

DETERMINATION: Impairment

FITNESS TO PRACTISE PANEL HEARING: Commencing 3 January 2012

Dr Iain STEPHENSON (4069256)

Dr Stephenson:

The Panel has considered under Rule 17(2)(k) of the General Medical Council (GMC) (Fitness to Practise) Rules Order of Council 2004 whether, on the basis of the facts found proved, your fitness to practise is impaired. It has borne in mind all of the evidence adduced in the case, including the further oral and documentary evidence given and presented by you at this stage, and has taken account of Ms Nicholls' submissions on behalf of the GMC and your own submissions.

The Legal Assessor referred the Panel to relevant case law, including:

- Meadow v General Medical Council [2006] EWCA Civ 1390; [2007] 1 QB 462;
- Cohen v GMC [2008] EWHC 581 (Admin);
- Zygmunt v GMC [2008] EWHC 2643 (Admin);
- Cheatle v GMC [2009] EWHC 645 (Admin);
- Remedy UK v GMC [2010] EWHC 1245 (Admin);
- CHRE v Grant & NMC [2011] EWHC 927 (Admin).

In making its determination the Panel has exercised its own professional judgement. It has borne in mind its duty to protect the public interest. The public interest includes the protection of patients, the maintenance of public confidence in the profession, and the declaring and upholding of proper standards of conduct and behaviour.

The Panel has followed the two step process set out in the case of Cheatle and has considered whether the facts in this case amount to serious misconduct which establishes that your fitness to practise is impaired.

Serious Misconduct

Paragraph 4 of the judgement in the case of Remedy UK states that:

“Misconduct may also fall within the scope of a medical calling where it has no direct link with clinical practice at all. Meadow provides an example, where the activity in question was acting as an expert witness... Other examples may be someone who is involved in medical education or research when their medical skills are directly engaged.”

The GMC’s Good Medical Practice (November 2006) states at paragraphs 56 and 57:

“Probity means being honest and trustworthy, and acting with integrity: this is at the heart of medical professionalism.

You must make sure that your conduct at all times justifies your patients’ trust in you and the public’s trust in the profession.”

Paragraphs 70 and 71 state:

“Research involving people directly or indirectly is vital in improving care and reducing uncertainty for patients now and in the future, and improving the health of the population as a whole.

If you are involved in designing, organising or carrying out research, you must:

- (a) put the protection of the participants’ interests first*
- (b) act with honesty and integrity*
- (c) follow the appropriate national research governance guidelines and the guidance in Research: The role and responsibilities of doctors.”*

The GMC Guidance on Research: The Role and Responsibilities of Doctors (2002) also emphasises the importance of maintaining integrity.

You acted dishonestly on a number of occasions during the period from September 2009, when you recruited yourself into your Open Label Study as a volunteer and disguised your involvement by changing the spelling of your name in trial records, to May 2010, when you recruited three subjects into your Open Label Study who had already been recruited into another study (the Prime Boost Study). This dual-recruitment was itself inappropriate, but you compounded the situation by acting dishonestly in a number of ways. You recorded falsely on the vaccine log that these subjects had been given vaccine. You asked Nurse Phayre Parkinson to countersign on the log that she had checked the administration of vaccine, when she had not. Once Nurse Parkinson had realised that she had signed for something she had not witnessed and asked you to cross out her signatures (which you did), you dishonestly destroyed the original log sheet and replaced it with two new sheets of your own creation. As the Panel has found, part of your purpose in replacing the sheet was to conceal two forgeries of Dr Clark’s (a research colleague) signature. During this period, you forged Dr Clark’s signature six times and you forged his and that of Professor Karl Nicholson, Professor of Infectious Diseases at Leicester University, on their respective CVs.

The Panel is of the view that your actions display significant breaches of Good Medical Practice and GMC guidance on research responsibilities requiring honesty and integrity and that they amount to research fraud. In addition to this, asking Nurse Parkinson to

countersign the log sheet falsely in order to maintain concealment of your dual-recruitment of subject numbers 54 to 56 posed a real risk to her own professional integrity and reputation. She has given evidence that she felt worried and the Panel considers that your behaviour demonstrated a disregard of the principle set out in paragraph 46 of Good Medical Practice that you must treat your colleagues fairly and with respect.

From an experienced consultant and researcher such as yourself, the profession and the public would expect scrupulous adherence to research protocol, honesty at all times and due respect for colleagues. The Panel finds that your conduct was a clear departure from the standards expected and, in respect of dishonesty, breached a fundamental tenet of the profession. Your actions were liable to bring the profession into disrepute and the Panel considers that they amount to serious misconduct.

Impairment of Fitness to Practise

In her judgement in the case of Grant, Cox J reviewed earlier case law and confirmed that current fitness to practise is properly to be judged by reference to past misconduct and, looking to the future, whether the misconduct has been remedied and whether it is highly unlikely to be repeated in the future. She also set out in a number of paragraphs helpful guidance on the approach which Panels should adopt to the question whether a doctor's fitness to practise is impaired.

Paragraph 71 states that:

“...it is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations... namely the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.”

Paragraph 74 states that:

“In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.”

Finally, in paragraph 76, she refers to and approves the test identified by Dame Janet Smith in her Fifth Shipman Report:

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

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

*c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.”*

There is no evidence which could lead the Panel to conclude that your misconduct put patients at risk of unwarranted harm or that you are liable to put patients at risk in the future. Indeed, there is positive evidence to the contrary. Without exception your professional colleagues say that you are an excellent clinician, who is well regarded by colleagues, patients and patients' families. There is recent support for this from patient satisfaction surveys and 360 degree appraisal feedback. You have told the Panel that maintaining the standard of your clinical practice at all times is a priority for you and the Panel accepts that your dishonesty with respect to your research which is under consideration by this Panel did not pose any risk to patients. It also accepts the evidence of Professor Nicholson that your dishonest misconduct did not in fact adversely affect the Study itself, although this is linked to the discovery of your dual-recruitment of three subjects and their withdrawal from both studies.

Nonetheless, the Panel considers that your dishonest actions brought the medical profession into disrepute and breached a fundamental tenet of the profession. There is a strong public interest in the integrity of medical research. The public are entitled to trust the conclusions of such research and have faith in it to improve treatment and care available. You volunteered for your own study under an altered name, forged signatures on several occasions, asked a junior colleague to provide false counter signatures and tampered with research records. In addition to seriously undermining the public interest, and particularly in light of your experience and seniority, your research fraud could have brought the reputation of your university into disrepute in national and international research communities.

It is made clear in all the judgements from Cohen to Grant that a Panel should consider whether the misconduct in question is easily remediable, whether it has been remedied and whether there is a risk of repetition. This is directly relevant to the question whether, having acted dishonestly in the past, you are liable to do so in the future.

Dishonesty, by its very nature, can be difficult to remediate. Evidence from you and your colleagues does indicate that you were mismanaged, overworked and extremely stressed and anxious, due to an excessive workload at the hospital and the imposition of a job plan, about which you had not been consulted, requiring you to take on additional responsibility for the care of elderly in-patients. This, however, occurred between December 2008 and July 2009 when Dr Paul McNally was appointed Clinical Director and brought a more considerate and robust approach to your situation. You have described this as making you feel an overwhelming sense of relief. You have maintained in evidence, however, that despite the reduction in your clinical commitments and the greater flexibility resulting from Dr McNally's intervention, you were still badly affected by the humiliating, embarrassing and undermining experiences of the first half of 2009. You believe that you were suffering from an unrecognised depressive illness which explains your lapses of judgement and engagement in dishonest acts. However, the Panel rejects this as the explanation for your misconduct. There is no independent medical evidence in support, although the Panel accepts that, almost by definition, an "unrecognised" illness will lack supporting evidence from the time in question. The Panel has inevitably formed its judgement on the basis of

evidence which is available and it has necessarily given very careful consideration to whether there is evidence of the presence of health factors in April and May 2010, given that the obvious triggers for stress or other health disorders occurred between December 2008 and July 2009. Although there is evidence of two specific instances apparently after July 2009 when you were uncharacteristically rude (from Dr Monk) and appeared low (from Dr Pereira), other colleagues who have commented on your behaviours relate their observations to the first half of 2009 and indicate that, following Dr McNally's appointment as Clinical Director, you appeared to be much better.

The Panel has noted that your act of dishonesty in disguising your self-recruitment into your Study occurred in September 2009, shortly after your relief at Dr McNally's intervention when your workload concerns were addressed. You told the Panel that your purpose in entering yourself into the Study was to receive the Study vaccine, which was not available to you by other means, for your own protection. This is a rational explanation which cannot easily be described as a lapse of judgement due to stress or ill health.

Of particular significance to the Panel's judgement is that, if you were suffering from a stress or depressive disorder in April and May 2010 as an explanation for your state of mind leading to acts of dishonesty, a manifestation of that would be expected more widely in your behaviours and moods than in just one area of your work. This does not appear to have been the case, based for example on evidence about your clinical practice during this time.

The Panel is also concerned that the insight you have shown into your misconduct is not fully developed, although it does recognise and accept Dr McNally's evidence, as your current mentor, that you continue to reflect on what occurred and that you are genuinely remorseful. You have however given evidence that you still feel resentful about your workload at the time of events and, in answer to Panel questions, you mainly suggested coping strategies which relied on others, for example mentoring, job planning and appraisals. You have not acknowledged additional factors which might explain your misconduct, such as pressure to get additional subjects for your study, and have not suggested any coping strategies which you yourself could implement in future.

For all the reasons given above, the Panel is not able to conclude with confidence that the risk of repetition of your misconduct is very unlikely. Furthermore, the Panel has not lost sight of the fundamental consideration relevant to this case, namely the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession. In its judgement, the nature of your research fraud and its potential damage to the integrity of research as an important arm of medical science is such that public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances of this case.

The Panel has determined that your fitness to practise is impaired by reason of your misconduct, pursuant to Section 35C(2)(a) of the Medical Act 1983, as amended. It will now invite further evidence and hear any further submissions as to the appropriate sanction, if any, to be imposed upon your registration.