing" or anything else, because she had a clear recollection of it and had taken a contemporaneous note. We accept that if he had said "effing" she would have written that.

124. We reminded ourselves of the inherent unreliability of untested hearsay evidence. In this case there are clear reasons why the man may have been surprised and annoyed when his request for a MED4 was refused, because he had clearly expected one as of right. In our view Dr Clarke's refusal was entirely appropriate, especially since the man did not want any treatment for short or long term illness, conclusion which Dr Clarke drew that consideration of such a request, especially for an apparently healthy 39 year old man, should be undertaken by his regular GP was also perfectly reasonable. We find that Dr Clarke acted considerately to the patient by giving him a note for 3 weeks, thereby demonstrating that he did not dismiss the man out of hand. We are not satisfied on the balance of probabilities that the evidence is sufficient to prove that Dr Clarke used offensive language on this occasion. The fact that Dr Clarke admitted it was possible he had used the term is not enough, since the PCT must show that it was more likely than not that the term was used

Patient 2 –admitted – not satisfied that this was inconsiderate.

The allegation of a refusal to provide duplicate sick notes for this patient is admitted.

125. The basis of this allegation is that the patient complained because Dr Clarke was inconsiderate and failed to say that he would get back to her. We are satisfied that Dr Clarke genuinely believed at the time of the consultation that he should not sign two separate notes. We are satisfied that he acted in accordance with what he believed to be right, and that the

patient was very annoyed that he had not given her what she wanted. We are not satisfied that there is any cogent evidence that what Dr Clarke did was incorrect. The unchallenged evidence of Mrs Sharples was that when she subsequently enquired the DSS were unable to give a straight answer and Dr Clarke gave unchallenged evidence that his research at the time suggested that he should not have issued two certificates. The PCT did not produce any evidence that what he did was incorrect, indeed the current guidance which formed part of the evidence bundle is that only one note should be issued.

126. We found Dr Clarke to approach the issue as honestly as he could when he said “I may be shooting myself in the foot here but to be honest I can’t remember saying that I would get back to her”. It is for the PCT to show that his actions were inconsiderate towards the patient on this occasion. We are not satisfied that his refusal to sign two notes is evidence that he was uncaring or inconsiderate. Dr Clarke listened to the request and the reasons for it, made a decision which is not demonstrably wrong and apologised in writing for the patient’s “upset” on 20 May 2003.

127. There is no evidence from the patient that in fact the photocopied certificate was not accepted. We have concluded that whilst a “gold standard” might be to offer to contact the patient if it turned out that he could sign two certificates we are not satisfied that what Dr Clarke did, in a situation he had not come across before or since, fell below acceptable standards of patient service.

Patient 3 -admitted – not proved that this was rude or inconsiderate.

128. The allegation that Dr Clarke declined the patient’s request for a “sick note” is admitted, but we had the benefit of hearing the direct evidence of patient 3. We found him to be an unreliable witness, whose evidence was confused, confusing and contradictory. Examples of this include his insistence that his consultation with Dr Clarke was on a Wednesday, which persisted even when research confirmed that the day of the week was Thursday. Equally, he insisted that he had gone to hospital after seeing Dr Clarke, when in fact the records demonstrated that he had visited hospital on the previous day after visiting Dr Smith. Further, he initially denied that Dr Clarke had prescribed antibiotics for him despite the written evidence that he did. He denied seeing Dr Smith the day before, when the written evidence demonstrated that he had and even denied that Dr Smith had sent him for tests –“No, he didn’t – I saw Dr Clarke”. Again, the documentary evidence demonstrates the contrary.

129. The complaint written by Patient 3 is dated 9.10.2003 and marked received by the surgery on 10.10.2003, but patient 3 insisted that he had not complained until several days later, Later, he adamantly denied receiving the apology letter from the surgery, saying that the first time he had seen it was at the hearing, then admitted that he couldn’t remember.

130. We accept Patient 3’s evidence that he found signing on degrading and that when he signed on he was not feeling well, was breathless and sweaty. We are satisfied that when Dr Clarke saw him he gave him appropriate medical attention, and that the issue of the sick note was brought up at the end of the consultation.

131. We are not satisfied that Patient 3 asked for a short term sick note. Patient 3's evidence was that he said he wanted "a week off" having to look for work, but he accepted there had been no issue with him looking for work raised by the DSS and that he was only required to sign on fortnightly. We find that his real motivation was that he wanted to stop having to sign on, which he found degrading, and that he knew that could only be achieved by a long term note. We are satisfied that a long term note was discussed, because Patient 3 accepted that Dr Clarke had said that he didn't think there were grounds for one, and there would have been no other reason for him to say that. We are not satisfied that Dr Clarke became angry or said that patient 3 had to get out at the end of the consultation, a finding which is in part supported by the fact that this patient did not complain at the time of being told to "get out" and the fact that according to the written evidence he returned to see Dr Clarke after this consultation, a matter which again he denied. We preferred Dr Clarke's evidence in relation to all aspects of the evidence about the consultation, because his evidence was measured, accorded with the written evidence and was inherently more likely. We are not satisfied that he acted in a rude or inconsiderate manner to this patient.

Patient 4 – not proved

On 9 July 2004 treated patient 4 as if he was wasting Dr Clarke's time despite the patient attending for a follow up after an accident and Emergency attendance.

132. Patient 4 did not give oral evidence. His handwritten complaint states "General attitude intimating I was wasting his time. This was after going to A and E Thursday night with a burst varicose vein in my ankle, was given appointment on Fri 9/7/04 to see a consultant at A/E who told me to see my GP for a further Reference on this matter".
133. We accepted the evidence of Dr Clarke on this matter. There was no detail from the PCT about this allegation, which is vague and unspecified. There was no statement from this Patient to elaborate on the written note from 2004, and Dr Clarke gave clear, credible and consistent evidence on the matter. We are not satisfied that Dr Clarke acted in any way which could be described as inconsiderate on the evidence before us.

Patient 5 – not proved that he acted inconsiderately.

The allegation of declining to deal with an additional clinical manner during a consultation is admitted.

134. We are not satisfied that Dr Clarke acted anyway improperly. He conducted 2 examinations for clinical matters and declined to give a third on what was either something trivial – cat flea bites or more serious – acne, because there were patients waiting and the practice has a one patient one problem policy.
135. We decided that Dr Clarke's evidence that this was probably the only

time that he had used the policy was true, and his evidence that he would deal with as many problems as the patient had if there was a clinical need to be honest and measured. The young man had come to see him again a couple of times after this consultation, the "bites" were not new and did not warrant immediate clinical consideration. There was insufficient evidence to prove on the civil standard that Dr Clarke was "bombastic" or that he was inconsiderate to the patient or his father, and we find that he was not. Consideration must be for all patients, and Dr Clarke could well have been criticised for ignoring the policy and dealing with the third matter, thereby being inconsiderate to those waiting in the surgery.

Patient 6 – not proved

On 16 January 2008 failed to adequately explain to the patient the reasons why a home visit would not be appropriate..

136. We are satisfied that Dr Clarke gave all the explanation he could to the patient as to why a home visit was not appropriate and had even offered a contingency surgery appointment. In our view it would have been inappropriate to offer a home visit to someone who was clearly capable of travelling to the surgery for a consultation, who had not sought treatment for several days and who denied the opportunity for further explanation by putting the phone down on Dr Clarke. We are satisfied on the evidence that the explanation was adequate and that Dr Clarke did not act inconsiderately towards this patient.

Patient 7 – proved.

On 30 April 2008 when the patient asked for a second opinion accused her of "slagging off" his colleagues (or words to the like effect).

137. Dr Clarke admitted that this was the wrong thing to say to this patient and that although he had meant to lighten the mood it was inconsiderate in the circumstances. Having heard this witness it was clear she was offended. It was clear that she was not the sort of person who would appreciate such comments and she was obviously upset by them. The allegation says "words to that effect" and Dr Clarke's admitted phraseology is very similar to that alleged by this patient. We are satisfied that he both used words to the effect of "slagging off" in his comments and that he was inconsiderate to do that. His conduct was in contravention of the relevant guidance on appropriate professional standards in "Good Medical Practice" (2006 edition) which provided that:. *To fulfil your role in the doctor-patient partnership you must:*

(a) be polite, considerate and honest
(b) treat patients with dignity …"

Patient 8 – not proved.

On 9 July 2008 said to the patient who had attended with a sore mouth that

3. he was having a “fucking bad morning”
4. telling her that she should tell her dentist to “fuck off”

138. Having heard both the patient and Dr Clarke give evidence in respect of this consultation it was clear that it was dysfunctional. Patient 8 was no doubt in a great deal of pain, had had a long wait at A and E and a long wait in the surgery. We find that by the time she saw Dr Clarke she was frustrated and fed up. It is clear that she sensed that he too was having a bad morning and his decision to telephone the dentist in front of her was ill advised given the fact that he was inevitably drawing the patient into the conflict, which was not in her interest. We find on a balance of probabilities that it is unlikely that he telephoned the dentist “not to remonstrate with her but to ensure the best outcome for their joint patient” because he was clearly frustrated that the patient had been “fobbed off” and sent to him when she needed a temporary filling.

139. The finding sought was that Dr Clarke used the expletives “fuck” and “fucking”. We had to balance the evidence of Patient 8 and the evidence of Dr Clarke on this issue. We concluded that we were not satisfied that Dr Clarke used those terms rather than saying she should tell the dentist to get stuffed.

140. We decided that patient 8 was apprehensive about seeing Dr Clarke, who she did not like. She was in pain and she was angry that he “banged” her tooth. We accept that this was something he had to do but she interpreted it as a hostile act and was clearly upset and angry with him. She was also frustrated that he brought her into the telephone discussion with the dentist. Patient 8 did not make any complaint at the time and told us that the complaint she made was because “Dr Smith rang me up. I had to tell him what had gone on. He said I had to write it all down in a form.” She was on medication for depression at the time and her evidence lacked clarity and cogency on the key issue of the words used.

141. Dr Clarke gave evidence which was measured and thoughtful. He accepted that some of his actions were wrong but we were satisfied that he did adapt his language to the situation and say something more akin to “get stuffed” than “fuck off” when telling the patient what to say to her dentist. We preferred his version of events because he made admissions against his own interest and because the patient seemed to us to be less reliable because of her anger towards him. In closing Mr Counsell said “He hardly comes out of it in a good light” and we agree.

1 B Communicating with and treating patients in an inappropriate manner

Number 8. - proved

> On or about 26 October 2009, during the course of a consultation with Patient 10, regarding the issue of a 'back to work note', Dr Clarke asked her questions about how often she had sexual intercourse without making her aware of any reason for doing so (admitted).

142. We find that this was a failure to "signpost" the need to ask questions of this nature, rather than asking questions of a prurient nature from any other motive. It is very important to distinguish the type of communication failure so that its seriousness can be assessed. We have carefully considered the evidence, including the expert evidence of Dr Crouch on this respect and decided that the questions were entirely appropriate in the context because the discussion was following a hysterectomy and was with a woman who appeared depressed. The failure was to give a clear explanation as to why the questions were being asked and was therefore inappropriate communication. There was no complaint raised at the time, the matter not coming to light until Patient 11 made a complaint.

Number 9. – Not proved as to a or b

On or about 31 October 2009, at the GUM clinic at the Sullivan Way Surgery, in relation to Patient 11 (a female patient over 18 years of age), Dr Clarke -

(a) sought to administer a Depo-Provera injection in a manner inconsistent with good practice, as described in:

(i) paragraphs 9, 14(d) and 15(c) of Maintaining Boundaries (General Medical Council, November 2006),

(ii) paragraphs 21(a) and 21(b) of Good Medical Practice (General Medical Council, March 2009),

and likely to cause embarrassment to her,

(b) asked her questions about how often she had sexual intercourse without making her aware of any reason for doing so;

143. In her written statement the clear impression given by Patient 11 is that there was a "sleazy" nature to this consultation with a sexual connotation, both as to Dr Clarke asking questions about her sex life without context or explanation and in the manner he beckoned her over and said that the injection would be administered "in yer bum".

144. Having heard this Patient's oral evidence and had an opportunity to assess her demeanour and motivation and having balanced this against the description of the consultation by Dr Clarke we are not satisfied that the administration of the injection was in breach of the guidance and was not likely to cause embarrassment to this patient, nor are we satisfied that he did not give her any reason for asking her questions about her sex life.

145. We are satisfied that on the day in question this patient expected Dr Clarke to act in the same way as her previous Depo injection visits had occurred. She did not welcome the fact that he wanted to perform a formal review of her contraceptive needs and she was very concerned that he would not give her the injection. She was dismissive of his attempts to

discuss osteoporosis and the efficacy and side effects of this method of contraception, and moreover was told by Sister X at the next consultation that what he had asked was inappropriate and wrong.

146. We find that Dr Clarke was clinically justified in considering that it was appropriate to conduct a review of contraception since it was clear that none had been conducted for some considerable time. Even on the evidence of this patient some explanation of the reasons was given – whereas the PCT allegation was that Dr Clarke did not give "any" explanation. We find that this patient did not want to listen to any explanation of why the questions needed to be asked, she was dismissive and uncooperative. She made it clear that she wanted the injection and that was that. We have decided that Dr Clarke appropriately attempted to conduct a perfectly proper review but was cut short by the Patient. We find that this patient did not think there was anything wrong with the questions at the time, other than they were unnecessary and delaying her getting her injection. When discussing the matter with Sister O about three months later she was told that Dr Clarke should not have asked the questions. In such circumstances many patients would be alarmed and concerned. We find as a fact that this patient's alarm and concern was caused by what she was told by Sister O rather than anything said or done by Dr Clarke, and as such her evidence is insufficient for us to be satisfied that this part of the allegation is made out.

147. Mr Clarkson and Mr Counsell were agreed that based on the expert evidence of Dr Crouch if the injection was administered as described by the patient it was administered inappropriately and if it was administered as described by Dr Clarke it was administered in an appropriate manner.

148. We have considered the written and oral evidence and are not satisfied on the balance of probabilities that the injection was administered as described by this patient.

149. Our reasons for this are that the patient was in a hurry, had not expected to be seen by a GP and clearly had not paid much notice to the surroundings in her haste to have the injection. Her two handed beckoning gesture with the implication that Dr Clarke was beckoning her towards his groin in a sexually motivated manner was unconvincing, and her description of the area, with no couch for her to rest on and no curtains lacked cogency because she was in such a hurry.

150. We preferred the evidence of Dr Clarke that he beckoned her over with one hand at a time when his groin would have been covered by the desk. We are satisfied that there was a couch upon which the patient could lie or lean, and we are satisfied that she did lean against it. We are also satisfied that it was Dr Clarke's practice to close the curtains for the patients' privacy and that he did so as far as he could on this occasion, administering the injection from his chair to ensure that it was horizontal and in the correct area despite a lack of cooperation from the patient. We placed reliance upon his description of the layout of a consulting room which was very familiar to him and preferred this to a description given by a patient who had been hurried.

151. Once again we find that this patient did not think there was anything wrong with the administration of the injection at the time. No complaint of inappropriate behaviour or lack of boundaries was made at the time by this

patient, who was in our view quite capable of speaking her mind as she demonstrated in dismissing Dr Clarke's attempt to review her contraception by indicating that he should just give her the injection. When discussing the matter with Sister O about three months later she was told that Dr Clarke should not have administered the injection in that manner. We find as a fact that this patient's subsequent alarm and concern was caused by what she was told by Sister O rather than anything said or done by Dr Clarke, and as such her evidence is insufficient for us to be satisfied that this part of the allegation is made out.

152. Having found that the facts were as described by Dr Clarke, we have concluded that on the basis of the guidance and Dr Crouch's expert report (and the PCT's stated position), that the guidance was not breached and the allegations are not proved.

1 C Friendship with a patient

Number 10. – not proved that this breached guidance.

> In or around November 2009, while treating her as a patient, Dr Clarke carried on a friendship with Patient 12 (a female patient over 18 years of age) (admitted).

153. Dr Clarke admits that he had a platonic friendship with this patient. We accept his admission, which is supported by the witness statement from this patient. The real question is where does this take us? The PCT do not seek any finding that Dr Clarke gave her preferential treatment. Mr Clarkson clarified in closing that the matter was left to the panel as to whether this friendship falls within the definition of "close personal relationship", and therefore someone who Dr Clarke should not have treated in his capacity as GP.

154. We have concluded on the evidence and on the basis of plain English that we are not satisfied that the relationship was a "close personal relationship". We accept that some friends could come into this category, for example those with whom one might share holidays or special occasions, but on the limited basis of this relationship as described it fell far short of such circumstances and could not be described as a "close personal relationship". We have therefore concluded that there was no breach of guidance or anything improper when Dr Clarke treated this patient who was also a platonic friend.

2. Allegations concerning staff

Number 4 – not proved

> On or about 12 June 2006, in relation to Staff Member 2, a patient and staff member at the practice, Dr Clarke, after all other practice staff had departed Sullivan Way Surgery for the evening -
>
> (a) asked her questions using words to the effect of "Are you getting

any? Are you getting any sex?",

(b) held her against filing cabinets,

(c) restrained her physically by holding her waist,

(d) attempted to kiss her;

155. We are not satisfied on the evidence that this allegation is proved, because we preferred Dr Clarke's evidence about the events to those given by Staff member 2. We did not believe staff member 2 when she said that she was not upset that evening. It was her husband's birthday and he was seriously ill. We find that she was under a great deal of stress and was apparently abusing alcohol in her personal time. We find that she confided in Dr Clarke who was put in a difficult position because he was her employer as well as a person who she clearly trusted.

156. We have decided that Patient 2 misinterpreted Dr Clarke's actions on that evening. This was evidenced by some of the things she said, such as "I *felt* he had to get it in that he was there if I needed him. I wasn't interested. I felt he abused me." We preferred Dr Clarke's evidence that his attempt to hug Staff member 2 was motivated to comfort her, whereas she thought it was more. We find that the location was somewhat cramped near to the filing cabinets but we are not satisfied that Dr Clarke propositioned her, held her against the filing cabinets, restrained her in any way or attempted to kiss her.

157. Staff member 2 accepted that at the end of this incident she had said words to the effect of "Sean you've got it wrong. I didn't need this, but thanks for caring". We find that this is consistent with his evidence that he was demonstrating compassion and concern rather than the description given by Staff member 2. She also told the panel that Dr Clarke has a "caring side" and that she had been upset on another occasion and he had empathised. She said that she had seen that side of him "plenty of times".

158. We heard that on the way home Staff member 2 had to stop the car because she felt humiliated and embarrassed. We are not satisfied that this was because he had attempted to assault her because equally it may have been because she had confided in him about her alcohol abuse. We are satisfied that Dr Clarke's evidence on this was corroborated by the fact that Patient 2 had told another GP in the surgery that she was abusing alcohol and that Dr Clarke could not have known the information from any source other than Patient 2 at that time. Patient 2's denial in cross examination that she had confided in Dr Clarke about her drink problem was contrary to the written evidence of the partner's meeting and was unconvincing.

Number 5 – not proved

In or around December 2007, in relation to Staff Member 3, a patient and staff member at the practice, Dr Clarke kissed her on the lips at the Surgery, without invitation, when she attended him for the purposes of

having a prescription signed.

159. This witness did not attend to give evidence through illness. In her statement she alleged that Dr Clarke kissed her on the lips when she attended upon him on Christmas Eve to have a prescription signed and that she was her shocked and embarrassed. Dr Clarke was clear that she was embarrassed but maintained that he had asked her for a kiss and she had proffered her cheek.

160. We are not satisfied on the written evidence that Dr Clarke gave this kiss without invitation or on the lips. We found his evidence, which was cogent and unshaken by cross examination to be believable, especially since some of it went against self interest. We concluded that the PCT had not shown on the balance of probabilities that the kiss was on the lips and was made without request.

161. We are therefore not satisfied that the allegation as drafted by the PCT is proved to the requisite standard. We note however that Dr Clarke's own description was of a woman who was reluctant to proffer her cheek and who left the room very quickly. He was aware that his actions had caused some embarrassment for both of them and had later apologised to her. He had reflected on his conduct and the following Christmas "There were no Christmas kisses". On his own admission therefore the actions were inappropriate and demonstrated that he had failed to main proper employer/staff boundaries and demonstrate appropriate respect to this member of staff.

<u>Number 6</u> a) proved b) proved on a factual basis of failure to signpost questions.

In relation to Staff Member 4, a staff member at the practice, Dr Clarke -

(a) attempted to put his arms around her on more than one occasion during 2008 when she asked him to sign repeat prescriptions (admitted),
(b) asked her about the state of her sex life on one occasion in 2008 or 2009 during her marriage (admitted),
(c) asked her about the state of her sex life on one occasion in 2009 when she had met a new partner (factually admitted but withdrawn as an allegation in closing by the PCT).

162. In respect of allegation a) Dr Clarke accepted he had conducted himself in an unprofessional manner towards a member of staff. This was clearly in breach of guidance to deal with colleagues fairly and with respect.

163. In relation to allegation b) we find that the circumstances were that Dr Clarke and Staff member 4 were friends and that she confided personal matters to him, including medical matters. The discussion was in the context of a discussion about IVF and the questions were appropriate, however Dr Clarke failed to adequately "signpost" the questions which led

the staff member to think that the questions were “odd”.

Tribunals’ conclusion on efficiency and suitability.

Summary of findings

1 A Treating patients in an inconsiderate manner

164. Under this heading we found the allegation in respect of Patient 7 proved and that Dr Clarke’s conduct was in contravention of the relevant guidance on appropriate professional standards in "Good Medical Practice" (2006 edition) which provided that:. *To fulfil your role in the doctor-patient partnership you must:*
    (a) be polite, considerate and honest
    (b) treat patients with dignity …"

165. Whilst we have made this finding in relation to Dr Clarke it is important to put it in context. During the period from 2003 to 2010 Dr Clarke treated hundreds of patients in thousands of consultations. Some of them complained, but a very small percentage overall. On occasion Dr Clarke admits that some consultations were suboptimal and certainly we have found that his treatment of Patient 7 was unsatisfactory, however the conduct was not very serious and it has to be balanced against the many satisfied patients he treated in this time. There was ample written evidence, both in very strong testimonial form, Dr Clarke’s appraisals and in respect of independently commissioned satisfaction surveys that in the overwhelming majority of cases Dr Clarke showed his patients consideration and politeness and that he treated them with dignity.

166. Dr Clarke has accepted that he used inappropriate language at times, a matter which he addressed in counselling. He had also undertaken training on “Mastering difficult interactions” and reducing complaints. He said that although he was initially sceptical about some of the methods taught he was now sure that they really do work. The panel noted that after Dr Clarke had taken some time off in late 2008 to address personal difficulties and obtain counselling, there were no further complaints of this nature until the matters which led to his suspension.

1 B Communicating with and treating patients in an inappropriate manner

167. Under this heading we have found that on occasions, and particularly in relation to Staff member 3/ patient 10 and Patient 11 that Dr Clarke failed to “signpost” the need to ask questions of a sensitive nature. We have not found that he asked questions of a sexual nature in a prurient

manner or from sexual motivation, which would be very serious indeed. Dr Clarke accepted that he needed to learn how to communicate more effectively in this regard. Dr Clarke had asked the Post Graduate Dean to recommend training to address this issue and he had recommended a course in "Effective Consultation" and Dr Clarke had attended the course. He told us that in relation to Patient 10/Staff member 3 "I can understand now why she was upset. I could have been more explicit and taken more time" and in relation to Patient 11 he would now try different techniques which he had learnt on the course.

168. Dr Clarke told the panel that he would like to practice the techniques he had learnt and that ultimately, giving better explanations would probably not lengthen his consultation times.

2. Allegations concerning staff

169. Dr Clarke has accepted that in asking a staff member 3 for a Christmas kiss, trying to put his arm around staff member 4 and the admitted "banter" he engaged in with some staff was inappropriate, demonstrated that he had failed to main proper employer/staff boundaries and demonstrated that on occasion he failed to show appropriate respect to members of staff, in breach of guidance.

170. Dr Clarke gave evidence that this was an area which he had started to address in 2008, and which he had more formally addressed since his suspension. He said that he did a great deal of background reading and had understood the concept of the slippery slope and how he had been perceived as "a womaniser" because he had not maintained professional boundaries. He also understood the need to avoid discussing intimate issues with staff and to avoid actions which could be misinterpreted. He had attended a course on professional boundaries at the Clinic for Boundary Studies and had sought further guidance from the course director.

171. Reg 10.3 provides the cases for removal on discretionary grounds:

The Primary Care Trust may remove a performer from its performers list where any of the conditions set out in paragraph (4) is satisfied.
(4) The conditions mentioned in paragraph (3) are that—
(a) his continued inclusion in its performers list would be prejudicial to the efficiency of the services which those included in the relevant performers list perform ("an efficiency case");
(c) he is unsuitable to be included in that performers list ("an unsuitability case").

172. We have considered our findings against the criteria set out in Regulation 11 in respect of unsuitability and in particular

a) the nature of any offence, investigation or incident.

The matters we have found proved are at the lower end of the scale.

b) the length of time since any such offence, incident, conviction or investigation.

We find that Dr Clarke has had opportunity since his suspension to reflect and undertake remedial training directly related to his deficiencies in conduct.

c) whether there are other offences, incidents or investigations to be considered.

There are none known to us.

d) any action taken or penalty imposed by any licensing or regulatory body, the police or the courts as a result of any such offence, incident or investigation.

We are not aware of any legal proceedings. Dr Clarke is currently suspended by the GMC pending a substantive hearing.

(e) the relevance of any offence, incident or investigation to his performing relevant primary services and any likely risk to any patients or to public finances.

We find that there is very little risk of Dr Clarke repeating his conduct. He has accepted his failings in the main and has shown depth of insight into his personal and professional failings. He has undertaken appropriate training and counselling and obtained appropriate medical assistance. The conduct was at the lower end of the scale. In such circumstances we assess that the risk of repeated behaviour is very low.

f) whether any offence was a sexual offence to which Part I of the Sexual Offences Act 1997(a) applies, or if it had been committed in England and Wales, would have applied.

The conduct we have found proved would not amount to a sexual offence or offences.

g) whether the performer has been refused admittance to, conditionally included in, removed, contingently removed or is currently suspended from any list or equivalent list, and if so, the facts relating to the matter which led to such action and the reasons given by the Primary Care Trust or equivalent body for such action; and

h) whether he was at the time, has in the preceding six months been, or was at the time of the originating events a director of a body corporate, which was refused admission to, conditionally included in, removed or contingently removed from any list or equivalent list or is currently suspended from any such list, and if so, what the fact were in each such case and the reasons given by the Primary Care Trust or equivalent body in each case for such action.

We are not aware of such circumstances.

173. Having considered the findings made, together with the submissions by

both advocates and having applied the above criteria we are not satisfied that Dr Clarke is unsuitable because the conduct is at the lower end of the scale of seriousness and there is little chance that it will be repeated because he has shown insight and has acted to receive appropriate training and help. Removal from the list on the ground of suitability would in all the circumstances be disproportionate to the findings we have made.

Efficiency

(a) the nature of any incident which was prejudicial to the efficiency of the services, which the performer performed.

We do not find that the number of complaints made against Dr Clarke was prejudicial to the efficiency of the surgery. Testimonials from senior members of the PCT who have worked closely with Dr Clarke on performance assessment and clinical governance matters attest to his clear, careful and measured dealings with colleagues and patients. Dr Clarke has addressed his communication deficits in respect of patients and his difficulties in maintaining boundaries with staff and we find that the likelihood of such incidents recurring is very small, and unlikely to be prejudicial to the efficiency of any practice with whom he is working.

(b) the length of time since the last incident occurred and since any investigation into it was concluded;
We find that Dr Clarke has had opportunity since his suspension to reflect and undertake remedial training directly related to his deficiencies in conduct.

(c) any action taken by any licensing, regulatory or other body, the police or the courts as a result of any such incident.
We are not aware of any legal proceedings. Dr Clarke is currently subject to an interim suspension by the GMC.

(d) the nature of the incident and whether there is a likely risk to patients;

The incidents relate to communicating with patients and maintaining boundaries with staff. We find that there is very little risk of Dr Clarke repeating his conduct. He has accepted his failings in the main and has shown depth of insight into his personal and professional failings. He has undertaken appropriate training and counselling and obtained appropriate medical assistance. The conduct was at the lower end of the scale. In such circumstances we assess that the risk of repeated behaviour is very low.

(e) whether the performer has ever failed to comply with a request to undertake an assessment by the NCAA.

We are not aware of such a failure.

(f) whether he has previously failed to supply information, make a declaration or comply with an undertaking required on inclusion in a list.

We are not aware of such a failure.

(g) whether he has been refused admittance to, conditionally included in, removed or contingently removed or is currently suspended from any list or equivalent list, and if so, the facts relating to the matter which led to such action and the reasons given by the Primary Care Trust or the equivalent body for such action; and
(h) whether he was at the time, has in the preceding six months been, or was at the time of the originating events a director of a body corporate, which was refused admission to, conditionally included in, removed or contingently removed from, any list or equivalent list, or is currently suspended from any such list, and if so, what the facts were in each such case and the reasons given by the Primary Care Trust or equivalent body in each case for such action.

We are not aware of such circumstances.

174. Having considered the findings made, together with the submissions by both advocates and having applied the above criteria we are not satisfied that Dr Clarke should be removed from the list on the grounds of efficiency because the conduct is at the lower end of the scale of seriousness and there is little chance that it will be repeated because he has shown insight and has acted to receive appropriate training and help. Removal from the list on the ground of efficiency would in all the circumstances be disproportionate to the findings we have made.

ORDER

Appeal allowed in full.

Judge Nancy Hillier

10 December 2011