IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY **CASE 12363**

Professor M Mildred- Chairman
Dr R Sadek - Professional Member
Mr T Bennett - Member

BETWEEN

DR SALLY JANE BRIDGET WHIPPLE
GMC NO: 2532749
Appellant

and

SOUTH WEST OXFORDSHIRE PRIMARY CARE TRUST
Respondent

DECISION WITH REASONS

A. <u>The underlying facts</u>

1. Dr Sally Whipple worked in general practice from 1983 to 1985. From 1989 to 1999 she was a school doctor and returned to general practice in 1999. From 2001 she worked as an assistant at the North Bicester Surgery and from 2003 was a salaried partner at the Grove Medical Centre, Wantage. She was placed on the Performer's List of South West Oxfordshire Primary Care Trust ("the PCT") in May 2002.

2. Concerns concerning Dr Whipple's practice began in 2003 and culminated in a meeting with Dr Brendan McDonald of the North Bicester practice on 17 June 2005. On 8 July 2005 she was advised to stop work and Dr Ian MacKenzie, the Associate Medical Director of the PCT with responsibility for performance issues, was asked to investigate the position.

3. On 20 July 2005 Dr MacKenzie met Dr Whipple and recommended she should consult her GP, undergo an occupational health assessment, use the Dovedale counselling service, consult her defence organisation and the BMA and attend a time management course. These suggestions were initially rejected although Dr Whipple did agree to meet Dr Rogers, an occupational health specialist on 19 August 2005 and to meet with the National Clinical Assessment Service on 6 September 2005. At that meeting Dr Whipple accepted the need for computer training but not for training in consultation skills or NCAS support.

4. By September 2005 Dr David Wise, the senior partner of the Grove Surgery, had also reported concerns about Dr Whipple's practice.

5. Dr Whipple agreed to be assessed by the Oxford Deanery Career Development Unit ("the CDU") on 1 November 2005. Neither practice at which she worked agreed to participate in her retraining.

B. Removal from the Performer's List

6. Dr MacKenzie prepared a case for removal or contingent removal from the Performer's List. The statement of case was formally made by Jane Dudley, the acting Chief Executive of the PCT, on 7 December 2005. At the oral hearing on 26 January 2006 the Panel consisted of a lay Chair and a lay member and a professional member, Dr Isabel Mower.

7. The Panel accepted as proved allegations of inadequacies in maintaining indemnity insurance, record keeping, patient referrals, prescribing skills, patient complaints, confidentiality, consultation times and lack of communication and clinical skills. The Panel rejected the option of contingent removal on the grounds of Dr Whipple's attitude and personality and the difficulties surrounding retraining and recommended her removal from the Performer's List on the efficiency ground. It recommended National Disqualification. Dr Whipple was informed of the PCT's decision to adopt the recommendations of the Panel.

C. The appeal

8. Dr Whipple appealed against the removal by letter dated 14 March. The grounds of appeal are unclear but appear to argue that her difficulties related only to computer use, that the Grove Practice did not sincerely hold the critical opinion of her alleged, that the CDU regarded her practice as sound, that she was supported by her patients and had had good appraisal reports.

9. The PCT's response to the appeal set out the history of the matter and maintained that removal on the efficiency ground was fair, reasonable and proportionate. The Panel confirmed that they had no conflicts of interest in hearing the appeal.

D. The Directions hearing

10. The hearing was fixed to begin on 15 June 2006 shortly before which Dr Whipple sustained a back injury. Given the doubts over her ability to attend the appointment was treated as a Directions hearing which, in the event, Dr Whipple was able to attend supported by her husband, Mr Christopher Green, who spoke on her behalf.

11. At the hearing it was clear that Dr Whipple was under considerable stress. She was unwilling or unable to listen without interrupting and failed to pay any real attention to the attempts by the Panel to explain the issues and the procedure to be adopted in the substantive hearing. On one occasion she rushed out of the room in tears. For these reasons a short judgement was given encouraging her to obtain legal representation for the substantive hearing which was fixed to begin on 25 July 2006 and directions were given for this hearing. We attempted at some length to explain the form the hearing would take, the procedures to be used and the issues upon which we would have to decide.

E. The substantive hearing

12. On 25 July 2006 Dr Whipple came with Mr Green and a friend, Dr Peter Savundra, both of whom we allowed to speak on Dr Whipple's behalf subject to

avoiding duplication. We again described the procedure and sequence of the giving of evidence and cross-examination of witnesses at some length. The PCT was represented by Mr Huw Lloyd. In this decision references in square brackets are to pages of the hearing bundle of documents. We have reproduced evidence directly in quotation marks only where there precise words themselves rather than the sense appeared to us to be important.

13. Before the PCT began to open its case events took an unusual turn. There was a loud sound like a mobile phone ring tone. It transpired that Dr Whipple had placed on the desk in front of her a miniature camel that was emitting the sound. On enquiry Dr Whipple said that she was "stressed about her friends in the Middle East".

14. It was explained that the PCT would call its witnesses who would give their evidence in its entirety and then submit to cross-examination by or on behalf of Dr Whipple. Dr Whipple appeared quite unwilling or unable to accept this and constantly interrupted the proceedings. On two occasions we rose simply because she would not accept the request to be silent. On the second of these Dr Whipple was describing her role in opposing a new Sainsburys supermarket "eyeballing Estelle Morris".

15. On three occasions she rushed out of the room, the first time shouting "I'm off – fiddle while Rome burns, boys" and on the third "I am going out to the toilet again to vomit – I don't like lies on the Bible". On her return from the second exit she began a speech about the closure of a Spinal Injuries Unit. On another occasion she interrupted cross-examination in an attempt to ask Dr Sadek, the professional member of the Panel, why he had signed the new GP contract.

16. On another occasion in the middle of cross-examination on the mention of December 2005 she interrupted by saying that at that time she had been "talking to Hezbollah trying to avoid world war".

17. Throughout a majority of the day's hearing Dr Whipple kept up an audible commentary on the proceedings and evidence, often knitting, sometimes sobbing and on occasions putting her head on Mr Green's shoulder, even when he was asking questions of the witness. When asked to consider the effect this might be having on a tribunal charged with deciding on her ability to contribute to the efficiency of general practice she gave no sensible reply.

E. <u>The PCT's case</u>

18. On 25 July the PCT submitted a skeleton argument, took us briefly through it in opening and called Dr MacKenzie and Dr David Wise.

19. Dr MacKenzie explained his responsibilities working for the PCT, including the lead responsibility for GP appraisal and the investigation of complaints, after working in general practice for 20 years and his involvement in the case.

20. He described the approach in July 2005 by the partners of the North Bicester practice in relation to Dr Whipple's time keeping, record keeping, prescribing,

patient referrals, patient complaints, attitude to confidentiality and teamworking.

Time keeping

21. He produced an analysis for 17 March to 16 June 2006 [129] showing an average length of consultation of 18 minutes against an appointment length of 10 minutes with a longest consultation of 176 minutes together.

Record keeping

22. Dr MacKenzie was highly critical of Dr Whipple's failure to keep consultation records in about 13% of the 480 appointments reviewed. In these cases there was either no record or only the record of a prescription without clinical information. In some cases consultations were recorded under the names of the wrong patients or under the name of the wrong healthcare professional. He referred to a clinical summary of appointments studied to support these views [313-314]. Dr MacKenzie said that entries in relation to 50 appointments were grossly inadequate and the 13% defective entries should be contrasted with a standard of 1% defective entries aimed at by the competent GP. He told us that Dr Whipple regarded this as exclusively a computer problem and did not accept the importance of contemporaneous records. He believed she had no insight into the seriousness of the problem. Dr Whipple's belief that records could be kept in a notebook or in her head did not accord with acceptable practice.

23. Dr MacKenzie described his work in involving NCAS and the meeting of 6 September 2005 and Dr Whipple's response that gave him further concerns about her insight. He also described the 17 November 2005 meeting and Dr Whipple's difficulty in providing references in 2002 and 2005.

Patient referrals

24. Dr MacKenzie identified shortcomings in referrals to consultants both in terms of delay [174, 445, 450] and the absence of records [450] and inappropriate tone and comments [452-3, 527, 530]. Dr Whipple responded that the last could have been amended by a secretary and was "just a bit of fun". Dr MacKenzie also criticised confusion between private and NHS referrals [442] and inadequate information [181-2, 444, 446].

25. In one case Dr Whipple had asked a patient with a neurological problem to arrange her own referral. Dr MacKenzie described this as absolutely unacceptable practice.

Prescribing

26. Dr MacKenzie criticised Dr Whipple's informal approach, for example changing a prescription from a wife who had died to her husband without noting the prescription to him in the records [458-9] and changing the name on the prescription in manuscript and refusing to correct the records to show which patient had in fact received the prescription [461].

Confidentiality and complaints

27. Dr MacKenzie described the unusually large number of complaints against Dr Whipple in both practices as suggesting a doctor in difficulties and put this down to her coming back into general practice after a long break with inadequate training or mentoring to compensate for the very different world of current day general practice.

28. In addition Dr Whipple had an inappropriately lax attitude to confidentiality, for example mentioning the nature of contraceptive requirements of a patient in the waiting room in front of others [467-470]. This was compounded by the fact that the patient was a local teacher and there were staff and pupils from the school in the waiting room. Further, when this was put to her at the PCT Panel hearing she replied "What's wrong with that?" [405].

29. The Panel had graphic evidence of Dr Whipple's lack of respect for patients' confidentiality both in a letter dated 8 June 2006 [A23-39] in which she describes in detail the medical history of potential witnesses and at the close of the hearing on 25 July when, again discussing her difficulties in bringing witnesses to the Tribunal, Dr Whipple announced that a person she had just named "had AIDS".

<u>Team working</u>
30. Dr MacKenzie described the importance of team working in modern general practice and Dr Whipple's excessively individual style. He gave as an example her refusal to keep her room tidy on the basis that this was not a doctor's job and referred to the offensive letters, e-mails and text messages sent by Dr Whipple to her colleagues after July 2005.

31. By the time of the January 2006 hearing Dr MacKenzie thought that Dr Whipple's lack of professionalism, refusal to change and lack of insight (only prepared to accept shortcomings in relation to computer usage) made it appropriate to seek outright rather than contingent removal from the List. The difficulties in finding a training practice did not affect the matter since he took the view that Dr Whipple was, in effect, beyond retraining.

32. In relation to all these matters Dr MacKenzie asserted that Dr Whipple's conduct was in breach of the guidelines in Good Medical Practice and fell considerably short of the standard required of a GP.

33. Dr MacKenzie was cross-examined mostly by Mr Green. Many of the points put to him did not go to the question of efficiency. For example it was put to him that he had left general practice to join the PCT for "selfish reasons" and the 10 minute length of the standard consultation was contrasted with the length of time it had taken the PCT to remove Dr Whipple from the List. He was asked whether he was aware that the MDU and the BMA were "useless" and was criticised for suggesting that Dr Whipple seek their help.

34. Dr Wise clearly had respect and affection for Dr Whipple and said that at first things had gone very well but that from the middle of 2005 things had become increasingly difficult mainly because of problems with timekeeping and computer use. He had some sympathy with Dr Whipple's antipathy to the dominance of the computer but, unlike Dr Whipple, accepted that it was

inevitable and necessary. He had provided Dr Whipple with help from a specialist in computer use.

35. He said that many of the consultant referrals were clinically appropriate but the content of some was "bizarre" and that it was totally inappropriate to ask a patient to arrange her own referral. There were no prescribing issues at his practice save in relation to HRT. There was a large number of complaints but most were more about approach and attitude rather than clinical matters.

36. Dr Wise said the practice had been disrupted by Dr Whipple's poor timekeeping and patients' complaints. He criticised her breaches of confidentiality saying she lacked insight into the problem but described her as pleasant and initially easy to work with. He would not re-employ her because of the non-clinical problems.

37. Cross-examined by Mr Green Dr Wise gave details of Dr Whipple's consulting room, agreed that Dr Whipple had come to him with concerns and that the weekly practice meeting took place on Tuesdays when Dr Whipple was not at the surgery. He was aware the CDU recommended retraining but felt his practice was not in a position to provide it. He accepted the need to balance "traditional" skills against computer use but said that one could not now be a good GP without the latter. He accepted that the complaint at [529] had begun as a complaint against his partner Dr Allen. Finally Dr Wise accepted that he had become distant from Dr Whipple in recent months since he had become a witness in these proceedings for the PCT.

38. In reply to Dr Sadek Dr Wise reiterated that his practice was unable to provide training but that in any event relations with Dr Whipple had gone from the initially satisfactory level to an effective breakdown. He had taken Dr Whipple's lack of indemnity insurance very seriously.

39. At the resumed hearing on 29 August Dr MacKenzie was further cross-examined by Dr Whipple and then by Mr Green. He said that Dr Whipple's clinical skills had been taken into account, that he had not based the case before the PCT on statistics alone but on the overall evidence and that his role was to collect evidence as the investigating officer. He accepted that the risks from lack of indemnity insurance or late consultant referrals had not as yet resulted in any harm. On re-examination he confirmed that he had taken steps to check Dr Whipple's references and that there had been similar shortcomings in her practice identified in 1999.

40. Dr Brendan McDonald gave evidence that there had been concerns at North Bicester Surgery from an early stage on the part of the practice nurses and receptionists as well as on his own part. These related to prescribing, hygiene, willingness to make computer records and unwillingness to communicate in a co-operative manner. These resulted in an acrimonious meeting on 17 June 2005 that Dr McDonald said was terminated after Dr Whipple had threatened to "dish the dirt" on him. After that relations deteriorated further.

41. Dr McDonald was very concerned at the lack of indemnity insurance creating, as it did, risks for all doctors in the practice, not just Dr Whipple. He was highly critical of the standard of Dr Whipple's record-keeping with frequent absence of history or diagnosis such that risks to the patient arose. He said this aspect became progressively worse. His opinion was that Dr Whipple was not coping and could not effectively work as GP in this century without substantial retraining that he was unwilling to offer owing to the complete breakdown of relations between them that he attributed to Dr Whipple's unprofessional conduct.

42. Dr McDonald went on to make detailed criticisms of Dr Whipple's delayed and inappropriate consultant referrals (for example at [441-450 and 453]), her breaches of confidentiality [469 and 472], her overlong consultation times and her lack of team working skills [444] and referred to the disproportionate number of complaints against her [468-9].

43. Cross-examined by Dr Whipple Dr McDonald accepted that they were only at the Practice together on Friday mornings. He said that the reduction of sessions requested by Dr Whipple would not have been practical and that the quality of Dr Whipple's work did not merit a rise in her pay. He accepted that Dr Gibson had also worked slowly but had managed the work more quickly and with better computer records than Dr Whipple. He was critical not only of the lack of computer records but also of the legibility of Dr Whipple's manuscript records. He accepted that praise was important but asserted that the "team" was functioning much better since Dr Whipple's departure.

44. Mr Green cross-examined Dr McDonald on his experience and professional standing. Dr McDonald explained the glowing reference he had initially written for Dr Whipple on the basis that he had only known her for a month when he wrote it. He rejected questions based on the premise that messiness around the sink would be immaterial since patients would not go near it by giving examples of situations in which patients would need to wash their hands during a consultation. He referred to the routine computer training provided and supplemented by a session Dr Gibson had given Dr Whipple on a Saturday morning. He accepted that team meetings happened on Wednesday lunchtimes when Dr Whipple was not there but said she had the opportunity to ask questions on Friday mornings.

F. <u>Dr. Whipple's case</u>

45. Dr Whipple gave her evidence in a highly articulate narrative setting out her academic history, motives for entering medicine and reasons for taking the variety of jobs she did. She described successful jobs in general practice as an assistant at Chorleywood and in Australia where she described the atmosphere as friendly and non-hierarchical. After two "body blows" in which jobs were discontinued she became the Child Medical Officer for West Berkshire where she worked happily from 1989 to 1999.

46. After this ended in an unhappy reorganisation (described as "serial bullying by management" and "nine months of kangaroo court with spurious accusations about my practice") Dr Whipple went back into general practice as a locum at

Charlbury and then at Long Furlong ("a tight-knit cabal of younger doctors in an ivory tower"). There was then nearly a year of very happy work in a non-computerised single-handed practice at Drayton. This practice was "closed down after Shipman".

47. After a series of "appalling locums where I was certainly abused" Dr Whipple joined the North Bicester practice where she found Dr Gibson, the senior partner, had the same perspective as her and things worked well but the 21 mile journey to the surgery made the job inconvenient. By this time Mr Green had inherited a farm in Shropshire to which the family intended to move and Dr Whipple refused the offer of partnership. She was then headhunted by the Grove Practice to work on Monday, Wednesday and part of Friday.

48. In December 2004 Dr Whipple had a very painful neck problem and asked for a reduction in hours work at North Bicester where she was by then less happy because Dr McDonald "divided and ruled the practice". The team was not working well, Dr McDonald spent his Fridays doing administration and Dr Gibson worked very slowly so by June and July 2005, when it was extremely hot, the workload had become very onerous indeed, Dr Whipple was "hyper", Dr McDonald was "shouting at female staff and failing to deal with clinical work and emergencies" and everyone was under stress.

49. Dr Whipple said that the Grove Practice had it right in keeping paper notes and using the computer for data. Using notes was much more discreet and allowed the doctor to give the patient more attention. She was, however, "more and more used by the Grove Practice", Dr Allen leaving the surgery to relax and Dr Wise to do private work.

50. Dr Whipple denied lack of hygiene save for occasionally forgetting to remove urine samples; she did not realise her indemnity insurance had lapsed and then waited to see her new income before renewing it; the insistence on using computer records was imposed on her and Dr Gibson by Dr McDonald; she denied a disproportionate number of complaints and said that a lady doctor was an easy target; she said that her consultation times were governed by giving patients the time they needed and described herself as a good team player in a co-operative atmosphere.

51. Dr Whipple was cross-examined by Mr Lloyd at some length. She explained the erroneous claim in the CV attached to her notice of appeal that she had been awarded the Edinburgh DCCH in 1995 on the basis that either she had attached the wrong CV and/or that the CV was not for a job application and/or that it was justified because although she had failed the examinations, she had worked hard for them and they were designed to catch candidates out.

52. She accepted that practising without insurance could be serious and place colleagues in difficulty but said that "life can be a gamble". In relation to deficiencies in record-keeping Dr Whipple accepted that colleagues could not use information that was in her head although they could "ask her, if it was serious". She said that the computer was often down and that at the time referred to she had a painful neck condition.

53. In relation to complaints Dr Whipple admitted that the complaint at [529] from a patient complaining of failure to refer and inappropriate consulting style was lucid but that the schedule of "irrelevancies" raised by Dr Whipple in those consultations [530-1] was untrue. She later accepted that she had "got the patient to phone around the hospitals since she felt desperate and put under pressure by the patient". She accepted her mistake in dealing with this patient and said she was very ashamed about it.

54. Dr Whipple accepted that she had had no formal retraining before returning to general practice in 1999 but said she had kept up to date with journals and by attending postgraduate meetings. She said she did not feel the need to put everything into records but accepted that not keeping clear records might be inefficient for the service and create risks for patients. She explained the referral delays at [441-5] by the need to prioritise other tasks and that at [450] on the basis that the patient was a frequent attender whom she was not convinced could not wait.

55. Asked about the paragraph in a referral letter [453] about breeding chickens and her Shropshire property Dr Whipple said that she liked a bit of humour and described it as inappropriate, unprofessional but fun. She admitted that the paragraph about New Zealand in [527] was inappropriate and unprofessional.

56. Overall Dr Whipple accepted that she had been slow in making referrals but only in the last couple of months when she was under great pressure but said that Dr Gibson had been much worse and that she did not in general accept criticisms made of her.

57. In relation to confidentiality Dr Whipple accepted the precepts in the Guide "except where it was very important that information is shared". She denied seeing a patient in the waiting room [472] or mentioning an appointment for fitting a coil in front of other patients [467-470] although she later accepted this may have happened. She did not accept that she made the remark about being tired of seeing women patients at a social occasion [545] and could not remember what happened in relation to mentioning the details of a wife's medical condition to her (the patient's) husband [536] but thought that she would not have done it lightly but that there must have been a very good reason for it. When it was put to her that there were similar complaints at Long Furlong in 1999 Dr Whipple replied that there may have been conversations in the corridor but that she was not in the habit of holding consultations outside her room.

58. Dr Whipple did not accept that five complaints about her at the Grove were "a lot". She accepted that she went back to prescribing after ten years absence from general practice without retraining.

59. It was put to Dr Whipple that the series of offensive communications to Dr McDonald and his colleagues [474-507] were incompatible with good team working. Her substantive reply was that these were private documents and that she felt abandoned by the practice and in particular by Dr Gibson. She described herself as a team player and a natural leader who regarded time

management as important and acknowledged the need to work with computers whilst keeping paper records as well. She accepted that her standards may have fallen in June and July 2006.

60. At the end of cross-examination Dr Sadek asked Dr Whipple whether she wished to comment on her behaviour during the hearings since it was of some concern. Dr Whipple had on that day again rushed out of the hearing, wept on occasions and had both kept up an audible commentary on the evidence of other witnesses and interrupted them to make statements of her own despite countless explanations that she would have her chance to give evidence in due course and requests to her to stop.

61. Dr Whipple asked Dr Sadek what he meant and at the same time Mr Green said that he thought it was Dr Sadek's behaviour in asking such a question that was in fact extraordinary. Dr Whipple clearly found it difficult to answer such a question but described herself as angry, nervous and despairing and feeling that her contribution to the profession had never been acknowledged. She had found it difficult to prepare for the hearing and the process distressing.

62. At the end of her evidence Dr Whipple gave way to her feelings and wept uncontrollably for some time during which she said she would never go back to medicine and would emigrate, again declaring that the NHS had killed her mother.

63. Yet a few minutes later (after it had been agreed that closing submissions would be made in writing) Mr Lloyd asked whether those submissions should deal with contingent removal. When the notion of continuing practice subject to conditions was explained to Dr Whipple she appeared interested in the possibility.

64. The Panel read letters in Dr Whipple's support from Charles Leakey and Susan Duff. Mr Leakey described Dr Whipple as unusually interesting and capable of frustrating those of a more pedestrian mind and suggested that that was the cause of her difficulties. Mrs Duff described Dr Whipple as very approachable and supportive to patients and colleagues with good communication and listening skills who gave her patients time. She ended that Dr Whipple has her faults "as have most practitioners as they are all human".

G. <u>Submissions of the parties</u>

65. We received submissions in writing from Dr Whipple, Mr Green and the PCT. Mr Green submitted that the odds were stacked against Dr Whipple by the process and her lack of legal representation. He referred to complimentary comments contained in the Smith Report [92-100] and the difficulty in obtaining evidence from patients who regarded her care highly. He characterised Dr Mackenzie as inexperienced and his evidence as speculative and criticised Dr Wise' understanding of the computer summaries produced in evidence, pointing to the reliance placed by the PCT on Dr Whipple's discomfort with computer records.

66. Mr Green also made the point that there were similarities in the witness statements produced on behalf of the PCT so as to raise doubts about the accuracy and authenticity of the evidence. He also pointed out that Dr McDonald was less well disposed than Dr Gibson to Dr Whipple and cited his taking over her room as inimical to good teamwork.

67. In relation to the areas of criticism Mr Green responded as follows:- lack of indemnity cover: lapse but no adverse consequences; record keeping: lapses but caused by concern for the patient and no adverse consequences; patient referrals: all lapses in June/July 2005 when Dr Whipple was under stress; prescribing issues: prescribing is an art as well as a science and Dr Whipple treated the patient rather than just the disease; patient complaints: no evidence from patients of their opinion of Dr Whipple; confidentiality: Dr Whipple's style is open which can be a good thing in many ways; consultation times: Dr Whipple treated the patient rather than just the disease; team working: clashes of personality meant that there were shortcomings on both sides; levels of skill: the practices overlooked Dr Whipple's skill in audiometry.

68. In summary he submitted that Dr Whipple recognised that she was under stress and her attempts to ameliorate the position were frustrated by the prevailing dysfunctionality of the North Bicester practice. The problems could and should have been dealt with more efficiently and humanely so as to allow her to continue providing a valuable service in general practice.

69. Dr Whipple produced 24 pages of manuscript entitled "Some Thoughts (of very many)" and annexed a page of quotations from Tom Ward Green entitled "On morality". Regrettably her submissions were hard to read, strewn with afterthoughts, unnecessary emphases and irrelevant digressions mainly relating to her family.

70. Where relevant to the issues in the appeal Dr Whipple described herself as subject to a history of bullying and victimisation. She described the practices as dysfunctional with colleagues focused on competitive data collection on flawed computer systems. She attributed the difficulties of July 2005 to two months of hot weather and the aftermath of the London bombings. She did not agree with aspects of the new GP contract and was critical of her medical colleagues in part for refusing her request to run a paper record system in parallel with the computer system.

71. She dealt with communication, team working, confidentiality and computers as separate topics. She described her communication skills with patients adding that paper records stood a better chance of telling the patient's story. She said that she felt sure that all doctors occasionally feel they must engage husbands in wives' health cases and that there was an occasional need to break confidence. On the page before this, however, there was gratuitous reference to health conditions in two identifiable individuals.

72. Dr Whipple sought partly to justify delays in referrals as an attempt to advance Enhanced Services by more minor surgical training although there was no other reference to this in the entire proceedings. In relation to computer

records Dr Whipple said that her painkillers might have been partly responsible for absent-minded failure to enter data. She added that she could feel the electro-magnetic field around the computer and consideration of the effect of this on the brain and mood of the user was a reason why she hated computers. She characterised dependence on computerised data as masculine and dangerous and inimical to the intuitive skills required for good clinical practice.

73. We quote from page 20: "It means (as is so obvious in my "case") that BIG BROTHER (ie the empires of top heavy "detached" from frontline and in many cases, clearly, non medically trained personell) are using this "Human frailty "data" (always health has an ethereal dynamism as the clouds and as the minds attached of ?course) which is so dangerous and so manipulable." Dr Whipple went on to decry centralisation of services, to ask that her long experience not be thrown away and to call for an apology from her disloyal male colleagues. She ended with a poem entitled Blind Hope and, in an apparently separate document addressed to the Panel Chair explained the toy camel as a good luck charm.

74. The PCT submitted that the matters of which complaints were made were not isolated nor restricted to a specific period of intense heat in 2005: complaints about note keeping, confidentiality and prescribing issues were made as long ago as 1999 at the Long Furlong practice. Dr. McDonald referred to concerns about Dr. Whipple's clinical performance and behaviour soon after he joined the North Bicester practice in early 2003 (424). Dr. Wise gave evidence that the Grove Medical centre had increasing concerns about Dr. Whipple in the period around six months to a year before Dr. MacKenzie approached them in July 2005 [505]. Despite efforts to improve matters by 8 July 2005 Dr Whipple was clearly unable to cope and only then was the step taken of bringing in the PCT.

75. The submissions rehearse the requirements of Good Medical Practice and set out with supporting detail specific allegations under eight headings. These (with the number of references to contemporaneous documents – as opposed to statements from witnesses called by the PCT – in respect of each) relate to record keeping (7), patient referrals (10), prescribing issues (16), patient complaints (8), confidentiality (5), consultation times (3), team working and surgery management (7) and levels of skill (2).

76. We will not extend this decision by inclusion of all matters of detail but will make a decision on specific disputes of fact below.

77. In summary the PCT submitted that the duration, gravity and extent of Dr Whipple's shortcomings when coupled with her reluctance to accept the need for any change apart from computer training would inevitably be prejudicial to the provision of general medical services.

H. Findings of fact

78. Some allegations made by the PCT were denied by Dr Whipple and we must make findings of fact in respect of them.

79. We find that failures in surgery hygiene were not limited to occasional oversight of removal of urine samples. We find that the number of complaints

against Dr Whipple was greater than to be expected and cannot be explained by her gender. We find the alternative explanations for the misleading information in Dr Whipple's CV unsatisfactory. We find that the remarks attributed to Dr Whipple at [530-1] were in fact made. In relation to patient referrals we find no evidence in the documentation before us that a problem existed before 2005. We find that Dr Whipple's attitude to confidentiality was unacceptable: if it was very important that information be shared, the permission of the patient entitled to the confidence should have been obtained.

80. We accept the evidence that patients were seen in the waiting room at Long Furlong and at North Bicester and that an appointment for a coil fitting was made in front of other patients in the waiting room. We accept that the conversation on a social occasion took place [545] but do not place any weight upon it, given the circumstances in which it was made. We do not accept the explanation for the highly offensive e-mails [474-507] that these were private documents or that the contents were excusable by Dr Whipple's feeling of being abandoned.

I. Discussion

81. It follows from the evidence (including Dr Whipple's concessions) and findings of fact referred to above Dr Whipple has been in breach of the requirements of Good Medical Practice in respect of record keeping, patient referrals, prescribing issues, patient complaints, confidentiality, consultation times, team working and surgery management and levels of skill. We have no doubt that on 8 July 2005 Dr Whipple's continued activity at either or both the Grove Practice or the North Bicester Surgery would not only have been seriously prejudicial to the services there provided but would also have been damaging to her own health and well-being.

82. In deciding whether to remove her from the Performer's List we must consider the causes of those breaches and whether they are remediable.

83. Dr Whipple's case was that her difficulties in July were the result of two months of hot weather and the aftermath of the London bombings; the PCT's case was that they were acute manifestations of chronic shortcomings. That this was true in relation to record-keeping and prescribing is clear from the contemporaneous and later documents from Long Furlong [124, 125 and 127]. We reject Dr Whipple's explanation of those criticisms as coming from "a tight-knit cabal of younger doctors in an ivory tower" and note the sincere encouragement to her [124] to undertake necessary retraining.

84. Whilst the London bombings may well have caused apprehension, the fact that they occurred the day before Dr Whipple was sent home suggests that they cannot have been a cause of the difficulties that came to a head on 8 July 2005.

85. It appears far more probable to us that the root cause of Dr Whipple's difficulties was her ten-year absence from UK general practice at a time of very rapid change without her undergoing any effective or substantive retraining. In particular this decade had seen a fundamental change in the computerisation of

records and in the delivery of primary care services. Dr Whipple objected to both on various grounds.

86. The difficulty is that neither of these changes is optional. Paper records and the "traditional" relationship between GP and patient may have much to commend them but an implacable opposition to both cannot fail to compromise the efficiency of the service. Although Dr Whipple claimed whilst giving evidence that she was able to use computers satisfactorily we judge that her real attitude towards them was as revealed in her closing submissions summarised above. We find it unacceptable that Dr Whipple thought it appropriate to keep clinical records in manuscript as an aide memoire in her own possession to the exclusion of the practice records.

87. We accept that Dr Whipple's style of practice had its advantages (and recall Dr Wise's initial enthusiasm for her) but find that her implacable opposition to the disciplines of the current NHS inevitably resulted in the crisis of July 2005. The style of practice spreads over into the level of Dr Whipple's skills. Our view is that her skills had fallen behind the times and could only have been brought up to date by the retraining that Dr Whipple, despite encouragement, never undertook.

88. Dr Whipple's conduct in other respects also fell far short of acceptable practice. Her attitude to confidentiality was seriously deficient. The examples in the documents and referred to in evidence were bad enough but were compounded by her evidence to the PCT Panel [402-405] and by her breaches of confidence in front of us and even in her written submissions.

89. We reject her explanation that delays in referral could be explained by a desire to do more minor surgery on-site for which, even if it were credible for the variety of referrals where there was delay (which we find it was not), there was no evidence at all that such a development was on the agenda of either practice.

90. We accept the criticisms made by the PCT concerning prescribing both in respect of drugs prescribed and, perhaps more importantly, in respect of the slapdash approach to the necessary formalities of the prescription itself.

91. We accept that the level of complaints against Dr Whipple was disproportionately high but the only period for which statistics are available is that short period during which the situation was declining and it does not seem to us helpful or fair to ascribe an importance to them over and above our findings on the various subject areas out of which the complaints themselves arose.

92. We accept the evidence that Dr Whipple's practice management skills including timekeeping and hygiene were deficient and we accept that the over-running of consultation times, even after protection to the timing of sessions was introduced, together with the record-keeping problem was increasingly serious and very unlikely to improve.

93. In relation to team working there was a mixed picture. Dr Whipple has the capacity to work in a team and it was clear that there was initially goodwill towards and from her in both practices. The pressures upon her coupled with the frustrations on both sides led to the rapid and irreversible breakdown of relationships and loss of that goodwill. Whatever the provocation we find that the series of e-mails at [474-507] was inexcusable and completely unprofessional.

94. Dr Whipple alleged sexual discrimination, bullying and victimisation and made frequent derogatory remarks about English men. We find that Dr Whipple's unusual manner and reluctance to change or compromise were far more potent factors in her serial disillusionment with so many NHS institutions.

95. In summary we consider there are ample grounds for concluding that Dr Whipple's presence on the List was prejudicial to efficiency. The criterion is prejudice to the service as it is, not as the appellant would like it to be.

97. The crucial question remains whether the position is remediable. Refusal of retraining suggests that it is not. What is equally concerning is the manner in which Dr Whipple conducted the proceedings. We accept that she was handicapped by lack of legal representation, although the reason for this was never adequately explained, and also that the appeal process is capable of being stressful in itself. These, however, go nowhere near explaining Dr Whipple's behaviour: her uncontrollable outbursts, interruptions even of Mr Green in his attempts to cross-examine witnesses, her numerous rushes out of the hearing room, her apparent failure to understand, or at least attempt to comply with, the universal procedure of letting a witness give evidence without interruptions at every paragraph. To have a lucky charm is one thing; to play the sound device in that toy at the outset of the proceedings is as bizarre as it is attention-seeking. Our constant attempts to explain the procedure and to make Dr Whipple see the effect her behaviour was having on our impression of her in potentially career-breaking decisions fell entirely upon stony ground.

98. The dignity of the proceedings was vastly less important than the impression Dr Whipple made upon us by her abject failure sensibly to present her case and her plans, if she had any, to get her career back on track. Her failure to acknowledge how her quite extreme behaviour was affecting the Panel shows a very serious lack of insight. Taken with the other failures, this persuades us that Dr Whipple is not able to contribute to an efficient service of general medical practice and will not be so able until she acknowledges the shortcomings identified by the PCT and accepted by us.

99. Dr Whipple, minutes after saying that she would never work in the NHS again and would emigrate, warmed to the idea of a supervised return to practice via a contingent removal. A direction was accordingly given that the question of contingent removal should be dealt with in final submissions. All that Dr Whipple said on the subject (at page 15 of her submission) was an unintelligible statement that she "would certainly <u>welcome</u> the "never produced" by the well – would they have? Dr Ian MacKenzie in practice mentor" before going on in the same sentence to accuse Dr MacKenzie of helping to betray the nice aging folk of Drayton in public in 1999.

100. Dr Whipple has simply failed to address this possibility seriously. In the light of this, the refusal to retrain and the breakdown of relations with the two practices and other NHS facilities before it, we do not consider contingent removal a viable option.

J. Decision

101. For all these reasons the Panel unanimously finds that Dr Whipple's inclusion on the PCT's Performers List is prejudicial to the efficiency of the service, orders her removal from that List and dismisses her appeal.

K. National Disqualification

102. In its decision letter dated 16 February 2006 the PCT notified Dr Whipple that it would ask the Panel to make an order for National Disqualification. Guidance from the Department of Health is available in "Primary medical performers lists: Delivering quality in primary care – advice for primary care trust on list management" in paragraphs 39 and 40. The three criteria to be taken into account on an application for National Disqualification are: whether the issues raised are very serious; whether there is a prospect of change in practice style or habits and whether the grounds for removing Dr. Whipple from the Performers List are essentially local. For the reasons set out at some length in this decision we conclude the first question in the positive and the second in the negative.

103. In relation to the third element there is no doubt that there was a particular local element in the obvious antipathy between Dr McDonald and Dr Whipple. The former did himself little credit in the manner in which he gave his evidence and behaved while Dr Whipple gave hers. Even despite this, and discounting Dr McDonald's evidence appropriately, we conclude that the other identified shortcomings make it inevitable that there should be an order that Dr Whipple be nationally disqualified. Put another way, the lack of efficiency in general practice in Oxfordshire identified in this appeal would be no less, if it occurred in Shropshire where Dr Whipple now lives. Given Dr Whipple's obvious potential qualities we come to this conclusion with regret.

104. Taking all material factors into account the Panel determines that Dr Whipple be disqualified from inclusion in all lists held by all Health Authorities/Primary Care Trusts under 49F National Health Service Act 1948 or any succeeding or replacement provision.

L. Supplementary

105. We direct that a copy of this decision be sent to the persons and bodies referred to in Regulation 47 of the Family Health Services Appeal Authority (Procedure) Rules 2001.

106. Any party to these proceedings has the right to appeal this decision under and by virtue of Section 11 of the Tribunals and Inquiries Act 1992 by lodging notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days from the date of this decision.

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Mark Mildred
Chair of Appeal Panel
2 October 2006