PUBLIC DETERMINATION: Impairment
MEDICAL PRACTITIONERS TRIBUNAL: 12 November 2017
Dr Valerie MURPHY (6104053)

Mr Partridge:

1. The Tribunal has considered whether, on the basis of the facts admitted and found proved, Dr Murphy's fitness to practise is impaired. In so doing, the Tribunal has taken account of all the relevant evidence. The Tribunal has also taken account of the submissions made by you on Dr Murphy's behalf and the submissions made by Ms Fairley, Counsel on behalf of the General Medical Council (GMC).

2. The Tribunal, in its findings of facts, found the following matters proved:

- Between January 2012 and June 2014 Dr Murphy was employed by the Southern Health NHS Foundation Trust.

- The risk assessments carried out in relation to Patient A were inadequate in that she failed to carry out any risk assessments and failed to comment on a risk assessment carried out by the nursing staff.

- On 9 April 2013 Dr Murphy prescribed Risperidone to Patient A, and she failed to explain the benefits, risks and side effects of Risperidone to Patient A.

- On 16 April 2013, Dr Murphy's completion of a mental capacity assessment form for Patient A, regarding his decision to remain on the ward as an informal patient, was inadequate in that she failed to arrange a best interest meeting to discuss the advantages and disadvantages to decide what was in his best interests.

- Dr Murphy's completion of a subsequent mental capacity assessment form for Patient A, regarding his consent to treatment was inadequate in that she failed to:
  - establish whether he was able to understand the advantages and disadvantages of taking psychotropic medication;
  - explain the side-effects and risks of taking psychotropic medication;
  - arrange a best interest meeting.

- In Dr Murphy's review of Patient A on 9 April 2013 she failed to make an assessment of his mental state.
- Dr Murphy failed to formulate a diagnosis, an aetiology, and a risk assessment on 9 April 2013 and 20 May 2013.

- In her record keeping of Patient's A consultations, Dr Murphy failed to:

    a. make comprehensive notes;
    b. record adequate information regarding his:

    - symptoms;
    - signs;
    - diagnostic formulation;
    - risk assessment;
    - management plan.

- Dr Murphy failed to meet Patient A's clinical needs in that she did not:

    a. implement and/or develop an adequate care and detailed management plan, particularly regarding his epilepsy, at the point of admission;

    b. formulate any treatment plans, in that she did not specifically indicate:

    i. a working diagnosis;
    ii. the possible reasons for Patient A's presentation;
    iii. any specific treatment plan (save for the prescribing of risperidone).

- Dr Murphy failed to meet Patient A's clinical needs specifically relating to his epilepsy and bathroom/shower needs in that she did not:

    a. acknowledge that he was at an increased risk of having a further epileptic seizure on the ward;
    b. carry out a risk assessment to identify the risks concerned with the condition;
    c. consider the implications of allowing him to have a bath on his own with staff observing him every 15 minutes;
    d. follow the:

        i. National Institute for Health and Care Excellence guidelines ('NICE guidelines');
        ii. Epilepsy Action advice which was referred to within the care plan that was prepared by the nursing staff on 24 April 2013.

- Dr Murphy failed to obtain a history of Patient A's epilepsy to include:

    a. Patient A's presentation:

    i. before a seizure;
    ii. during a seizure;
    iii. after a seizure;

    b. the duration of seizures;
    c. whether seizures made Patient A:

i. incontinent;
ii. bite his mouth or tongue;
iii. experience headaches;
iv. experience tiredness;
v. need to sleep;

d. the recovery time after a seizure.

- Dr Murphy failed to obtain the information indicated above during discussions with Patient A's:

a. family;
b. neurologist.

- Dr Murphy failed to record the information (referred to in the two preceding paragraphs) in Patient A's medical notes.

Further Evidence

3. The Tribunal was presented with a bundle on Dr Murphy's behalf at this impairment stage which included, amongst other documents, the following:

- Audit for patients on STATT (Short Term Admission and Treatment Team) and JSH (John Sharich House) completed by Dr Murphy on 1 October 2013;
- Dr Murphy's reflective statements from 2014 and 2015 – including hand written reflective templates;
- Letter from Dr Dolman, Clinical Director, Learning Disability Service, Southern Health NHS Trust;
- Audit of handwritten patient records conducted by Professor Dinan dated 30 August 2017;
- Certificates of Attendance on Courses;
- Timeline of Remediation; and
- Testimonials.

4. The Tribunal heard oral evidence from Professor Ted Dinan, Professor of Psychiatry and a Principal Investigator in the APC Microbiome Institute at University College Cork. Professor Dinan also provided a written testimonial, in which he stated:

> *'I have known Dr Valerie Murphy since her appointment as a Consultant in Cork. Over this time, she has been actively involved in teaching in my Department and has been involved in the management of several patients in our General Adult Psychiatric Service. I have found her to be a highly reliable colleague. She is caring, compassionate and extremely diligent in her interaction with patients. Her note keeping and risk assessment would seem to me exemplary. In terms of competence I would place her in the top 10% of Consultants with whom I have worked in the UK or Ireland.'*

5. Professor Dinan was asked in his oral evidence to expand on his statement. He said that from his interactions with Dr Murphy (five patients over two years), he found her to be *"extremely helpful"* and that she was *"very willing to give her*

opinion". Professor Dinan clarified that Dr Murphy's post at University College Cork was as an honorary senior lecturer, and as such, she was not required to undergo appraisals. In an academic year she gave two lectures and approximately 14 hours of tutorials. He stated that she was popular with her students.

6. Professor Dinan stated that he was asked by Dr Murphy to carry out an audit of her hand written clinical records, which he did by randomly selecting notes from those brought to him by Dr Murphy herself. He said the audit comprised of him looking for the following:

- detailed history taking;
- adequate mental and physical examination;
- good formulation of the case; and
- a good treatment plan.

7. Professor Dinan told the Tribunal that from his analysis of the randomly selected hand written records he found the above and considered Dr Murphy's notes to be comprehensive and legible. He stated that he regarded Dr Murphy as *"extremely competent"* and marked her apart from other consultants he had worked with, particularly in respect of her willingness to come in and give her assistance.

Submissions of Counsel
For the GMC

8. Ms Fairley submitted that there has been a range of failures on the part of Dr Murphy identified within the findings of the Tribunal which amount to misconduct and that those failures, both in isolation and when taken together, amount to serious misconduct.

9. In relation to **charge 2**, Ms Fairley reminded the Tribunal of the evidence of Dr Ahmed which was that Dr Murphy was expected to carry out a total risk assessment and that the failure to carry out a comprehensive risk assessment was an error of the most serious kind, which ultimately had a fatal consequence. Ms Fairley also reminded the Tribunal of the evidence of Patient A's mother, who said that Patient A was a vulnerable young man when admitted to Slade House and that he was very dependent and unable to make decisions on his own. Ms Fairley submitted that given Patient A's history of epilepsy, the incident on 20 May should have caused Dr Murphy to carry out a comprehensive risk assessment, diagnosis and aetiology. She reminded the Tribunal that Dr Ahmed described this failure as 'seriously below the standard expected'. Furthermore, the Tribunal have identified this as a 'serious failing' in its facts determination. Ms Fairley submitted that Dr Murphy's failure to carry out a risk assessment is of itself sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. She submitted that in the circumstances, failing in this respect, even considered in isolation, amounts to serious misconduct.

10. In relation to **charges 4 (b) and 6(c) and (e)**, Ms Fairly stated that The Mental Capacity Act Code of Practice sets out the presumption of capacity. She reminded the Tribunal of the evidence of Dr Ahmed, which was that notwithstanding the fact Patient A was detained under section 2 of the MHA he would have expected

appropriate attempts to have been made to explain the benefits to him. Ms Fairley further submitted that Dr Murphy's failure to explain the benefits, risks and side effects of Risperidone to Patient A amounts to a breach of paragraph 32 of Good Medical Practice (GMP), which states:

> *'You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.'*

11. Ms Fairley also referred the Tribunal to paragraph 75 of the Consent: Patients and Doctors Making Decisions Together Guidance (the Consent Guidance), which states:

> *'In making decisions about the treatment and care of patients who lack capacity, you must:…*
>
> *…support and encourage patients to be involved, as far as they want to and are able, in decisions about their treatment and care.'*

12. She submitted that there was no evidence of Dr Murphy having made any attempts in this regard.

13. In relation to **charge 5**, Ms Fairly stated that Section 4 of the Mental Capacity Act 2005 specifically sets out the legal requirement to determine a patient's best interests. She reminded the Tribunal of the evidence of Dr Ahmed who made clear in his report that a key part of the mental capacity assessment process was the need to hold a best interests meeting if a patient does not have capacity. Ms Fairley submitted that a specific meeting involving Patient A's parents and other professionals involved in the care of Patient A should have been held and was not. She referred the Tribunal to paragraph 33 of GMP, which states:

> *'You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.'*

14. She also referred to Paragraph 76 of the Consent Guidance, which states:

> *'You must also consider:*
> *f. the views of people close to the patient on the patient's preferences, feelings, beliefs and values, and whether they consider the proposed treatment to be in the patient's best interests*
>
> *g. what you and the rest of the healthcare team know about the patient's wishes, feelings, beliefs and values.'*

15. Ms Fairley submitted that as a Consultant Psychiatrist Dr Murphy should have known and heeded this guidance. The requirements set out within GMP and the Consent Guidance are mandatory and therefore the failure to comply with GMP is serious.

16. In relation to **charges 8 and 13**, Ms Fairly stated that the failings in respect of Dr Murphy's record-keeping are further serious breaches of paragraphs 19 and 21 of GMP and in and of themselves a serious failing.

> *19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards….*
>
> *21. Clinical records should include:*
> *a. relevant clinical findings*
> *b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
> *c. the information given to patients*
> *d. any drugs prescribed or other investigation or treatment*
> *e. who is making the record and when.*

17. Ms Fairley submitted that the inadequacy of the records is described by Dr Ahmed as falling below the standards expected. She submitted that the necessity for clear and accurate records is a fundamental requirement and the extent to which this impedes onward care was exemplified by Dr Ahmed's evidence that he was unable to find a diagnosis, aetiology or management plan from Dr Murphy. She submitted that the fact Patient A was in an assessment unit makes this failing even more serious.

18. In relation to **charge 10**, Ms Fairley submitted that the failings identified, and admitted, in respect of Patient A's clinical needs relating to epilepsy and bathroom needs are particularly grave. She reminded the Tribunal of the evidence that Dr Murphy gave during the Verita investigation in December 2013, when she failed to accept that she should have had concerns, and instead sought to justify her position. She told investigators that she *"didn't have any concern", "there was no evidence that his epilepsy was active"* and was emphatic that *"he hadn't had a seizure".* Ms Fairley submitted that in Dr Murphy's written statement before this Tribunal, signed on the first day of these proceedings, she accepts for the first time that Patient A had a seizure on 20 May 2013. The written statement documents the precautionary steps Dr Murphy took, for example requesting the EEG, blood tests, moving Patient A downstairs and advice to increase vigilance. However, none of these aspects were followed up by Dr Murphy prior to the observation levels being reduced at the Clinical Team Meeting (CTM) on 3 June 2013.

19. Ms Fairley submitted that the decision to reduce the level of observations during the CTM on 3 June 2013, less than two weeks after the potential seizure, was, at best, misconceived. She submitted that Dr Murphy's explanation, which she maintained during the course of her evidence before the Tribunal, does not accord with the note recorded of the CTM and it is therefore of some concern that Dr Murphy continues to maintain this was a communication error. Ms Fairley submitted that as the most senior member of staff, and the responsible clinician for a vulnerable patient with a history of epilepsy, it was incumbent upon Dr Murphy to ensure staff who had direct care of the patient were clear as to the appropriate care, and not to do so was inexcusable.

20. Ms Fairley reminded the Tribunal that in her witness statement, Dr Murphy suggested that the responsibility for the epilepsy management plan was that of the nurses, and submitted that this is evidence of Dr Murphy seeking to minimise her responsibility in the circumstances. Ms Fairley acknowledged that during Tribunal questions Dr Murphy did finally accept that she *had 'lost sight of the basics'* and failed to follow up on a significant blood test and made incorrect assumptions about what had occurred on 20 May 2013. Ms Fairley submitted that these were failings of the most serious kind.

21. In respect of the critical aspect of the 15 minute bathing intervals, Ms Fairley reminded the Tribunal that Dr Murphy only accepted, in the course of cross-examination, that as lead clinician with overall responsibility for Patient A she should have known about this. She submitted that this was both a breach of the NICE Guidelines and a failing of the most basic kind, which resulted in the tragic death of a young man. Ms Fairley submitted that this failing alone amounts to serious misconduct.

22. In relation to **charges 11 and 12**, Ms Fairley reminded the Tribunal of Dr Ahmed's evidence that the failure to obtain a history of Patient A's seizures was important information precisely *"because epilepsy is associated with increased risk of injury and possible death"*. His opinion was that the potential for harm could not have been more serious and the failure to obtain that information was conduct which was *"seriously below the standard expected of a reasonably competent Consultant Psychiatrist."*

23. Ms Fairley submitted that it is the GMC's contention that Dr Murphy's failings in respect of these charges both in isolation and when taken together amount to serious misconduct.

24. As to impairment, Ms Fairley invited the Tribunal to have regard to the statutory overarching objective, which includes the need to:

> *a. protect and promote and maintain the health, safety and wellbeing of the public*
> *b. promote and maintain public confidence in the medical profession*
> *c. promote and maintain proper professional standards and conduct for members of that profession.*

25. Ms Fairley submitted that one of the key aspects the Tribunal has to consider in assessing whether Dr Murphy's current fitness to practise is impaired is the extent to which she can be said to have insight into her failings. The GMC submitted that whilst Dr Murphy made admissions in some areas, she contested other important failings and at times her evidence sought to minimise and excuse her failings. Ms Fairley argued that this must temper the extent to which the Tribunal can be satisfied that Dr Murphy has fully reflected upon her conduct and omissions, and thereby gained true insight. She reminded the Tribunal that Dr Murphy has had a number of opportunities to make admissions in the past and has failed to do so.

26. Ms Fairley submitted that the concern as to insight is sharply brought into focus by the position adopted by Dr Murphy in respect of the risk assessments and upon whom the duty to conduct them fell. In the written statement before the Tribunal Dr Murphy's position was that this was *"the responsibility of the band 5 nurses".* By the conclusion of her oral evidence Dr Murphy had conceded that she did have a duty to conduct some risk assessments and comment on those of others. Ms Fairley submitted that that was a reluctant concession and came very late in the day. She added that it is of grave concern that Dr Murphy had not accepted this crucial aspect earlier, despite the considerable period of time she has had to reflect.

27. Ms Fairley submitted that the attitude displayed by Dr Murphy towards the seizure incident on 20 May 2013, as recorded within the documentation, casts doubt as to the extent to which the Tribunal can have any confidence going forward that the risk of repetition has been properly addressed and eliminated. She submitted that whilst it is to Dr Murphy's credit that she made admissions to charge 8, her explanations for these failings does not withstand scrutiny. Ms Fairley submitted that Dr Murphy's evidence relating to these difficulties, which she advanced even in her oral evidence, is not credible and therefore the extent to which this admission can be said to reflect insight must be tempered. Ms Fairley submitted that it is of concern that Dr Murphy's acceptance has taken such an extensive period of time, as her evidence before the Inquest and during the Verita interview demonstrated a reluctance to identify any deficiencies on her own part. Ms Fairley submitted that there has not been at any point a full acceptance by Dr Murphy as to the extent of her failings.

28. As to the evidence called at this stage from Professor Dinan, Ms Fairley submitted that his evidence of Dr Murphy's clinical capabilities must be treated with a degree of caution given the limits of his knowledge of her practice. She submitted that caution must also be exercised in assessing the extent to which documentation within the bundle demonstrates remediation. An example of this was the 'yellow card', as it was not clear when, where or how this has been trialled or adopted. Further, the Tribunal have not had the opportunity to ask questions of Dr Murphy about this documentation or her current attitude and insight.

29. Ms Fairley submitted that Dr Murphy has yet to understand the need for clear and comprehensive risk assessments and that 'implicit' risk assessments are not acceptable. She submitted that the Tribunal cannot in these circumstances have confidence that Dr Murphy has modified her practice sufficiently to ensure there could be no risk of repetition of such events and there is no ongoing risk to patient safety.

30. Ms Fairley submitted that the seriousness of this case and the issues relating to insight are such that the steps taken to remediate are not sufficient to prevent public confidence in the profession being undermined. The GMC submitted that a finding of impairment is necessary in respect of all three limbs of the overarching objective and that in the absence of any clear evidence of full insight and thus remediation, the Tribunal cannot be satisfied that Dr Murphy no longer presents a risk to patient safety. She submitted that not only did Dr Murphy's failings have the most tragic of consequences in respect of patient safety, but the misconduct identified is such that public confidence in the profession would be severely

undermined were a finding of impairment not made. Ms Fairley concluded her submissions by stating that the need to uphold proper professional standards and public confidence in the profession would be seriously undermined if a finding of impairment were not made in all the circumstances of this case.

On Dr Murphy's Behalf

31. You commenced your submissions by reminding the Tribunal that there has always been an acceptance by Dr Murphy that she had a responsibility to carry out a risk assessment in relation to epilepsy and that there was a very early understanding of the seriousness and import of what had happened. You submitted that ever since, not only has Dr Murphy reflected, but she has also engaged in improving areas she had found problematic. You stated that Dr Murphy has embraced the recommendations made in the Verita report and attended appropriate courses.

32. As to insight, you reminded the Tribunal of Dr Murphy's evidence and of her acceptance that she got it wrong. You submitted that she has learnt that part of her error was that some of the basics were not done. As a result of that she has produced a 'yellow card' scheme, which is an all embracing tool which captures the important information regarding a patient's epilepsy, and is easy for all concerned with the care of the patient to see. You submitted that the yellow card addresses the failings in this case and referred the Tribunal to the evidence of Dr Murphy's mentor Dr Kelly who states that the scheme is being audited nationally in Ireland. You clarified your instructions were that the scheme was being piloted in some psychiatric hospitals in Ireland and in one UK based setting. You submitted that the yellow card system may well be extended to all the psychiatric hospitals in Ireland and to the prison service.

33. You submitted that the audit of clinical record keeping conducted by Professor Dinan is evidence that Dr Murphy has remediated the deficiencies around record keeping found in relation to Patient A.

34. As to impairment, you submitted that given the considerable remediation that has been undertaken, Dr Murphy is not currently clinically impaired. You said this case involved a single patient episode in 2013. You reminded the Tribunal of the evidence of Professor Dinan that in her field of intellectual disability, Dr Murphy is highly thought of. You submitted that there have been no concerns raised as to her clinical care, although there has been no formal appraisal process for Dr Murphy in Ireland.

35. You concluded that it is accepted that the matters found globally in this case are clearly serious and amount to misconduct but that given the insight and remediation undertaken Dr Murphy's fitness to practise is not impaired.

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LEGAL ADVICE

36. The Tribunal and both Counsel have accepted the advice of the Legally Qualified Chair (LQC) on the proper approach to misconduct and impairment and the Tribunal took note of the relevant authorities, to which he referred.

37. In summary, the LQC advised that the first step for the Tribunal to take at this stage in these Fitness to Practise proceedings is to decide if, on the facts found proved, there has been "misconduct". He referred the Tribunal to General Medical Council v Meadow [2006] EWCA Civ 1390, in which at paragraphs 200 to 201 the court adopted the approach to identifying "serious professional misconduct" which was taken in the earlier case of Roylance v General Medical Council [2000] 1 AC 311. He advised that the circumstances giving rise to a finding of "misconduct" must be linked to the practice by the doctor of medicine, or be conduct that otherwise brings the profession into disrepute, and must be serious. The LQC advised that the courts have upheld the concept that for there to be a finding of "misconduct" it should be behaviour which is serious because, as was said in Nandi v General Medical Council [2004] EWHC (Admin), it would be "regarded as deplorable by fellow practitioners".

38. The LQC advised that in '*In considering this issue we also need to have regard to how we exercise our functions to discharge the over-arching objective now set out in section 1A of the Medical Act 1983. We will have to consider the context in which any alleged "misconduct" occurs, because that is important in considering whether the facts found proved do actually amount to misconduct. We should, therefore, look at all the relevant circumstances surrounding the events which gave rise to those matters admitted and our findings of fact on the other matters proved at the first stage when deciding whether there has been "misconduct". … We should also have regard to any relevant principles set out in Good Medical Practice 2006 for any events up to and including 21st April 2013, and to Good Medical Practice 2013 for any events on 22nd April 2013 and thereafter. Only if we conclude there has been "misconduct" on the part of the doctor should we then go on to consider whether her fitness to practice is impaired because of any misconduct found to have occurred. Deciding whether the doctor's fitness to practice is impaired is a matter for the Tribunal exercising its own professional judgement. There is no burden on either party to prove the existence or absence of impairment, and no standard of proof that has to be met to reach a conclusion on impairment. When considering the issue of whether a practitioner's fitness to practice is impaired, the Tribunal is considering the question both at present and in the future.'*

39. The LQC also advised the Tribunal that, following the case of Nicholas-Pillai v GMC [2009] EWHC 1048 (Admin), it is entitled to have regard to the doctor's own attitude towards the events bringing the doctor before a Medical Practitioners Tribunal. That is something which may count either in the doctor's favour, or against the doctor, when considering the question of impairment.

40. As to impairment, the LQC advised '*… the Tribunal should have regard to the questions set out in Cohen v General Medical Council [2008] EWHC 581 (Admin) on that issue, namely: 1 – if there is misconduct, is it remediable?; 2 - if so, has the conduct been remediated?; and 3 – if it has been remediated, is it then highly unlikely to recur?'*

TRIBUNAL'S DECISION

41. The Tribunal has exercised its own judgment in determining whether Dr Murphy's fitness to practise is impaired by reason of misconduct.

MISCONDUCT

42. The Tribunal first considered, in accordance with the above advice, whether Dr Murphy's conduct in relation to the facts found proved, constitutes misconduct.

43. The Tribunal considered the facts in this tragic case. It accepts that doctors are human and do make mistakes and therefore it is important to have safety netting in place, to ensure effective risk management. In this case Patient A, who had a difficult and complex medical condition, was admitted to the unit as an urgent referral. The Tribunal is of the view that when concerns were raised in relation to Patient A having a seizure (the tongue biting incident), at that point Dr Murphy failed in her duty to ensure his care needs were met. Her assessment that it wasn't a seizure was based on a history taken by a nurse.

44. Dr Murphy eventually accepted in her response to Tribunal questions that that incident was a partial complex seizure. However, her error at that time was that she did not make sufficient enquiries. She accepted in her witness statement that she did not seek to obtain information from Patient A's mother or his Consultant Neurologist Dr Adcock about Patient A's epilepsy. In her oral evidence she accepted that she "failed" in this respect. The next red flag was the bloody nose incident in the bath on 7 June. It was evident from this incident that Patient A had been unsupervised whilst in the bath. The Tribunal regards this as another major opportunity that was missed by Dr Murphy. She missed key signs, twice, and failed to check or record in the notes what others in the MDT had done. This is despite her position as the Consultant Psychiatrist with overall responsibility for Patient A, and notwithstanding her attendance in 2012 at an Epilepsy Masterclass specifically for psychiatrists working in the area of learning disabilities.

45. In considering the question of misconduct, the Tribunal went through each of the paragraphs of the allegation and has borne in mind the standards expected of a medical practitioner set out in the GMC's guidance in GMP (both the 2006 and 2013 editions are applicable)

46. In relation to **charge 2**, the following paragraph from the 2006 edition of GMP is relevant:-

> Paragraph 2a: *'Good clinical care must include adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient.'*

47. Also relevant is paragraph 15a from the 2013 edition of GMP, which states:-

> Paragraph 15: *'You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> *a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient.'*

48. The Tribunal considers that carrying out a risk assessment is part and parcel of undertaking an adequate assessment of the patient's condition.

49. In relation to **charge 4b** the following paragraphs of the 2006 edition of GMP are relevant:–

Paragraph 22: `*To communicate effectively you must:*

a. listen to patients, ask for and respect their views about their health, and respond to their concerns and preferences

b. share with patients, in a way they can understand, the information they want or need to know about their condition, its likely progression, and the treatment options available to them, including associated risks and uncertainties

Paragraph 23: *You must make sure, wherever practical, that arrangements are made to meet patients' language and communication needs*

50. In relation to **charges 5b and 6f** the Tribunal observes that the need to have a best interests meeting was a legal requirement and therefore it was mandatory for Dr Murphy to have arranged one.

51. In relation to **charges 6c and 6e**, paragraphs 31 and 32 of the 2013 edition of GMP are relevant, which states:

Paragraph 31 *'You must listen to patients, take account of their views, and respond honestly to their questions.'*

Paragraph 32 *'You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.'*

52. In relation to **charge 7a**, paragraph 2a of GMP, 2006 is relevant

53. In relation to **charge 7dii**, paragraph 15a of GMP, 2013 is relevant

54. In relation to **charge 8**, paragraphs 3f and 3g of GMP, 2006 are relevant

Paragraph 3: *'In providing care you must:*

f. keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment

g. make records at the same time as the events you are recording or as soon as possible afterwards'

55. Also relevant are paragraphs 19 and 21 from the 2013 edition:

Paragraph 19 '*Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.'*

Paragraph 21 *'Clinical records should include:*

a. relevant clinical findings

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

d. any drugs prescribed or other investigation or treatment .'

56. In relation to **charge 9a**, paragraph 48 of GMP, 2006 is relevant:

Paragraph 48 *'You must be satisfied that, when you are off duty, suitable arrangements have been made for your patients' medical care. These arrangements should include effective hand-over procedures, involving clear communication with healthcare colleagues. If you are concerned that the arrangements are not suitable, you should take steps to safeguard patient care and you must follow the guidance in paragraph 6.'*

57. The Tribunal has noted the contents of the medical records and in particular the notes made at the time by Dr Johnson, the admitting doctor. The admission of Patient A was approved by both Dr Johnson and Dr Murphy. Under cross-examination Dr Murphy accepted that she had a 10-15 minute conversation with Dr Johnson, yet she did not ensure that what she had assumed was expected to happen did in fact happen. This was a particularly serious failing given that this was an admission of a vulnerable young patient with significant risk factors.

58. In relation to **charge 9b**, both the 2006 and 2013 editions of GMP are engaged: From the 2006 edition – paragraphs 41b and 50

Paragraph 41 *'Most doctors work in teams with colleagues from other professions. Working in teams does not change your personal accountability for your professional conduct and the care you provide. When working in a team, you should act as a positive role model and try to motivate and inspire your colleagues. You must:*

b. communicate effectively with colleagues within and outside the team'

Paragraph 50 *'Sharing information with other healthcare professionals is important for safe and effective patient care.'*

59. From the 2013 edition – paragraphs 21 and 44a are relevant:

Paragraph 21 *'Clinical records should include:*

a. relevant clinical findings

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions'

Paragraph 44 *'You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:*

a. share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers.'

60. In the Tribunal's view this is another example of Dr Murphy's failure of good clinical care and of her failure to communicate effectively – the failure to formulate a treatment plan particularly where there is MDT involvement and in the absence of CTM notes was in the Tribunal's view very serious and therefore Dr Murphy failed to 'Protect and promote the health of [Patient A] '.

61. In relation to **charge 10**, both versions of GMP apply. Dr Murphy admitted she failed to meet Patient A's clinical needs and this was a failure to comply with the duty to provide good clinical care as set out in paragraphs 2a of the 2006 edition and paragraph 15a of the 2013 edition of GMP. This is notwithstanding Dr Murphy's admitted awareness of the NICE Guidelines.

62. In relation to **charges 11 and 12**, the failures amount to a clear breach of paragraph 2a of the 2006 edition and paragraph 15a of the 2013 edition of GMP.

63. The Tribunal is of the view that the extent and gravity of the above breaches of the fundamental principles of GMP together with Dr Murphy's failure to comply with mandatory legal obligations to conduct a best interests meeting on two occasions are such that those parts of the allegation found proved cannot, when considered all together, be anything other than misconduct. It is satisfied that applying the test in Nandi fellow professionals would regard them to be deplorable. The Tribunal regards it to be sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise.

IMPAIRMENT

64. In considering whether Dr Murphy's fitness to practise is impaired the Tribunal must look forward not back. However, in order to form a view as to the fitness of a person to practise today, the Tribunal will have to take into account the way the doctor has acted or failed to act in the past and how he or she is likely to act in the future.

65. The Tribunal then considered the three questions posed in the case of Cohen. In considers that the failings identified in this case are capable of being remediated. It then considered whether they have been remediated.

66. The Tribunal has been presented with a considerable amount of evidence as to the steps Dr Murphy has taken in remediation. It has taken account of her

attendance on various appropriate courses and of her enhancing her knowledge of epilepsy. It has noted the evidence of the yellow card system, which was developed by Dr Murphy with colleagues to act as an aide memoire and which does address some of her failings regarding the recording of the history and impact of Patient A's epilepsy that occurred in this case. The Tribunal considers that the yellow card has the potential of benefit as it will ensure key information about a patient will be readily identifiable to all practitioners responsible for the care of a patient.

67. The Tribunal is of the view that Dr Murphy has gone some way in remediating this one area. However, she has not addressed the other issues that have arisen in this case, namely taking responsibility and asserting leadership for a team. Furthermore, the Tribunal is not convinced there has been remediation on the critical area of record keeping. Although there has been an audit of her handwritten notes, the Tribunal notes that there was no issue with these in the first place. It was her record keeping on a computerised system that was found to be lacking. There has been no evidence presented to assure the Tribunal that Dr Murphy is now able to use a computerised system of the type that would be used in a UK NHS system.

68. Therefore, the Tribunal has concluded that although the process of remediation has started and there has been partial remediation of a discrete and readily identifiable area, other more wide ranging failures of her handling of the case of Patient A have not been remedied.

69. The Tribunal then considered the third question posed in Cohen as to the likelihood of repetition. The Tribunal considers that remediation in terms of a recognition of responsibilities, insight and overall fitness to practise is a critical element of remediation. Of concern is the fact that Dr Murphy has not demonstrated insight into the gravity of the findings of facts made against her. She has not availed herself of the opportunity to put any evidence before this Tribunal at the impairment stage to show that she has considered and reflected on the findings of facts made nearly three months earlier in August 2017 which could have demonstrated real insight. In her reflective statements of 2014 and 2015 Dr Murphy appears not to recognise the extent of her failings. Even at the beginning of these proceedings in 2017, she still appeared to be looking for excuses, a position from which she has not departed significantly to date. There is a clear reluctance to admit full responsibility for her actions, as she appears to have only accepted responsibility for those parts which cannot be denied. Furthermore, the Tribunal has noted that there has been an absence of apology to Patient A's mother and an absence of remorse for the consequences. It considers that the remorse displayed was limited to the consequences these proceedings have had upon her.

70. The Tribunal has an obligation to protect the wider public interest, including maintaining standards of professional conduct and public confidence in the profession. The Tribunal considers that Dr Murphy's misconduct has adversely affected the reputation of the profession. Were the Tribunal not to find impairment of fitness to practise in this case, that would, in its judgement, not acknowledge the seriousness of Dr Murphy's misconduct and would undermine public confidence in the medical profession and fail to maintain proper standards of conduct for doctors.

71. The combination of the absence of real and full insight; the partial steps taken towards remediation; and the impact of Dr Murphy's misconduct on the reputation of the profession must, in this Tribunal's view, therefore lead to a finding of impairment. Accordingly the Tribunal has determined that Dr Murphy's fitness to practise is currently impaired by reason of her misconduct, pursuant to Section 35C(2) of the Medical Act 1983, as amended.