Tribunals Service
Primary Health Lists

Podium 31
Mowden Hall
Staindrop Road
Darlington
DL3 9BG
T 01325 391130/391051
F 01325 391045
EPrimaryHealthLists@tribunals.gsi.gov.uk

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IN THE FIRST TIER TRIBUNAL OF THE TRIBUNALS SERVICE
HEALTH EDUCATION AND SOCIAL CARE CHAMBER
PRIMARY HEATH LISTS CASE PHL/15180

Professor M Mildred - Chairman
Dr R Rathi – Professional Member
Ms K Wortham - General Member

BETWEEN

LUCIA NJOKU GIBSON (Registration Number 3515141)

Appellant

and

SURREY NHS PRIMARY CARE TRUST

Respondent

DECISION WITH REASONS

The appeal

1.The Appellant ("Dr Gibson") appeals from the decision of Surrey Primary Care Trust ("the PCT") of 12 June 2009 removing her from its Performers List on the ground of efficiency. The hearing of an appeal to a differently constituted Panel of the Tribunal was adjourned and a decision relating to the admissibility of evidence sought to be introduced by the PCT was successfully appealed by Dr Gibson to the Upper Tribunal. That body quashed the decision on 18 February 2011 and remitted the case to a new Panel of the First Tier Tribunal.

Background

2. On 16th March 2009 a letter was sent to Dr Gibson notifying her of the PCT's intention to remove her from its list on the ground of efficiency under Regulation 10(3) and 10(4)(a) of the NHS Performers Lists Regulations 2004 (as amended) ("the Regulations"). This was followed by an oral hearing on 1st June 2009. Dr Gibson, on advice from her legal team, withdrew from that

hearing on the basis that matters which she considered ought to have been excluded from that hearing had not been not excluded. The PCT relied upon a report by Dr Jonathan Lewis whom it had appointed to investigate the allegations against Dr Gibson and a record of an interview between Dr Lewis and Dr Gibson.

3. The PCT Panel had deemed 11 of 14 clinical cases relied on by the PCT were primarily concerned with the criterion of efficiency and made a finding of inefficiency in 10 of those 11 cases. The PCT Panel decided that Dr Gibson should be removed from the PCT's Performers List on ground of efficiency and recommended national disqualification.

4. Dr Gibson appealed against the PCT's decision to remove her from its List. The hearing was originally listed in March 2010, having been postponed until after the resolution of a criminal trial at the conclusion of which Dr Gibson was acquitted of all 37 charges alleging fraud in the course of her practice as a GP. The hearing in this Tribunal was adjourned shortly after it began as a result of the evidential issues referred to in paragraph 1 above.

The decision of the Upper Tribunal

5. The Upper Tribunal decided the First-tier Tribunal had erred in not considering at the beginning of the hearing whether any specific evidence should be excluded or redacted or whether there needed to be a clearer ruling as to the potential relevance of the evidence. It erred in law because it failed to rule that there was an inconsistency in the way the PCT presented its case and it failed to require the PCT to give the Dr Gibson adequate notice of the inferences it wished the First-tier Tribunal to draw from evidence of uninvestigated complaints and allegations that was not being admitted to prove the contents of the complaints and allegations.

The 2011 application

6. The parties sought to resolve differences in approach to the admissibility of evidence but there were 30 documents part or all of whose admissibility is disputed. I was asked and agreed to rule on the admissibility of these documents sitting alone as a case management matter. At the request of the parties I have (but my Panel colleagues have not) read the disputed documents.

7. I heard argument on 6th June 2011 from Mr Jeremy Hyam (instructed by RadcliffesLeBrasseur) on behalf of Dr Gibson and from Mr John de Bono (instructed by Weightmans) on behalf of the PCT at the Care Standards Tribunal, London SE1 before making a decision on the admissibility of the disputed evidence the same day.

Dr Gibson's concession

8. In the course of that application Dr Gibson conceded that her presence on the List did cause prejudice to the efficiency of the PCT's services (although not to the extent argued for by the PCT) sufficient to justify contingent removal. This was explicitly on the bases of Regulation 11(6)(b) and (c) inasmuch as Dr Gibson accepted that she had been out of practice for over 3 ½ years and that she accepted some (but not all) the deficiencies alleged by Dr Lewis in respect of the 10 cases.

The substantive hearing

9. The appeal was heard on 7-10 June and 6 July 2011 at the Care Standards Tribunal, London SE1. Representation was as set out in paragraph 7 above.

The PCT's case

10. The PCT accepted that Dr Gibson had been acquitted of all criminal charges of fraud made against her but contended that those acquittals did not prevent it saying that she had not been truthful in relation to the matters before us.

11. It was agreed that the key issue for this Panel was whether the continued inclusion of her in the list would is so prejudicial to the efficiency of those services that the only fair and proportionate sanction either to:

(i) Impose conditions on her inclusion in the performers list breach of which would render her liable to removal (contingent removal under Regulations 12 and 15); or, in the event that that is not sufficient, to

(ii) Remove her from the list entirely (Regulation 10(3)).

12. The PCT's case was that there were no conditions that could be imposed that would be proportionate and fair to both sides and that would address the problems in Dr Gibson's practice.

13. At this point Mr Hyam informed us that Dr Gibson had been suspended by the GMC on 23 September 2008 and acquitted in the criminal court in December 2009. Her suspension was extended and there was a performance assessment by the GMC which had led to a referral to the GMC Fitness to Practice Panel for which no date was yet fixed. Whilst Dr Gibson was suspended pending that GMC hearing, if she was contingently removed by this Panel, she would apply to vary her suspension so as to allow her to practice under training conditions. More would be disclosed about the position with the GMC in due course. Mr de Bono said that the PCT's position was that it was possible but not likely that the GMC would vary its suspension to allow a contingent removal to take effect.

The PCT's evidence

14. The PCT's main witness was Dr Jonathan Lewis, a full-time GP for 22 years and a GP trainer who had played various roles in teaching final year medical students and the PCT and its predecessors and had vetted some 20,000 referral letters from GPs to secondary care as part of a PCT cost-saving exercise. He had been asked by the PCT and agreed to conduct an investigation into Dr Gibson's clinical practice and had produced a report for the PCT Panel hearing. This report had been amended in the light of the report from Dr Gibson's expert and Dr Gibson's witness statement. The final report was dated 15 April 2011. Parts of it had been redacted by agreement or in consequence of my decision of 6 June. Dr Lewis said he was impartial and came to assist the Panel rather than achieve a particular outcome for the PCT

15. Dr Lewis was the third witness and began his evidence on 8 June 2011. Since his report forms the backbone of the PCT's case and deals in detail with the 10 patients whose treatment by Dr Gibson is central to this appeal, it is convenient to begin with his evidence out of sequence.

16. In November 2007 Dr Lewis went to speak to Janet Wilson, the Manager of Walton Health Centre, who had told him of the problems she had encountered with Dr Gibson. He then interviewed

any staff members who wanted to be interviewed and none who did not. He would sit in a room with the staff member with the computer records of a patient in respect of whom a concern had been expressed open on the screen.

17. Dr Lewis made notes of what was said by staff members then read the whole records and copied relevant extracts and audit trails of changes to the records. He was later asked by the PCT's solicitors to convert summaries of those investigations into Appendices to be signed by the witnesses. Nine of the 10 cases were referred to him by staff members; he discovered Case 1 by himself following on from his examination of patients who had died during the time Dr Gibson was at the Health Centre.

18. The computer system in the surgery was EMIS with which he was very familiar. Dr Lewis explained that the consultation mode showed where and how the consultation had taken place. A user would log in with a password and everything would be recorded under the username (DLG for Dr Gibson, BLOC for a locum in the Blue Practice etc). To log off, the user should input CU to show a change of user. Receptionists were good at doing this: doctors less so. Notes were recorded in free text, using macros set up by the doctor and templates.

19. The notes produced were as at the time they were printed. An audit trail showed the time, date and detail of any amendment of the original entry including any additions such as read codes. A read code is a 5-character code for every medical problem. Dr Lewis then dealt with the 10 cases in order.

20. <u>Case 1</u> concerned a 63 year old man who died from rectal cancer in May 2006. Examination of the records showed that Dr Gibson had not examined the patient again after 7/9/05 when she noted "gen cond satis" a macro for general condition satisfactory and "some faecal masses felt [on the patient's] r[igh]t [side].

21. Dr Lewis said that the mass was highly unlikely to have been faecal as the construction of the bowel was such that the mass, if faecal, would have been palpable on the left first and then the middle, neither of which was observed or noted by Dr Gibson. This mass was not the rectal cancer from which the patient died but was also not faeces. It is familiar medical terminology to describe faeces alone as "indentable". A cancer is not indentable. In his interview Dr Gibson said that it was not unusual to feel constipation on the right side – it depended on how far down the faecal mass is.

22. The 2 week rule in relation to cancer requires a mass on the right of the body to be referred unless it is constipation, which this was not. Dr Lewis would have considered a change of bowel habit and tested for occult faecal blood that would indicate cancer. The minimum acceptable process in this case would be to review the abdomen again but there is no indication in the records that this was planned and it never happened.

23. Dr Gibson looked at the faecal culture test report and assigned it "normal". Whilst the results may have been normal for infection it was very abnormal in relation to cancer as it included the findings of red and white blood cells +++ and should have been acted upon and referred to a gastro-enterologist. This referral was later made by a locum. Presence of the mass was an opportunity to investigate further or re-examine. Failure to do either was a very serious failure.

24. In cross-examination Dr Lewis said that he had never confidently felt a faecal mass in an adult. Dr Gibson had first described the mass as soft and only 2 years later as indentable. The 2-week rule does not distinguish between hard and soft masses; if the mass was on the patient's right side, it must be referred. It should also have been investigated. The locum and consultant could not feel the mass. It was possible but highly unlikely that what Dr Gibson felt was a sigmoid colon with faeces in it.

25. Case 2 was drawn to Dr Lewis' attention by Madeline Williams, a practice nurse, and concerned a 38 year old woman whose anaemia Dr Gibson failed properly to investigate in February 2004. She was found on 12 November 2004 to have a cervical cancer on examination. A GP should ask herself why a 38 year old woman was anaemic since bowel or cervical cancers were worrying possibilities although the most common cause would be heavy periods. A GP should take a full history of the patient's bleeding including frequency and heaviness, ask about bleeding between periods or after intercourse and test for faecal occult blood in case the patient had bowel cancer.

26. There is no record in the notes of Dr Gibson asking any of these questions or of any test for faecal blood or blood in urine (which might indicate a cancer of the kidney). Dr Lewis could not understand why she had sent a stool sample for culture and the laboratory result reminded Dr Gibson that a clinical summary should always be sent with the sample. A stool sample would not normally be tested in a case of anaemia.

27. The entry for 25 June 2004 was coded "anaemia unspecified" which suggested that Dr Gibson did not know what was the cause. The blood tests on 16 July and 8 October were probably for anaemia; Dr Gibson was checking the patient's blood and prescribing her iron rather than investigating the cause of anaemia.

28. The prescription of a Mirena coil was designed to control heavy bleeding by the release of a progestogen and it was appropriate to take a swab for chlamydia first. Dr Gibson did not record asking whether the patient had bled after intercourse; if she had asked the patient this on 22 October, she should then have examined her or taken a swab. The coil would have been appropriate to control heavy periods, not irregular bleeding.

29. The letter from Dr Gibson dated 12 November 2004 referring the patient to hospital described her as complaining about irregular menstrual bleeding for some months. The problem with the case was that Dr Gibson did not try to discover the cause of the anaemia.

30. In cross-examination Dr Lewis said that, if the cancer was 2 cm and friable on 12 November, it must have been growing for a year and have bled after intercourse. Dr Lewis accepted that the patient may not have mentioned bleeding after intercourse to Dr Gibson as he had not been present at the consultation.

31. Case 3 concerned the sudden delivery of a child in the surgery on 29 March 2005. Dr Lewis said that the emergency referral letter to the hospital had been written on 29 March 2005. When Dr Gibson wrote "on examination" in the letter she had implied that she had actually examined the patient whereas he thought the examination may have only been a visual examination and the taking of pulse and blood pressure. There was no evidence in the initial record that a physical examination

had been offered and refused: a baby at 36 weeks gestation could easily be felt and distinguished from a distended abdomen.

32. Dr Gibson changed the entry the next day to say that the patient had refused an examination. This was bad practice: it was better to write a new note explicitly correcting the day before's note (for example, by saying I now remember the patient refused an examination) as it was important to know when a note had been written.

33. It was a major change from patient examined to patient refused examination and the inference Dr Lewis drew was of a cover up. If the patient was in fact 36 weeks pregnant, she would not have told Dr Gibson that her last menstrual period was 3 weeks ago , although it is possible she could have had showing of blood.

34. In cross-examination Dr Lewis said that labour pain comes at regular intervals and there could have been an examination during one of these: he thought it unlikely that Dr Gibson had examined the abdomen in this case. He accepted that he had investigated the case on the information provided by Jackie Lindsey and that neither she nor Samantha Church was a nurse. He said that Dr Sillick may have said that the midwife who was in the building as a patient delivered the baby. He agreed it was a very confused episode.

35. Case 4 concerned a 48 year old woman who had a retained tampon discovered by Sarah Jack, a nurse, 6 days after Dr Gibson had noted a vaginal discharge after a period and referred her for a high vaginal and Chlamydia swab although she now said that she had observed bleeding rather than a discharge. Although the tampon may have been retained after the consultation, retention was rare and a competent GP should have suspected it on seeing a discharge after a period. Dr Gibson should have considered all causes of vaginal infection and taken a swab herself: this would have revealed the tampon. The note of the consultation refers to discharge whereas Dr Gibson reported the patient complaining of bleeding. The nurse Sarah Jack's record on 22 June 2007 clearly implied a clear discharge, rather than bleeding had been observable on 16 June. The pathological report implied the existence of bugs with no specific infection, rather than bleeding for which in any event a swab would not normally be requested.

36. Dr Gibson referred the patient to the GUM clinic. This should be a referral only when an STD is suspected. Dr Gibson had told Dr Lewis that she would sometimes send patients there for other reasons because there was a consultant in attendance and tests were done quickly.

37. Cross-examined, Dr Lewis said that Sarah Jack's account was that the patient went to Dr Gibson with a discharge, not bleeding and that there would have been no reason for a high vaginal and chlamydia swab unless there had been a discharge. There had been a finding of numerous bacteria present on the swab although these had not grown.

38. Case 5 concerned an 84 year old woman. In a consultation on 2 May 2006 Dr Gibson had recorded dizziness and cough for 1 week and the inference from the note was that she would have listened to the patient's chest with clothes raised. There was no evidence that Dr Gibson looked for a raised temperature or breathing rate, crepitations, bronchial breathing or a pleural rub. In the light of

later findings Dr Lewis thought it very unlikely the patient's chest had been clear on 2 May. The description "general cond satis" was very unlikely to have been accurate and it was very unlikely that her chest was clear.

39. Dr Gibson removed a keratosis by cryotherapy. The entry in the records that payment for this could be claimed suggested that the keratosis was actinic. An actinic keratosis could be pre-malignant but this would not happen for years so that there was no clinical basis for removing it: it would have hurt and been uncomfortable for days. The chance that the keratosis on the chest of an 84 year old was actinic was about 5% and the procedure should not have been carried out. Dr Gibson did vastly more of these procedures than other doctors in the Health Centre.

40. Dr Gibson said she had carried out a mental health review because of the patient's insomnia. The consultation notes were edited on 8 June to record the review and Dr Lewis could not understand how Dr Gibson would have remembered more than a month after the review that she had forgotten to record it on the computer (which would trigger a payment from the PCT). Asking about the patient's insomnia alone would not count as a mental health review.

41. On 20 June , the day after the patient died, Dr Gibson added an entry of a consultation in the surgery on a template "cancer care review discussed diagnosis" which implied that the patient had been seen in the surgery and the cancer discussed. The hospital report had described the patient as at status 4 on 9 June 2006 from which it could be inferred that the major concern for the patient was her cancer, rather than the stroke she suffered.

42. In cross-examination Dr Lewis conceded that it was possible the patient's chest was clear on 2 May but said, drawing on his experience as a medical officer at a hospice, that her general condition must have been far from satisfactory as she died a few weeks later of cancer. He accepted that the giving of consent to the cryotherapy implied a discussion between doctor and patient and that it was possible that there could have been a comfort-based reason for removing the keratosis.

43. Case 6 involved a 75 year old diabetic male. The patient was susceptible to hypoglycaemia and was maintained on insulin, metformin and glicazide. Dr Lewis was informed by a practice nurse that she had spoken to Dr Gibson about the patient's repeated hypoglycaemic attacks ("hypos") caused by low blood sugar down to 1.6 to no avail. Dr Gibson treated him by reference to his levels of glycosylated haemoglobin (HbA1c) which measures levels of blood sugar over the last 3 months) alone. It rose from 6.9% in August 2006 to 7.7% in March 2007 and then fell to 5.9% on 14 May 2007. The normal range is up to 6.5% and a well-controlled elderly diabetic would be in the range 7-7.5%.

44. The patient saw Dr Gibson on 14 May 2007 after a severe hypo the day before but she did not reduce his medication to prevent a recurrence. He suffered another hypo on 15 May. These were caused by excessive gliclazide.

45. Dr Lewis had never seen a patient given all 3 medicines together and adding gliclazide after insulin and metformin is contrary to the recommendations of the BNF. The recommendations are to add bedtime insulin, if control is not met. This patient was on twice-daily insulin when the gliclazide

was added. Dr Gibson doubled the gliclazide to the maximum dose of 160mg twice a day because she wanted to get the HbA1c down rather than deal with the patient's problem with hypos. The dose was increased without seeing the patient or speaking to him on the telephone even though he was known to neglect himself.

46. A raised HbA1c does not by itself put the patient at risk: it may increase the risk of a heart attack or stroke but this was nowhere near as bad as the risk of hypos. This treatment was very poor and out of the range of normal practice. Dr Gibson should have involved the hospital specialist in the patient's care when she saw him on 14 May. He had been discharged into GP care in 1997 on insulin alone and was not under shared care as Dr Gibson had said in her statement. He had had hypos noted in his records in 1985, 1987 and 2000: these should have been noted in the summary when his Lloyd George notes were summarized in the new computer records.

47. Cross-examined, Dr Lewis accepted that between June 2006 and March 2007 the patient had achieved good control of his HbA1c without any hypos. There had been a hypo on 13 May after Dr Gibson had increased his gliclazide on 15 March 2007 without seeing the patient, based on HbA1c results. He considered she should have reduced the patient's gliclazide on 14 May considered she should have reduced the patient's gliclazide on 14 May to respond to his hypo but did not do so until she had the HbA1c results through .

48. The failure to summarise his previous history of hypos on the new computer records under "significant (not active)" was a moderate problem, depending on how serious those hypos were. Dr Lewis regarded doubling the dose of gliclazide to the maximum permissible dose as a very serious failure. He accepted that NICE guidelines contemplated a patient being on all 3 medicines but not in the same sequence as Dr Gibson had prescribed in this case. Dr Gibson should have avoided pursuing the highly intensive management simply designed to maintain Hb1Ac levels.

49. Case 7 involved removal on 7 June 2007 of a single rheumatoid nodule from the right elbow of a 72 year old woman with long standing rheumatoid arthritis ("RA"). She had rheumatoid nodules on her elbows and ankles caused by the disease. These were clinically obvious, hard and painful. Given the number of nodules, the patient should have all on one side (and subsequently all on the other side) removed by an orthopaedic surgeon under general anaesthetic ("GA"). Individual removal under local anaesthetic ("LA") would have been very traumatic.

50. Removal could in theory be done by a GP with appropriate training, experience and facilities but Dr Lewis would not expect a GP to undertake what Dr Gibson had done in her surgery under LA: a GP specialist in minor surgery local to him would not have undertaken this operation.

51. If the lump had been bursitis (inflammation of the bursa which is filled with fluid), it should not be excised. Rheumatoid nodules can be very adhesive and difficult to remove. They would have been there for years and it was highly unlikely that there was only one present when Dr Gibson removed it.

52. The record of the procedure was only a template: there should have been a note of the length of the incision and number of stitches and the difficulty of the procedure. There was no mention of the excessive haemorrhage: Dr Gibson had said in her interview, when asked if she remembered the

operation and the 'blood everywhere', that she did not want to remember the case. When Dr Gibson had seen the patient on 2 April 2007 she had coded the condition as "other bursitis of [the left] elbow" and ordered an X-ray which suggested she did not know that it was a rheumatoid nodule.

53. An X-ray was inappropriate for a bursa which is soft and boggy, not hard: it should have been obvious to a 5 year medical student that this was a rheumatoid nodule. The clinical details note "excision (rt elbow, excision of mass.)" on the histopathology report again suggested that Dr Gibson did not know what it was.

54. A 6cm incision required more than 4 sutures, perhaps 7. There would normally be an uneven number with one placed centrally and the others evenly from that point. The whole procedure was beyond Dr Gibson's competence.

55. In cross-examination Dr Lewis accepted that his report was inaccurate in describing Jackie Lindsey as a nurse (although he had begun the section of his report dealing with Case 7 by describing her as the treatment room manager) and implying that she had been present during the operation. He said that the finding of "dried blood +++" on the dressing the next day implied significant bleeding which was unusual after minor surgery. It was also unusual to have the dressing changed the next day. It was also unusual to have swelling 2 weeks after the operation. It would have been routine to send the excised mass for histology. Given that the patient had 7 or 8 nodules the matter should have been left to an orthopaedic surgeon in hospital.

56. In <u>Case 8</u> a nurse entered a BMI of 27.3 and a blood pressure reading of 143/99 for an existing patient of the practice on 25 October 2005. This was deleted by someone logged in as DLG (Dr Gibson) on 8 November 2005 and a blood pressure of 120/80 substituted for the original entry on 10 November 2005. Dr Lewis said that no competent GP would delete a blood pressure reading without a good reason, eg that it was clearly wrong. At interview Dr Gibson denied that it was she who had deleted the entry. The new blood pressure entry would give Dr Gibson Quality and Outcomes Framework ("QOF") points.

57. <u>Case 9</u> concerned the complaint of a mother that her 2 year old son had received the MMR vaccine without her consent and against her express instructions that the vaccination not be given. There was no record of the mother's consent in the records although Dr Gibson's practice in other cases was to record consent.

58. The 72 year old female patient in <u>Case 10</u> had a past history of vulval cancer. She was seen by the out of hours service ("OOH") at about 1700 on 22 September 2007 complaining of right hypochondrial pain for 5 days with similar pain a few weeks before. The OOH asked the GP to arrange an upper abdominal ultrasound as the patient might have gallstones.

59. Dr Gibson saw the patient on 24 September 2007 and requested a standard chest X-ray. She should have examined the chest and abdomen but there was no record of this in the notes. Although the documentation is not clear it appears that Dr Salim responded to the OOH message by requesting the ultrasound as the patient on examination had a ?? enlarged liver. The ultrasound report shows that the referral came from Dr Salim from Dr Gibson's practice.

60. Dr Gibson should have examined the patient's chest and abdomen and should have been able to feel an enlarged liver. The differential diagnosis would then have included cancer in the liver.

61. In cross-examination Dr Lewis accepted that the OOH doctor had not found an enlarged liver and Dr Gibson's record on 24 September was to the same effect. Dr Kacker told Dr Lewis that she had expedited the ultrasound because she had been worried about the patient's liver. In her interview Dr Gibson had told Dr Lewis that she had examined the chest but could not remember whether she had examined the abdomen.

62. Madeline Williams, a practice nurse at all four practices at the Health Centre, including Dr Gibson's practice drew some cases to Dr Lewis' attention when he came to the practice in the course of his investigation. She signed as true notes of his discussion with her.

63. The patient in Case 2 was referred to her by Dr Gibson for an endocervical swab for chlamydia in November 2004 before a coil fitment. She asked the patient why she was having the coil and was told it was because of very heavy periods and bleeding between periods and after intercourse.

64. When Ms Williams inserted the speculum she saw an obvious lesion on the cervix that was very friable, that is bleeding. She called Dr Gibson to the patient and later went back through the patient's notes and saw no note of her having been examined or investigated for the cause of her anaemia. Ms Williams did not enter "bleeding after intercourse" in her consultation note as she assumed it was already there. She only knew about that because the patient told her. This patient stuck in her mind which is why she looked up the notes and later raised it with Dr Lewis.

65. Cross-examined by Mr Hyam, Ms Williams accepted that she had not mentioned bleeding in her record entry and assumed that the patient had mentioned it to Dr Gibson. Her complaint was that Dr Gibson had not made a record of any examination that she had performed. She was very shocked and thought the patient would stick in her mind for ever. She accepted that her memory may have been faulty, if the patient told the hospital that she had only suffered the bleeding for 3 months since August.

66. Ms Williams also brought up Case 5 with Dr Lewis because she was concerned about an old lady she knew well through looking after her husband whom she saw in the surgery looking unwell. She was surprised when she found out by reading in the local newspaper that the lady had died and, looking at her notes, saw that she had died of lung cancer having seen Dr Gibson about a month before she died. The date of death was 19 June 2006 but there was an entry by Dr Gibson in the notes dated the day after that saying "cancer care review". She took that to mean that there had been a discussion about care between Dr Gibson and the patient, not that a letter had been received from the hospital.

66. In cross-examination Ms Williams accepted she had not been involved in the patient's care and had looked at the records about the end of June 2006.

67. In Case 9 on 14 March 2007 Ms Williams obtained consent from a mother for overdue vaccinations of Paedicel and for meningitis for her 3 year old. The mother then asked when the boy's

next vaccinations were due and then when her daughter's were due. Ms Williams told the mother that they were up to date except for MMR and the mother said that she did not want any of her children to have the MMR jab. Ms Williams replied that the other 2 children had had the MMR jab: the mother said they had not and Ms Williams checked the records and confirmed that the MMR jab had been given by Dr Gibson to her son on 29 December 2006. The mother was furious and went to see Dr Gibson. Ms Williams who made a written statement the same day because she believed that the mother was quite rightly going to make a complaint.

68. Cross-examined by Mr Hyam, Ms Williams confirmed she had been a nurse since 1975 and had been at the Health Centre from 1990 to 2002 and from 2004 where she now worked at the Red and Yellow practices.

69. Jackie Lindsey was the treatment room manager at the Health Centre at the relevant time and is now manager of 2 nurses and of clinical operations. She has worked as a phlebotomist but is not a nurse. She raised concerns with Dr Lewis when he came to the practice in the course of his investigation.

70. She mentioned the patient in Case 7 to Dr Lewis because she had been concerned by the amount of blood covering a room not normally used for minor surgery and for the patient whom she knew from taking her blood. She did not see the patient immediately after the operation.

71. Ms Lindsey was responsible for sterilization of instruments at the time because she was working for the dermatology team and was the only person who would have to do with the instruments. She had sterilized the surgical equipment but left it to cool before storing it and believed that Dr Gibson had used the equipment without sterilizing it as should be done within 30 minutes before use. This patient had been near the top of Dr Gibson's surgery list so there would not have been time for the equipment to be sterilized again before use.

72. Ms Lindsey had several times observed a lot of mess in a room Dr Gibson had used for fitting coils and occasionally seen a syringe with liquid and an unguarded needle left by Dr Gibson.

73. Cross-examined in relation to Case 7 Ms Lindsey said she saw for herself the amount of blood in the room after the operation and that the instruments had been left beside the sterilizer. Madeline Williams had helped Dr Gibson with the operation.

74. Ms Lindsey heard the patient in Case 3 making a loud noise in the corridor outside Dr Gibson's room whilst she was in the treatment room nearby and was worried about the impact on other patients. Her colleague Samantha Church, the treatment room receptionist, invited the patient to come into the treatment room to lie down. Dr Gibson had seen her and was writing a referral letter in her room.

75. The patient came into the treatment room, sat briefly then walked round the room before lying on the couch and saying that she wanted to push. Ms Lindsey said that it sounded as if she was having a baby and went to get Dr Gibson who was in her room alone and asked her to see the patient because she thought she was having a baby.

76. Dr Gibson said no, it was all right, she was writing a letter. Ms Lindsey tried to insist but Dr Gibson fobbed her off so she went back to the treatment room where the patient's partner was removing her underwear and she was pushing and saying she had not realized she was pregnant. Ms Lindsey went back to insist Dr Gibson attend her patient: Dr Gibson said she would be there in a minute and arrived later without running.

77. Dr Gibson then knelt and was rummaging around to find sterile gloves whilst the patient was obviously in labour and got to the patient only as she was giving birth. Ms Lindsey was outside the door but with a clear view and said that the baby "delivered itself".

78. The patient's mother and partner both said that Dr Gibson had not examined her and suspected appendicitis. Ms Lindsey saw Dr Gibson do nothing to help pre-birth. She then cut the cord but another patient in the building who was a midwife delivered the placenta. Ms Lindsey could not remember whether she had looked at this patient's notes.

79. Ms Lindsey described Dr Gibson as unlike all the other doctors in that she had little or no concern for her patients and avoided seeing and examining them as much as possible. She was financially driven. Ms Lindsey could not possibly work with her again

80. In cross-examination Ms Lindsey said that she had offered to speak to Dr Lewis, that she had never been a nurse but had looked at some patients' records. She did not now work for the Blue or White practices. When the favourable results of the patient satisfaction questionnaires were put to her Ms Lindsey said that she had only come across one or two patients who were very happy. She got feedback when taking blood from patients every day and they were saying negative things all the time.

81. Ms Lindsey had seen the state of the room after the surgery in Case 7: there was blood all over and the instruments had been left by the sterilizer. After she had removed the sutures on 22 June 2007 Patricia Sargeant told her that the operation was botched.

82. Cross-examined, she confirmed she did not now work for the Blue or White practices, that she had volunteered to speak to Dr Lewis, had never been a nurse and had looked at a few patients' records.

83. Ms Lindsey was challenged on her statement to Dr Lewis that Dr Gibson never dipped a urine sample or took a blood pressure. She said that the results on 2/133 were probably obtained by a nurse on a new patient registration but conceded that the blood pressure result at 2/131 was probably obtained by Dr Gibson but it was Dr Gibson's practice very rarely, if ever to take bloods or BP; she would send the patient to the treatment room for this purpose.

84. In re-examination Ms Lindsey said that staff could do BP or urine tests for any of the practices and there was a huge difference between Dr Gibson and the other doctors in this respect.

85. Janice Sumner is a health visitor who visited the mother in Case 9. She was told by a practice nurse that the mother had found out that her children had been given the MMR vaccination by mistake. She was due to visit the mother again so telephoned the mother to make an appointment and brought the matter up. The mother was very cross and wanted to change GPs.

86. On a home visit the mother had described what had happened and Ms Sumner had written it down. She handed the notes to the mother who said she would get a friend to help her write a letter of complaint. Her complaint was that she had given instructions that her children were not to be given MMR but they had been and she was very cross about it.

87. The evidence of Dr Kacker, a locum at Dr Gibson's practice, given to Dr Lewis on 30 November 2007 was agreed. She stated she had examined Case 10 recently and found an enlarged liver, vulval cancer and liver secondaries and that the enlarged liver would have been apparent on examination on 20 September 2007.

Dr Gibson's evidence

88. Dr Gibson confirmed that her extensive witness statement was true and relied upon it. She qualified in medicine in Benin, Nigeria in 1983 and came to England in 1986 to work in Obstetrics and Gynaecology ("O&G"), undertaking hospital posts up to the level of locum Consultant and obtained Membership of the Royal College of Obstetricians and Gynaecologists and then Fellowship in 2004. In 1994 she did vocational training in general practice and obtained MRCGP, returned to work in O & G and came back to full time general practice in 1998.

89. Dr Gibson denied the suggestion by Dr Kirby, her trainer, that she had gone at the end of her training period on a 2 week exchange with the practice in Chingford of the Associate Dean. She told the Panel that she had gone for one week on study leave to a practice in Essex, not by way of exchange.

90. In 2003 she joined the Blue practice at Walton Health Centre. This was then a 2-partner practice but 3 months after Dr Gibson joined the other partner left and she has practised single-handed since November 2003 with 2 part-time associates with a list size of about 3,000. The Blue practice shares the Centre with 3 other practices with shared use of the treatment room, a Health Centre Manager and Practice Nurses until March 2010. Doctors do not see patients from other practices and keep their own computer records via a shared server.

91. Dr Gibson said she had done well on objective assessments and scored highly on QOF. She had a low referral rate as she did minor surgery, insulin initiation, Practice Based Commissioning diabetic care, family planning, Warfarin monitoring and new patient testing in house. She felt she had been subject to close scrutiny by the PCT in particular in relation to patient registration. She relied on the reports of Dr Bevington and Dr Blackburn (Exhibits LGN/2 and 3 to her statement) as evidence of the PCT's general satisfaction with her practice.

92. Dr Gibson had received a visit to her practice by trainers with a view to her becoming a GP trainer at the beginning of 2008. At the end of this the recommendation of the assessors was that a further visit was required before approval could be granted (LGN 3/228). In her interview with Dr Lewis Dr Gibson said "I am a GP trainer but do not have a training practice". She relied upon her explanation that the other doctors at the Health Centre would not co-operate with her plan and accepted that, for that reason, she did not in fact have GP trainer status.

Tribunals Service
Primary Health Lists

Podium 31
Mowden Hall
Staindrop Road
Darlington
DL3 9BG
T 01325 391130/391051
F 01325 391045
EPrimaryHealthLists@tribunals.gsi.gov.uk

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IN THE FIRST TIER TRIBUNAL OF THE TRIBUNALS SERVICE
HEALTH EDUCATION AND SOCIAL CARE CHAMBER
PRIMARY HEATH LISTS CASE PHL/15180

Professor M Mildred - Chairman
Dr R Rathi – Professional Member
Ms K Wortham - General Member

BETWEEN

LUCIA NJOKU GIBSON (Registration Number 3515141)

Appellant

and

SURREY NHS PRIMARY CARE TRUST

Respondent

DECISION WITH REASONS

The appeal

1.The Appellant ("Dr Gibson") appeals from the decision of Surrey Primary Care Trust ("the PCT") of 12 June 2009 removing her from its Performers List on the ground of efficiency. The hearing of an appeal to a differently constituted Panel of the Tribunal was adjourned and a decision relating to the admissibility of evidence sought to be introduced by the PCT was successfully appealed by Dr Gibson to the Upper Tribunal. That body quashed the decision on 18 February 2011 and remitted the case to a new Panel of the First Tier Tribunal.

Background

2. On 16th March 2009 a letter was sent to Dr Gibson notifying her of the PCT's intention to remove her from its list on the ground of efficiency under Regulation 10(3) and 10(4)(a) of the NHS Performers Lists Regulations 2004 (as amended) ("the Regulations"). This was followed by an oral hearing on 1st June 2009. Dr Gibson, on advice from her legal team, withdrew from that

hearing on the basis that matters which she considered ought to have been excluded from that hearing had not been not excluded. The PCT relied upon a report by Dr Jonathan Lewis whom it had appointed to investigate the allegations against Dr Gibson and a record of an interview between Dr Lewis and Dr Gibson.

3. The PCT Panel had deemed 11 of 14 clinical cases relied on by the PCT were primarily concerned with the criterion of efficiency and made a finding of inefficiency in 10 of those 11 cases. The PCT Panel decided that Dr Gibson should be removed from the PCT's Performers List on ground of efficiency and recommended national disqualification.

4. Dr Gibson appealed against the PCT's decision to remove her from its List. The hearing was originally listed in March 2010, having been postponed until after the resolution of a criminal trial at the conclusion of which Dr Gibson was acquitted of all 37 charges alleging fraud in the course of her practice as a GP. The hearing in this Tribunal was adjourned shortly after it began as a result of the evidential issues referred to in paragraph 1 above.

The decision of the Upper Tribunal

5. The Upper Tribunal decided the First-tier Tribunal had erred in not considering at the beginning of the hearing whether any specific evidence should be excluded or redacted or whether there needed to be a clearer ruling as to the potential relevance of the evidence. It erred in law because it failed to rule that there was an inconsistency in the way the PCT presented its case and it failed to require the PCT to give the Dr Gibson adequate notice of the inferences it wished the First-tier Tribunal to draw from evidence of uninvestigated complaints and allegations that was not being admitted to prove the contents of the complaints and allegations.

The 2011 application

6. The parties sought to resolve differences in approach to the admissibility of evidence but there were 30 documents part or all of whose admissibility is disputed. I was asked and agreed to rule on the admissibility of these documents sitting alone as a case management matter. At the request of the parties I have (but my Panel colleagues have not) read the disputed documents.

7. I heard argument on 6th June 2011 from Mr Jeremy Hyam (instructed by RadcliffesLeBrasseur) on behalf of Dr Gibson and from Mr John de Bono (instructed by Weightmans) on behalf of the PCT at the Care Standards Tribunal, London SE1 before making a decision on the admissibility of the disputed evidence the same day.

Dr Gibson's concession

8. In the course of that application Dr Gibson conceded that her presence on the List did cause prejudice to the efficiency of the PCT's services (although not to the extent argued for by the PCT) sufficient to justify contingent removal. This was explicitly on the bases of Regulation 11(6)(b) and (c) inasmuch as Dr Gibson accepted that she had been out of practice for over 3 ½ years and that she accepted some (but not all) the deficiencies alleged by Dr Lewis in respect of the 10 cases.

The substantive hearing

9. The appeal was heard on 7-10 June and 6 July 2011 at the Care Standards Tribunal, London SE1. Representation was as set out in paragraph 7 above.

The PCT's case

10. The PCT accepted that Dr Gibson had been acquitted of all criminal charges of fraud made against her but contended that those acquittals did not prevent it saying that she had not been truthful in relation to the matters before us.

11. It was agreed that the key issue for this Panel was whether the continued inclusion of her in the list would is so prejudicial to the efficiency of those services that the only fair and proportionate sanction either to:

(i) Impose conditions on her inclusion in the performers list breach of which would render her liable to removal (contingent removal under Regulations 12 and 15); or, in the event that that is not sufficient, to
(ii) Remove her from the list entirely (Regulation 10(3)).

12. The PCT's case was that there were no conditions that could be imposed that would be proportionate and fair to both sides and that would address the problems in Dr Gibson's practice.

13. At this point Mr Hyam informed us that Dr Gibson had been suspended by the GMC on 23 September 2008 and acquitted in the criminal court in December 2009. Her suspension was extended and there was a performance assessment by the GMC which had led to a referral to the GMC Fitness to Practice Panel for which no date was yet fixed. Whilst Dr Gibson was suspended pending that GMC hearing, if she was contingently removed by this Panel, she would apply to vary her suspension so as to allow her to practice under training conditions. More would be disclosed about the position with the GMC in due course. Mr de Bono said that the PCT's position was that it was possible but not likely that the GMC would vary its suspension to allow a contingent removal to take effect.

The PCT's evidence

14. The PCT's main witness was Dr Jonathan Lewis, a full-time GP for 22 years and a GP trainer who had played various roles in teaching final year medical students and the PCT and its predecessors and had vetted some 20,000 referral letters from GPs to secondary care as part of a PCT cost-saving exercise. He had been asked by the PCT and agreed to conduct an investigation into Dr Gibson's clinical practice and had produced a report for the PCT Panel hearing. This report had been amended in the light of the report from Dr Gibson's expert and Dr Gibson's witness statement. The final report was dated 15 April 2011. Parts of it had been redacted by agreement or in consequence of my decision of 6 June. Dr Lewis said he was impartial and came to assist the Panel rather than achieve a particular outcome for the PCT

15. Dr Lewis was the third witness and began his evidence on 8 June 2011. Since his report forms the backbone of the PCT's case and deals in detail with the 10 patients whose treatment by Dr Gibson is central to this appeal, it is convenient to begin with his evidence out of sequence.

16. In November 2007 Dr Lewis went to speak to Janet Wilson, the Manager of Walton Health Centre, who had told him of the problems she had encountered with Dr Gibson. He then interviewed

any staff members who wanted to be interviewed and none who did not. He would sit in a room with the staff member with the computer records of a patient in respect of whom a concern had been expressed open on the screen.

17. Dr Lewis made notes of what was said by staff members then read the whole records and copied relevant extracts and audit trails of changes to the records. He was later asked by the PCT's solicitors to convert summaries of those investigations into Appendices to be signed by the witnesses. Nine of the 10 cases were referred to him by staff members; he discovered Case 1 by himself following on from his examination of patients who had died during the time Dr Gibson was at the Health Centre.

18. The computer system in the surgery was EMIS with which he was very familiar. Dr Lewis explained that the consultation mode showed where and how the consultation had taken place. A user would log in with a password and everything would be recorded under the username (DLG for Dr Gibson, BLOC for a locum in the Blue Practice etc). To log off, the user should input CU to show a change of user. Receptionists were good at doing this: doctors less so. Notes were recorded in free text, using macros set up by the doctor and templates.

19. The notes produced were as at the time they were printed. An audit trail showed the time, date and detail of any amendment of the original entry including any additions such as read codes. A read code is a 5-character code for every medical problem. Dr Lewis then dealt with the 10 cases in order.

20. <u>Case 1</u> concerned a 63 year old man who died from rectal cancer in May 2006. Examination of the records showed that Dr Gibson had not examined the patient again after 7/9/05 when she noted "gen cond satis" a macro for general condition satisfactory and "some faecal masses felt [on the patient's] r[igh]t [side].

21. Dr Lewis said that the mass was highly unlikely to have been faecal as the construction of the bowel was such that the mass, if faecal, would have been palpable on the left first and then the middle, neither of which was observed or noted by Dr Gibson. This mass was not the rectal cancer from which the patient died but was also not faeces. It is familiar medical terminology to describe faeces alone as "indentable". A cancer is not indentable. In his interview Dr Gibson said that it was not unusual to feel constipation on the right side – it depended on how far down the faecal mass is.

22. The 2 week rule in relation to cancer requires a mass on the right of the body to be referred unless it is constipation, which this was not. Dr Lewis would have considered a change of bowel habit and tested for occult faecal blood that would indicate cancer. The minimum acceptable process in this case would be to review the abdomen again but there is no indication in the records that this was planned and it never happened.

23. Dr Gibson looked at the faecal culture test report and assigned it "normal". Whilst the results may have been normal for infection it was very abnormal in relation to cancer as it included the findings of red and white blood cells +++ and should have been acted upon and referred to a gastro-enterologist. This referral was later made by a locum. Presence of the mass was an opportunity to investigate further or re-examine. Failure to do either was a very serious failure.

24. In cross-examination Dr Lewis said that he had never confidently felt a faecal mass in an adult. Dr Gibson had first described the mass as soft and only 2 years later as indentable. The 2-week rule does not distinguish between hard and soft masses; if the mass was on the patient's right side, it must be referred. It should also have been investigated. The locum and consultant could not feel the mass. It was possible but highly unlikely that what Dr Gibson felt was a sigmoid colon with faeces in it.

25. Case 2 was drawn to Dr Lewis' attention by Madeline Williams, a practice nurse, and concerned a 38 year old woman whose anaemia Dr Gibson failed properly to investigate in February 2004. She was found on 12 November 2004 to have a cervical cancer on examination. A GP should ask herself why a 38 year old woman was anaemic since bowel or cervical cancers were worrying possibilities although the most common cause would be heavy periods. A GP should take a full history of the patient's bleeding including frequency and heaviness, ask about bleeding between periods or after intercourse and test for faecal occult blood in case the patient had bowel cancer.

26. There is no record in the notes of Dr Gibson asking any of these questions or of any test for faecal blood or blood in urine (which might indicate a cancer of the kidney). Dr Lewis could not understand why she had sent a stool sample for culture and the laboratory result reminded Dr Gibson that a clinical summary should always be sent with the sample. A stool sample would not normally be tested in a case of anaemia.

27. The entry for 25 June 2004 was coded "anaemia unspecified" which suggested that Dr Gibson did not know what was the cause. The blood tests on 16 July and 8 October were probably for anaemia; Dr Gibson was checking the patient's blood and prescribing her iron rather than investigating the cause of anaemia.

28. The prescription of a Mirena coil was designed to control heavy bleeding by the release of a progestogen and it was appropriate to take a swab for chlamydia first. Dr Gibson did not record asking whether the patient had bled after intercourse; if she had asked the patient this on 22 October, she should then have examined her or taken a swab. The coil would have been appropriate to control heavy periods, not irregular bleeding.

29. The letter from Dr Gibson dated 12 November 2004 referring the patient to hospital described her as complaining about irregular menstrual bleeding for some months. The problem with the case was that Dr Gibson did not try to discover the cause of the anaemia.

30. In cross-examination Dr Lewis said that, if the cancer was 2 cm and friable on 12 November, it must have been growing for a year and have bled after intercourse. Dr Lewis accepted that the patient may not have mentioned bleeding after intercourse to Dr Gibson as he had not been present at the consultation.

31. Case 3 concerned the sudden delivery of a child in the surgery on 29 March 2005. Dr Lewis said that the emergency referral letter to the hospital had been written on 29 March 2005. When Dr Gibson wrote "on examination" in the letter she had implied that she had actually examined the patient whereas he thought the examination may have only been a visual examination and the taking of pulse and blood pressure. There was no evidence in the initial record that a physical examination

had been offered and refused: a baby at 36 weeks gestation could easily be felt and distinguished from a distended abdomen.

32. Dr Gibson changed the entry the next day to say that the patient had refused an examination. This was bad practice: it was better to write a new note explicitly correcting the day before's note (for example, by saying I now remember the patient refused an examination) as it was important to know when a note had been written.

33. It was a major change from patient examined to patient refused examination and the inference Dr Lewis drew was of a cover up. If the patient was in fact 36 weeks pregnant, she would not have told Dr Gibson that her last menstrual period was 3 weeks ago , although it is possible she could have had showing of blood.

34. In cross-examination Dr Lewis said that labour pain comes at regular intervals and there could have been an examination during one of these: he thought it unlikely that Dr Gibson had examined the abdomen in this case. He accepted that he had investigated the case on the information provided by Jackie Lindsey and that neither she nor Samantha Church was a nurse. He said that Dr Sillick may have said that the midwife who was in the building as a patient delivered the baby. He agreed it was a very confused episode.

35. Case 4 concerned a 48 year old woman who had a retained tampon discovered by Sarah Jack, a nurse, 6 days after Dr Gibson had noted a vaginal discharge after a period and referred her for a high vaginal and Chlamydia swab although she now said that she had observed bleeding rather than a discharge. Although the tampon may have been retained after the consultation, retention was rare and a competent GP should have suspected it on seeing a discharge after a period. Dr Gibson should have considered all causes of vaginal infection and taken a swab herself: this would have revealed the tampon. The note of the consultation refers to discharge whereas Dr Gibson reported the patient complaining of bleeding. The nurse Sarah Jack's record on 22 June 2007 clearly implied a clear discharge, rather than bleeding had been observable on 16 June. The pathological report implied the existence of bugs with no specific infection, rather than bleeding for which in any event a swab would not normally be requested.

36. Dr Gibson referred the patient to the GUM clinic. This should be a referral only when an STD is suspected. Dr Gibson had told Dr Lewis that she would sometimes send patients there for other reasons because there was a consultant in attendance and tests were done quickly.

37. Cross-examined, Dr Lewis said that Sarah Jack's account was that the patient went to Dr Gibson with a discharge, not bleeding and that there would have been no reason for a high vaginal and chlamydia swab unless there had been a discharge. There had been a finding of numerous bacteria present on the swab although these had not grown.

38. Case 5 concerned an 84 year old woman. In a consultation on 2 May 2006 Dr Gibson had recorded dizziness and cough for 1 week and the inference from the note was that she would have listened to the patient's chest with clothes raised. There was no evidence that Dr Gibson looked for a raised temperature or breathing rate, crepitations, bronchial breathing or a pleural rub. In the light of

later findings Dr Lewis thought it very unlikely the patient's chest had been clear on 2 May. The description "general cond satis" was very unlikely to have been accurate and it was very unlikely that her chest was clear.

39. Dr Gibson removed a keratosis by cryotherapy. The entry in the records that payment for this could be claimed suggested that the keratosis was actinic. An actinic keratosis could be pre-malignant but this would not happen for years so that there was no clinical basis for removing it: it would have hurt and been uncomfortable for days. The chance that the keratosis on the chest of an 84 year old was actinic was about 5% and the procedure should not have been carried out. Dr Gibson did vastly more of these procedures than other doctors in the Health Centre.

40. Dr Gibson said she had carried out a mental health review because of the patient's insomnia. The consultation notes were edited on 8 June to record the review and Dr Lewis could not understand how Dr Gibson would have remembered more than a month after the review that she had forgotten to record it on the computer (which would trigger a payment from the PCT). Asking about the patient's insomnia alone would not count as a mental health review.

41. On 20 June , the day after the patient died, Dr Gibson added an entry of a consultation in the surgery on a template "cancer care review discussed diagnosis" which implied that the patient had been seen in the surgery and the cancer discussed. The hospital report had described the patient as at status 4 on 9 June 2006 from which it could be inferred that the major concern for the patient was her cancer, rather than the stroke she suffered.

42. In cross-examination Dr Lewis conceded that it was possible the patient's chest was clear on 2 May but said, drawing on his experience as a medical officer at a hospice, that her general condition must have been far from satisfactory as she died a few weeks later of cancer. He accepted that the giving of consent to the cryotherapy implied a discussion between doctor and patient and that it was possible that there could have been a comfort-based reason for removing the keratosis.

43. Case 6 involved a 75 year old diabetic male. The patient was susceptible to hypoglycaemia and was maintained on insulin, metformin and glicazide. Dr Lewis was informed by a practice nurse that she had spoken to Dr Gibson about the patient's repeated hypoglycaemic attacks ("hypos") caused by low blood sugar down to 1.6 to no avail. Dr Gibson treated him by reference to his levels of glycosylated haemoglobin (HbA1c) which measures levels of blood sugar over the last 3 months) alone. It rose from 6.9% in August 2006 to 7.7% in March 2007 and then fell to 5.9% on 14 May 2007. The normal range is up to 6.5% and a well-controlled elderly diabetic would be in the range 7-7.5%.

44. The patient saw Dr Gibson on 14 May 2007 after a severe hypo the day before but she did not reduce his medication to prevent a recurrence. He suffered another hypo on 15 May. These were caused by excessive gliclazide.

45. Dr Lewis had never seen a patient given all 3 medicines together and adding gliclazide after insulin and metformin is contrary to the recommendations of the BNF. The recommendations are to add bedtime insulin, if control is not met. This patient was on twice-daily insulin when the gliclazide

was added. Dr Gibson doubled the gliclazide to the maximum dose of 160mg twice a day because she wanted to get the HbA1c down rather than deal with the patient's problem with hypos. The dose was increased without seeing the patient or speaking to him on the telephone even though he was known to neglect himself.

46. A raised HbA1c does not by itself put the patient at risk: it may increase the risk of a heart attack or stroke but this was nowhere near as bad as the risk of hypos. This treatment was very poor and out of the range of normal practice. Dr Gibson should have involved the hospital specialist in the patient's care when she saw him on 14 May. He had been discharged into GP care in 1997 on insulin alone and was not under shared care as Dr Gibson had said in her statement. He had had hypos noted in his records in 1985, 1987 and 2000: these should have been noted in the summary when his Lloyd George notes were summarized in the new computer records.

47. Cross-examined, Dr Lewis accepted that between June 2006 and March 2007 the patient had achieved good control of his HbA1c without any hypos. There had been a hypo on 13 May after Dr Gibson had increased his gliclazide on 15 March 2007 without seeing the patient, based on HbA1c results. He considered she should have reduced the patient's gliclazide on 14 May considered she should have reduced the patient's gliclazide on 14 May to respond to his hypo but did not do so until she had the HbA1c results through .

48. The failure to summarise his previous history of hypos on the new computer records under "significant (not active)" was a moderate problem, depending on how serious those hypos were. Dr Lewis regarded doubling the dose of gliclazide to the maximum permissible dose as a very serious failure. He accepted that NICE guidelines contemplated a patient being on all 3 medicines but not in the same sequence as Dr Gibson had prescribed in this case. Dr Gibson should have avoided pursuing the highly intensive management simply designed to maintain Hb1Ac levels.

49. Case 7 involved removal on 7 June 2007 of a single rheumatoid nodule from the right elbow of a 72 year old woman with long standing rheumatoid arthritis ("RA"). She had rheumatoid nodules on her elbows and ankles caused by the disease. These were clinically obvious, hard and painful. Given the number of nodules, the patient should have all on one side (and subsequently all on the other side) removed by an orthopaedic surgeon under general anaesthetic ("GA"). Individual removal under local anaesthetic ("LA") would have been very traumatic.

50. Removal could in theory be done by a GP with appropriate training, experience and facilities but Dr Lewis would not expect a GP to undertake what Dr Gibson had done in her surgery under LA: a GP specialist in minor surgery local to him would not have undertaken this operation.

51. If the lump had been bursitis (inflammation of the bursa which is filled with fluid), it should not be excised. Rheumatoid nodules can be very adhesive and difficult to remove. They would have been there for years and it was highly unlikely that there was only one present when Dr Gibson removed it.

52. The record of the procedure was only a template: there should have been a note of the length of the incision and number of stitches and the difficulty of the procedure. There was no mention of the excessive haemorrhage: Dr Gibson had said in her interview, when asked if she remembered the

operation and the ‘blood everywhere’, that she did not want to remember the case. When Dr Gibson had seen the patient on 2 April 2007 she had coded the condition as “other bursitis of [the left] elbow” and ordered an X-ray which suggested she did not know that it was a rheumatoid nodule.

53. An X-ray was inappropriate for a bursa which is soft and boggy, not hard: it should have been obvious to a 5 year medical student that this was a rheumatoid nodule. The clinical details note “excision (rt elbow, excision of mass.)” on the histopathology report again suggested that Dr Gibson did not know what it was.

54. A 6cm incision required more than 4 sutures, perhaps 7. There would normally be an uneven number with one placed centrally and the others evenly from that point. The whole procedure was beyond Dr Gibson’s competence.

55. In cross-examination Dr Lewis accepted that his report was inaccurate in describing Jackie Lindsey as a nurse (although he had begun the section of his report dealing with Case 7 by describing her as the treatment room manager) and implying that she had been present during the operation. He said that the finding of “dried blood +++” on the dressing the next day implied significant bleeding which was unusual after minor surgery. It was also unusual to have the dressing changed the next day. It was also unusual to have swelling 2 weeks after the operation. It would have been routine to send the excised mass for histology. Given that the patient had 7 or 8 nodules the matter should have been left to an orthopaedic surgeon in hospital.

56. In Case 8 a nurse entered a BMI of 27.3 and a blood pressure reading of 143/99 for an existing patient of the practice on 25 October 2005. This was deleted by someone logged in as DLG (Dr Gibson) on 8 November 2005 and a blood pressure of 120/80 substituted for the original entry on 10 November 2005. Dr Lewis said that no competent GP would delete a blood pressure reading without a good reason, eg that it was clearly wrong. At interview Dr Gibson denied that it was she who had deleted the entry. The new blood pressure entry would give Dr Gibson Quality and Outcomes Framework (“QOF”) points.

57. Case 9 concerned the complaint of a mother that her 2 year old son had received the MMR vaccine without her consent and against her express instructions that the vaccination not be given. There was no record of the mother’s consent in the records although Dr Gibson’s practice in other cases was to record consent.

58. The 72 year old female patient in Case 10 had a past history of vulval cancer. She was seen by the out of hours service (“OOH”) at about 1700 on 22 September 2007 complaining of right hypochondrial pain for 5 days with similar pain a few weeks before. The OOH asked the GP to arrange an upper abdominal ultrasound as the patient might have gallstones.

59. Dr Gibson saw the patient on 24 September 2007 and requested a standard chest X-ray. She should have examined the chest and abdomen but there was no record of this in the notes. Although the documentation is not clear it appears that Dr Salim responded to the OOH message by requesting the ultrasound as the patient on examination had a ?? enlarged liver. The ultrasound report shows that the referral came from Dr Salim from Dr Gibson’s practice.

60. Dr Gibson should have examined the patient's chest and abdomen and should have been able to feel an enlarged liver. The differential diagnosis would then have included cancer in the liver.

61. In cross-examination Dr Lewis accepted that the OOH doctor had not found an enlarged liver and Dr Gibson's record on 24 September was to the same effect. Dr Kacker told Dr Lewis that she had expedited the ultrasound because she had been worried about the patient's liver. In her interview Dr Gibson had told Dr Lewis that she had examined the chest but could not remember whether she had examined the abdomen.

62. Madeline Williams, a practice nurse at all four practices at the Health Centre, including Dr Gibson's practice drew some cases to Dr Lewis' attention when he came to the practice in the course of his investigation. She signed as true notes of his discussion with her.

63. The patient in Case 2 was referred to her by Dr Gibson for an endocervical swab for chlamydia in November 2004 before a coil fitment. She asked the patient why she was having the coil and was told it was because of very heavy periods and bleeding between periods and after intercourse.

64. When Ms Williams inserted the speculum she saw an obvious lesion on the cervix that was very friable, that is bleeding. She called Dr Gibson to the patient and later went back through the patient's notes and saw no note of her having been examined or investigated for the cause of her anaemia. Ms Williams did not enter "bleeding after intercourse" in her consultation note as she assumed it was already there. She only knew about that because the patient told her. This patient stuck in her mind which is why she looked up the notes and later raised it with Dr Lewis.

65. Cross-examined by Mr Hyam, Ms Williams accepted that she had not mentioned bleeding in her record entry and assumed that the patient had mentioned it to Dr Gibson. Her complaint was that Dr Gibson had not made a record of any examination that she had performed. She was very shocked and thought the patient would stick in her mind for ever. She accepted that her memory may have been faulty, if the patient told the hospital that she had only suffered the bleeding for 3 months since August.

66. Ms Williams also brought up Case 5 with Dr Lewis because she was concerned about an old lady she knew well through looking after her husband whom she saw in the surgery looking unwell. She was surprised when she found out by reading in the local newspaper that the lady had died and, looking at her notes, saw that she had died of lung cancer having seen Dr Gibson about a month before she died. The date of death was 19 June 2006 but there was an entry by Dr Gibson in the notes dated the day after that saying "cancer care review". She took that to mean that there had been a discussion about care between Dr Gibson and the patient, not that a letter had been received from the hospital.

66. In cross-examination Ms Williams accepted she had not been involved in the patient's care and had looked at the records about the end of June 2006.

67. In Case 9 on 14 March 2007 Ms Williams obtained consent from a mother for overdue vaccinations of Paedicel and for meningitis for her 3 year old. The mother then asked when the boy's

next vaccinations were due and then when her daughter's were due. Ms Williams told the mother that they were up to date except for MMR and the mother said that she did not want any of her children to have the MMR jab. Ms Williams replied that the other 2 children had had the MMR jab: the mother said they had not and Ms Williams checked the records and confirmed that the MMR jab had been given by Dr Gibson to her son on 29 December 2006. The mother was furious and went to see Dr Gibson. Ms Williams who made a written statement the same day because she believed that the mother was quite rightly going to make a complaint.

68. Cross-examined by Mr Hyam, Ms Williams confirmed she had been a nurse since 1975 and had been at the Health Centre from 1990 to 2002 and from 2004 where she now worked at the Red and Yellow practices.

69. Jackie Lindsey was the treatment room manager at the Health Centre at the relevant time and is now manager of 2 nurses and of clinical operations. She has worked as a phlebotomist but is not a nurse. She raised concerns with Dr Lewis when he came to the practice in the course of his investigation.

70. She mentioned the patient in Case 7 to Dr Lewis because she had been concerned by the amount of blood covering a room not normally used for minor surgery and for the patient whom she knew from taking her blood. She did not see the patient immediately after the operation.

71. Ms Lindsey was responsible for sterilization of instruments at the time because she was working for the dermatology team and was the only person who would have to do with the instruments. She had sterilized the surgical equipment but left it to cool before storing it and believed that Dr Gibson had used the equipment without sterilizing it as should be done within 30 minutes before use. This patient had been near the top of Dr Gibson's surgery list so there would not have been time for the equipment to be sterilized again before use.

72. Ms Lindsey had several times observed a lot of mess in a room Dr Gibson had used for fitting coils and occasionally seen a syringe with liquid and an unguarded needle left by Dr Gibson.

73. Cross-examined in relation to Case 7 Ms Lindsey said she saw for herself the amount of blood in the room after the operation and that the instruments had been left beside the sterilizer. Madeline Williams had helped Dr Gibson with the operation.

74. Ms Lindsey heard the patient in Case 3 making a loud noise in the corridor outside Dr Gibson's room whilst she was in the treatment room nearby and was worried about the impact on other patients. Her colleague Samantha Church, the treatment room receptionist, invited the patient to come into the treatment room to lie down. Dr Gibson had seen her and was writing a referral letter in her room.

75. The patient came into the treatment room, sat briefly then walked round the room before lying on the couch and saying that she wanted to push. Ms Lindsey said that it sounded as if she was having a baby and went to get Dr Gibson who was in her room alone and asked her to see the patient because she thought she was having a baby.

76. Dr Gibson said no, it was all right, she was writing a letter. Ms Lindsey tried to insist but Dr Gibson fobbed her off so she went back to the treatment room where the patient's partner was removing her underwear and she was pushing and saying she had not realized she was pregnant. Ms Lindsey went back to insist Dr Gibson attend her patient: Dr Gibson said she would be there in a minute and arrived later without running.

77. Dr Gibson then knelt and was rummaging around to find sterile gloves whilst the patient was obviously in labour and got to the patient only as she was giving birth. Ms Lindsey was outside the door but with a clear view and said that the baby "delivered itself".

78. The patient's mother and partner both said that Dr Gibson had not examined her and suspected appendicitis. Ms Lindsey saw Dr Gibson do nothing to help pre-birth. She then cut the cord but another patient in the building who was a midwife delivered the placenta. Ms Lindsey could not remember whether she had looked at this patient's notes.

79. Ms Lindsey described Dr Gibson as unlike all the other doctors in that she had little or no concern for her patients and avoided seeing and examining them as much as possible. She was financially driven. Ms Lindsey could not possibly work with her again

80. In cross-examination Ms Lindsey said that she had offered to speak to Dr Lewis, that she had never been a nurse but had looked at some patients' records. She did not now work for the Blue or White practices. When the favourable results of the patient satisfaction questionnaires were put to her Ms Lindsey said that she had only come across one or two patients who were very happy. She got feedback when taking blood from patients every day and they were saying negative things all the time.

81. Ms Lindsey had seen the state of the room after the surgery in Case 7: there was blood all over and the instruments had been left by the sterilizer. After she had removed the sutures on 22 June 2007 Patricia Sargeant told her that the operation was botched.

82. Cross-examined, she confirmed she did not now work for the Blue or White practices, that she had volunteered to speak to Dr Lewis, had never been a nurse and had looked at a few patients' records.

83. Ms Lindsey was challenged on her statement to Dr Lewis that Dr Gibson never dipped a urine sample or took a blood pressure. She said that the results on 2/133 were probably obtained by a nurse on a new patient registration but conceded that the blood pressure result at 2/131 was probably obtained by Dr Gibson but it was Dr Gibson's practice very rarely, if ever to take bloods or BP; she would send the patient to the treatment room for this purpose.

84. In re-examination Ms Lindsey said that staff could do BP or urine tests for any of the practices and there was a huge difference between Dr Gibson and the other doctors in this respect.

85. Janice Sumner is a health visitor who visited the mother in Case 9. She was told by a practice nurse that the mother had found out that her children had been given the MMR vaccination by mistake. She was due to visit the mother again so telephoned the mother to make an appointment and brought the matter up. The mother was very cross and wanted to change GPs.

86. On a home visit the mother had described what had happened and Ms Sumner had written it down. She handed the notes to the mother who said she would get a friend to help her write a letter of complaint. Her complaint was that she had given instructions that her children were not to be given MMR but they had been and she was very cross about it.

87. The evidence of Dr Kacker, a locum at Dr Gibson's practice, given to Dr Lewis on 30 November 2007 was agreed. She stated she had examined Case 10 recently and found an enlarged liver, vulval cancer and liver secondaries and that the enlarged liver would have been apparent on examination on 20 September 2007.

Dr Gibson's evidence

88. Dr Gibson confirmed that her extensive witness statement was true and relied upon it. She qualified in medicine in Benin, Nigeria in 1983 and came to England in 1986 to work in Obstetrics and Gynaecology ("O&G"), undertaking hospital posts up to the level of locum Consultant and obtained Membership of the Royal College of Obstetricians and Gynaecologists and then Fellowship in 2004. In 1994 she did vocational training in general practice and obtained MRCGP, returned to work in O & G and came back to full time general practice in 1998.

89. Dr Gibson denied the suggestion by Dr Kirby, her trainer, that she had gone at the end of her training period on a 2 week exchange with the practice in Chingford of the Associate Dean. She told the Panel that she had gone for one week on study leave to a practice in Essex, not by way of exchange.

90. In 2003 she joined the Blue practice at Walton Health Centre. This was then a 2-partner practice but 3 months after Dr Gibson joined the other partner left and she has practised single-handed since November 2003 with 2 part-time associates with a list size of about 3,000. The Blue practice shares the Centre with 3 other practices with shared use of the treatment room, a Health Centre Manager and Practice Nurses until March 2010. Doctors do not see patients from other practices and keep their own computer records via a shared server.

91. Dr Gibson said she had done well on objective assessments and scored highly on QOF. She had a low referral rate as she did minor surgery, insulin initiation, Practice Based Commissioning diabetic care, family planning, Warfarin monitoring and new patient testing in house. She felt she had been subject to close scrutiny by the PCT in particular in relation to patient registration. She relied on the reports of Dr Bevington and Dr Blackburn (Exhibits LGN/2 and 3 to her statement) as evidence of the PCT's general satisfaction with her practice.

92. Dr Gibson had received a visit to her practice by trainers with a view to her becoming a GP trainer at the beginning of 2008. At the end of this the recommendation of the assessors was that a further visit was required before approval could be granted (LGN 3/228). In her interview with Dr Lewis Dr Gibson said "I am a GP trainer but do not have a training practice". She relied upon her explanation that the other doctors at the Health Centre would not co-operate with her plan and accepted that, for that reason, she did not in fact have GP trainer status.

94. Dr Gibson then dealt with the 10 cases in turn. On Case 1 she said she had felt a definite faecal mass: if she had been unsure, she would have written ?? in the notes. She agreed she would not expect to feel the mass in the (right) ascending colon and said that it must have been in the sigmoid colon. She was familiar with the anatomy from her surgical experience. Constipation can cause the sigmoid colon to flop to the right side. She accepted that she should have re-examined the patient on 3 October or 10 November 2005 and that this was a significant failing.

95. In cross-examination Dr Gibson said that, given the long history of constipation and the absence of other signs or symptoms, the differential diagnosis was constipation or irritable bowel syndrome. She examined the patient to check for other problems such as cancer of the colon or rectum. She considered cancer but excluded it from the history of no change of bowel habit. She asked the patient about rectal bleeding but did not record the negative answer. She was not surprised to find the mass on the patient's right side as he was slimly built and she had felt such a mass in another patient before this. Dr Gibson did, however, accept that a faecal mass would be more common on the left side because that was where the sigmoid colon sat. She did not accept that it was very rare to find constipation on the right side.

96. She had used the word "indentable" in her witness statement but not in her interview: this was because she was sure it was faecal. If a mass is indentable, it would also be soft. If indentable it is faecal although a faecal mass could also be hard. The only thing Dr Gibson did not do was a rectal examination and a faecal occult blood test as her working diagnosis was constipation. She accepted that in retrospect the latter would have been a good idea, that she had not given the patient a fixed appointment to come back to see her after the second consultation on 3 October 2005 and that she was mistaken in her interview with Dr Lewis that he was feeling better on that date.

97. Dr Gibson accepted that her earlier statement had said that the stool sample taken on 5 December 2005 was reported normal. She had meant this in relation to infection but accepted that she should have mentioned the presence of red and white blood cells +++. Importantly she accepted that this entry in the records on 5.12.2005 under the username DLG was 99% likely made by her. The presence of the blood cells in the stool could have been caused by straining in constipation but agreed that cancer was a much more likely cause.

98. Dr Gibson accepted that on 4 April 2006 she had added to the note of the consultation with Dr Pirrie on 29 March 2006 the entries "Cancer care review 29.3.2006; cancer diagnosis discussed 29.3.2006 and Ca care plan discussed with pt 29.3.2006". Dr Pirrie should have made these entries and Dr Gibson was tidying up the notes. Dr Pirrie would have mentioned the cancer diagnosis to her because it was unusual; she may have asked Dr Gibson to tidy up the notes because she wasn't very conversant with EMIS. Dr Pirrie may have mentioned this to Dr Gibson on 4 April or earlier in which case Dr Gibson would have made herself a paper note to remind her to make the entries when she had time. Since it was unusual Dr Gibson wanted to check the case. Dr Pirrie had done the review on 29 March but not put in the read code for it. Dr Gibson could not remember whether Dr Pirrie had asked her to insert the read code or whether she had checked the notes and found the code absent.

99. In Case 2 Dr Gibson accepted that she had erred in not recording questions about heaviness of periods, irregular or post-coital bleeding) and in sending a stool sample rather than asking for faecal occult blood testing and negative findings and that these constituted a moderate failure.

100. In cross-examination Dr Gibson said she knew the patient well and as a matter of practice would have asked the questions set out in the last paragraph. The differential diagnosis would have included nutritional problems, menstrual dysfunction, peptic ulceration, chronic diseases and bowel cancer. The patient did not tell Dr Gibson on 5 February 2004 that she had heavy periods but did tell her this on 22 October 2004. This and the time it had gone on should have been recorded. Dr Gibson's referral letter of 12 November 2004 records irregular menstrual bleeding "for some months now" although that is not mentioned in the consultation record for 22 October 2004.

101. Dr Gibson said that the growth was not friable but was a cauliflower type adenocarcinoma that was not likely to bleed after intercourse. She would have recorded irregular bleeding on 5 February, if the patient had mentioned it. From the test results Dr Gibson thought the patient had a mild iron deficiency and investigated the anaemia by taking the history and doing some investigations.

102. In Case 3 Dr Gibson accepted that Jackie Lindsey might have thought she was fobbing her off because she did not want to deliver the baby but she had attended the birth. She was having a very busy surgery and this patient had no appointment. Dr Gibson said she did not examine the patient's abdomen but accepted that the first record in the notes "exam. transferred to rx room" suggested that she had. She had had a long day so finished off writing the patient's notes the next day to read "screaming ref[used] exam".

103. In cross-examination Dr Gibson said that she would have recognised the labour, if she had examined the patient. To say the patient refused examination may have been a bit strong; she lay on the couch in Dr Gibson's room and agreed to be examined – this could have been explained better. Her pulse and blood pressure were taken but she did not want Dr Gibson to touch her. Dr Gibson asked the patient about her periods as she wondered whether there was an ectopic pregnancy and rang 999 from her room while the patient was on the couch. Samantha Church heard her and asked her to go to the treatment room where the couch was more comfortable. Dr Gibson and Ms Church took her there and Dr Gibson tried to examine her and found the membranes bulging so she went back to her room to type the referral letter because her computer was open and that in the treatment room was not. Dr Gibson did not want the membranes to be ruptured because there was no equipment to resuscitate the baby, if necessary.

104. Dr Gibson examined the patient twice "down below" in the treatment room without gloves. On the first occasion she could hardly feel the head and the labour was at the first stage and on the second the baby was about to be born. Dr Gibson accepted that none of this was recorded as it should have been. She did not, however, do anything to avoid helping the patient and Jackie Lindsey was wrong about this and about her insisting Dr Gibson should attend the patient and about Dr Gibson searching for gloves: they were obviously available on the trolley.

105. Dr Gibson did not have time to make proper notes there and then and went back to her surgery which had begun at 3pm and this incident took place at about 4pm. Accordingly she completed the notes the next day but she accepted she should have made it clear this was a retrospective entry. She could not update the notes that evening from home as the system did not allow entry of consultations or prescriptions from home only for summaries.

106. In Case 4 Dr Gibson insisted that the entry of vaginal discharge was misleading as what she observed was clearly blood. She accepted that it was her fault for not being specific and she probably wrote "vg dx" as a general term. If it had been a discharge, she would have examined the patient and taken a swab.

107. In cross-examination Dr Gibson accepted she had written the entry herself rather than used a macro and that she should have written "bleeding", also that it was important for the diagnosis to say which it was. She would normally describe the discharge in the records. She could remember the patient and advised her about, rather than referred her to the GU clinic. The consultant at that clinic, Mr Pritchard, was keen to attract gynaecological work.

108. The nurses at the practice at the time believed that married women should not be given chlamydia tests. Dr Gibson accepted that she should have examined the patient for a retained tampon, if she had mentioned a discharge, rather than bleeding.

109. Dr Gibson could not remember her consultation with Case 5 on 2 May 2006 in detail. The patient normally drove to the surgery and would probably have come alone by car that day. Dr Gibson made the notes of the consultation that day. Dr Gibson knew that the patient was considering removal of an ankle nail but not that she would die so soon. She had a clear chest and Dr Gibson prescribed antibiotics for her occasional cough. Dr Gibson wrote "gen con satis" in the notes. The patient had a stroke on 6 May. The hospital had made no criticism of her findings.

110. Dr Gibson could not remember whether the patient had asked for the keratosis to be removed; she might have noticed it on examining the patient's chest. She had removed a keratosis before on this patient and did it very carefully.

111. On 8 June Dr Gibson entered the cautery procedure, patient's condition improved and a mental health review into the record of the 2 May consultation. She thought this was an administrative entry. The mental health review does not need the patient present: it is a review of what has happened to the patient in the last year. On 12 June 2006 she added the hospital report received from St Peters Multi-Disciplinary Team that day. On 20 June, not knowing that the patient was dead, she entered under the consultation mode GP Surgery "T [template] Cancer care review Cancer diagnosis discussed. F (ie follow up) Cancer care review on 20.9.2006". Dr Gibson apologised for this error which was caused by the default setting on the computer being GP Surgery which she had failed to amend.

112. In cross-examination Dr Gibson that she always used "gen con satis" as an abbreviation either by typing it or as a template but only if she was satisfied that the patient's condition was indeed

satisfactory. She would have listened to the chest and lungs before writing “chest clinically clear” and checked her blood pressure and pulse and assessed her properly.

113. Dr Gibson accepted that she should have been more specific in saying whether the keratosis she had removed on 2 May was actinic. The patient may have wanted it removed, if it caused irritation or bleeding; Dr Gibson would not have done it unless there would be clinical benefit to the patient but could not be sure whether the patient had asked for or she had suggested removal. Dr Gibson accepted that she performed more minor surgery including removal of actinic keratoses than the other Health Centre practices.

114. On 2 May 2006 Dr Gibson asked the patient how she was feeling. She was a bad sleeper caring for a demented husband and on long-term benzodiazepine therapy. She would have written on a card what she had done for the patient over the last year in order to complete a mental health review later. She kept cards in a file on top of a high cabinet in reception with a view to entering these into the practice computer records when she had time.

115. On receipt of the letter from St Peters Hospital on 12 June Dr Gibson’s priority was to inform Thamesdoc. She must have left the letter unfiled to enter the cancer care review later and agreed that the record looks as if she had a consultation on 20 June and that she should have changed the mode to Third Party. Dr Gibson accepted that she entered palliative care in the records in medical record mode on 20 June but then changed into consultation mode to enter the template “Cancer care review Cancer diagnosis discussed. F [follow up] Cancer care review on 20.9.2006” and that this was misleading.

117. Dr Gibson accepted that increasing the gliclazide in Case 6 on 14 March 2007 was wrong but said that the combined therapy with all 3 medicines was not unusual although she later accepted that there were not many patients on this combination and that it was exceptional for a patient to be started on insulin rather than metformin. She accepted she should have stopped the gliclazide after the patient’s hypo on 13 May when she in fact reduced it to its previous level. The patient was isolated and neglected himself. She had arranged for monitoring of his HbA1c over 2 years and his control improved considerably.

118. In cross-examination Dr Gibson said it was necessary to get authority from the PCT to manage diabetic patients. She had attended the Warwick workshop on 2 November 2005 and had been overseen by and had a specialist link to Dr Baxter, the local consultant endocrinologist. She had discussed the patient with Dr Baxter and he had been seen by David Taylor the specialist diabetic nurse. The patient had been started on insulin in 1982 but it had not been correct to say in the witness statement that his care was shared with the diabetologist. Dr Gibson did discuss putting the patient on metformin with Dr Baxter in 2005/6. She could have referred him to hospital clinics but he would not have attended.

119. Dr Gibson said she had only discovered that the patient had had previous hypos when she had recently looked at the Lloyd George notes. She had “not necessarily” summarised these notes herself although she accepted that the summary was under the code DLG and material she had

produced at LNG/2 and LNG/4 suggested that she had summarised the old notes for entry onto the computer system.

120. Metformin was started on11 April 2005 and the dose increased by Dr Gibson to 2tds on 17 June 2005. Gliclazide was started bd on 6 April 2006 and increased to the maximum dose of 2bd on 15 March 2007. On 14 May 2007, after the patient's hypo the day before, Dr Gibson saw the patient and made the assumption that he had been to hospital. She said she should have reduced the doses of metformin and gliclazide then without waiting for blood results but did not. She was waiting for the HbA1c results to see the blood sugars over the last 3 months and was only looking at the HbA1c levels. She felt bad about the case and accepted the criticism. On 14 May 2007 she told him not to take any more gliclazide until the blood result came in and wrote "advice given, re med. etc" in the records rather than explicitly noting that she had told him to stop the glicazide. She had not mentioned telling him to stop before because she felt bad about the case and did not want to claim any credit for her management of this patient.

121. When the result came in Dr Gibson reduced the doses of metformin and gliclazide and amended the current medication section of the records on 17 May. She has no recollection and no record about how the patient was told to take a lower dose but was 99% sure he would have been informed by telephoning the neighbour as the patient did not have a phone. She accepted she should have given him an appointment earlier than 2 weeks after 14 May and that his hypo on 15 May was while he was still on the higher dose.

122. The repeat prescription of metformin on 14 May did not matter as the hypo had been caused by the gliclazide which she stopped on that day. She wanted to start him on a lower dose of gliclazide when she received the test results on 17 May 2007. On 17 May she halved the dose of metformin to respond to the HbA1c result.

123. Dr Gibson accepted that she had increased gliclazide to the maximum dose on 15 March without seeing the patient solely on the basis of the Hb1Ac result.

124.The patient in Case 7 had a long standing diagnosis of RA and had several rheumatoid nodules. One on her right elbow was uncomfortable and the patient wanted it removed. Dr Gibson suspected a rheumatoid nodule but arranged an X-ray to exclude other pathology. She accepted that most GPs would not have removed this nodule but, given her surgical experience in O & G, she considered it suitable for removal under LA. She felt competent to undertake the excision. The patient was satisfied with the result and later had several more lesions removed by an orthopaedic surgeon under LA. Those lesions had required 13 sutures each whereas she had used 4.

125. Dr Gibson accepted she should have put "? rheumatoid nodule" in the records because she had in fact suspected that was what it was.

126. In cross-examination Dr Gibson accepted that other nodules would have been present on the right elbow on 7 June 2007 and that she should have recorded the number of nodules, why she removed one of them and how big it was and that it was uncomfortable. The reference in the records to the left elbow was Dr Gibson's mistake. "Other bursitis" was the correct read code for

the nodule at this stage. Dr Gibson did not accept that she did not recognise the nodule as such: she "largely" agrees that a rheumatoid nodule was clearly recognisable as such and suspected that is what it was but wanted it confirmed by histology. She had probably put "excision of lump right elbow" on the pathology request and was not sure whether she had added "?rheumatoid nodule".

127. Removal was well within her expertise. She remembered the case well because she had to clean the room herself after her surgery. She remembered sterilising the instruments but did not note the number of sutures and it was not necessary or generally done to record the number: she accepted that she had probably used 4 and said that that was sufficient. There was no hard and fast rule about the number needed: that depended on the operation site. Dr Gibson would have offered to send the patient to hospital for surgery. She accepted that her statement that the hospital had removed nodules under LA was wrong.

128. In relation to Case 8 Dr Gibson accepted that the records appeared to show that she had deleted a blood pressure reading recorded by the diabetic nurse Mary Stephens but denied that she had. Other people were capable of making entries under her log in. She could not say for sure why anyone would have done it but it had happened before and indeed on one occasion when she had been on holiday. The suppliers of the EMIS system had confirmed for her criminal defence that there had been "bugs" in the system at that time.

129. In cross-examination Dr Gibson accepted that the 25 October 2005 record of BMI and blood pressure had been deleted on 8 November and the lower blood pressure measurements inserted on 10 November 2005.

130. In Case 9 Dr Gibson had called at the mother's house at 0830 on 29 December 2006 to encourage her to bring her 2 year old son to the surgery to bring his vaccinations up to date, offering to do them herself, if the weekly Thursday morning vaccination clinic was inconvenient. The mother brought the year old and her other children in that morning and Dr Gibson explained all the vaccinations to be given and the mother made no objection to the MMR jab. The only distraction was the children playing in the room. The mother wrote a letter of complaint on 9 May 2007 after the matter had come to light through Madeline Williams on 14 March 2007. The complaint had been resolved and the family were still patients of the practice.

131. In cross-examination Dr Gibson said she clearly remembered her long conversation with the mother at her house. The 2 year old had missed the jabs due at 3, 4, 12 and 13 months and Dr Gibson listed these on the doorstep including the MMR due at 13 months. The mother agreed to come in about 11am. The treatment room staff brought the tray of vaccinations into Dr Gibson's room and named all of them in front of the mother and the mother made no objection to the MMR. There might have been a misunderstanding as the children were making a noise. Dr Gibson then explained each vaccine to the mother in turn including the MMR and the mother made no objection.

132. When asked by the Panel why, in that case, the mother had been so cross Dr Gibson replied maybe she had mentioned MMR but the mother did not understand what she was saying. Dr Gibson accepted the contrast between her note of 29 December 2006 "imms given, re notes" and

the note of Madeline Williams on 14 March 2007 "Informed consent for immunisations. Second meningitis C vaccination. Right leg GP Surgery (24926) 3rd DTaP/IPV/Hib vaccination Left Leg GP Surgery (C2451AA)". She said she had obtained the mother's verbal consent and that she should have made a fuller note in free text.

133. In Case 10 the patient attended the OOH on 22 September 2007 with pain under the ribs, nausea and foul-smelling urine. There was upper quadrant tenderness and an urinary tract infection was suspected and the examining doctor suggested an ultrasound to rule out gallstones. A GP whom she had consulted a few weeks before whilst on holiday had also suspected gallstones. Dr Gibson said in her statement that she had sent the request for ultrasound to St Peters Hospital on 23 September. When she saw the patient on 24 September she described pain and difficulty breathing and Dr Gibson examined her chest, which was clear, and her abdomen but did not record the negative findings. She requested a chest X-ray which was normal. She was arrested the next day and excluded from the practice. She accepted that she did not spot the liver enlargement but pointed out that neither had the Thamesdoc doctor. She thought the patient was coming on 24 July to ask her to order an ultrasound.

134. In cross-examination Dr Gibson accepted that the ultrasound request was filled in by Dr Salim. She had definitely examined the patient on 24 September. She accepted that she had told Dr Lewis in interview that she could not remember whether or not she had examined the abdomen. After the interview she had looked at the patient's records and recognised the patient (the only South African patient in the practice) and remembered doing the abdominal examination. She accepted, given Dr Kacker's entry on 1 October, that either she had not examined the abdomen or, if she had, she should have found the tenderness.

135. Generally, Dr Gibson denied she had influenced who had received Patient Satisfaction Questionnaires and that Mrs Wilkie had been forbidden to hand them out: the receptionists gave them to anyone who would take them until the required number had been given out.

136. Dr Gibson maintained that she had said she did not have trainer status although she had done the training and the Deanery was happy with her. In reply to the Panel she said that she would only have made card notes to remind her to input text into the computer records on less than 20 occasions per year. She said it was acceptable to alter records retrospectively on administrative matters and that it was better to make new entries for clinical matters.

137. Dr Nicholas Silk gave expert evidence on behalf of Dr Gibson producing a report dated February 2010 and an addendum dated 2 June 2011in the light of Dr Lewis' report. His comments on the 10 cases were as follows.

138. Case 1: the patient should have been re-examined on 3 October or 10 November 2005. There was no reason to refer a slim man, if a doctor felt a faecal rather than a discrete mass. This was an error at 1 to 2 on a scale of 1 to 10. In cross-examination Dr Silk agreed that one would not expect a faecal mass on the right side or that what Dr Gibson would have felt was the patient's colon: the explanation was thin and did not make sense. Most GPs would not be alarmed by RBC+++ and WBC+++ even where cancer was the differential diagnosis.

139. Case 2: Dr Gibson should have recorded negative finding and should have ordered a faecal occult blood rather than a stool test. This was a moderate failing.

140. Case 3: the patient's refusal of an abdominal examination placed Dr Gibson in an invidious position. The urgent referral to hospital was appropriate. The notes were amended to clarify what had happened within 24 hours. This case provided no hard evidence of a failing doctor.

141. Case 4: it was not mandatory for Dr Gibson to examine the patient. The absence of a foul smell would make a retained tampon less likely. The mention of a GUM clinic does suggest a discharge rather than a bleeding. This was an error at 1 to 2 on a scale of 1 to 10. In cross-examination Dr Silk agreed that what Dr Gibson had seen was probably a discharge rather than bleeding.

142. Case 5: the lung cancer would likely have made the pneumonic presentation less classical than usual. On reflection Dr Gibson should have picked up that the patient was terminally ill. It is not uncommon to hear little in the chest in the early stages of pneumonia. Dr Silk was not convinced of the indication for cryotherapy.

143. In cross-examination Dr Silk said that he did not think most GPs would undertake cryotherapy in this patient unless there had been a big problem with the keratosis, particularly since she had come about her dizziness and cough. In re-examination Dr Silk said that the patient may have asked for the cryotherapy since she had had it before.

144. Case 6: the combination of 3 medicines is not unknown but the hospital should have been involved in the patient's care. The increase in gliclazide was certainly wrong. This was an error at 4 to 5 on a scale of 1 to 10.

145. Case 7: Dr Silk could not say whether or not Dr Gibson was competent to remove the nodule. If she was not, there was an error at 4 on a scale of 1 to 10. The outcome was satisfactory for the patient.

146. In cross-examination Dr Silk said it was logical to get the pathology result before entering the nature of the lump in the records. It was likely from the hospital's letter that there was more than one nodule on the right elbow. The operation note was open to criticism.

147. Cases 8 and 9 depended on findings of fact so that no comment would be appropriate.

148. Case 10: Dr Gibson should have examined the abdomen and should have recorded her examination findings. The OOH doctor had failed to pick up an enlarged liver 2 days before Dr Gibson's examination. This was an error at 1 to 2 on a scale of 1 to 10.

149. In cross-examination Dr Silk said that above 5 on his scale suggested a serious error that might have endangered a patient. None of these cases were serious errors with the possible exception of Case 6 insofar as Dr Gibson had only prescribed in response to the patient's HbA1c levels. She should probably have referred him to hospital on 14 May and, if on that date she had

decided to stop the gliclazide, she should have recorded it: Dr Silk had not understood when writing his report that Dr Gibson had made that positive decision or that the patient was not under shared care with the hospital. He accepted now that the combination of the 3 medicines was unusual.

150. Dr Gibson's note-keeping merits criticism at 8 to 9 out of 10 although not examining a patient was worse than failing to record findings. To some degree a series of minor failings had a cumulative effect.

151. At this point on10 June 2011 the hearing was adjourned until 6 July. On that date some short further submissions on the question of inefficiency (to supplement the written submissions referred to beginning in the next paragraph) and evidence was heard on the questions of remediation and the GMC proceedings.

Questions for our determination

152. The parties very helpfully tabulated a series of questions (largely agreed) that we need to answer before considering the extent of Dr Gibson's prejudice to the efficiency of the PCT's services and whether, in the light of those findings, there should be a contingent removal. In relation to each there follows a summary in short form the submissions of the parties (using R for the PCT and A for Dr Gibson) then the questions and our findings.

153. We accept that we should consider in relation to each allegation (i) that the burden of proof is on the PCT; and (ii) the standard of proof is the balance of probabilities and in assessing the factual findings have borne in mind the observation of Lord Nicholls in *H v. H minors* [1996] AC 563 at para. 73.

154. Case 1: alleged failure to investigate a significant clinical finding and then failing to follow it up.

155. R: a GP should have thought a right side faecal mass surprising. A did not understand why this was. She only used the word "indentable" in her witness statement. She probably did not feel an indentable right side mass on 7 September 2005. She did not consider the possibility of cancer then or on the 2 following consultations or she would have examined the patient. If she did consider the possibility of cancer on 7 September 2005, she failed to re-examine the patient or undertake investigations such as a faecal occult blood test. She should have included cancer in the differential diagnosis and failed to work the case up properly. Her explanation that the patient was feeling better was wrong because "no change" was recorded at the second consultation. She probably added the read code for cancer in tidying up the records rather than after a discussion with Dr Pirrie.

156. A: Dr Gibson did not identify a 'definite' palpable right-sided abdominal mass so no referral was mandated. Subsequent diagnostic imaging revealed that there was no mass, faecal or otherwise. This is consistent with A's account of a faecal mass at the visit on 7th September which had passed in the interval before imaging. Dr Lewis ultimately accepted the finding of a faecal mass on the right side was not impossible but rather unusual or rare. A accepted that she should

have re-examined the patient. This was not a finding that required referral under the 2-week rule.
157. At the initial consultation Dr Gibson made a diagnosis of constipation based on the patient's symptoms and so did not arrange a faecal occult blood test. Dr Pirrie was poor at entering read codes. It was accepted by Dr Lewis that entering such codes to make the notes more searchable and useful to the user was appropriate within this time period. Dr Silk agreed that a faecal mass on the right side would have been unusual – but not impossible – and said that it would have been wise to check the abdomen again on either 3rd and 10th November 2005 to confirm no palpable abnormality. When Dr Gibson said it was 99% likely that she had made the entry on the computer it was specific to this case and made sense because she was the person who usually made entries of this type.

158. Questions: (a) Did Dr Gibson probably feel an indentable (faecal) mass on the right side or not?
Answer: although Dr Gibson's evidence was far from compelling the Panel cannot conclude that she probably did not.

(b) Should Dr Gibson either have referred to hospital under the two week rule or arranged a review?

Answer: she should certainly have made an appointment fully to re-examine and review the patient.

(c) Did Dr Gibson carry out any examination when she saw the patient again on 3.10.05 or 10.11.05?

Answer: she did not. If, contrary to this finding, she did, she did not record it.

(d) Given that her differential diagnosis included carcinoma of the bowel should Dr Gibson have arranged a faecal occult blood test?

Answer: this should certainly have been done.

(e) Should Dr Gibson have noted the stool microscopy sample as normal given the presence of RBC "+++"?

Answer: no, the result should have been noted as abnormal and appropriate action been taken.

(f) In what circumstances did Dr Gibson review this man's notes and enter a cancer read code on 4.4.06 in respect of Dr Pirrie's consultation on 29.3.06?

Answer: Dr Gibson was probably "tidying up" the records in the light of a colleague who was inexpert in computer recording. The Panel did not consider this a serious error.

159. Case 2: alleged possible missed carcinoma of the cervix in a 38 year old woman.
R: A never gave any thought to the underlying cause of anaemia. She should have included cancer in the differential diagnosis and undertaken a faecal occult blood test. Ms Williams was probably correct in saying that the patient told her she had dysmenorrhoea including post-coital bleeding for 12 months and this was consistent with the size and nature of the tumour. Even if the symptoms had been present only since August, they should have been elicited and recorded on 22 October 2004. A either failed to do this or failed to appreciate the significance of the findings. If A elicited no positive history in February 2004, there was no explanation for the anaemia.

160. A: Dr Gibson has accepted that: there are deficiencies in the note-keeping; that negative findings ought to have been recorded; and stool microscopy is not a suitable substitute for faecal occult blood testing. The investigations which she did carry out, which admittedly were directed at measuring levels of anaemia, were relevant to the underlying cause, because her thinking was that

mild anaemia Hb 10.8 in a 38 year old woman was most likely due to menstrual problems. This patient had a normal smear history and it would have been extremely uncommon to find advanced carcinoma of the cervix under these clinical circumstances. A admits and accepts the failure to carry out a faecal occult blood test to investigate such possible differential diagnosis. An appropriate history was taken in accordance with her normal practice and negative findings should have been recorded. It is impossible to establish when this tumour started. The most likely source of the entry 'August 2005' in the hospital letter is the patient because that date is not mentioned in Dr Gibson's letter of referral. The entry "discussed mirena coil re periods" indicated problems with periods in October 2005. The clinical indication for Mirena coil insertion was due to menstrual irregularities: this was the first time this patient had a positive menstrual history. Apart from faecal occult blood other necessary investigations were done. In some cases of mild anaemia no identifiable cause is found and the general advice is to treat and monitor improvement. The size of the tumour is no guide to its age.

161. Questions: (a) Did Dr Gibson ever investigate the underlying cause of anaemia and should she have done so?
Answer: this should have been done but was not.
(b) Did Dr Gibson take an appropriate history in respect of the patient's menstrual history at the appointments between February and October 2004?
Answer: there is no record that she did. The most common cause of anaemia in a woman of this age is dysfunctional menstrual bleeding. It was at least possible that the cause was cancer and this should have been considered and promptly and fully investigated.

161. Case 3: alleged missed diagnosis of pregnancy and labour on 29 March 2005 and the retrospective altering of the patient's notes.
R: A claimed obstetric expertise and accepted that, if she had examined the patient, she would probably have diagnosed the pregnancy and labour. In oral evidence she altered her previous accounts to say that the patient waited in her room while she phoned 999 and that she made 2 internal examinations of the patient immediately before the delivery. There was a real difference between a difficult examination and the patient refusing examination. A would not have changed her note the next day, if there had been no difference in meaning. If the patient had co-operated in pulling up her legs and her vital signs being recorded, it was improbable that she had refused to be examined. A would have recorded any refusal in the notes and in her referral letter.

162. It was probable that there had been no examination and A had written a vague letter to conceal the failure to conduct an adequate examination. A had sought to cover up her failure to examine by amending the records the next day to say examination had been refused. The hospital referral letter supports the accuracy of the original note and that an examination had not been refused. The oral evidence had been wholly different from the witness statement and Dr Gibson had changed her evidence to try to fit the facts. The PCT accepted that the evidence from EMIS showed that at this time there was a "bug" in the system but nothing more.

163. A: The facts are disputed in particular the account given by Jackie Lyndsey, who it turns out was a witness of doubtful reliability and who, at the outset of the hearing confirmed to the Panel (through Counsel) that, contrary to Dr Lewis's report, A had in fact been present at time of (or at

least in the immediate aftermath of) delivery. A's evidence on this case should be accepted: she was presented with a lady on 29 March 2005 who, unknown to her and, it appears to Nurse Stephens who had seen her 8 days before, was pregnant. The patient was reluctant to be examined and was difficult to assess, but when it became apparent she was in labour, A responded appropriately. She accepts that she should not have edited the computer records but rather should have made a separate entry. There is really only one issue of fact relating to this particular case and it has already been conceded, namely whether A was present at the birth (or its immediate aftermath). It had previously been the PCT's case that she was not present at all. That was Dr Lewis's position in his report but in fact the witness did not support it. This in itself says something about how much reliance can be placed on the 'notes of interview' of witnesses prepared by Dr Lewis and who did not give oral evidence. It was justifiable to amend the notes which were inaccurate since they appeared to record that there had been an abdominal examination when in fact the examination had been declined because the patient was in significant pain.

164. Questions: (a) What happened when Dr Gibson first attempted to examine the patient i.e. at the stage when the patient first presented rather than at or around the time of delivery?
Answer: Dr Gibson saw the patient as an emergency just before beginning a surgery. She decided to get her into hospital as quickly as possible. She did not conduct an adequate examination.
(b) Did Dr Gibson seek to delay and/ or avoid playing an appropriate role in the care of this patient and the delivery of her baby as alleged by Jacqueline Lyndsey?
Answer: there is inadequate evidence to found a conclusion adverse to Dr Gibson. The evidence is confusing. It is unclear why Dr Gibson left the patient after seeing her bulging membranes (as she said in evidence) to write the referral since it appears that the letter had been written (on any account) before Dr Gibson realized that the patient was in labour. Dr Gibson was at the birth.

(c) Why did Dr Gibson edit her notes the following day?

Answer: probably to cover up the fact that she had not adequately examined the patient.

(d) Is Dr Gibson to be criticised for the alteration to the notes and/ or for not making clear that she was changing the notes retrospectively?

Answer: yes to both. It is also significant that Dr Gibson did not use the opportunity to input more information about the case and that the hospital referral letter was consistent with the initial note (ie that she had examined the patient) rather than with the amended note that she had refused an examination. The very tentative suggestion that computer software errors may have distorted the records is wholly unsubstantiated.

165. Case 4: alleged failure to examine a patient with a retained tampon.
R: at the consultation on 16 February 2007 the patient had just finished her period and the tampon was probably then in place and the cause of the discharge. A's own note suggests a discharge, not bleeding, as do the referral for high vaginal swab and chlamydia test. If the complaint was of bleeding, there was no reason to refer to the GUM clinic. The nurse refers to a discharge on 22 February 2007. The negative culture did not mean there was no discharge and the smear had bacteria+++. A should have examined the patient and would then have found the tampon.

166. A: There is in fact no evidence that the tampon was present on that day save that there is a note of 'vg/dx' in the note, and it is inferred that because A advised the patient to go to the GUM clinic, she considered the problem was vaginal discharge rather than bleeding but yet failed to identify the

retained tampon. There is no evidence that this patient went to the GUM clinic for HVS and chlamydia test. A's evidence is that despite the 'vg/dx' note, which she accepts was inappropriate and misleading, there was only bleeding. She also does not accept that the tampon was necessarily in situ on the date she saw the patient. The reference (not referral) to the GUM clinic was not because of discharge but rather to promote awareness of it. Sarah Jack, the nurse who undertook the examination recorded in the notes on 22nd February 2007 has died so there is no further explanation of what is contained in her note the following week. This was a case of extended bleeding by a few days, maybe the start of a perimenopausal period, which did not warrant a vaginal examination at this stage. A normal period of bleeding can be followed by lighter bleeding and spotting, which are considered to be abnormal discharges (of blood). Generally, and having regard to the appropriate standard of proof, there is too much disputed fact in relation to this consultation to permit of any firm findings other than that, on 22 February 2007 a week after being she had been noted to be suffering some sort of bleeding/discharge, a retained tampon was discovered. A can be properly criticized for her note keeping but nothing more.

167. Questions: (a) When Dr Gibson wrote in the notes 'vg dx' did she mean 'discharge' or only 'bleeding'?
Answer: the computer entry meant "discharge" and all actions initiated by Dr Gibson are consistent with that. The Panel cannot accept Dr Gibson's evidence to the contrary whose purpose was probably to exculpate her for an inadequate investigation of the patient.

(b) In the light of the panel's finding should Dr Gibson have examined the patient to see whether there was a retained tampon?
(c) Answer: Yes, although rare, a retained tampon is a known cause of vaginal discharge.

168. Case 5: 84 year old female with advanced lung cancer in respect of whom Dr Gibson noted 'gen con satis' and upon whom she performed cryotherapy. Further, a cancer care review was entered on 20 May 2006.
R: 'gen con satis' was insufficient as an entry and implied too superficial an examination. There was no justification for cryotherapy which was not a reason for the consultation. A's statement that there was no contra-indication for the procedure does not justify it, nor does the fact that a similar procedure had been carried out previously. The fact that A was not cautious in performing cryotherapy diminishes her assertion that she would only perform the procedure where it was properly indicated. There was no sensible explanation for entering the mental health review into the records 5 ½ weeks after it had been carried out. Her explanation of a paper reminder system was unsatisfactory: her evidence that this happened in very few cases was inconsistent with the fact that it was a frequent explanation in her evidence for retrospective amendment of the notes. Leaving a paper note around the surgery for 5 ½ weeks was unsatisfactory in any event.

169. The cancer care review was entered on receipt of the hospital report. The discussion with the patient at the surgery was entered 8 days later when the patient was dead. There was no good explanation for the late entry. A mistake was inconsistent with the careful editing and correction of notes and with A's claimed expertise with computers. The PCT did not know whether Dr Gibson claimed payment for this procedure. Dr Gibson could have set up the system to avoid the word "claimable" or recorded that the keratosis was not actinic (and therefore not claimable). Dr Gibson

claimed for a very high number of removals of actinic keratoses. Dr Gibson probably did not know at the time that the patient was not on the mental health register so that a claim for the review could not be made. There was no other reason to enter the review. Dr Gibson says in her witness statement that she did not make a claim for the review but does not say why the entry was made in the notes.

170. A: Dr Gibson did examine the patient's chest on 2 May 2006 to obtain the finding 'gen con. satis'? Dr Lewis's suggestion that she cannot have been seems to ignore the fact that she later suffered a stroke. He repeatedly seemed to downplay or ignore this very relevant fact. In circumstances where this patient had had cryotherapy procedures carried out before (by other doctors, not just Dr Gibson), in 1987, 1991 and 2004 it was reasonable for A to perform the cryotherapy. Moreover, according to the notes the patient gave informed consent to the treatment which would of necessity have involved a discussion of the pros and cons of the treatment. The fact that informed consent was given in this case is not questioned by the PCT. As the keratosis was not actinic it was not claimable: the word "claimable" came up automatically as part of the only available template for minor surgery on the computer. Claims would be made manually thereafter where appropriate.

171. A added a mental health review on 8 June 2006 to the notes for the consultation on 2 May 2006 in order accurately to record that one had been done. It was attributed to the 2 May 2006 as being the relevant date of last consultation.

172. The entry of 20 June 2006 is on its face misleading but A is not to be severely criticised for this. Her explanation - that she wanted to record the fact that a cancer care review (and conclusion that the patient was for palliative care only) had been carried out by the hospital is consistent with the hospital letter which prompted the entry. The manner in which she recorded this information was misleading and involved at least two mistakes, first the attribution of the date, and second, that it was not made clear that the review had been carried out in hospital.

173. The suggestion here that A deliberately sought to make an inaccurate note is that she was committing some sort of fraud. Such a finding would require very strong evidence, and there is no such evidence. The alternative put by the PCT is that she was 'sloppy'. This was based on her answers in relation to the use of templates. She accepts the record is misleading but it is clear that the entry and content are based on the content of hospital letter which prompted her to make the entry.

174. The PCT, rightly say in their submissions: "There is no great science in Dr Lewis' 14,000%". Indeed there is not. It is a most surprisingly unscientific and unrealistic figure to put forward. It is not a comparison of like with like or quarter with quarter. The underlying evidence for this figure appears to be that in one quarter specifically selected by Dr Lewis, A claimed 154 times for surgery, and that in a different quarter, one of the other practices (the Red Practice) at the surgery (about whose routine surgical activity the Panel know nothing at all) claimed 1. The use of the statistic in this way by Dr Lewis is telling. It is of a piece with much of the rest of his report which on every issue seems to amplify, far more than is justified by an impartial and independent assessment, the significance of a particular identified error or criticism. It was also notable that although the PCT tried to present Dr

Lewis as expert giving objective independent evidence to the Panel, he was in truth doing no such thing. No independent and impartial expert would ever present evidence in this way. The Panel is also reminded of Dr Lewis' repeated statements that 'I would not have done X' or 'I would have done Y' rather missing the point that in judging clinical practice one looks at the range of reasonable and responsible medical opinion. Dr Lewis's continued overplaying of each incident was notable. For example his evidence as to the combination of drugs in Case 6 which he thought would never be given and said something to the effect that no GP would ever prescribe such a combination because it was not countenanced by the BNF. An opinion he had to promptly revise significantly on being shown the relevant NICE guidance.

175. Further the PCT say that: 'If Dr Gibson did make such written notes then it is of concern that such a note will have been floating around her surgery between 2.5.06 and 8.6.06.**'.** This is misleading and not a reflection of the evidence. The note was not floating around. Such notes were kept in a file next to the practice manager's desk.

176. Questions: (a) Did Dr Gibson examine the patient's chest on 2 May 2006?
Answer: probably.

(b) Was Dr Gibson's overall assessment of the patient on 2 May 2006 reasonable, in particular her conclusion 'gen. con. satis'?

Answer: the Panel interprets this as a macro intended to convey that the patient did not look ill in the surgery. To that extent it was acceptable but it ignored the patient's known orthopaedic and family problems. The diagnosis of and prescription for a chest infection were reasonable.

(c) Was it reasonable for Dr Gibson to perform cryotherapy on this patient?

Answer: certainly not, given her age and the concerns noted under (b) above. The patient had not consulted Dr Gibson for this purpose and there is no evidence that the keratosis was causing her any problem. The cryotherapy should not have been performed, even if the patient had asked for it.

(d) Why did Dr Gibson add a mental health review on 8 June 2006 to the notes for the consultation on 2 May 2006?

Answer: the Panel can see no good reason for this or for the 5 week delay in adding it or for failing to make plain that the record was added retrospectively. It is highly improbable that any worthwhile review was carried out at this consultation.

(e) Is the entry of 20 June 2006 misleading when it says that there was a cancer care discussion at the surgery and is Dr Gibson to be criticised for this?

Answer: yes to both. In particular the record clearly implies that the review was carried out by Dr Gibson and not by the hospital, as she submits was the intended meaning of the entry.

(f) Does the panel accept Dr Gibson's explanation for the 20 June 2006 that she simply made an 'inputting error' or does the panel find that on 20.6.06 Dr Gibson deliberately sought to make an inaccurate note?

Answer: the Panel does not accept Dr Gibson's submission that "it is pretty clear that the entry and content are based on the content of hospital letter which prompted her to make the entry". On the contrary Dr Gibson claims to be an expert in the EMIS system. The entry would suggest to any fair-minded observer that Dr Gibson had conducted a cancer care review with the patient on that day when she was in fact dead. The Panel concludes that the inaccuracy was deliberate.

177. Case 6: allegation that 75 year old male's diabetes was over-treated.

R: A’s witness statement acknowledged no fault in her management; in opening it was conceded that gliclazide should have been reduced at the consultation on 14 May after the patient’s hypo rather than on 17 May after receipt of the test results. In evidence A claimed that she had stopped the gliclazide on 14 May. It was incredible that she did not mention this earlier because she did not want to claim any credit. She failed in her summary of the Lloyd George notes to refer to hypos in 1985, 1987 and 2000 despite claiming expertise in diabetes care. The reference in her witness statement to shared care was wrong (and misled her own expert). When she took over the patient’s care from the hospital he was on insulin alone. She made no record of telling the patient to stop taking gliclazide on 14 May but instead altered the current medication record from 112 to 56 tablets 2bd. This was wholly inconsistent. She did not record altering the metformin dose on 17 May. She conceded that she was treating the patient’s HbA1C level rather than the whole clinical picture which was of concern and the inference from her witness statement at paragraph 36 was that she did not think her approach inappropriate. She ascribed the hypo to the patient’s failure to eat with no recognition of her overtreatment. Prescribing the 3 drugs together was unusual and there was no rationale for it.

177. A: Dr Lewis’s initial evidence was that no doctor would ever prescribe the combination of Glyclazide, Metformin and Insulin. This was clearly an overstatement and he was forced to withdraw it on being shown that a patient can properly be treated on this combination of drugs in accordance with NICE guidelines, fact of which he ought to have been aware prior to condemning the treatment in the way that he did. There are clearly aspects of the treatment of this patient which are properly the subject of criticism and, where appropriate, A has accepted that criticism**.** The Panel is invited to conclude that exceptionally, given the patient’s reluctance to attend hospital, and the fact that the patient had been successfully treated on this combination of drugs for a year, it was justified, although it would clearly have been far preferable to have shared care with a diabetic consultant.

178. The circumstances in which the prescription was stopped or reduced are less than clear, and after this period of time precise recollection by A (as opposed to an attempted reconstruction of what happened from the noted entries) is difficult. She should not be criticised for her attempt to reconstruct events based on the notes. The notes appear to record that the patient was not issued with gliclazide on May 14. This would have been because A was awaiting test results. The gliclazide was not discontinued as it was still on repeat prescription but it was not issued. Had the HbA1c result been available on May 14 a direct instruction to reduce would have been given. As it was not available, it may properly be inferred the instruction to reduce was not given on that date, however it was given on the 17 May probably by telephone to a neighbour. The medications were altered on the receipt of the blood test result which came down the link at 1413hrs on 16 May 2007 and was entered on 17 May 2007 at 1126hrs. On the balance of probability they would have been communicated to the patient’s neighbour by telephone as such a link was clearly in existence. The evidence had been confused as a result of a misunderstanding of A’s witness statement.

179. Questions: (a) Was Dr Gibson’s overall management of this patient’s diabetes appropriate? Answer: certainly not. She did not properly, if at all, share his care with a diabetologist as she claimed in her witness statement. She failed properly to assess the patient and his medication and

sought only to tailor her management to one variable: the HbA1c levels. The standard of treatment fell far short of her claimed expertise.

(b) Was it justified for Dr Gibson to prescribe a combination of insulin, metformin and gliclazide for this patient?

Answer: no. This is an unusual combination, especially in the order in which the medications were prescribed. The increases in dosage of metformin and gliclazide were ill-thought out and not in conformity with good practice, particularly without the collaboration of a diabetologist. The probable cause of his hypos was over-treatment.

(c) What was Dr Gibson's management of this patient on 14 May 2007, specifically did she tell him to stop gliclazide?

Answer: Dr Gibson's oral evidence that she specifically instructed the patient to stop taking gliclazide on 14 May 2007 given the records, her interview and witness statement (all suggesting the contrary or failing to corroborate it) is incredible. We accept the criticisms made on behalf of the PCT in paragraph 177 above.

(d) Was Dr Gibson's management on 14 May 2007 appropriate, specifically should she have referred him to hospital and/ or sought specialist advice?

Answer: even given the patient's reluctance to go to hospital, his learning difficulties and lifestyle choices, this patient should have been sent for specialist care. At the very least advice and help should have been obtained from a specialist.

(e) In what circumstances did Dr Gibson alter the patient's medication on 17 May 2007 and did she inform the patient of the change in medication?

Answer: Dr Gibson altered the medication after receipt of the laboratory results. She probably attempted to communicate with the patient via a telephone call to his neighbour. This was insufficient.

180. Case 7: case of the 72 year old lady with a rheumatoid nodule.
R: it is possible but improbable, given her overall reliability and tendency to overstate her ability, that Dr Gibson made the correct diagnosis, was competent to remove the nodule and did so to a reasonable standard. She described the excision of a mass and other bursitis of elbow (rather than a rheumatoid nodule) in the records and a lump in the pathology request and an X-ray would not be appropriate for a bursitis or a rheumatoid nodule (which are very different things). If it should be recognisable by a final year student, it was surprising that a GP who needed an X-ray to exclude other pathology considered herself competent to remove it. The operation note was poor and the post-operative condition at 1 and 2 weeks suggested the procedure was poorly conducted, fortified by the evidence of the mess in the room and Dr Gibson's comment in her interview that she did not want to remember the case. It was inappropriate to remove one of several nodules under LA rather than all of them in hospital under GA. There was no rationale for this in the records. It was wrong to use 4 sutures to close a 6cm incision and wrong to think the procedure was appropriate.

181. A: Dr Gibson explains in her statement that she has significant operative experience having worked to the level of registrar in Obstetrics and Gynaecology. She diagnosed a suspected rheumatoid nodule. Removing it was within her expertise. There is no good evidence to suggest that it was not carried out competently. The PCT also suggest a lack of frankness or openness in her evidence. A has accepted appropriate criticism but where she feels the facts are being misrepresented or that Dr Lewis' criticism is not justified she defends herself. This is hardly

unreasonable, or demonstrative of a lack of frankness and openness. There is no real reason to doubt that she suspected it was a rheumatoid nodule. As Dr Lewis was only too keen to observe, any final year medical student would on the balance of probabilities have suspected it. A is substantially more experienced and qualified (her qualifications are not seriously in doubt) than a final year medical student, so on the balance of probabilities the Panel can properly conclude that she did indeed suspect it. There is nothing in the point that she does not use this phrase in the notes. The phrases lump or mass are by themselves not misleading. The phrase, '*Other bursitis of the elbow'* is a macro used to describe a) other disorders of the synovium, tendon and bursa, b) rheumatism excluding the back, c) diseases of the musculoskeletal system and connective tissue disorder affecting the elbow which includes rheumatoid nodule, d) diseases and injuries of the elbow. This is quite different from Olecranon bursitis which is the point Dr Lewis has (wrongly) seized upon. The X-ray was performed to rule out other pathology such as calcification. If A had noted calcification, she would have referred the patient to hospital.

182. As to the suggestion that the removal was not clinically indicated (an allegation for which Dr Lewis tries to use the retrospectoscope, i.e. he says that because there was subsequent anaesthetic removal of nodules in hospital), A (who should have foreseen this with superhuman acuity) should not have removed this nodule. A observes that the clinical indication for removal of rheumatoid nodules is that it is causing discomfort over a pressure point as in this case etc. There is no criticism or complaint by the patient that there was no consent for this procedure or that it was not requested or desired. A is not to be criticised with regard to this case.

183. Questions: (a) Did Dr Gibson diagnose a rheumatoid nodule prior to surgery i.e. did she know what she operating on?
Answer: ordering an X-ray is consistent with such a diagnosis as is the strong history of rheumatoid arthritis. The coding "other bursitis of elbow" and the referral to pathology of a lump in the right elbow are not. The evidence is insufficient to conclude that Dr Gibson did not diagnose the nodule.

(b) Was it reasonable for Dr Gibson to carry out such surgery?

Answer: Dr Gibson acknowledged that the patient had other similar nodules at the time which would require removal. There was no benefit to the patient in removing one when she would need multiple removals on each side under general anaesthetic in hospital.

(c) Did Dr Gibson carry out such surgery competently?

Answer: the extent of the blood loss, subsequent condition of the wound and use of 4 sutures for a 6cm incision together suggest that the procedure was at best carried out with bare competence but in any event should not have been undertaken in these circumstances.

184. Case 8: alleged deletion of blood pressure.
R: Dr Gibson had agreed in evidence that an entry under her log in was 99% certainly made by her and she was in the habit of altering records. Her denial in this case was untruthful. There was no reason to suppose the original entries in this case were incorrect: given the 2-week delay before amendment and the fact that the amendment was in 2 separate entries 2 days apart the alteration was deliberate and without foundation. Changing a high reading to a perfect reading would be a very serious matter. Computer anomalies hinted at but undocumented do not provide a satisfactory explanation. The standard of proof remains the balance of probabilities and the evidence

185. A: Dr Gibson denies that she deleted the blood pressure reading, noting that alteration to a patient record will be attributed to whoever was logged on to the terminal at which the alteration was made. She points out that the issue of deletion of blood pressures was investigated by the NHS counter-fraud service and no charges were laid in respect of it. There are anomalies in the computer records that may throw the entries into doubt.

186. What is really being alleged here is some sort of dishonesty or fraud. The observations of Lord Nicholls in *H v. H (Minors)* are in point viz.:-
'that the more serious the allegation the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability. Fraud is usually less likely than negligence. Deliberate physical injury is usually less likely than accidental physical injury....'.

187. There is no sufficient evidence to prove on the balance of probabilities that A made this entry when (i) it is not suggested that there was any reason for her to do so; (ii) the reliability of what is recorded on the audit trail is in doubt in particular: - the BMI should normally appear in the audit trail as well as the medical record as can be seen as an example from the audit trial of a computer entry made by Mary Stephens on the 10 April 2007 for Case 1 BMI is recorded as 32.7. The audit trail of the 25 October 2005 shows the first entry made by Mary Stephens which starts with "follow up diabetic....." and ends with "alc 0 units". The audit trail of 8 November 2005 shows deletion of both blood pressure and BMI reading even though the BMI still appears in the consultation and it also shows the old entry as below being 2 BMI 27.3, Bp 143mm Hg/99mmHg only, whereas normally the other entries in the consultation note starting from 'follow up diabetic'etc. should appear as part of old entry; (iii) when it is a real, rather than fanciful possibility that another person may have used A's log-in. There was such evidence at her criminal trial as she explained to the Panel. The entries made in her absence were file attachments which cannot be done remotely. (iv)That there is no suggestion that it was her who took the blood pressure that was subsequently deleted, or that there could be any advantage to A in deleting the blood pressure at the time when a new blood pressure was entered. Furthermore, if the evidence of Jackie Lyndsey is to be believed, A did not take blood pressures in any event, increasing the likelihood that another person, perhaps a nurse using her log-in details (A having not logged-off) would have entered and perhaps deleted blood pressures on the record. Dr Silk explained that it was common to find that doctors generally were not so good at logging off the EMIS system, such that this opportunity for others to make an entry on another's log-in is facilitated. On 6 July Mr Hyam conceded that the "bug" in the EMIS system referred to at her criminal trial had no relevance to this case.

188. It is submitted that the proper questions for the panel are*:*

> *(a)* Is there sufficient cogent evidence for the Panel to conclude on the balance of probability that it was Dr Gibson who deleted the blood pressure to which the answer should be: no.
> *(b)* Was there any justification for her doing so? Answer: Not relevant.

189. Questions: (a) Was it probably Dr Gibson who edited the record of 25.10.05 on 8.11.05 and 10.11.05?

Answer: yes, there is sufficient cogent evidence for us to conclude that it was. It is wholly implausible that any other person would have deleted the record of a 25 October result on 8 November and substituted lower readings on 10 November. If a nurse took a later blood pressure, she would have entered it as new data. There was no evidence that anyone other than Dr Gibson made manuscript records that she later used to make new or amend existing computer records. Nobody other than Dr Gibson stood to gain from the amendment from a high to a near-perfect blood pressure. Dr Gibson acknowledged in another case that any entry under her login was 99% probably made by her. There is no evidence that Dr Gibson had left her computer on that day or was apt so to do in general: she prided herself on her computer expertise. It was expressly conceded that the EMIS "bug" referred to at the criminal trial and before us has no application to this case. The universal capacity of computer systems to be fallible does not provide evidence to rebut the other considerations listed above.
(b) Was there any justification for her doing so?
Answer: the only justification would have been that the initial entries were clearly wrong. There is no evidence that was the case.

190. Case 9: allegation that MMR vaccination was given without the consent of a 2 year old's mother.
R: A gives differing accounts but there is no reference to a positive consent by the mother in the 2 relevant entries in the records or any other versions of events. The records and the statements of Madeline Williams and Janice Sumner all demonstrate that the mother was very upset about her child being vaccinated with MMR. It is unlikely that the mother would not have asked what vaccinations were to be given and her extreme reaction when she discovered that MMR had been given suggests it was unlikely that MMR was not discussed prior to the vaccinations. If there was a misunderstanding, this was still a very serious lapse.

191. A: It is perhaps surprising to find this included in the ten cases which Dr Lewis identified as being 'hard evidence' of wrongdoing by A because, as Dr Silk records, the facts are squarely in dispute and no examination of the records etc. is likely to shed any further light on it. The account of the practice nurse is hearsay, but it is clear that the mother of the boy was upset because she thought she had made it clear she did not want her son to have the MMR and was therefore upset when she found this out to be the case. A made a formal response to that written complaint (included in the medical records) in June 2007.

192. She did not recall the mother saying that she did not want her child to have the MMR; that she did not use the term or phrase 'why is that'; and that, as a responsible GP had she realized that the mother did not want her child to have the MMR, she would have discussed the options and implications during the consultation. She also apologised for the confusion and the perception that might to have been thought to have been laughing disrespectfully. She offered a further meeting with the mother to discuss any outstanding concerns as well as a right to refer the matter to the Healthcare Commission.

193. A plainly thought she did have consent. The fact that the mother says firmly that she did not consent does not mean that A did not think she had consented, and indeed by words, or conduct or silence she may have done so. What is evident is that there was confusion – thus the complaint. A

is not helped by the fact that she did not record in the notes "informed consent given" but this is not to say there was no consent. The Panel is invited to find that as a result of the conversations she had had with the mother that A genuinely considered that consent had been given, and, having discussed the matter with the mother, had grounds for doing so. Objectively, therefore, consent was given. Subsequent events (in particular the letter of complaint) have demonstrated that there was clearly a confusion here at least in the mind of the mother as to what she had consented to, but A is not to be faulted for that. This was not a deliberate flouting of the mother's expressed wishes. A plainly thought for reasons she has given – including the discussion of injections at the mother's house – that consent had been forthcoming. If she was in error in this regard she has appropriately responded and apologised. The complaint went no further.

195. Questions: (a) Did Dr Gibson ask for the mother's consent to give MMR?
Answer: The evidence does not justify the conclusion that Dr Gibson explicitly and clearly asked the mother's consent. Dr Gibson's evidence changed. She first said that a member of staff brought the tray of vaccinations into her room and named all of them in front of the mother and the mother made no objection to the MMR. She then said there might have been a misunderstanding as the children were making a noise. She then said she explained each vaccine to the mother in turn including the MMR and the mother made no objection. That evidence changed, when asked by the Panel, to maybe she had mentioned MMR but the mother did not understand what she was saying.

(b) Did the mother give consent for MMR?
Answer: Taken together with the answer to (a) above this evidence is unsatisfactory and we conclude that the mother did not give any informed consent. Dr Gibson's note of "imms given, re notes" was far less impressive than that of Madeline Williams on 14 March 2007 "Informed consent for immunisations. Second meningitis C vaccination. Right leg GP Surgery (24926) 3rd DTaP/IPV/Hib vaccination Left Leg GP Surgery (C2451AA)". Dr Gibson's response that she obtained the mother's verbal consent and should have made a fuller note in free text was unsatisfactory.

(c)Was this an 'innocent' misunderstanding or is Dr Gibson to be criticised and, if so, what is the criticism of her (this will depend on the Panel's factual findings as to what probably happened)?
Answer: the shifting accounts make it probable that this was not an innocent misunderstanding. Dr Gibson should have sought and obtained a clear informed consent before giving the vaccination. She failed to obtain or record this. The mother's documented anger is consistent with her believing she had had the wool pulled over her eyes.

196. Case 10: 72 year old lady whom it is alleged was not examined by Dr Gibson despite being in pain.
R: there is no record for A's examination on 24/9/2007. The records by others on 22/9/2007 and 1/10/2007make it probable that the patient was suffering from RUQ tenderness on 22/9/2007. Dr Kacker's agreed evidence was that the liver would have been enlarged and detectable on 24/9/2007 ie a positive finding.. The patient's daughter's balanced evidence was that there was no examination (of chest or abdomen) on that day. In her interview A said she could not remember whether she examined the patient's abdomen. In her witness statement she said she had examined chest and abdomen and failed to record negative findings. R says that was untruthful and

consistent with her habit of minimizing any criticism of her patient management without regard to truth or accuracy. It is probable there was no examination at all. A's submission that the Thamesdoc examination had not found tenderness was wrong: the report of 22 September described abdominal softness with RUQ (right upper quadrant) tenderness. The tenderness was accordingly palpable 2 days before and 8 days after A's examination of the patient. A either did not examine the abdomen or missed the RUQ tenderness or found the tenderness but failed to record it.

197. A: The criticism here is that a more thorough examination ought to have been conducted and better notes made on 24 September 2007. A did examine this patient's abdomen and should have recorded a negative finding on examination. There is no evidence that the daughter (whose letter is relied on) was even present at the time of the examination. A's position is that she was not. For all the insinuation contained in the PCT's submission there is nothing to suggest that what she says is false. She did examine, she did not find enlarged liver and in doing so was only making a finding entirely consistent with another doctor who had examined 2 days earlier. Dr Salim's request for an ultrasound was probably made only on 1 October 2007. The Thamesdoc report of 22 September was probably scanned into the computer on 23 September before the consultation of 24 September.

198. Questions: (a) Did Dr Gibson examine this patient at all?
Answer: probably not. The fair-minded complaint written by the patient's daughter (who was not present at the consultation) alleged that there was no examination but that her mother was simply referred for a chest X-ray. There was no record in the notes of an examination, not even the macro "chest clinically clear" that Dr Gibson was in the habit of using.
(b) Did Dr Gibson examine this patient's abdomen?
Answer: probably not as her evidence changed over time to protect her position. Tenderness in the RUQ was apparent to the OOH 2 days before the patient was examined by Dr Gibson and to Dr Kacker 8 days later. The fair-minded complaint written by the patient's daughter (who was not present at the consultation) alleged that there was no examination.
(c)Should Dr Gibson have recorded a negative finding on examination?
Answer: yes as Dr Gibson accepts.
(d)Was Dr Gibson's management of this patient appropriate?
Answer: no; Dr Gibson should have examined the patient and found the tenderness in the RUQ, suspected at least the possibility of an enlarged liver and investigated the potential presence of a serious condition.

<u>Remediability</u>
199. On 6 July Mr Hyam produced the Rule 7 letter dated 14 March 2011 from the Standards and Fitness to Practice Department at the GMC. This reported the results of an assessment by peer review on 1-3 November 2010 and of tests of competence on 8 November 2010. Dr Gibson had contested the findings but her response was not put before us. He submitted that his conclusions were untested and should be treated with caution.

200. The GMC had written to the PCT on 17 May 2011 confirming that, after its preliminary investigation, it had referred the case to the Fitness to Practise Panel. Mr Hyam drew our attention

to the point made by Dr Gibson's solicitors in reply to the letter of 14 March that it was surprising that a doctor who had been out of practice since 2007 could score over 70% in the knowledge test. The fitness to practice hearing would be in late 2011 or early 2012.

201. Mr Hyam submitted that Drs Bevington and Blackburn had visited and inspected Dr Gibson's practice in 2005 at the PCT's request (around the time 5 of the 10 cases focused on occurred) and had found an enthusiastic and energetic doctor with average knowledge prepared to learn. The training practice report in February 2006 by Dr Diack described Dr Gibson as efficient and organized with good systems in place and good learner centred skills with active listening.

202. On 4 May 2011 Dr Julius Parker, Chief Executive of Surrey and Sussex LMCs, suggested that Dr Gibson should attend a 6 month return to work retraining of the type run by the London Deanery in a middle to large size GP training practice and have a separate experienced GP mentor. She had shown the ability to learn and accepted that she needed to remediate the faults in her practice.

203. Further enquiries had been made and in a letter dated 5 July 2011 Dr Parker said that he believed it would be possible to construct a local remediation plan equivalent to that run by the London Deanery with regular reports from the trainer to the PCT. The Kent Surrey and Sussex Deanery would support him in identifying a suitable trainer and the Dean had proposed a meeting with the LMC which would act as a financial intermediary between Dr Gibson and her trainer. A precursor to entry on retraining would be passing the MCQ and simulated surgery tests at the London Deanery: these could take in October and retraining for 6 months at Dr Gibson's own expense could begin in January 2012. This would be a stepwise process with no risk to patients during the training and no return to practice, if the retraining was not completed to the reasonable satisfaction of the Deanery and the PCT. Dr Gibson would not be paid during the retraining period. Thus there could be no prejudice to the efficiency of the PCT's services.

204. Mr Hyam accepted that Dr Gibson had been pressed for details and concrete proposals on several occasions since 15 April 2011. It took time to put details in place: these proposals were not excessively vague. It would not have been possible to ask the GMC to lift the suspension before it saw the decision of this Panel. The ball had been started rolling; Dr Gibson had the support of the LMC and the Deanery. She was keen to learn and improve, willing to self-fund and had in the past been willing to accept and learn from a mistake. A trainer could be identified whilst Dr Gibson took the MCQ and simulated surgery test and retraining could start in January 2012. A telephone call between Dr Gibson's solicitor and Dr Richard Brown at the LMC suggested that it was "eminently doable" that a trainer could be in place by January 2012.

205. If Dr Gibson were to be given the chance to remediate herself at her own expense in a risk-free environment, it would be disproportionate for the GMC to refuse to lift her suspension for that purpose. There was a real prospect the GMC would agree to lift the suspension for this purpose. It was premature to consider a condition that Dr Gibson should not practice as a single-handed GP. If need be, Dr Gibson would albeit reluctantly give up her management of her practice with immediate effect.

206. In reply Mr de Bono submitted that remediation was impossible and impracticable. The 10 cases showed a very wide spectrum of multiple clinical failings: Dr Gibson's practice was so far from safe that she would have to start again from the beginning. The return to work programme referred to by Dr Parker was a refresher course rather than the fundamental retraining necessary in this case and compounded by 4 years absence from practice.

207. The PCT had made multiple requests since 15 April for detailed proposals for remediation but had only yesterday evening received Dr Parker's letter. This was devoid of detail for the PCT to scrutinise. Dr Parker had supported Dr Gibson through the LMS throughout the entire process and made assertions on behalf of the Deanery for which there was no evidence from the Deanery itself. It was canvassed that he would give evidence to the Panel but had not. He had no knowledge of where Dr Gibson was on the spectrum of incompetence or unsafety and may have based his views solely on the faults that Dr Gibson was prepared to admit.

208. There was currently no scheme run by the local Deanery. It would need to be established and validated, even if the Deanery (as was unclear) was offering to help identify a trainer or to oversee the scheme itself to any extent. What the training and the final assessment would comprise and how they would be benchmarked was unknown. The Panel should not hand over the responsibility to the LMC and the Deanery to judge whether Dr Gibson could practice safely and certainly not so late in the day and on such meagre information.

209. If a doctor acknowledged clinical failings frankly, remediation might be possible but where frankness and insight were lacking it was more difficult. Dr Gibson had sought to put the best conceivable interpretation on everything she had done and had failed honestly to confront her shortcomings. Dr Gibson's interview and witness statement admitted as little as she could get away with: Case 6 was a good example. In her statement she said care was shared with the diabetologist (which it was not – as a result of finding this out Dr Silk increased his criticism of this case) and made no reference at all to her management of the patient's condition, as opposed to his HbA1C readings. She attributed the patient's problems to his poor diet. In paragraph 29 of Counsel's opening submission she accepted that she should have stopped gliclazide on 14 May 2007, rather than wait for HbA1c results.

210. In evidence she first said that she made the decision to stop gliclazide on 14 May. When it was pointed out that the patient still had unused tablets from a previous prescription she said that she told him not to take any more gliclazide until the blood result came in and wrote "advice given, re med. etc" in the records rather than explicitly noting that she had told him to stop the glicazide. She said had not mentioned telling him to stop on 14 May previously because she felt bad about the case and did not want to claim any credit for her management of this patient. This sits wholly incongruously her approach to these and the PCT's proceedings. Throughout all this she was claiming to be an expert in diabetic care. In addition Dr Silk said in his report that he had discussed the cases with Dr Gibson so that she would have had the opportunity to correct any misapprehensions on his part.

211. There were further examples of lack of straightforwardness. In Case 3 Dr Gibson gave a very detailed account of the circumstances containing elements that had not appeared in her witness

statement or her interview with Dr Lewis and had, in the PCT's submission, changed the records to cover up that the fact that she had not discovered the patient's pregnancy. In Case 4 Dr Gibson persisted in saying she had observed bleeding rather than discharge when she had recorded a discharge in the records and her own expert had accepted the management only made sense, if there had been a discharge. The object was presumably to cover up the lack of proper treatment.

212. In Case 10 Dr Gibson had changed her story from being unsure in her interview whether she had examined the abdomen to asserting in her witness statement that she had. In Case 8 deletion of the blood pressure result may have been justified but it was dishonest to deny she had deleted it.

213. Dr Gibson had convinced reviewers in the past that she was competent when, on detailed analysis, she was not. A trainer might similarly be taken in. The fact that Dr Gibson wanted to keep her options open in relation to single-handed practice was itself evidence of her lack of insight. If a contingent removal were to be allowed, there should be a condition that a permanent practice manager be appointed immediately.

214. The GMC would be very likely to wait for its own Fitness to Practice hearing and there was simply no evidence from which to infer that there was a real prospect that the suspension would be lifted in the interim to allow retraining. If this approach was to be adopted, it should have been canvassed with the GMC in advance of this hearing. There was no prospect of a realistic remedial package available in a realistic time.

Discussion

215. In the light of the findings set out above it will be clear that the has Panel accepted that widespread failings in Dr Gibson's practice (in addition to those she has herself accepted) have been proved. The same mistakes, for example in record-keeping, were repeated so often as to provide incontrovertible evidence of bad practice. That in itself would not be of the most serious but there were also clear failures in relation to clinical competence in relation to examination of patients, diagnosis of conditions, maintenance of patients with chronic or complex conditions and prescribing.

216. On the non-clinical side there was ample evidence of poor leadership of staff, difficulty in communication and team work skills. The Panel found the GMC Rule 7 letter highly significant, even allowing for the fact that its criticisms were, to an unknown extent, not accepted by Dr Gibson.

217. At the end of 2010 her performance was found to be unacceptable in the following areas of Good Medical Practice: assessment of patients' conditions, treatment, records, and relationship with patients and with colleagues. Her performance was a cause for concern in relation to providing or arranging investigations and Maintaining Good Medical Practice. In the Applied Knowledge Test she scored below the minimum acceptable standard and towards the lowest end of acceptable scores (in fairness it is hard to see a logical consistency in these 2 outcomes).

218. In the Simulated Surgery her scores were below the range of volunteer scores in the domain of information gathering and below the 25th percentile in explanation and management and below the

median in the domain of doctor/patient interaction. In the Objective Structured Clinical Examination her score was below the range of volunteer scores in the station knee examination and below the lowest scores of other doctors (except outliers) in the stations of establishing cardiovascular risk, discussion with colleague, post natal depression, telephoning result, immunisation issues, swallowing and communication and complaint against team member.

219. Of course, these are findings of an assessment rather than a Fitness to Practice Panel but this assessment process is of international renown and there is no reason to suppose that it was conducted in some way unfairly to Dr Gibson or was inaccurate in any major feature. Compared to this, the endorsements of Drs Bevington and Blackburn on a fleeting review of Dr Gibson in 2005 weigh lightly in the balance.

220. In view of the overall contents of the Rule 7 letter the point apparently made by Dr Gibson's solicitors to the GMC that Dr Gibson had scored over 70% in the knowledge test, repeated in Mr Hyam's submissions to us appears to be a striking example of looking on the bright side of life. On the basis of this evidence we do not accept that there is a real possibility that the GMC would lift the suspension before the outcome of the Fitness to Practise proceedings was known.

221. We accept Mr de Bono's general submission that insight is necessary to cure all but the least serious failures and we consider that Dr Gibson's clinical and non-clinical deficiencies are great indeed. The criticism that Dr Gibson has sought to minimise her failures in the evidence she has given to the PCT and in these proceedings appears to be well-founded.

222. In cases 3, 4, 6, 9 and 10 the changes in Dr Gibson's evidence (including her patients' records) detailed above seem to us to be evidence of a desire to exculpate herself rather than to face up to her professional failings and thereby give herself a chance to remedy them. Cases 5, 7, 8 and 9 appear to be examples of Dr Gibson putting the potential financial gain ensuing from a course of action above the interests of the patient.

223. We have found Dr Gibson's witness statement a very unhelpful document. Although she has attested to the truth of the facts contained in it is perfectly clear that it has not been her last word on certain topics, for example claiming shared care and the failure to accept any responsibility in Case 6. Just as importantly the statement is highly selective and appears to duck difficult issues. The Panel would have been much more greatly assisted by a frank narrative asserting what had been done correctly and what had gone wrong with an honest appreciation of lessons to be learnt and evidence of a determination to learn them.

224. What the document provided, however, was a carefully crafted professional commentary in a style and in words that bore very little resemblance to the oral evidence that Dr Gibson gave and the manner in which she gave it. In consequence of this and its selectivity the Panel had very little confidence indeed of its accuracy or utility.

225. It was telling that, over lunchtime on 6 July, Mr Hyam appeared to have received instructions to submit in Case 10 that an OOH doctor had seen no sign of an enlarged liver 2 days before Dr

Gibson saw the patient. The point was shortly dealt with by Mr de Bono as set out in paragraph 196 above.

226. Dr Gibson's reaction to the proceedings was also significant in her obvious reluctance to give up her position as practice manager and her insistence that the question whether she should be allowed to practice single-handed was not conceded but left over to the future. There is no objection to GPs behaving entrepreneurially provided the provision of safe and competent patient care trumps commercial considerations. The Panel also observed her taking amiss the submission on behalf of the PCT that she was very far from an expert in the care of patients with diabetes. This in itself betrayed a considerable lack of insight. Her image of herself as expert in diabetes care, minor surgery and O & G was impossible to square with her performance in the cases before us and with the provisional findings of the GMC assessment.

227. It was surprising that Dr Gibson was said by the GMC in its letter to the PCT of 17 May 2011 "very unusually for a practice manager" to be telephoning patients in evenings and at weekends and this suggested that, despite all the evidence in this case, she simply could not bear to relax her grip on the practice.

228. Overall the Panel formed the view that Dr Gibson had very little insight indeed into her professional shortcomings and showed a lack of candour in her evidence.

229. The question remains whether those shortcomings are remediable and a view must be formed on the basis of the available evidence. Dr Gibson has been out of practice for 4 years and it is extraordinary that such evidence as was available to us comprised a letter from the LMC dated 5 July 2011. Dr Gibson accepts that she had been pressed for details of the proposed remediation programme from at least 15 April 2011. It is surprising, given that the burden was on her, that she needed to be pressed at all. The evidence provided only at the last moment is speculative, is unconfirmed by the Deanery and has inadequate detail of the content of the intended programme (still to be established), the assessment process and the timescale.

230. A programme fit for the purpose of remediation of a GP with Dr Gibson's would need careful and detailed consideration by the intended providers and by this Tribunal. The rejoinder that "these things take time" is simply not good enough. The financial burden on Dr Gibson and the savings to the PCT are minor considerations in the scheme of things. It <u>may</u> be that there would be no risk to patient safety during a period of supervised practice but we have no confidence that Dr Gibson would be able sufficiently to change her professional habits and attitudes and we consider that it is probable that she would be unable to practise safely and with integrity, even if the retraining she proposes were completed.

231. We have looked at matters entirely afresh in our own redetermination. We are mindful that we have a complete discretion. In all the circumstances described above it is our view that it is fair, just and proportionate that Dr Gibson's name is removed from the List of Surrey PCT.

<u>Decision</u>

232. The appeal is therefore dismissed. Dr Gibson is removed from the List on the efficiency ground under Regulation 10(4)(a). If it has not already done so, the PCT shall notify the various bodies referred to in paragraph 16 of the Regulations.

Review and appeals

233. The attention of the parties is drawn to Part 5 of the Tribunal Procedure (First Tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008, 2008 S.I. No. 2699 in relation to reviews of and appeals from this decision.

Tribunal Judge: Mark Mildred
Date Issued: 11 July 2011