



**An Independent Investigation Report into allegations of bullying and clinical  
practice concerns in relation to Dr Malcolm Gerald  
by Capsticks Solicitors LLP**

**Commissioned by NHS England and NHS Gloucestershire Clinical  
Commissioning Group**

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## INTRODUCTION

1. In November and December 2016, NHS Gloucestershire Clinical Commissioning Group (“**GCCG**”) and NHS England (“**NHSE**”) received information from members of the public and former members of the Romney House Surgery (“**the Practice**”) staff which alleged the following concerns in relation to Dr Malcolm Gerald (“**Dr MG**”):
  - 1.1 bullying and harassment;
  - 1.2 poor clinical practice;
  - 1.3 poor patient experience in relation to the care he provided; and
  - 1.4 management of patient complaints.
2. Capsticks Solicitors LLP (“**Capsticks**”) were commissioned to undertake an independent investigation. The Terms of reference for the investigation are set out at the paragraph 10 of this report (“**the Report**”).
3. The investigating team (“**the IT**”) comprised individuals from Capsticks and expert independent clinical advisors appointed by NHS England. It was established prior to the commencement of the investigation that no IT member had a conflict of interest in carrying out the investigation and preparation of the Report.

## BACKGROUND

4. The Practice is based at 41-43 Long Street, Tetbury, GL8 8AA. It is the main primary care facility in the town of Tetbury, with a list size of 7,718 patients.
5. There is a single GMS Contract with the partnership (Romney House Surgery). The contract is managed on behalf of NHSE by GCCG under full delegated authority.
6. The clinical records are provided using TPP SystemOne software and are fully computerised.
7. On 1 February 2017, the Practice entered a joint partnership arrangement with another local practice – the Phoenix Surgery, 9 Chesterton Lane, Cirencester, GL7 1XG. The Practice retains its identity as Romney House Surgery.

8. Dr MG retired from the Practice on 4 September 2017.

## **INVESTIGATION OBJECTIVE**

9. The independent investigation was set up to examine the concerns raised and in order to inform consideration of regulatory action by NHSE under the National Health Service (Performers Lists) (England) Regulations 2013 (as amended) (“the Regulations”) and the possibility of referral to third party stakeholders, including but not limited to the GMC, and other regulatory bodies as applicable.

## **TERMS OF REFERENCE**

10. The investigation’s terms of reference (“**TOR**”) addressed the following three issues:
  - 10.1 Bullying and Harassment (“**TOR 1**”) specifically:

Is there evidence to substantiate the allegation that the named GP has acted in a bullying, intimidating and undermining manner in his interfaces with staff and/or patients?
  - 10.2 Clinical Practice (“**TOR 2**”), specifically:

Are the concerns raised in relation to poor clinical practice and patient experience substantiated, as benchmarked against recommended good medical practice and in line with recognised standards such as, but not limited to, GMC’s Good Medical Practice and national and local guidelines?
  - 10.3 Complaints Handling (“**TOR 3**”), specifically:

Does the named GP manage and respond to complaints about their practice appropriately and in line with recognised national and local standards/guidelines and practice policy?

## **METHODOLOGY**

### **Summary**

11. The methodology adopted for the investigation comprised a clinical case review and notes audit; interviews (46 in total); a review of submissions received between 31 January and 21 February 2017 at a dedicated

confidential email address and Freepost address (the “Dropbox”); and a review of applicable supporting information.

12. Further detail as to how the IT undertook each element of the investigation is set out below.

### **Clinical Case Reviews**

13. NHSE independent clinical advisors conducted targeted case reviews of 22 patient records. The majority of those reviews were prompted by concerns presented in an appendix to a letter initially attached to correspondence from Geoffrey Clifton Brown MP. That appendix was subsequently updated and further amended on numerous occasions by Mrs Alison Hesketh, ex Patient Participation Group (“PPG”) Chair. A cut-off date was applied so as to give the cases for review finality.
14. These concerns were therefore collated by one or more third parties and were written in the third person, rather than by the complainants themselves in most cases. The concerns raised did not initially name or give contact details for the individuals who had raised them.
15. The timing of the events was not initially specified, and when identified ranged over a period of 23 years. During this period, hand written records, then later the synergy system, and subsequently SystemOne computers were used, where collectively there is inevitably some error in transcription and diagnostic coding in translation.
16. Other concerns became known through communication with GCCG, NHSE or from the Dropbox described above, set up for patients to register issues relating to the investigation’s TOR. All concerns raised within the period, and five received after it, were considered on the basis that they were relevant and clinically significant. All were triaged to determine whether or not they identified clinical elements relevant to TOR 2.
17. Irrespective of source (“collated” complaints, Dropbox etc.) where clinical elements were identified, strenuous efforts were made to contact the individuals and ensure that they were aware that the concern had been raised (if not by the individual him/herself) and to obtain their consent in writing. Consent was assumed where a complaint or letter had been received directly from the individual. Cases were reviewed when they met the criteria of (a) Dr MG having direct involvement in their case, for which patient consent was required; and (b) issues of clinical significance existing,

for which patient consent was not required due to the serious nature of the concern.

18. Concerns that related to Practice administration or other named GPs were not included within the clinical review process.
19. In all, 22 cases were included for review. Those comprised 16 from the appendix to Geoffrey Brown MP's letter (as added to on behalf of the PPG), two referred from GCCG, one referred from NHSE and three from the Dropbox.
20. Using NHSE procedures for reviewing complaints, the cases were examined with a clinical review of the paper and electronic records at the Practice, and a report written for each case (one case involving two children, so 21 reports in total). In many cases, the factual information in the records did not entirely, or in some cases at all, relate to facts stated in the concern. For example, a patient might say they had seen a particular doctor three times, but the records show only one contact. In such instances, the records, which are contemporaneous and cannot be altered without an audit trail, were taken to be correct.
21. The reports were sent to Dr MG for review prior to an interview with him. At interview, all cases were discussed and a transcript of the interview was distributed to the reviewers, who had been present at the interview.
22. Where considered relevant and necessary, interviews with the patient (or their representative where they were deceased or minors), were arranged. All interviews were attended by an independent clinical advisor.
23. Following the review and interview process described above, and after consideration of all documentation supplied in relation to the clinical cases, review reports for each of the individual cases were compiled to establish whether or not, in each specific case, the concerns identified were substantiated and if so, to what extent.
24. Further, an overall assessment was made as to:
  - 25.1 Consultation, examination and investigation technique;
  - 25.2 Clinical appropriateness of treatment and follow up, specifically whether the treatment is in line with recommended practice (e.g. NICE) and the Practice's policies and procedures;
  - 25.3 Record keeping; and

#### 25.4 Complaints handling.

#### **Clinical notes audit**

25. A clinical notes audit of 30 randomly selected notes relating to Dr MG was also carried out with a view to assessing the same issues as those outlined immediately above.

#### **Interviews**

26. Interviews were conducted with a representative sample of:
- 26.1. Current and former Practice staff, and those associated with the Practice. References in this Report to “staff” include all such persons;
  - 26.2. Patients;
  - 26.3. Stakeholders of the Practice, including current and former members of the PPG; and
  - 26.4. Other interested individuals possessing information relevant to the investigation.
27. At the start of every interview, the following was explained:
- 27.1. The purpose of the interview;
  - 27.2. How and for what purpose the information provided would be used;
  - 27.3. To whom the information would be disclosed;
  - 27.4. Interviews would be recorded and transcribed;
  - 27.5. A statement/record of the meeting would be produced;
  - 27.6. That interviewees would be asked to check their individual statement/meeting note for factual accuracy and sign to confirm that the statement is a true and accurate record of their recollection of event; and
  - 27.7. That the process was entirely elective.
28. All interviewees were asked to confirm in advance that they understood and consented to that process and whether or not they had any conflicts of interest they wished to declare.

29. 46 interviews were conducted in total. Notes for all 46 interviews were drafted and sent to each interviewee for review and approval.
30. 31 signed statements were received. Where a signed statement was not returned, despite repeated contact to obtain it, the note has been included as unapproved. The consequences of not signing and returning their statement were clearly explained to each interviewee, namely that an unsigned statement would be viewed as less reliable, all other things being equal, than a signed version. Corroborative evidence via a signed statement would restore a degree of confidence in any given unsigned statement.

#### **Dropbox submissions**

31. Between 31 January and 21 February 2017, a confidential email address and freepost address was opened to allow individuals an opportunity to raise relevant concerns or comments.
32. Submissions to the Dropbox were reviewed by the IT as part of the investigation.

#### **Review of other supporting information**

33. A review was also undertaken of other relevant supporting information available to or provided to the IT.

## INFORMATION RECEIVED AND CONSIDERED

### BULLYING AND HARASSMENT (TOR1)

#### Definitions

34. TOR1 posed the following question: *is there evidence to substantiate the allegation that the named GP has acted in a bullying, intimidating and undermining manner in his interfaces with staff and/or patients?*
35. “Harassment” is included in the title to TOR1, but not in the question it poses. Nevertheless, harassment, in the sense of aggressive pressure or intimidation, or within the definition given by the Protection from Harassment Act 1997 (a course of conduct causing alarm or distress to another person) falls within the range of behaviour set out in the question, namely one or more of: bullying, intimidation and undermining conduct. However, the IT at all times kept in mind the possibility of encountering persuasive evidence that indicated harassment that might not have constituted examples of the conduct spelled out in TOR1.
36. Each of these behaviours covers a relatively broad range of conduct and inevitably, one person encountering or directly witnessing such conduct will react differently to another person in the same position. Some witnesses will be more sensitive than others, whether due to their personal circumstances and sensitivities or due to working in a stressful role (staff) or because of the reason why they attended at the Practice (patients/their friends or relatives). The range of behaviours encompassed within TOR1 and the consideration of corroborative evidence, where available, means that no reported episode of unprofessional or otherwise unpleasant behaviour, whether bullying, intimidation or making a person feel undermined, will have gone unexamined in the course of the investigation.
37. The IT looked to a number of sources when defining, for the purpose of this Report, the various behaviours. It should be noted that this Report was not prepared in contemplation of legal proceedings. Its deliberations on bullying for instance do not seek to determine either way whether a staff member has or had an employment law claim against the Practice or any other claim against Dr MG personally. Similarly, some of the questions posed at interview, such as *“did you ever feel bullied, intimidated or belittled [or similar] by Dr MG”*, would be ruled inadmissible in criminal legal

proceedings, but led to a rigorous examination of the various issues alleged within the terms of reference.

38. The Practice has a Bullying and Harassment Policy, although bullying is not defined within it. Guidance is, however, available from a number of sources, including the Equality Act 2010 which defines harassment as *“unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual’s dignity or creating and intimidating, hostile, degrading, humiliating or offensive environment for that individual”*.
39. Bullying is not defined in law. NHS England accepts the following Advisory, Conciliation and Arbitration Service (ACAS) characterisation, based on fair perception: *“ACAS characterises bullying as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient”*.
40. This report makes a distinction between bullying in the sense of intimidation, typically where the bully is or should be aware of the effect of the conduct upon the victim, and undermining which is usually taken to mean *“lowering someone’s confidence or self-esteem or lessening their effectiveness, power or ability”*. In the latter case, the person may be marginally less likely to appreciate the probable consequences but that does not mean that undermining conduct is considered in any way acceptable. The Oxford English Dictionary definition of intimidation is to *“frighten or overawe someone, especially in order to make them do what one wants”*. No evidence alleging intentional bullying (or whatever kind), or knowing indifference to its effect, was received by the IT.
41. Allegations of bullying were primarily investigated in the course of the 41 interviews with staff and patients. The IT took a firm view on hearsay evidence, mindful of the subject material examined in accordance with TOR 1 and the reputational damage on both Dr MG personally and the Practice corporately, if substantiated. Given the extent of the efforts they made, follow up concerns raised by third parties via first-hand accounts, the IT dismissed hearsay evidence out of hand unless supported by corroborative evidence from persons who had directly witnessed the alleged conduct. An analysis of the interviews conducted is set out below.

## **Bullying – information received at interview**

### **Staff**

42. 35 staff (current, former or those associated with the Practice: see explanation of the “staff” definition at paragraph 20 above) were interviewed. Of these, five (14%), all of whom were former staff members or GP Partners, gave evidence that they felt bullied by Dr MG.
- 42.1. 30 out of the 35 staff who came forward gave evidence that they did not feel bullied by Dr MG.
- 42.2. Dr MG categorically denies that he acted in a bullying manner towards any member of staff and cites multiple examples to the contrary.

### **Patients**

43. Two out of the six (33%) patients interviewed stated that they felt bullied by Dr MG, and four (66%) gave evidence that they did not feel bullied.
44. Again, Dr MG denies that he acted in such a way towards patients and cites multiple examples of exemplary patient care and testimonial feedback to support his position.

## **Intimidation**

### **Staff**

45. Out of the 35 staff interviewed, two (6%), stated that whilst they did not feel bullied, they did feel intimidated. The remaining 33 out of the 35 staff, (94%) interviewed did not describe feeling intimidated.
46. Dr MG categorically denies that he acted in an intimidatory manner towards any member of staff and cites multiple examples to the contrary.

### **Patients**

47. One out of the six patients (17%) interviewed stated that whilst they did not feel bullied, they did feel intimidated by Dr MG. Of this group, the remaining five patients (83%) interviewed did not describe intimidation.
48. Again, Dr MG denies that he acted in such a way towards patients and cites multiple examples of exemplary patient care and testimonial feedback to support his position.

## **Undermining**

### **Staff**

49. Six (17%) of the 35 staff gave account at interview that whilst they did not feel bullied or intimidated, they did describe behaviour that on the IT's analysis would be classified as undermining.
50. Various examples of feeling undermined were given by these six individuals, for example, one described Dr MG as "stomping all over work"; another felt "belittled/dismissed" with another feeling "dismissed/not listened to". The remaining three described being undermined, treated dismissively, patronised, including because the incidents took place in public forum.
51. 29 (82%) of the staff interviewed did not allege undermining behaviour. Indeed, many described their interaction with Dr MG as being very supportive and him being approachable, amenable and open to discussion.
52. Dr MG disagrees that he acted in an undermining manner towards any member of staff and cites multiple examples to the contrary, particularly in one case where he describes actively offering support, wholly in contrast to the complainant feeling undermined.

### **Patients**

53. One of the six patients (17%) interviewed described that she felt undermined by Dr MG. The remaining three patients (who did not consider themselves to be bullied, intimidated or undermined) instead reported:
  - 53.1. a lack of empathy;
  - 53.2. a feeling of not being engaged with; and
  - 53.3. behaviour which they felt was blunt, rude, unsympathetic, uncaring, arrogant and condescending.
54. Again, Dr MG disagrees that he acted in such a way towards patients and cites multiple examples of exemplary patient care and testimonial feedback to support his view.

### **Witnessed conduct towards staff**

55. Of the 35 staff and six patients interviewed, three (7%) gave evidence that they had witnessed bullying, harassing, intimidatory behaviour by Dr MG towards other members of staff/persons associated with the Practice.

56. Of the same group of 35 staff, eight (23%) described witnessing dismissive or undermining behaviour by Dr MG towards other members of staff.

#### **Witnessed conduct towards patients**

57. Again, none of the group of 35 gave evidence that they had witnessed directly bullying, harassing and intimidatory behaviour towards patients.
58. One of the 35 interviewees related that patients had said that they had felt undermined/ dismissed but that was not a first-hand account by the interviewee. Another interviewee referred to reports by patients that they had felt patronised, dismissed, belittled but again, this had not been witnessed direct by the interviewee. No weight is given in this report to unsubstantiated hearsay evidence.

#### **Dropbox analysis**

59. 118 submissions were received into the Dropbox. Of those, five respondents attended for interview. Eight responses either did not relate directly to Dr MG but referred to Practice issues, related to the wider context of the investigation, or were not direct accounts.
60. That left a total of 105 relevant responses that were not considered at interview. Of those, 90 (86%) were positive responses on behalf of Dr MG either concerned practical arrangements associated with (notwithstanding efforts to enable such interviews to proceed) from staff members/ colleagues or patients.
61. Comments from staff members/colleagues include:
- 61.1 *“I always found him [Dr MG] to be very hard working, enthusiastic and clinically competent GP. I value and respected him as a colleague, and never once felt anything but supported by him”;*
- 61.2 *“I was deeply saddened to read the articles in the tabloids. [Dr MG] is a highly competent and caring Doctor...He supported me daily, teaching, supervising and encouraging my development. I successfully passed the CSA at first attempt and feel this was due to [Dr MG]’s support and mentoring.... I did not witness any bullying. I was truly shocked and saddened to hear of these accusations”;*
- 61.3 *“During my time at the surgery [Dr MG] has only been kind and supportive... [Dr MG] has always had the interest of the patients*

*at heart and has worked relentlessly to achieve this and create ways to do this in an organised way to promote safe and consistent working....His dedication to the town and the profession are inspiring...I have had the pleasure of getting second opinions from [Dr MG] and have sat in when he has consulted my patients, he does this with the utmost care and compassion and clinical acumen.”*

- 61.4 *“I am aware of the current allegations against [Dr MG]. This portrayal could not be further from the truth from my experience. As a GP [Dr MG] is always highly professional, honest and kind to all his patients. As a tutor, [Dr MG] is equally always very helpful.... These impressions are not based on occasional passing conversations but rather spending considerable time observing [Dr MG] in the surgery with his patients. As a GP he has a high workload but always remains courteous and attentive with each patient. His manner is approachable and always has time for questions both from his patients and myself. [Dr MG] is from my perspective, a highly clever GP with a huge amount of professional experience. [redacted], he is always happy to discuss any issue or concern I have and always does so in a non-condescending manner.”*
- 61.5 *“I have worked with the very best of GPs and have no reservations in commending [Dr MG].”*
- 61.6 *“My personal experience of [Dr MG] was of a professional relationship built on mutual respect.... I have found [Dr MG] to be knowledgeable and an excellent prescriber. If I made any recommendations on clinical practice open to changing his practice for the better and to the benefit of his patients and the NHS I found [Dr MG] open to advice and would make changes if clinically sound and relevant.”*

62. The 84 (80%) positive responses and support expressed from patients were particularly significant. Comments in the first 30 responses included:

- 62.1 *“I am generally happy to see any Doctor, but have a strong preference for [Dr MG], whom I consider to be a fine, thoughtful and compassionate clinician”*

- 62.2 *“We always ask to see him [Dr MG] first as he is polite, professional and very courteous”*
- 62.3 *“We have always found him [Dr MG] to be considerate and polite. If ever we need to make an appointment with a doctor... we always ask to see [Dr MG]. He has always been courteous and obliging and has often gone out of his way to help us.”*
- 62.4 *“As my GP for several years he [Dr MG] has been excellent. I have found him thoughtful, willing to listen and good at explaining issues. He has at all times been professional and courteous.”*
- 62.5 *“[Dr MG] has been my family’s Doctor for 22 years. In that time I have found him to be the ultimate professional....He always makes time to discuss the problem/concerns we have... and has been unfailing in his care.”*
- 62.6 *“I have known [Dr MG] for the last seventeen years.... During that time he has shown me nothing but compassion...[Dr MG] has always been at the end of the phone for me and will ring and check how I am feeling. He does this off his own back and out of pure concern for my health, sometimes late into the night. Whenever I visit the surgery I am greeted with a smile. Not once have I ever witnessed [Dr MG] showing malice or for that matter, being unprofessional in any way towards staff or patients in the surgery. [Dr MG] is one of the most well- mannered, kind and charming gentlemen I have ever had the pleasure to meet an as a Doctor is totally thorough, proficient and considerate.”*
- 62.7 *“I have been registered with Romney House Surgery for almost 29 years. Through my own choice, for many of these years, I have had many consultations with him. During this time, I have always found him to be: easy to speak to and discuss issues with, polite patient and generous with his time (he has contacted me at home out of hours), very concerned and constructive in his approach, very thorough in his investigations with reference to outside consultants and specialists where necessary, excellent in his resultant treatment and aftercare, [and] quick to respond to other concerns... In conclusion I believe that I would struggle to find a better doctor and I reiterate my absolute faith and trust in him.”*

63. 15 (14%) responses were negative, ten of which were from patients. Four of the ten related to Dr MG's attitude/style/approach.
- 63.1 One related to a consultation where the patient stated that Dr MG had made two comments to her many years ago in consultation which affected her deeply and made the patient avoid seeing him and one more recently in the last six months which the patient described as being "derogatory" towards a family member based on lifestyle choice/weight, and (lack of) recent employment history. The patient was subsequently interviewed.
- 63.2 One related to a consultation in 2002 during which it is alleged on the presentation of a child with a sports injury Dr MG said: "*if every child were taken into the surgery with a bump on the head then [the doctors] would not have time to see other patients*".
- 63.3 One related to a consultation in 2008 where it is alleged that Dr MG stated to the elderly patient's daughter that he did not read discharge letters, that her mother was simply "*old*" and that she was "*not coping*" and "*maybe she would benefit from seeing a counsellor*"; and
- 63.4 One related to a consultation in 2011 which the IT regarded as not significant because the issue raised was not relevant to any of the matters under consideration in this investigation.
64. Two related to Dr MG's clinical care and were referred to the clinical advisors. The remaining four of the ten negative responses from patients related to both attitudinal and clinical issues. All were referred to the clinical advisors. One related to a complaint in 2007. Two were scheduled for interview and their account is taken account of in the interview analysis below.
65. The remaining five negative responses were from current or former members of staff:
- 65.1. One alleged bullying, towards usually female members of staff, and poor patient experience.
- 65.2. Another described an incident in 2008 at Malmesbury hospital of an exchange with Dr MG in which he is alleged to have said that the patient "*had not been sutured by a proper practitioner*" and that he would: "*hold [her] responsible for this woman's sexual health for the*

*rest of [her] career and don't you forget it"*; Malmesbury hospital is located in Wiltshire and falls outside the jurisdiction of GCCG/its predecessor NHS body. The tone and language of what is alleged to have been said is, however, consistent with that of other alleged verbal remarks and is included here for completeness.

- 65.3. One former member of staff described a difficult atmosphere at the Practice due to difficult relationships between staff, by way of uncorroborated hearsay and that both she one colleague had been very upset by Dr MG's comments which she described as "*cultural and misogynistic assumptions*" as well as poor patient experience. She also described feeling undermined and that her views were not considered. The Dropbox contributor described not staying at the Practice because of the experience of working with Dr MG. The IT found this Dropbox contributor's version of events to be unreliable for a number of reasons, including that the contributor was approached for interview but did not respond. Further, her views were not corroborated and in fact were sometimes contradicted by the various individuals she had referred to, all of whom did come forward for interview.
- 65.4. Another Dropbox contributor alleged in further hearsay submissions, that Dr MG humiliated, bullied and controlled several members of staff resulting in two GPs resigning and one being forced to retire. No corroborative evidence supports this specific allegation. She also stated that she took early retirement as she could no longer continue working under his regime but did not come forward for interview and so her allegations, uncorroborated as they are, were not accepted by the IT; and
- 65.5. The final account, again uncorroborated, alleged that many patients expressed a wish not to see Dr MG and that she did not like the way he came across to patients and families particularly in relation to palliative care patients. This highly contentious allegation is in contrast to the findings set out in a CQC report (see further below) and is unsupported by any corroborative evidence.
66. All were approached for interview: three agreed to attend for that purpose, and did so. Their account forms part of the analysis in the "Findings of the Investigation" section of this Report, further below.

## Document review

67. As part of the investigation, a significant amount of documentation was received and reviewed. That documentation included the Practice's most recent CQC report, appraisal and 360 degree feedback information on Dr MG, staff complaint information received from the Deanery, and well as patient letters of thanks/testimonials.

## CQC report

68. This publically-accessible report, dated 29 April 2016 relates to an inspection on 8 March 2016. As with all such reports, the performance of the Practice rather than any individual GP within it, forms its subject material. The overall rating received by the Practice was "Good" across all of the domains including: "*are the services caring*" and "*well led?*"
69. In the context of staff, the CQC report found that there was a clear leadership structure and staff felt supported by the management. The Practice proactively sought feedback from staff and patients, which it acted on. Staff reported that there was an open culture within the Practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and supported if they did. They also reported that they felt respected, valued and supported, particularly by the partners at the practice. All staff were involved in discussions about how to run and develop the Practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered at the Practice.
70. According to the CQC report, staff felt the Practice had an open and accessible approach and that they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Finally, the partners were visible at the Practice and staff reported that they were approachable and always took the time to listen to all members of staff.
71. The CQC report quoted patients saying that they were treated with care and compassion, dignity and respect and they were involved in their care and decisions about their treatment. The national GP survey results confirmed that 74% of patients surveyed rated their overall experience as fairly or very good (as against a CCG average of 89% and national average of 85%).
72. The Practice was generally in line with local averages for its satisfaction scores on consultations with GPs and nurses. By way of illustration:

- 72.1 90% reported the GP (not specifically Dr MG) was good at listening to them (compared to the CCG average of 91% and national average of 89%);
  - 72.2 100% said they had trust and confidence in the last GP they saw (compared to a CCG average of 97% and a national average of 95%);
  - 72.3 88% reported that the last GP they spoke to was good at treating them with care and concern (compared to a CCG average of 88 and national average of 85%).
  - 72.4 Of the CQC comment cards, all 27 were positive about the standard of care received and reported excellent and caring staff and that patients felt listened to and supported; and
  - 72.5 Of the eight patients interviewed by the CQC, seven reported that they were happy with the care received and thought that staff were approachable, committed and caring.
73. It is of particular note that the CQC inspection process involves the conduct of private and anonymous interviews. Accordingly, if ever there was a forum for raising issues of concern, the inspection would represent an ideal opportunity to do precisely that. Not only were no issues raised with respect to bullying, undermining or intimidation but responses from staff and patients were in fact extremely positive.

### **360 degree survey**

- 74. 360 degree survey feedback for colleagues and staff conducted on 13 January 2017 reflects positive views of Dr MG. Feedback from 18 respondents confirms ratings of “good” to “very good” in all domains (including teaching and supervising colleagues, communication with patients and relatives and working effectively with colleagues). There are also many positive comments in the feedback section, particularly from those Dr MG supervised or mentored, such as: “no matter how busy he is, he always finds time to answer questions and offer support” and “very supportive to the clinical team members”. One comment implied that Dr MG’s intelligence could be threatening to those who were not as confident or skilled as he was considered to be.
- 75. The patient feedback about Dr MG from 46 respondents has a rating of: “very good” across all of the domains which include: being polite, listening,

explanation, involvement and arrangement of treatment. All of the comments are positive and include: “*excellent, sympathetic doctor*” “*fantastic manner*”, “*very friendly and professional*” and “*sympathetic and interested in my problem*”.

76. It is of note that both surveys are anonymously collated and that not one of the 46 should offer negative criticism when presented with an opportunity to do so without fear of identification. Further, this was against the background of negative press reports and with local feelings on Dr MG (for and against) running high. The absence of criticism in the survey is, in the circumstances, remarkable as well as informative.

### **Appraisal documentation**

77. Dr MG’s appraisal was completed 31 March 2017. No significant issues of concern identified as part of the appraisal process, and only one reflection was offered regarding the need to work with colleagues to ensure that their voices are heard. The positive outcomes of the 360 feedback are discussed and reflected on in that document. It reflects on the comment about Dr MG’s intelligence having been threatening to those who (comparatively) lack confidence, advising on the importance of “bringing others along” but also noting that he had become less didactic in manner than previously. Reference is made to positive comments about Dr MG from patients and medical students, including “*people like this make a difference between a good and an unforgettable attachment*”.

### **Staff complaints**

78. All information relating to staff complaints and grievances was requested as part of the investigation. A review of that information confirms that no complaints or grievances were raised against Dr MG by staff at the Practice at any time during his 32 years’ service there.

### **Deanery information**

79. Reference was made in a Dropbox submission to concerns raised with the Deanery by GP registrars for whom Dr MG was the trainer. Review of that information confirms concerns identified in June 2015 by a person connected with the Practice. These concerns relate to difficulties with respect to arranging practice visits and receiving feedback on the individual’s training log and to a lack of/delayed communication and input in terms of the review process. There is no reference to any issue with respect

Dr MG's style or approach, which is consistent with the individual's very positive submission about Dr MG as GP trainer.

### **Patient testimonials**

80. Dr MG retired from the Practice at the beginning of September 2017. Communication was sent to patients to notify them of his retirement. In response, Dr MG received eleven letters of thanks and testimonials. Notable comments include:
- 80.1. *"Your care and treatment to me over the past few months has not only been exemplary on a professional basis (out of hours, home visits, telephone calls) but typifies all that is about courtesy, empathy and duty of care";*
  - 80.2. *"I shall miss your kindness and support";*
  - 80.3. *"We wanted to thank you so much for the excellent healthcare and attention, thorough many episodes, you have given the family and are extremely grateful for always managing to set back onto the path of good health"; and*
  - 80.4. *"Many thanks for all you have given, you have had a wonderfully successful career and won the love of your patients".*

## **CLINICAL PRACTICE (TOR2)**

81. The remit of TOR 2 was: “*are the concerns raised in relation to poor clinical practice and patient experience substantiated, as benchmarked against recommended good medical practice and in line with recognised standards such as, but not limited to, GMC’s Good Medical Practice and national and local guidelines*”.
82. TOR2 was investigated by way of Notes Audit, Clinical Case Review, interview and documentary analysis by NHS England’s Independent Clinical Advisors.

### **Notes audit**

83. The overall assessment, conclusions and recommendations of the clinical expert carrying out the audit are set out below.

### **Overall assessment and conclusion**

84. Dr MG’s clinical notes tend to be brief. Whilst being succinct is laudable, there is a case to be made for ensuring that:
- 84.1. Sufficient history is recorded to explain the reasons for the patient’s consultation;
  - 84.2. Appropriate examination to elicit key positives and negatives should be undertaken. For example: writing “chest NAD” and consulting a child with possible “lower lobe pneumonia” yet not recording vital signs, pulse oximetry and capillary refill time is inadequate; and
  - 84.3. The implications of each prescription are considered. For example, the stomach should be protected. Also, in patients on steroids, osteoporosis risk needs to be considered and this is not mentioned in at least two cases
  - 84.4. Appropriate safety-netting measures need to be documented in the notes. Some consultations have it, others do not;
  - 84.5. The use of abbreviations that are specific to the doctor and are not universally recognised makes the consultations harder for a third party to understand. Most clinical systems allow keyboard shortcuts, whereby abbreviated text is automatically expanded (such as AE: air entry; ISQ: in status quo – i.e. no change; KIV-keep in view; NSI-no sexual intercourse; SOS: *si opus sit*, i.e. come back if things

deteriorate; SNST: sciatic nerve stretch test). Whilst Dr MG would doubtless understand his own notes, continuity of care and the need for other healthcare professionals to access patient notes could be made more difficult due to the brevity of Dr MG's notes as well as certain abbreviations used by him.

85. GMC Good Medical Practice (2012) states that clinical records should include:
- 85.1. Relevant clinical findings;
  - 85.2. The decisions made and actions agreed, and who is making the decisions and agreeing the actions;
  - 85.3. The information given to patients;
  - 85.4. Any drugs prescribed or other investigation or treatment; and
  - 85.5. Who is making the record and when.
86. Dr MG's notes are too brief at times. The history is brief and on occasion it is difficult to understand the setting and the full extent of the symptoms with which the patient is presenting.
87. The examination records contain abbreviations that do not allow anyone else to double-check what was found; e.g. "chest NAD" is not the same as "clear breath sounds; no wheezing; respiration rate 14; good air entry bilaterally; no percussion dullness" to give an example.
88. Shared decision making may be taking place but there is no documentation of it in the consultation notes on most occasions. If there is a discussion about the pros and cons of the medications prescribed then this is also missing from the clinical notes.
89. Safety netting is cursory at times and needs to be more specific; e.g. "review SOS" would be better phrased as "review if x, y or z happens": the more specific the safety netting the easier it is to understand the doctor's thinking and planning.

#### **Clinical advisors' recommendations**

90. Dr MG would benefit from attending a record keeping course to compare and contrast his record keeping with current recommended guidelines.

91. Dr MG needs to consider how he can capture shared decision making in his consultation entries.
92. Dr MG needs to consider how his safety netting can be clearer and specific. If Dr MG decides to change course of action following a consultation then he needs to ensure that communication of this change of course to the patient is documented in the notes.
93. In summary, the notes audit identified no clinical concerns with respect to Dr MG's decision making or treatment planning. It did however identify certain limited weaknesses in his record keeping.

### **Clinical Case Reviews**

94. The detail of the methodology for the case reviews and background to it is set out in detail above. In all, prior to interview four cases were upheld, that is to say the clinical advisors found the concerns to be on balance accurate. At that same stage, five were partially upheld and 13 not upheld.
95. The interview with Dr MG took place on 4 May 2017. The main focus of this interview was the clinical concerns. All 22 cases were discussed with greater focus on the cases where the concern was upheld or partially upheld following notes audit and clinical case review as outlined above.
96. Following the interview with Dr MG and deeper enquiry into the computer system, based on the new information the clinical reviews were revisited and updated and revised as necessary. As a result of those further steps, no concern was found to be justified in full and three of the 22 cases were found to be partially justified. Detail to support the clinical advisors' findings is set out in the following paragraph.
97. The clinical advisors made the following findings:
  - 97.1. The number of concerns identified as having significant clinical elements from a 23 year period was not considered excessive. No doctor is infallible, and the number of consultations undertaken by the doctor in this period is estimated to be well in excess of 100,000. The frequency of concerns raised is not unusual and Dr MG was reflective in his approach to the areas of concern;
  - 97.2. While in some cases aspects of clinical care could have been improved, no serious issues of patient safety were confirmed after full investigation;

- 97.3. Dr MG has demonstrated good clinical knowledge and attention to detail which is above the average level expected of a reasonably competent GP;
- 97.4. The record keeping was of a variable quality, but the period of time needs to be taken into account, and the standard of record keeping 20 years ago was considerably different to that of today;
- 97.5. A main theme in all the concerns was Dr MG's attitudes and interpersonal skills. This must be taken in the context of 22 cases reviewed over a 23 year period but this element of concern was persistent in the material reviewed. In mitigation, there were in recent years, tensions and difficulties in the Practice which may have influenced behaviour between doctors;
- 97.6. However it should be acknowledged that this is a significant issue for Dr MG to address. Terms such as "paternalistic" "patronising" and "dismissive" recur in the concerns raised and in some cases the records suggest that such exchanges did take place;
- 97.7. Dr MG has acknowledged that he has over 30 years developed certain phrases which might be misinterpreted. For example, to avoid causing offence by calling patients old, he uses the term "over 21". This and other phrases have sometimes been misconstrued causing offence or upset; and
- 97.8. Dr MG has also acknowledged that at times he has been irritated by demanding patients. According to interviewees who have worked at or are associated with the Practice, patients have come to expect a particular standard of care in the sense of specific GP availability and engagement over and above "standard" appointments. This may lead to long consultations on a number of topics and the doctor agrees that this has been allowed to persist even when the local health services have been under extreme pressure.
- 97.9. Recommendations as to how Dr MG may profitably review his manner and method of communication are set out in the final section of this Report.

## Interviews

### Poor patient experience

98. Of the 35 staff interviewed, eight (23%) described negative patient experience specifically attributable to Dr MG, including that:
- 98.1. Some palliative care patients felt talked down to and not listened to by Dr MG;
  - 98.2. Some patients were kept waiting by Dr MG, that he often ran late for appointments, implying that he had neglected them;
  - 98.3. Patients had reported that they felt intimidated and fearful;
  - 98.4. He lacked empathy and sensitivity, and could be rude and arrogant towards patients.
99. 12 (34%) of staff interviewed described Dr MG as being an outlier in terms of patients not wishing to see him. Further exploration as to the reason for that revealed a variety of contributing factors including:
- 99.1. That he is a doctor who treats “need” as opposed to “want” – the explanation to that being that some doctors more readily give the patient what they request (i.e. a sick note or antibiotics) than others;
  - 99.2. The impact of strained relationships between partners at the Practice which had filtered to patients and resulted in patients aligning themselves to a particular doctor and in Dr MG’s case refusing to see him; and
  - 99.3. Poor patient experience.
  - 99.4. A detailed analysis of the clinical view on patient experience and clinical issues of the six patients interviewed is contained in the case reviews.

### Poor clinical practice

100. Of the 35 staff interviewed, very few issues of concern were identified with respect to the clinical care provided by Dr MG (who was repeatedly described as a “good doctor”). However, the interviews did reveal sporadic failings spread across the 23 year period to which this report relates.
- 100.1. Dr MG failing to: read correspondence, check blood test results and complete home visit entries;

100.2. Dr MG not being prompt with his clinical administration, for example review of blood test results and updating of home visit records; and

100.3. Examples of misdiagnosis and concerns in respect of the care provided.

### **Dropbox analysis**

101. As detailed above, of the 105 substantive responses, 90 (86%) were positive responses on behalf of Dr MG either from staff members or patients. This Report has also highlighted the significantly high number of positive patient responses (80%) and provides examples of those responses.
102. Of the 15 (14 percent) negative responses, ten were received from patients of which three related to Dr MGs attitude/style/approach. Of these:
  - 99.1 The first one related to a consultation where the patient stated that Dr MG had made two comments to her many years ago in consultation which affected her deeply and made the patient avoid seeing him, and one in the last six months which the patient described as being “derogatory” towards a family member, based on lifestyle choice/weight and (lack of) recent employment history;
  - 99.2 one related to a complaint in 2002 during which it is alleged on the presentation of a child with a sports injury Dr MG said: “if every child were taken into the surgery with a bump on the head then [the Practice] would not have time to see other patients”;
  - 99.3 one related to a consultation in 2008 where it is alleged that Dr MG stated to the elderly patient’s daughter that: that he did not read discharge letters, her mother was simply “old” and that she was “not coping” and “maybe she would benefit from seeing a counsellor”; and
103. Two of the 15 negative responses related to Dr MGs clinical care and were referred to the clinical advisors to form part of their review. Four related to both attitudinal and clinical issues. All were referred to the independent clinical advisors.
104. Five were from staff (current and former), three of whose comments relate to clinical practice, such as patients being kept waiting and Dr MG declining to treat patients due to inappropriate referral (there is an acknowledgment that that may well be the case) and patients would often refuse to see Dr MG.

105. Dr MG's allegedly difficult relationship with both staff and patients was also aired in the Dropbox submissions, including the opinion that it was not uncommon for patients to voice that they did not want to see Dr MG and that he was "very rude" towards them. Similarly, criticism was expressed of his manner with patients and families, particularly in the context of palliative care patients.
106. All Dropbox contributors were approached for interview and two came forward. Their account forms part of the analysis in the Findings section below.

#### **Document review**

107. The investigation took account of a significant amount of documentation including, with particular reference to TOR2, the most recent CQC report; appraisal and 360 degree feedback information from patients; and patient letters of thanks/ testimonials.
108. Observations in respect of each of those in the context of TOR 2 are set out below in the Findings section.

#### **CQC Report**

109. Reference to the CQC report is made above. In summary:
  - 109.1. An overall rating of "Good" was awarded across all of the domains including: are services safe, effective, caring, responsive to people's needs;
  - 109.2. No clinical issues were identified;
  - 109.3. Data from the national GP survey showed patients rated the Practice higher than others for several aspects of care.
  - 109.4. Feedback from patients about their care was consistently strong and positive with all of the 27 comment cards being positive and 7/8 patient interviews reporting that they were happy with the care received and that staff were approachable, committed and caring; and
  - 109.5. Patients commented that they felt involved in decision making, listened to and supported.

### **Appraisal and 360 degree review**

110. Patient feedback for Dr MG as part of the 360 degree process from 46 respondents has been outlined above. No issues in terms of negative patient experience are identified, indeed a rating of: “*very good*” across all of the domains was given which included: being polite, listening, explanation, involvement and arrangement of treatment. All of the comments are positive and include: “*excellent sympathetic doctor*” “*fantastic manner*”, “*very friendly and professional*” “*sympathetic and interested in my problem*”.
111. Similarly with respect to Dr MG’s most recent appraisal, in March 2017, no significant issues of concern were identified as part of the appraisal process either in terms of clinical ability or patient experience. There was evidence of continued professional development and reference is made to positive comments from patients.

### **Patient testimonials**

112. Dr MG retired from the Practice at the beginning of September 2017. In response to communications to patients regarding his retirement, Dr MG received eleven letters of thanks/testimonials from which notable comments are set out above.

### **COMPLAINTS HANDLING (TOR 3)**

113. The remit of TOR3 was: *“Does the named GP manage and respond to complaints about their practice appropriately and in line with recognised national and local standards/guidelines and practice policy?”*
114. Based on the information received, two specific issues fell for consideration under this term of reference: first, Dr MG responding to complaints; and secondly complaints information going “missing”.

### **Responding to complaints**

#### **Interviews**

115. Of the 35 staff and patients interviewed, two (6%) alleged that complaints had not been responded to. The first interviewee stated that two patients received no response to their complaints; that certain of Dr MG’s responses were verbal only; that she received no response to the complaint she made about her husband’s death (relating to the triaging of home visits by the Practice); and that responsibility sat with Dr MG as senior partner at the relevant time for these issues.
116. The second interviewee mentioned that many patients had reported making complaints which were not followed up. This hearsay submission is uncorroborated either by direct evidence from those patients allegedly involved, or from other hearsay commentary. Further in relation to the testimony at both interviewees, the overwhelming majority of responses confirmed that the complaints process is efficiently managed by the Practice. That is in line with the Policy and confirmed to be the case by the current Practice Manager.
117. Of the six patients interviewed, two (33%) had made a complaint/ raised an issue, one of which was raised as a formal complaint and was followed up with a meeting to address the issue. The second was not raised as a formal complaint but was addressed locally by way of meeting with a third party.
118. A number of specific examples of Dr MG inputting into the complaints process were cited. The current Chair of the Patient Participation Group (PPG) confirmed that she had received no negative feedback through the PPG regarding any failure to follow up or to action complaints that had been made.

119. Staff responses confirmed that detail of complaints were discussed at a number of forums, including staff meetings, as part of protected learning time.

### **Complaints information going “missing”**

#### **Interviews**

120. Of the 35 staff and patients interviewed, three (9%), indicated that certain complaints information had missing: the first, a GP related that a patient’s complaints file had been removed from his office: subsequent enquiries confirmed that the file in question has been removed and relocated within the Practice, and was available for review when preparing this report there is no firm evidence to show that Dr MG removed and redacted the complaints file in question.
121. Another colleague referred to correspondence she had written relating to another GP’s retirement not being kept on file. Whilst corroborated in part (another staff member recalls the patient asking if “complaint” information had been kept on file) it is questionable whether or not correspondence expressing a view on a GP’s retirement constitutes “complaint information”. Further it has subsequently been confirmed that correspondence from the patient on this issue was in any event kept on file.
122. Another GP concluded that given the relatively high number of complaints in comparison with those actually recorded on a file, by implication complaints information must have gone missing. The individual’s conclusions are highly speculative in nature and can be neither confirmed as accurate and relevant, nor rejected outright.

#### **Dropbox review**

123. Of the 118 responses received, only one related to complaints handling, not obviously concerning the Practice itself and not in any event involving Dr MG.

#### **Documentary review**

124. A significant amount of documentation was received and reviewed. Of particular relevance to TOR3 are: the complaints policy and procedure, complaints files, the most recent CQC report, and appraisal and 360 degree feedback information from patients. Observations in respect of each of those in the context of TOR3 are set out immediately below.

### **Complaints policy and procedure**

125. When the investigation was commissioned, the complaints policy/procedure in place was the “Dr Sethi and Partners procedure”. Since the joint partnership was created in February 2017, the policy in place is the “Phoenix Surgery Complaints Procedure”. Both policies have been reviewed and confirmed to be consistent with the relevant contemporaneous national guidance. There are no local applicable standards.

### **Complaints files**

126. A review of the complaints file at the Practice running under the current practice management confirms that of the 22 complaints on file, all were responded to save for one which was withdrawn. With respect to the previous practice management in the 18 months to September 2013, analysis of the patient complaints files confirms that in this period, 22 complaints were on file. Of those 20 (91%) were responded to. From 2013-2014, there are nine complaints on file, eight (89%) were responded to.

### **CQC report**

127. The most recent CQC Report (29 April 2016) which gave an overall rating of “Good” found, in the context of responding to complaints that the Practice had in place an effective system in place for handling complaints and concerns, and that its complaints policy and procedures were in line with recognised guidance and contractual obligations.
128. The report also confirmed that a designated responsible person handled all complaints at the Practice and that the two complaints reviewed in the previous 12 months, were dealt with in a timely open and transparent way with an apology and explanation given and lessons learned and action taken as a result.
129. Overall, the report concluded that information about how to complain was available and easy to understand and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

### **Appraisal and 360 degree survey**

130. No issues with respect to responding to complaints were identified as part of Dr MG's appraisal or as part of the 360 degree feedback from staff or patients.

## FINDINGS OF THE INVESTIGATION

### BULLYING AND HARASSMENT (TOR1)

131. Is there evidence to substantiate the allegation that the named GP has acted in a bullying, intimidating and undermining manner in his interfaces with staff and/or patients?

#### Staff – bullying

132. As detailed in the “Information Received and Considered” section, paragraph 42, five out of the 35 members of staff interviewed reported that they felt bullied by Dr MG. Four of those five completed signed statements to that effect, with their accounts corroborated by secondary direct witness account. As with all aspects of the investigation, less credence was given to unsigned statements than signed versions, unless corroborative signed statements were received regarding the same issue.
133. The examples cited by the individuals in their statements of behaviours they describe as bullying include:
- 133.1. Correction of letters and changing of protocols and intimidation/ belittling in front of staff - specifically Dr MG seeking from a GP colleague justification in front of patient for an ultrasound, specifically his comment: *“you’ve arranged an ultrasound, can you explain why you have done it, I don’t think you should have and I have cancelled it if you don’t mind”* and *“if you thought it was something different why did you not refer it to a urologist to check for cancer”* and cancellation of referrals.
  - 133.2. Another colleague describes not being backed up, receiving constant put downs and, on one occasion, being shouted at by Dr MG;
  - 133.3. A second GP colleague describes feeling being forced out, undermined in meetings, dismissed, belittled, and made to feel small in front of others;
  - 133.4. Other colleagues have reported Dr MG describing her suturing not being done by a *“proper practitioner”*, statements to *“not meddle with his patients”* and that she was a *“guest in the practice”*, together with invasion of her personal space; and another feeling belittled, on the basis that Dr MG did not wish to listen to her opinion on setting up of cardiovascular clinics, specifically disagreement over the target set.

134. Applying analysis to those examples, the correction of letters and changing of protocols could be regarded as bullying if they are persistent and deliberate attempts to belittle. Equally, they could be regarded as undermining or a difference of approach/opinion which will inevitably occur between partners in general practice, particularly so where strong personalities are involved. Recommendations as to how Dr MG may review his manner and method of communication with staff and patients are set out in the final section of this report.
135. Comments made in front of patients such as: “*you’ve arranged an ultrasound can you explain why you have done it, I don’t think you should have and I have cancelled it if you don’t mind*” and “*if you thought it was something different, why did you not refer it to a urologist to check for cancer?*” and cancellation of referrals, could constitute bullying if they are persistent and deliberate attempts to belittle. Alternatively, they could be viewed as undermining in effect or instead expressing a difference in professional opinion, an almost inevitable facet of general practice. However, the tone and content of these comments, and the fact that one was made in front of a patient, indicates inappropriate conduct which requires addressing.
136. The examples cited of not being backed up and constant put downs, and the isolated incident of shouting in the context of the staff members asking Dr MG to attend a scheduled meeting (specifically his response “*this is all your fault ..., I haven’t got time for this, this is absolute rubbish*”) the “constant put downs” could constitute bullying if persistent and deliberate belittling. Alternatively they may be objectively viewed as undermining in effect.
137. The IT considers that the shouting incident immediately above fails in two respects to constitute bullying in the sense of intimidation, that is to say frightening someone or making them feel overawed in order to make them take action. It is clear from the words used that the intention was not to precipitate action but to express frustration, whether justifiably or not, at organisation/attendance at the meeting. Further, this was a one-off incident and thus lacks the element of persistence/repetition to constitute bullying.
138. The instances of apparent belittling arguably constitute bullying if persistent and deliberate but there is no evidence from the witness in question, or corroborative evidence from others, to suggest that either element was present. The episode could equally be described as undermining conduct

but neither targeted bullying nor undermining being acceptable or appropriate behaviour from a person in Dr MG's position, Again, however, this may be a further instance of a difference of professional opinion, to be expected in general practice but nonetheless one that could be expressed in a less confrontational manner.

139. The incident involving suturing "*not being done by a "proper practitioner"*", statements to "*not meddle with his patients*" and that the colleague in question was a "*guest in the practice*" is also open to different interpretations. The first statement could have the effect of undermining as it is focused on the staff member's skills as an individual and thus seeks to undervalue or disparage. Again, however it appears to be a one-off incident and thus lacks the persistent nature to constitute bullying in the sense of intimidating conduct. The second statement is intemperate and unfriendly, but not personal in nature, whereas the final one does contain a hint of bullying, in the sense that the colleague could justifiably gain the impression that her position is at risk.
140. Invasion of personal space could be viewed as intimidating and thus constitute bullying if persistent and having the effect of undermining self-esteem. However, it appears to be an isolated incident, is a wholly subjective view on the part of the witness and it is not clear if the witness perceived this as intimidatory. On balance therefore, it is concluded that the incident does not constitute bullying.
141. With reference to the example cited of feeling belittled as a result of Dr MG not wishing to listen to his colleague's opinion on setting up of cardiovascular clinics, specifically disagreement over the target set, applying an objective assessment, the IT concluded this is not an example of bullying. At its highest, it could constitute undermining but could equally be regarded as a difference of professional opinion.
142. In conclusion, whilst the five members of staffs may have felt they had been bullied, the IT concludes that in two cases (suturing, and cardiovascular clinics), no bullying occurred. Instead, the incidents were either examples of undermining behaviour, or differences of professional opinion, however tersely expressed these were.
143. In relation the other three reported incidents, there is a point at which the alleged behaviour can be considered to be persistent and deliberate belittling, and thus bullying and undermining. Whilst the persistency element

is present in all three incidents, there is no clear evidence that the intentional/deliberate element is present, too. It is impossible to state definitively what was Dr MG's intention in those exchanges: did he deliberately intend to belittle those individuals or not? A review of evidence "in the round", i.e. not just from staff in relation to bullying, suggests that intentional belittling or intimidation would have been out of character. The examples cited are reactive in the context of partnership discussions or clinical practice, and in the absence of evidence of intention, it is not reasonable to definitively conclude that they constitute bullying.

144. As a result, it is concluded that the accounts show conduct that is undermining in effect and/or an examples of differences of professional opinion but do not provide definitive evidence of bullying.
145. Further, 30 out of the 35 (86%) members of staff interviewed confirmed that they had not been subject to such behaviour and 32 (91%) confirmed that they had not witnessed it.
146. In addition, as set out above, the documentary analysis of the CQC findings, 360 degree feedback, staff complaints, Deanery information and majority of Dropbox responses do not support that Dr MG has acted in a bullying manner towards staff. Indeed there is consistent reference to him being supportive, approachable and encouraging to members of staff.
147. The overall conclusion, apportioning due weight to the evidence, is it does not support that Dr MG acted in a bullying manner towards staff.

#### **Staff – intimidation**

148. As detailed above, two gave account that whilst they did not feel bullied, they did feel intimidated making their own distinction (the Oxford English Dictionary defines intimidation as "*to frighten or overawe someone, especially in order to make them do what one wants*"). In any event, their accounts were not corroborated by other staff members.
149. The example cited by one staff member as being intimidated through being "put upon" does not meet the definition of intimidation, notwithstanding her own reaction to the incident.
150. Likewise, the above definition is not met in the example of Dr MG stating to a colleague that if she wanted him to work with the PPG, she should not publish the article proposed. Again, she may well have felt intimidated by

that single discussion but an objective assessment, in the context of the above definition does not provide evidence of it.

151. Furthermore, 38 staff did not give evidence of such behaviour. In addition, the documentary analysis of the CQC findings, 360 degree feedback, staff complaints, Deanery information and majority of DropBox responses do not support that Dr MG has acted in an intimidating manner towards staff. Indeed, there is consistent reference to him being: supportive, approachable and encouraging to members of staff.
152. The overall conclusion, apportioning due weight to the evidence, is that Dr MG did not act in an intimidating manner towards staff or persons associated with the Practice.

#### **Staff – undermining**

153. Out of the 35 staff interviewed, six described the following behaviour as undermining or behaviour that could have that effect:
  - 153.1. “*stomping all over work*”;
  - 153.2. being treated dismissively/not listened to;
  - 153.3. being undermined, treated dismissively, patronised;
  - 153.4. being treated dismissively and undermined given that the incidents in question such incidences took place in public forum.
154. Five of those reporting the conduct outlined above returned signed statements, one did not.
155. Six members of staff and one patient provided direct first-hand accounts corroborating the reported behaviour, while 29 of the 35 provided no direct account of such behaviour.
156. It is clear that the six individuals felt undermined. Their reaction alone is not determinative but, based both on corroborative accounts and applying an objective assessment to the definition, such examples could constitute behaviour classified as undermining in nature or effect.
157. That said, the documentary analysis of the CQC findings, 360 degree feedback, staff complaints, Deanery information and majority of DropBox responses do not identify that Dr MG acted in an undermining manner towards staff.

158. The overall conclusion is that there is evidence to support that Dr MG acted in a manner that had the effect of a small number of staff feeling undermined.

#### **Overall conclusion in respect of staff**

159. On balance, the evidence does not show that Dr MG acted in a bullying and intimidatory manner towards staff. There are reports of conduct that could constitute undermining behaviour towards a minority of staff members, but that should be viewed in the context of:
- 159.1. A high number of interfaces over a significant period of time;
  - 159.2. General practice which is a pressured environment; and
  - 159.3. This specific practice, involving strong personalities, particularly amongst the partnership group.
160. It is also of note that no reference was made to this issue at appraisal, as part of 360 degree feedback, CQC inspection, in the Deanery information or in the great majority of Dropbox entries.

#### **Patients – bullying**

161. Two out of the six (33%) of patients interviewed stated that they felt bullied by Dr MG. Both returned signed statements citing, in the first case, that when the patient had requested a consultant referral, Dr MG's response was that she would be unwise to bring other doctors in as that would only "muddy the waters". This left her feeling upset and bullied to concede to Dr MG's wishes in terms of referral (MG being of the view that referral was not required).
162. The second patient says she felt bullied by Dr MG's criticism of the management of her child's eczema and in his reference that if she was not happy she should "find another surgery".
163. In relation to the first example, whilst the patient may have felt that she was bullied, she nevertheless circumvented Dr MG's advice and arranged the referral via one of his GP colleagues. Thus she did not accept Dr MG's view or evidently feel sufficiently "cowed" by it to take no action to follow up her own wishes and in the IT's view, the episode does not constitute bullying. She may have felt bullied to accept Dr MG's view point, but she did not do so. It is, however, recognised that the patient clearly did not feel supported in her decision making and was upset by the experience.

164. In relation to criticism of the patient's management of her child's eczema and reference to finding another surgery, it remains unclear if the criticism was levelled at the patient or the treatment generally. Even if it can be said to have been directed at the patient, with the consequent potential effect of undermining her self-esteem, it is not persistent behaviour that is intimidating. However, whilst not in the IT's view bullying, it is unnecessarily critical, which is unprofessional and clearly left her feeling upset.
165. Four gave evidence that they did not feel bullied.
166. Of the 35 staff interviewed, none gave evidence that they had directly witnessed bullying, harassing and intimidatory behaviour towards patients.
167. Furthermore the documentary analysis of the CQC report, 360 degree feedback from patients, patient feedback and majority of Dropbox submission entries do not support it.
168. The overall conclusion is that, on balance the evidence does not support that Dr MG acted in a bullying manner towards patients.

#### **Patients – intimidatory behaviour**

169. One out of the six patients interviewed stated that whilst he did not feel bullied, he felt intimidated by Dr MG. He cites examples of "mild intimidation" on the basis that he was not afforded sufficient time with Dr MG. He also describes feeling not listened to, made to feel a nuisance, "*like a naughty schoolboy*".
170. Five out of the six patients interviewed did not report feeling intimidated, even when that leading question was posed to them unprompted.
171. In conclusion, whilst it is clear that one of the six patients felt "mildly intimidated", the episode he reports does not meet the objective definition of intimidating conduct, but does highlight an issue with respect to style and approach.
172. Furthermore the documentary analysis of the CQC report, 360 degree feedback from patients, patient feedback and majority of Dropbox submission entries does not support a conclusion of intimidation.
173. The overall conclusion is that, on balance the evidence does not support that Dr MG acted in an intimidatory manner towards patients.

### **Patients – undermined**

174. One of the six of patients interviewed confirmed that she felt Dr MG was undermining in the context of feeling criticised as a parent for the management of her child's eczema, as related above.
175. Also as related above, it is unclear whether Dr MG's comment that the condition was "badly managed" was directed at the patient herself or the clinical management, specifically that of one of Dr MG's colleagues. The patient certainly took it as criticism of her personally.
176. Applying the definition of undermining, if the comment was directed at the patient rather than the fellow clinician, it is nonetheless suggested that Dr MG's conduct in that instance is not undermining in that it does not lessen her effectiveness, power, or ability. It is however clearly unnecessarily critical and thus unprofessional with the consequent effect of leaving the patient feeling upset.
177. Of the 35 current and former staff/ persons associated with the Practice, none gave evidence that they had witnessed directly undermining behaviour towards patients. Two GP colleagues mentioned that patients had said that they had felt undermined but the GPs had not witnessed it directly.
178. Furthermore the documentary analysis of the CQC report, 360 degree feedback from patients, patient feedback and majority of Dropbox submission entries do not support a conclusion of undermining conduct. To the extent that it is reasonable to rely on three incidents within a 23 year period (incidents from 2016, 2002 and 2008 related above) as evidence of undermining conduct to patients, each example shows brusqueness or even a lack of sensitivity, but not "undermining" as a subcategory of bullying.
179. The overall conclusion is that, on balance the evidence does not support that Dr MG acted in an undermining manner towards patients.

### **Overall conclusion with respect to patients**

180. The overall conclusion is that on balance, the evidence does not support that Dr MG acted in a bullying, intimidatory or undermining manner towards patients.
181. At interview, three patients felt that Dr MG's manner fell short of acceptable, courteous conduct. Their views were corroborated in some staff interviews and reflected in the 10 negative responses out of the 118 Dropbox

submissions. They were not, however, identified as part of the 360 patient feedback survey most recent PPG feedback from patients or CQC inspection. As noted elsewhere, the CQC inspection gave respondents an opportunity to comment anonymously and in the IT's view, it is significant that no mention was made in those responses to Dr MG's allegedly brusque (or worse) manner.

182. The overall conclusion is that certain patients experienced what they subjectively felt was a lack of empathy and engagement in some cases. Those patients represent a small minority when viewed in the context of:
- 182.1. A large number of very positive responses;
  - 182.2. The backdrop, at least according to some commentators, of a high patient expectation created by the legacy of two of the Practice GPs;
  - 182.3. The pressure of general practice; and
  - 182.4. The local/political context of there being a tension between the GP partners which rippled out into the local patient population and public domain, impacting adversely on patient perception.

## **CLINICAL PRACTICE (TOR2)**

183. At the outset, this Report acknowledges that allegations of poor or otherwise imperfect clinical practice relate to a 23 year period. The IT is of the view that it would be rare indeed for no such allegations, whether justified or otherwise, to arise in the course of so many years.
184. This investigation, at a time of great stress and activity within the Practice, has already provided a significant learning experience for Dr MG. He has shown a willingness to cooperate and has acknowledged honestly where he has got things wrong. His clinical standards have been found to be at or above the standard expected of an NHS GP providing NHS funded/contracted services.
185. Negative patient experience was highlighted in a minority (20%) of staff interviews, with two common themes emerging. First, patients being kept waiting/Dr MG running late and secondly, style/approach issues: where patients felt they were not listened to, or otherwise not empathised with.
186. Approximately 32 percent of staff interviewed described Dr MG as an outlier in terms of patients not wishing to see him. Further exploration as to supporting reasons revealed a combination of potential factors including: that Dr MG is a doctor who less readily accedes to patient "wants", the history of difficult working relationships between the GP partners, a narrative which passed into the public domain and influenced patient opinion and patient experience. Both sets of negative experiences constitute a small minority, to be set against a very significant proportion of very positive responses. That positive view is supported by CQC inspection, patient 360 degree and PPG feedback, a relatively small number of patient complaints for a Practice with a list size of 7,718 patients, Dropbox submission, and patient testimonials.
187. Whilst negative patient experience is evidently limited in numbers and in scope, Dr MG does clearly need to review his manner and method of communication with patients to avoid problems in the future. This could be achieved via video analysis of consultations, and by review of language and body language used. These elements should be included in his PDP and discussed at his next appraisal.
188. In addition, the records review demonstrated some structural aspects which should be improved, such as failure to record examination in sufficient detail;

inadequate safety netting; use of obscure abbreviations; and poor evidence of shared decision making. However many of these defects are common to GPs in general, and do not of themselves constitute serious performance concerns. As such, improvements may be achieved via the simple means of Dr MG attending a records course and in making efforts to improve his documentation of shared decisions and safety netting.

### **COMPLAINTS HANDLING (TOR3)**

189. The management of complaints is a Practice issue, the lead for which is taken by the Practice Manager supported by the Practice Management Team. Clinicians and other staff provide input into that process. There is no direct evidence that the current practice management has failed to appropriately manage or follow up current patient complaints.
190. Indeed, strong evidence in the form of testimonials from patients and staff, a complaints file showing responses to all filed complaints, positive feedback from PPG, and CQC findings, all support the conclusion to support that complaints are appropriately managed and followed up.
191. There is no evidence to support the allegation cited by four individuals related above that complaints information has gone “missing”.
192. Details to support these conclusions are set out at further above, but in summary, there is no evidence to support the assertion that complaints information was not followed up or went missing, under the tenure of the current practice management which confirmed that all complaints on file had been responded to. Even if that conclusion were incorrect, responsibility for such failings would rest with the Practice rather than with Dr MG as an individual.
193. Evidence shows that Dr MG inputs into the complaints process in accordance with the Practice policy, which as the CQC concluded meets the recognised guidance and contractual obligations and has been confirmed to comply with the nationally recognised standards.

## SUMMARY OF FINDINGS

### TOR1 – bullying and harassment

194. The evidence does not support the allegation that Dr MG acted in a bullying and intimidatory manner towards staff. There is evidence of what could constitute undermining behaviour towards a minority of staff members, but that must be considered in the context of a high number of interfaces over a significant period of time. It should also be viewed in the context of general practice which is a pressured environment and the fact that strong personalities exist within the Practice, particularly within the partnership group itself.
195. Likewise, on balance, the evidence reviewed does not support the allegation that Dr MG acted in a bullying, intimidatory and undermining manner towards patients. There is a theme, albeit from the minority of those responding, that some patients felt that they were not listened to and that Dr MG lacked empathy in his approach. Some patients say they found Dr MG rude, arrogant, condescending etc. but this Report emphasises that such negative comments were received from a minority of those who provided evidence to the investigation and are in any event subjective assessments.
196. It is however clear that there is a style/communication issue to be addressed both in his communications with staff and patients, so as to ensure that the duties under GMC Good Medical Practice described below are adhered to. At interview, Dr MG reflected on these and indeed recognised the following as issues for consideration at his most recent appraisal.
197. Listen to patients and take account of their views;
198. Be considerate to those close to the patient sensitive and responsive in giving them information and support;
199. Work collaboratively with colleagues, respecting their skills and contributions;
200. Treat colleagues fairly and with respect;
201. Be aware of how behaviour may influence others within and outside the team; and
202. Be polite and considerate to patients.

### **TOR2 – clinical practice**

203. Concerns with respect to clinical practice and patient experience are not substantiated to the degree presented. While areas for improvement and change have been identified for Dr MG, and for the Practice, no serious patient safety concerns have been identified where the actions of Dr MG can be shown to have compromised patient care.
204. However, the learning points identified should be incorporated into Dr MG's personal development plan and discussed at his next appraisal and in the future.

### **TOR3 – complaints handling**

205. Managing and responding to complaints is a practice issue, managed by the Practice management team and with input from all members of staff. The evidence presented shows that the complaints process is well managed and complaints are responded to under a policy that meets the necessary national requirements, and that Dr MG inputs into that process in accordance with the Practice policy.

## RECOMMENDATIONS

206. As core members of the IT, the clinical advisors identified no risks to patient safety posed by the various issues they were called upon to investigate in relation to Dr MG. They found no concerns that prejudiced the efficiency of the service or its suitability. Any decision with respect to performer's list action under the Regulations is one for NHSE, but against that background, no interim action in the form of suspension or more substantive action in the form of the imposition of conditions or removal from the performers list is considered necessary.
207. However, it is suggested that Dr MG does need to review his manner and method of communication with staff and patients to avoid problems in the future. This could be addressed by:
- 207.1. Video analysis of consultations, and
  - 207.2. Review of language and body language used.
208. These elements could be included in a Personal Development Plan ("PDP") and discussed at his next appraisal.
209. In addition, it is also recommended that he would benefit from
- 209.1. Attending a record keeping course to ensure that his record keeping is consistent with best practice;
  - 209.2. Consideration of how he captures shared decision-making in his consultation entries; and
  - 209.3. Consideration of how his safety netting can be clearer and specific in his communication of it to the patient and documentation of it in the records.
210. Again, these elements could be included in a PDP and discussed at his next appraisal.
211. The matter has already been referred to the GMC. It is recommended that a copy of this report be shared with the GMC and an open channel of communication maintained with them. No other third party stakeholder referrals in the context of Dr MG are recommended.

**Capsticks Solicitors LLP**

**5 February 2018**