PUBLIC RECORD

Dates: 02/06/2025 – 11/06/2025 and 19/06/2025

Doctor:	Dr Paul SCOTT
GMC reference number:	3340392
Primary medical qualification:	MB ChB 1989 University of Edinburgh

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome
Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr Douglas Mackay
Lay Tribunal Member:	Mr Matthew Fiander
Registrant Tribunal Member:	Mr Ian Crighton

Tribunal Clerk:	Ms Maria Khan 02/06/2025 to 04/06/2025 Ms Ciara Fogarty 05/06/2025 to 11/06/2025 Ms Angela Carney 19/06/2025

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Stephen Brassington, Counsel, instructed by Clyde & Co 02/06/2025 to 11/06/2025 Ms Claire Raftery of Clyde & Co 19/06/2025
GMC Representative:	Mr Ian Brook, Counsel

Attendance of Press / Public
In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly in private.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 06/06/2025

1. This determination will be handed down in private. However, as this case concerns Dr Scott's misconduct, a redacted version will be published at the close of the hearing.

Background

2. Dr Scott qualified from the University of Edinburgh in 1989. He worked as a locum for a period before undertaking a law degree between 1991 and 1993. Dr Scott worked with the Scottish Office on the Special Projects Team. While working for the Scottish Office, he worked one day a week in a training post in anaesthetics at Edinburgh Royal Infirmary. After working at the Scottish Office for a year, Dr Scott decided to become a GP.

3. Dr Scott completed his GP vocational training and qualified as a GP in 1999. He then worked in Shetland as a salaried GP before becoming a partner at the Brae Health Centre ('Brae'). From 2008 Dr Scott undertook medical examinations for the Maritime and Coastguard Agency (MCA). He undertook examinations for Oil & Gas UK between 2015 and 2019.

4. The allegation that has led to Dr Scott's hearing can be summarised as that, in January and March 2018 whilst working at Brae, Dr Scott behaved aggressively towards Colleague A. It is also alleged that, in August/September 2021, Dr Scott made calls to Dr C which were abusive and caused her to feel threatened and intimidated.

5. It is further alleged that, in April 2020, Dr Scott carried out Statutory Seafarer Medical Examinations in a place other than his work address when he was not authorised to do so and falsely recorded information about his work address. It is alleged that his conduct was dishonest. It is also alleged that, in December 2020 and March 2021, Dr Scott issued two-year Seafarer Certificates to separate patients without discussing hypoglycaemia, without conducting a risk assessment without issuing conditions letters. It was also alleged that he had not placed appropriate restrictions on the Certificates.

6. Dr Scott was suspended by NHS Shetland in April 2020 and then took early retirement from the NHS in 2021.

The Outcome of Applications Made during the Facts Stage

7. On day one of the hearing, Mr Ian Brook, Counsel, made an application on behalf of the GMC pursuant to Rule 17(6) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'), to amend some typographical errors in the stems of Paragraph 1 and Paragraph 9 of the Allegation. This was to amend the stem of Paragraph 1 from *'On around 3 January 2018 …' to 'On or around 3 January 2018 …'* and the stem of Paragraph 9 from *'On 8 December 2020 …'* to *'On ~~8~~ 18 December 2020 …'*

8. It was not disputed that these were typographical errors and there being no unfairness and no prejudice to Dr Scott's case incurred. The Tribunal determined to grant the application.

9. On day two of the hearing, Mr Brook made an application on behalf of the GMC pursuant to Rule 17(6) of the Rules to amend Paragraph 4 of the Allegation. This came about after the conclusion of Dr C's oral evidence, in which she stated she had received the telephone calls from Dr Scott on both 30 August 2021 and 5 September 2021. Mr Brook submitted that it was appropriate to have accurate boundaries to include the full nature of the allegations and, therefore, to reflect this, the wording should be changed from, *'Your behaviour in telephone calls to Dr C between 30 August 2021 and 5 September 2021 …'* to *'Your behaviour in telephone calls to Dr C between 29 August 2021 and 6 September 2021 …'* The GMC also made an application to remove the words in square brackets in the Confidential Patient Key part of the Allegation and to add that the date referred to there in should read 18 December and not 8 December.

10. Mr Brook submitted that the application could be made without injustice or unfairness to Dr Scott. There was no objection from Dr Scott. The Tribunal determined that there was no unfairness and that it was in the interests of justice to allow the application on the basis that this accurately reflected the GMC's case that had been clear.

The Allegation and the Doctor's Response

11. The Allegation made against Dr Scott is as follows:

That being registered under the Medical Act 1983 (as amended):

1. On or around 3 January 2018 at the Brae Health Centre, Shetland (Brae), when Colleague A was attending a patient in a consultation room, you:
Amended under Rule 17(6)

a. kicked the door of the consultation room;
To be determined

b. aggressively hit the door of the consultation room.
To be determined

2. On 6 March 2018, when Colleague A was talking to Colleague B, you approached Colleague A and you:

a. backed Colleague A up against the wall of her room;
To be determined

b. shouted at Colleague A;
To be determined

c. did not respect personal space in that you put your face in very close proximity to Colleague A's;
To be determined

d. told Colleague A that you would get rid of her.
To be determined

3. Between 3 and 6 September 2021 you made telephone calls to Dr C and you were abusive in that you said 'fuck you' and 'fuck off' on one or more occasions.
To be determined

4. Your behaviour in telephone calls to Dr C between ~~30~~ 29 August 2021 and ~~5~~ 6 September 2021 caused her to feel threatened and intimidated.
To be determined
Amended under Rule 17(6)

Seafarer Examinations

5. After 7 April 2020 you carried out Statutory Seafarer Medical Examinations under the Merchant Shipping (Maritime Labour Convention) Regulations 2010 ('Seafarer Examinations') as set out at Schedule 1 at an address(es) other than Brae which weren't registered for Seafarer Examinations.
Admitted and found proved

6. You returned a completed and signed form to the Maritime Coastguard Agency in December 2020 in which you falsely recorded your only work address as Brae. Admitted and found proved

7. You knew:

a. that you were not authorised to carry out any Seafarer Examinations at any address other than Brae;
Admitted and found proved

b. that the information you provided at paragraph 6 was untrue because of the work you were carrying out as described in paragraph 5.
Admitted and found proved

8. Your conduct at paragraph:

a. 5 was dishonest by virtue of paragraph 7a;
Admitted and found proved

b. 6 was dishonest by virtue of paragraph 5 and 7b.
Admitted and found proved

9. On ~~8~~ 18 December 2020 you issued a two- year Seafarer Certificate to Patient D, who had diabetes. In doing so you failed to:
Amended under Rule 17(6)

a. limit the Certificate to one year;
Admitted and found proved

b. discuss hypoglycaemia with the patient;
To be determined

c. perform a risk assessment;
To be determined

d. issue a conditions letter;
Admitted and found proved

e. place a restriction on the Certificate restricting the patient to UK Near coastal waters.
Admitted and found proved

10. On 29 March 2021 you issued a two- year Seafarer Certificate to Patient E, who had diabetes. In doing do you failed to:

a. limit the Certificate to one year;
Admitted and found proved

b. discuss hypoglycaemia with the patient;
To be determined

c. perform a risk assessment;
To be determined

d. issue a conditions letter;
Admitted and found proved

e. place a restriction on the Certificate restricting the patient to UK Near coastal waters.
Admitted and found proved

And that by reason of the matters set out above your fitness to practice is impaired because of your misconduct. To be determined

The Admitted Facts

12. At the outset of these proceedings, through his Counsel, Mr Stephen Brassington, Dr Scott made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Witness Evidence

13. The Tribunal received evidence on behalf of the GMC from the following witnesses:

- Colleague A, XXX at the Practice. Colleague A also provided a witness statement dated 20 January 2022;
- Dr C, Principal GP at a different Shetland Islands practice. Dr C also provided a witness statement dated 10 December 2024.

14. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Ms D; Primary Care Manager at NHS Shetland. Ms D provided a statement dated 7 December 2021 and a supplemental statement dated 18 December 2024;
- Dr E; Chief Medical Advisor, Maritime and Coastguard Agency ('MCA'). Dr E provided a witness statement dated 2 November 2021 and two supplemental statements dated 4 November 2021 and 10 October 2023.

15. Dr Scott provided his own witness statement dated 3 May 2025, as well as a supplemental statement dated 29 May 2025. Dr Scott also gave oral evidence at the hearing.

Expert Witness Evidence

16. The Tribunal also received evidence from Dr F, an expert witness on behalf of the GMC. Dr F is an MCA Approved Doctor (AD). His evidence assisted the Tribunal in understanding the purpose and usual format of a Seafarer Assessment and its expected output. Dr F highlighted the standards expected of a reasonably competent MCA AD and opined on whether any aspects of Dr Scott's care fell below, or seriously below, these standards.

17. Dr F provided a report dated 10 March 2024, as well as two supplemental reports dated 4 December 2024 and 2 June 2025, respectively.

Documentary Evidence

18. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:

- An email sent on behalf of the Chief Nurse for Community Nursing to Dr Scott and Colleague A, following the events as set out in Paragraphs 1 and 2 of the Allegation, dated 9 March 2018;
- Letter to Dr Scott from NHS Shetland, confirming his suspension, dated 14 April 2020;
- WhatsApp messages between Colleague A and Colleague B, dated 9 March 2018, 18 May 2018, 30 June 2018 and 3 December 2018;
- MCA AD appointment letters sent to Dr Scott, dated 7 March 2018 and 21 March 2019;
- Letter from Dr E to Dr Scott instructing him to stop carrying out medical examinations immediately, dated 14 May 2021;
- Further letter from Dr E to Dr Scott reiterating the above and confirming MCA investigation, dated 18 May 2021;
- Email to the GMC with copies of Dr Scott's Annual Return for 2020 and reappointment letter for 2021 attached, dated 19 May 2021;
- Email correspondence between Dr E and Dr Scott, various dates from 18 May 2012 to 6 June 2021 inclusive;
- Facility checklist provided by Dr Scott to the MCA;
- Review of a sample of Dr Scott's records from ENG medicals performed since April 2020, along with Dr E's comments and concerns;
- Email from Dr E to the GMC advising of the MCA investigation findings and letter to Dr Scott advising of the same, both dated 17 June 2021;
- Email from Dr E to the GMC, dated 25 June 2021;
- Dr Scott's unredacted Vodafone phone bill, covering from 11 August 2021 –11 September 2021 inclusive.

The Tribunal's Approach

19. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Scott does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

20. In reaching its decision on facts, the Tribunal has borne in mind the statutory overarching objective which is protection of the public. The pursuit of that objective involves the pursuit of the following objectives:

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

21. The Legally Qualified Chair ('LQC') reminded the Tribunal that it should not assess a witness's credibility exclusively on their demeanour when giving evidence. The Tribunal should consider all of the evidence before coming to a conclusion as to the credibility of a witness.

22. The Tribunal took into account of Dr Scott's good character and its relevance to his credibility and propensity to have committed the allegations. It also considered that good character of itself is not a defence to the allegations.

23. The LQC stated that the Tribunal has heard that Dr Scott recounted what his *'usual practice'* would be. However, the significance of such evidence, if the Tribunal accepts that as credible, goes to the propensity of him being more likely than not to follow that *'usual practice'*. That is a weighty factor in assessing what Dr Scott is now alleged to have failed to have done.

24. The LQC stated that the Tribunal must reach a decision on the facts based on the evidence before it. It can draw reasonable inferences on what it has heard but it must not speculate.

The Tribunal's Analysis of the Evidence and Findings

25. The Tribunal has considered each outstanding paragraph of the Allegation separately and this was done by taking account of the documentary evidence, the oral evidence and subjecting that to critical scrutiny in order to make its findings on the facts.

Paragraph 1(a) and 1(b)

26. In determining the particulars of Paragraph 1, the Tribunal assessed the credibility of Colleague A and Dr Scott and the cogency of the evidence that they both presented. This was done by taking account the totality of the evidence in this case.

27. The Tribunal found Colleague A to be a credible and reliable witness. Her account remained consistent between her written and oral evidence, and she withstood robust cross-examination without contradiction or embellishment. She gave her responses clearly and without hesitation. When asked how long the March incident lasted (paragraph 2); she answered immediately and proportionately, indicating that it was not prolonged, and did not appear to exaggerate. Her inclusion of specific details, such as a recollection of Dr Scott being so close to her that she could feel his spittle on her face, was not viewed as an attempt to

worsen the allegation, but rather as evidence of her experience of the event alleged. In the Tribunal's assessment Colleague A appeared to be genuinely distressed by what she said had occurred. The Tribunal considered this as strengthening, rather than undermining her credibility.

28. The Tribunal further noted that there was no evidence to suggest Colleague A was driven by any ulterior motive to fabricate the allegation. Although there was a complaint against her concerning patient care, this was not considered material to her credibility. A witness statement from Ms D confirmed that the matters subject to paragraph 1 of the Allegation of January 2018 were brought to her attention either that same month or in February 2018, which predates the complaint. Accordingly, the Tribunal was satisfied that Colleague A's account was given honestly and was not influenced by any subsequent allegation of poor performance. Her use of descriptors such as *"hammering"* and *"kicking"* in her written statement and her description of the event as *"so out of the ordinary"* in oral evidence were consistent with her overall account. The Tribunal accepted her evidence as a genuine and accurate account of what she perceived at the time.

29. The Tribunal considered Dr Scott's credibility. The Tribunal considered that Dr Scott's credibility was undermined by apparent selective recollection and inconsistency. Whilst he consistently denied behaving at all aggressively or kicking the door in January 2018, his evidence when considered in the round over the entire Allegation was less consistent. For example, in relation to Paragraph 4 of the Allegation, his evidence in both his written statement and orally was that he *"may have had one or two glasses of wine"* on 29 August 2021. In oral evidence he was firm that he had only consumed one or two drinks. Furthermore, in both his oral and written evidence he was clear that Dr C told him that XXX in a phone call at 23:46 on 29 August 2021. This level of certainty about these aspects of evidence was in contrast to his evidence that he only recalled making one telephone call.

30. The Tribunal has taken into account that under cross examination he was presented with contemporaneous documentary evidence of a Facebook post he accepts having made on Saturday 4 September. He conceded that it was likely that any reference by Dr C to XXX probably occurred in a telephone call made that day which he has no recollection of making. In the Tribunal's assessment Dr Scott's credibility was undermined to a degree by his asserted certainty over some detail when he was unable to recall any of the contents in any of the telephone calls in paragraphs 3 and 4.

31. In short, Dr Scott was more certain of facts in his oral evidence than he was in his written evidence provided earlier further detail of less important parts of his evidence contrasted with a lack of recollection of key parts of the Allegation. The Tribunal has taken into account the evidence it has heard of the XXX in August and September of 2021.

32. The Tribunal also found Dr Scott's credibility to be undermined by some of his assertions in relation to the events of March 2018 (paragraph 2 of the Allegation). Under cross-examination he asserted that he had no XXX over Colleague A, an implication being that a confrontation over this issue did not happen, however, he accepted that he had still taken it

upon himself to make check with XXX to find out XXX. The Tribunal found that Dr Scott was vested in the issue of Colleague A's XXX as the senior practitioner in the practice and therefore it was more likely than not that there had been an incident as described by Colleague A. In the Tribunal's judgement Dr Scott's lack of XXX of Colleague A was not relevant.

33. Colleague A was not challenged in relation to her evidence that a patient had been in the room when Dr Scott aggressively banged on the door in January 2018, her evidence in that matter was clear. Dr Scott said in his statement, "I recall the incident when I went into the consultation room to speak to Colleague A. I don't recall a patient being in the room''. The Tribunal found that to a limited degree this undermined the reliability of his evidence. Whilst he did not recollect the presence of a patient that presence was not challenged.

34. In all circumstances the Tribunal concluded that Dr Scott's evidence suggested a selective memory, and while it did not find Dr Scott to be entirely lacking in credibility, it could not accept his evidence uncritically.

35. The Tribunal took into account Dr Scott's good character, as supported by the evidence of Dr C who had known him XXX prior to the events in August and September 2021. It acknowledged that Dr Scott's behaviour could be viewed as out of character and there was no suggestion that he had previously behaved in this way. However, the Tribunal was of the view that this was tempered by the admissions of dishonesty in connection with the Seafarer Examinations undertaken in 2020, with all 39 examinations analysed found to be fraudulent in relation to the premises where they were undertaken. Dr C's evidence was helpful in relation to Dr Scott's good character. Dr C felt able to provide a reference for Dr Scott in May 2021, and described him in that reference as trustworthy. However, at that time she was unaware of the ongoing dishonesty in regard to allegations 5, 6, 7 and 8. Dr C stated in her oral evidence that she could not describe Dr Scott as dishonest. However, she had been unaware of his dishonest conduct in 2020.

36. The Tribunal carefully considered the evidence relating to paragraph 1 of the Allegation. Colleague A maintained throughout both her written and oral evidence that Dr Scott had either *"hammered"* or *"kicked"* the door. She described the noise as being so loud and forceful that it could not have been an ordinary knock. She was consistent in stating that the sound and nature of the impact were sufficiently aggressive and alarming to lead her to believe that Dr Scott had kicked the door. In oral evidence, she reinforced this impression by stating that the force used was *"so out of the ordinary."* The Tribunal accepted that this was her honest belief at the time, and that her account reflected a genuine and immediate response to what she perceived as a forceful and threatening action.

37. The Tribunal bore in mind the alleged kicking of the door took place on the other side of the door, and there is no eyewitness account of the events from that side of the door other than that of Dr Scott. Dr Scott stated that he knocked normally three times before he opened the door to enter the room. The Tribunal had regard to Colleague A's evidence to what it considered to be her genuine alarm as to what it deemed to be an aggressive

repeated impact on the door. It was satisfied that Colleague A formed the reasonable belief that the door had been kicked. It was submitted by Dr Scott's counsel that there was lack of corroboration for what was alleged in January 2018. The Tribunal considered the absence of corroborative evidence and concluded that that did not preclude the Tribunal from making findings on the balance of probabilities. The findings around the relative reliability and credibility of Dr Scott and Colleague A are outlined in the paragraph above.

38. In the circumstances the Tribunal concluded that the GMC had discharged its burden of proof in relation to paragraph 1(b). The Tribunal also considered Dr Scott's account in the context of his reliability, which was found to be compromised.

39. While the Tribunal accepted that there was no direct evidence that Dr Scott had kicked the door, given that the action was not seen, it nonetheless concluded that his conduct amounted to more than a routine knock. The Tribunal found it proven, on the balance of probabilities, that Dr Scott hit the door with sufficient force that it caused genuine alarm to Colleague A and led her to form a reasonable, albeit mistaken, belief that the door had been kicked. The Tribunal concluded that although the burden of proof had not been discharged in relation to the specific allegation of kicking, the facts demonstrated that, on the balance of probabilities, Dr Scott had knocked on the door in a manner that was aggressive.

40. In reaching this finding, the Tribunal placed weight on the overall credibility of Colleague A's evidence, and that of Dr Scott's account when viewed in light of the other concerns regarding his credibility and reliability. While the Tribunal genuinely believed that Dr Scott was convinced that he did not kick the door or behave aggressively, it was satisfied that the incident did occur in a manner that would reasonably be perceived by Colleague A as aggressive, even if the precise mechanism of the impact, whether a hand, fist, or foot, could not be definitively determined.

41. The Tribunal therefore found Paragraph 1(a) of the Allegation to be not proved and Paragraph 1(b) of the Allegation to be proved.

<u>Paragraph 2(a) 2(b) 2(c) and 2(d)</u>

42. In reaching its conclusion regarding paragraph 2 of the Allegation the Tribunal took into account of its findings in relation to paragraph of 1. The Tribunal took into account its findings on witness credibility and reliability as outlined above.

43. It had regard to the fact that Dr Scott, in oral evidence, denied aggressively confronting Colleague A about her whereabouts on Wednesday afternoons, stating that he XXX. However, he had still taken it upon himself to investigate alleged complaints from staff and he challenged Colleague A about it when she came back from leave on XXX.

44. The Tribunal considered the possibility that Colleague A's evidence was motivated by Dr Scott's response to a complaint made about her. It did not find that to be the case.

45. The Tribunal found Colleague A's evidence in regard to the incident to be compelling and consistent. There had been no exaggeration, and it was satisfied that, on the balance of probabilities, it was more likely than not that these particulars of the Allegation occurred.

46. Accordingly, The Tribunal found Paragraph 2 of the Allegation to be proved in its entirety.

Paragraph 3

47. In determining paragraph 3 of the Allegation, the Tribunal considered both the oral and the documentary evidence. The Tribunal noted that Dr Scott's evidence was clear. He explained that he was XXX at the relevant time (August and September 2021) and that he could not recall making he made any calls on 4 and 5 September 2021 and their content. Indeed, the only call he could recollect making to Dr C was on 29 August 2021.

48. Dr Scott did not recall ever using the abusive words attributed to him by Dr C. Under cross-examination he was taken to a note that he had entered on Facebook on Saturday 4 September 2021 in which he stated that Dr C had referred to him as XXX. Dr Scott said that he had struggled to reconcile this with his lack of recollection of the relevant calls. Notably, he accepted that the calls and their content, as reported by Dr C could have happened as outlined in her written and oral evidence. This acknowledgment supported Dr C's credibility and the reliability of her evidence.

49. Notwithstanding Dr Scott's poor memory of that period, the Tribunal did not form the view that Dr Scott was evasive in this part of his evidence. Nevertheless, there was inconsistency and selective recall, and his limited memory undermined the reliability of his account.

50. In contrast, the Tribunal found Dr C to be a credible and reliable witness. Her account was consistent, detailed, and supported by contemporaneous documentation, including her own notes and a police report. The police report was relatively contemporaneous.

51. The Tribunal had regard to Dr C's 'timeline of events' document, it had particular regard to the following,

> '' Saturday 4th of September […]
>
> Saturday night.
> He started phoning me at around 11pm and phoned roughly every half an hour a further twice into Sunday morning. *I emailed Dr G after the first call.*
>
> *"He has been on the phone tonight, abusing me, calling me XXX, saying he doesn't trust me and saying XXX, and it was all true. He said he had the right to do this as XXX. He was drunk. I'm minded to speak to the police to make them aware- he has no right to abuse or frighten me*

[Dr C]"

He wouldn't listen to me when I asked him to get off the phone and stop this. He sounded drunk and in a rage. One of the phone calls was just 'fuck you fuck you fuck you over and over.

On Sunday Morning I emailed Dr G to keep her updated.

3 phone calls in the end, getting progressively worse, in the night at half hour intervals.

In the end shouting at me to fuck off, XXX and he wanted to speak to my colleague [Name] (who is off until October). He doesn't like me or trust me, I'm a liar, in collusion, I need referred to the GMC, and on and on. Anything I said was twisted and thrown back. He continued to attack XXX as well as me. I couldn't get a word in to respond if I tried, he screamed at me. He repeated my name over and over, was intimidating and saying 'you need help Paul made it worse.

All of this seems to have been kicked off by me doing that locum XXX for 2 days.

I spoke with the police Scot and said it's intolerable, I'm on call and have to answer the phone, and eventually spoke to the police in Lerwick. The officer I spoke to was reluctant to phone him (Paul was phoning from his mobile and we had the number) as he said "he doesn't respond well to police contact"

I said I was concerned after speaking with his relative that he might try and come through my door, if he was in the vicinity. He said I shouldn't be worried about that, as there was XXX.

In the end the best I could do was put the phone through to the hospital. The policeman said if he abused the person on hospital switchboard then they would act. The hospital agreed to phone me on another line if there were any calls

He subsequently went on FB and said I'd called him XXX (no I hadn't)''

52. The Tribunal accepted that Dr C had made relatively contemporaneous notes of the calls and their content at different times over a two-week period starting with the concerning calls. The Tribunal noted that she provided a clear and coherent explanation of the events she recalled. The Tribunal noted that Dr Scott's position remained that he had no recollection of the calls or any such behaviour that might amount to abuse.

53. The Tribunal noted that Dr C had known Dr Scott XXX, having worked with him, being XXX, being friends and having shared social occasions including XXX. She spoke highly of him as a clinician, described him as a "thoroughly decent man", and the Tribunal did not note any

malice or embellishment in her evidence. Indeed, the Tribunal concluded that her evidence was detailed, measured, consistent and fair to Dr Scott.

54. The Tribunal was mindful that much time passed between the allegations set out by Colleague A and those that arose from Dr C's evidence (over three and a half years). Further, Dr Scott explained that he was XXX in September 2021 and that he had not been XXX in January 2018. Nonetheless, it noted that the conduct alleged under paragraph 3 bore similarities to the conduct found proved under paragraphs 1 and 2 of the Allegation.

55. The Tribunal was satisfied, on the balance of probabilities, that the GMC had discharged its burden of proof in respect of Allegation 3.

56. Accordingly, paragraph 3 of the Allegation is found proved.

Paragraph 4

57. In determining this allegation, the Tribunal had regard to its earlier findings under Allegation 3, which included abusive language and repeated calls made by Dr Scott to Dr C within the wider time period. The Tribunal found that the conduct already found proved under Paragraph 3 was, in itself, threatening in nature.

58. The Tribunal took full account of each of the calls and their content outlined by Dr C that occurred between 29 August 2021 and 6 September 2021. The first of those calls was in the early hours of 30 August. The Tribunal took account of Dr C's timeline evidence, which set out the sequence of Dr Scott's contact with Dr C. Dr C provided a clear account that the first call left her extremely upset she had called the police on 30 August 2021 out of concern for her personal safety. Her actions at the time, reporting the matter to the police, were considered to be by the Tribunal reasonable and proportionate given her expressed fear in the light of the frequency and content of the evidenced calls from Dr Scott to her.

59. The Tribunal also had regard to the time log, which supported the frequency and pattern of the calls. Dr C's evidence, including her statement that she called the police because she was fearful for her safety was considered to be compelling evidence.

60. As found in relation to paragraph 3, the Tribunal found Dr C to be a credible and reliable witness. Her account remained consistent throughout and was supported by contemporaneous documents, including the timeline and the accepted fact of police involvement.

61. The Tribunal again took account of Dr Scott's lack of recollection for the relevant period. As with paragraph 3 of the Allegation, the Tribunal accepted that XXX may have played some part in this. However, the Tribunal was able to conclude that he behaved in a manner that caused her to feel threatened and intimidated.

62. Dr C spoke about Dr Scott in terms that were positive, describing him as "trustworthy", and made clear that, prior to this incident, she had never experienced or observed any aggressive behaviour from him. The Tribunal considered this to be a credible testimonial to Dr C's character. The contrast between the Dr Scott she had previously known and his behaviour during these calls contributed significantly to the fear and distress she experienced. The Tribunal in particular noted that in Dr C's Timeline of events, she wrote,

> *'' I did two days locum at XXX, as they were so dreadfully short-staffed GP wise, requested by XXX. I was able to offer to do XXX and also XXX.*
>
> *<u>On the morning of Monday 30th August at 12:30 am</u> I was awakened from sleep by a phone call from Dr Paul Scott, who was at that point also XXX. Dr Scott previously was the GP at Brae HC but had been suspended in the spring of 2020 by SHB management. Up until this point I appeared to have had a reasonable relationship with him as a colleague, had XXX.*
>
> *He was very agitated when he phoned. Shouting at me, repeating my name over and over. He seemed to be very angry because I had worked at XXX on the Friday and had been in the next room to [name] 'What did you talk about at coffee [name]? ''you had coffee with her' ' 'She is a bad person' 'Have YOU ever been referred to the GMC?' 'Are you colluding with them?' He said he wouldn't put it on FB - yet. He would not let me speak, even though I tried to say XXX He was pretty intimidating- sounded quite XXX- and I felt extremely upset, ended up putting the phone down and had little sleep that night before going to do a day's locum XXX in the morning. This was witnessed by XXX*
>
> *<u>1st September</u> I considered what to do, and discussed it with my colleague in Hillswick Dr I, who suggested I speak to Paul J regarding boundaries re phone calls so late at night. I tried to send email to Paul's email address that I had but it bounced.*
>
> *'I hope you are feeling a bit better and less distressed than the other night Paul.*
>
> *I can reassure you that XXX - I was helping out at XXX 2 days because they were so short staffed. I happened to be in the next room to [name] but that certainly doesn't mean I would discuss anything XXX confidential with her.*
>
> *I was upset that you were clearly upset and felt the need to contact me after midnight. I was half asleep when we spoke.*
>
> *If you want to discuss anything, phone me during the day please.*
>
> *Regards*
>
> *Dr C*
>
> *<u>3rd September</u>*

I had an email from XXX in the morning. They wanted to speak with me. They said "XXX he's very unpredictable and its affecting everyone XXX"

I replied I could listen and hear what's happening, and I spoke to them later that day.

They said that he was drinking XXX. He has been phoning XXX when drunk during the night and sending abusive texts. Trying to control and intimidate. They said he had XXX. They said he seems to be in a terrible rage much of the time. Apparently, he is completely in denial XXX. They said XXX. They said he is phoning XXX during the night. Apparently is XXX. Started getting worse after his suspension. XXX"

63. The Tribunal was satisfied, on the balance of probabilities, that Dr Scott's behaviour during the relevant telephone calls, their frequency and the time of night he made them, and their content caused Dr C to feel threatened and intimidated.

64. Accordingly, paragraph 4 of the Allegation is found proved.

Paragraph 9b, 9c, 10b, and 10c

65. The Tribunal considered the facts in relation to Allegations 9 and 10, specifically 9(b), 9(c), 10(b) and 10(c), which remained to be determined.

66. The Tribunal noted that Dr Scott gave evidence, both in his written statements and orally, that he had discussed hypoglycaemia with patients D and E and had performed risk assessments. He agreed that no specific contemporaneous record was made of these actions and admitted to overall poor documentation during this period. He also stated XXX, and that he was increasingly disorganised and not following his usual work patterns.

67. The Tribunal considered this explanation and noted that Dr Scott himself relied on his "usual practice" when asserting that discussions and assessments would have taken place. However, he also candidly accepted that at the material time he was not adhering to that usual practice.

68. The Tribunal placed weight on the expert evidence of Dr F, which was uncontested. In his supplemental statement Dr F stated that the absence of a "conditions letter" was significant and inconsistent with a proper risk assessment or adequate discussion of hypoglycaemia having taken place. Dr F set out in detail the standard of care expected, including the importance of documenting such discussions and assessments. The Tribunal accepted his conclusion that the absence of evidence was indicative of a failure to carry out those required steps. The Tribunal took the view that whilst the absence of written records could be used in its determinations on whether the discussions and assessments were performed, of itself, the lack of records was not determinative of the issue.

69. The Tribunal accepted Dr F's evidence. He wrote in his supplemental statement that,

''Dr Scott has failed to carry out any 'hypoglycaemia risk assessment.' This risk assessment should have included an enquiry about previous hypoglycaemic episodes plus a review of work-related factors that might affect blood sugars. There are no objective reliable tests. However, the AD should give an opinion on the 'risk' and justify this on the ENG2.''

70. The Tribunal noted in cross-examination, Dr Scott stated that he had known the patients and believed he was aware of their diabetic control and recent episodes. However, there was no documentation to support that he was aware of any recent hypoglycaemic events, nor that any risk assessment had been carried out to inform the two-year certification that he provided (when he knew that he could only certify for one year) given the diagnosis.

71. Dr Scott admitted that he did not write "conditions letters" for either patient D or patient E. In its deliberations the Tribunal found that had he written the letters then they would each have been informed by discussion of hypoglycaemia and an appropriate risk assessment. Whilst the absence of these letters did not of itself prove that there were no discussions or no risk assessments, the Tribunal did attribute some weight to the fact that the letters might reasonably follow from those discussions and assessments.

72. The Tribunal took account of Dr Scott's previous good character and his usual good practice. It also took account of the fact that during this period XXX, and also his dishonesty. His dishonesty was admitted by virtue of his admissions to the conduct set out in Allegation paragraph 8.

73. Accordingly, the Tribunal found paragraphs 9(b), 9(c), 10 (b) and 10(c) proved.

The Tribunal's Overall Determination on the Facts

74. The Tribunal has determined the facts as follows:

1. On or around 3 January 2018 at the Brae Health Centre, Shetland (Brae), when Colleague A was attending a patient in a consultation room, you:
Amended under Rule 17(6)

a. kicked the door of the consultation room;
Not proved

b. aggressively hit the door of the consultation room.
Determined and found proved

2. On 6 March 2018, when Colleague A was talking to Colleague B, you approached Colleague A and you:

a. backed Colleague A up against the wall of her room;
Determined and found proved

b. shouted at Colleague A;
Determined and found proved

c. did not respect personal space in that you put your face in very close proximity to Colleague A's;
Determined and found proved

d. told Colleague A that you would get rid of her.
Determined and found proved

3. Between 3 and 6 September 2021 you made telephone calls to Dr C and you were abusive in that you said 'fuck you' and 'fuck off' on one or more occasions.
Determined and found proved

4. Your behaviour in telephone calls to Dr C between ~~30~~ 29 August 2021 and ~~5~~ 6 September 2021 caused her to feel threatened and intimidated.
Determined and found proved
(Dates amended under Rule 17(6))

Seafarer Examinations

5. After 7 April 2020 you carried out Statutory Seafarer Medical Examinations under the Merchant Shipping (Maritime Labour Convention) Regulations 2010 ('Seafarer Examinations') as set out at Schedule 1 at an address(es) other than Brae which weren't registered for Seafarer Examinations.
Admitted and found proved

6. You returned a completed and signed form to the Maritime Coastguard Agency in December 2020 in which you falsely recorded your only work address as Brae.
Admitted and found proved

7. You knew:

a. that you were not authorised to carry out any Seafarer Examinations at any address other than Brae;
Admitted and found proved

b. that the information you provided at paragraph 6 was untrue because of the work you were carrying out as described in paragraph 5.
Admitted and found proved

8. Your conduct at paragraph:

a. 5 was dishonest by virtue of paragraph 7a;
Admitted and found proved

b. 6 was dishonest by virtue of paragraph 5 and 7b.
Admitted and found proved

9. On ~~8~~ 18 December 2020 you issued a two- year Seafarer Certificate to Patient D, who had diabetes. In doing do you failed to:
Amended under Rule 17(6)

a. limit the Certificate to one year;
Admitted and found proved

b. discuss hypoglycaemia with the patient;
Determined and found proved

c. perform a risk assessment;
Determined and found proved

d. issue a conditions letter;
Admitted and found proved

e. place a restriction on the Certificate restricting the patient to UK Near coastal waters.
Admitted and found proved

10. On 29 March 2021 you issued a two- year Seafarer Certificate to Patient E, who had diabetes. In doing do you failed to:

a. limit the Certificate to one year;
Admitted and found proved

b. discuss hypoglycaemia with the patient;
Determined and found proved

c. perform a risk assessment;
Determined and found proved

d. issue a conditions letter;
Admitted and found proved

e. place a restriction on the Certificate restricting the patient to UK Near coastal waters.
Admitted and found proved

Yet to be determined is whether by reason of the findings concerning the matters set out above, Dr Scott's fitness to practice is impaired because of his misconduct.

Determination on Impairment - 10/06/2025

1. This determination will be read in private. However, as this case concerns Dr Scott's misconduct, a redacted version will be published at the close of the hearing XXX.

2. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Scott's fitness to practise is impaired by reason of misconduct.

The Evidence

3. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

Submissions

4. On behalf of the GMC, Mr Brook, counsel, submitted that the facts found proved in this case amount to serious misconduct and that Dr Scott's fitness to practise is impaired by reason of that misconduct.

5. Mr Brook, submitted that the Tribunal's findings of fact showed that Dr Scott's actions were contrary to paragraphs 1, 12 ,36, 37, and 65 of Good Medical Practice (2013) ('GMP'). He submitted that the need to uphold proper professional standards and to uphold public confidence in the profession would require a finding of impairment in this case. Those paragraphs state that;

> *"1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*
>
> *12. You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*
>
> *36. You must treat colleagues fairly and with respect.*
>
> *37. You must be aware of how your behaviour may influence others within and outside the team*
>
> *65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession."*

6. Mr Brook submitted that there was very limited evidence of genuine insight. He acknowledged that Dr Scott was entitled to contest the allegations but maintained that his insight remained superficial. He submitted that Dr Scott recalled one phone call, apparently prompted by reviewing Vodafone billing records and a Facebook message. However, he had no recollection of the alleged abuse. Mr Brook acknowledged Dr Scott's explanation for his lack of memory but noted that he had nevertheless conceded he may have made all the calls and that they may have been abusive. This concession, Mr Brook argued, might be taken as a degree of insight.

7. Mr Brook submitted that whilst there was some evidence of XXX in 2022 any reference to XXX would likely be advanced in mitigation at Stage 3, if reached, rather than forming part of the current consideration on impairment.

8. Mr Brooks submitted that, while some insight was evidenced by virtue of the partial admissions to the allegation, it remained limited.

9. Mr Brook reminded the Tribunal that dishonesty is difficult to remediate. He referred to the volume of sample certificates on the schedule that evidenced persistent dishonesty and the lengthy period over which the dishonesty was perpetrated. Mr Brook submitted that there is a presumption of impairment in cases involving dishonesty.

10. Mr Brook submitted that all three limbs of the overarching objective, were engaged by the Tribunal's findings of fact. These are in summary; maintaining public safety, maintaining public confidence in the profession, and upholding proper professional standards. He submitted that this was a case of serious misconduct.

11. Mr Brook referred to the case of *Roylance v GMC* as authority on misconduct and the case of *Calhaem v GMC* concerning the five guiding principles. He further cited *Meadow v GMC*, noting the reference to conduct that would be regarded as deplorable by fellow practitioners. He also referred to *Malone v GMC*, *Remedy*, and *Aga* as relevant authorities. Mr Brook submitted that this was clearly a case of serious misconduct and, while acknowledging that the issue was for the Tribunal, suggested that this point may not be in dispute.

12. Mr Brook referred to the fifth report of the Shipman Inquiry and *CHRE v NMC and Grant*; specifically, whether the conduct would be regarded as unacceptable by the profession and whether it needed to be marked by a finding of impairment in the public interest.

13. Mr Brook referred the Tribunal to the case of *Yeong v GMC* as authority for the principle that impairment must be found as a matter of public policy in cases where failing to do so would undermine public confidence in the profession. Mr Brook submitted that this principle clearly applied in the present case.

14. Finally, Mr Brook referred to the case of *Biswas* and *Uppal [PSA & GMC & Parvan Kaur Uppal [2015} EWCHA 1304 (Admins)}* as being relevant to cases involving allegations of dishonesty. However, he acknowledged that the latter might be of limited assistance given that the present case did not concern a one-off incident.

15. Mr Brook concluded by submitting that, in line with established principles, the conduct embracing all the facts found proved amounted to serious misconduct, and that Dr Scott's fitness to practise was currently impaired.

16. On behalf of Dr Scott, Mr Brassington, counsel submitted he was not in a position to make formal admissions in respect of misconduct or impairment because these determinations were not matters capable of admission. They were matters for the Tribunal to determine. However, he submitted Dr Scott would readily concede both serious misconduct and impairment of fitness to practise in relation to paragraphs 5 to 10 of the Allegation, which related to the conduct of the seafarer medical examinations and the subsequent admitted dishonesty concerning where the examinations had taken place.

17. Mr Brassington submitted that certain aspects of the case were straightforward. He did not dispute that the dishonesty amounted to serious professional misconduct. Nor did he dispute that the failures found proved under paragraphs 9 and 10 of the Allegation also amounted to serious misconduct. He referenced the evidence of the expert witness (Dr F) who had stated that the conduct was 'seriously below the expected standard.'

18. Mr Brassington submitted that paragraphs 1 to 4 of the Allegation were more nuanced and required careful consideration. He invited the Tribunal to apply perspective and proportionality in determining whether the facts found proved in these allegations constituted serious professional misconduct.

19. In relation to paragraph 1, Mr Brassington referred to the Tribunal's facts determination at paragraph 40, which recorded that Dr Scott genuinely believed he had not kicked the door or behaved aggressively, and that while the event was perceived by Colleague A as aggressive, the precise mechanism of the impact could not be determined. Mr Brassington submitted that the incident occurred in a tense clinical situation involving a potentially unwell patient requiring an ECG. Dr Scott's conduct, he argued, amounted to an overreaction in a high-pressure setting, not an act of misconduct warranting disciplinary sanction. He cautioned that characterising such conduct as misconduct could risk setting an unhelpful precedent for clinical professionals working under pressure.

20. In respect of paragraph 2 of the Allegation**,** Mr Brassington emphasised the importance of viewing the incident within the context of a workplace disagreement between professional colleagues. He submitted that the notion of Dr Scott wielding hierarchical authority over Colleague A was misconceived, and that a proper assessment should consider the nature of the interaction as one between equals.

21. Mr Brassington submitted that paragraphs 3 and 4 of the Allegation involved conduct during a period of XXX. Mr Brassington submitted that Dr Scott was, by that time, XXX, and his actions of making repeated phone calls, some of which were potentially abusive, occurred during a period in which he was XXX. Whilst Dr Scott partially recalled the events (through his own research into telephone records), he had fully accepted during cross-examination that he may have made all the calls and that he may have been abusive. Mr Brassington submitted that the Tribunal must consider whether such conduct, carried out by a person XXX, would be regarded as "deplorable" by a reasonable, well-informed member of the public or by fellow practitioners. Mr Brassington invited the Tribunal to reflect on the extent to which a member of the public would view such conduct by XXX as serious professional misconduct, suggesting that appropriate deliberation should include understanding that situation and contextualising it.

22. Mr Brassington referred to the case of *Roylance v GMC*, reminding the Tribunal that not every instance of professional misconduct meets the threshold of serious misconduct. He also cited the cases of *Cheatle*, to reinforce the distinction between misconduct and impairment, and *Beckwith v SRA*, noting that professionals are not required to be paragons of virtue.

23. Mr Brassington summarised the relevant case law pertaining to impairment, including *CHRE v NMC and Grant*, noting the shift in focus from whether conduct could be remedied and whether it was likely to be repeated, and whether public confidence and professional standards would be undermined by a failure to make a finding of impairment. He accepted that the Tribunal must also consider the guidance set out in Dame Janet Smith's Fifth Shipman Report.

24. Turning to insight, Mr Brassington submitted that Dr Scott's insight was not absent, as had been suggested by the GMC, but was limited. He reminded the Tribunal of its own findings at paragraph 40 of the Facts determination, which demonstrated that Dr Scott's denial of allegation paragraph 1 was not misleading. He made the point that that whilst Dr Scott denied the allegations, he had admitted the knowledge in paragraphs 6 and 7(b) and therefore the dishonesty in 8(b). Dr Scott had accepted the possibility of having behaved inappropriately during XXX.

25. Mr Brassington further submitted that Dr Scott now had significant insight into the impact of XXX on his conduct. XXX.

26. Mr Brassington accepted that dishonesty cases are difficult to remediate, but submitted that Dr Scott had demonstrated openness, cooperation, and genuine remorse. He took issue with the GMC's reference to *PSA v Uppal* as being of limited relevance, noting that this case did in fact concern a single, isolated act of dishonesty, namely, the submission of a signed form in December 2020 which Dr Scott knew to be false. This, Mr Brassington argued, was distinguishable from repeated or ongoing dishonest conduct. He agreed that in certifying the documents returned to the Maritime and Coastal Agency to say that the consultations

with the relevant seafarers took place at authorised premises was dishonesty and that it had occurred repetitively.

27. Mr Brassington concluded by submitting that the case would, inevitably, proceed to Stage 3 due to the admitted dishonesty. However, he asked the Tribunal to apply careful judgment and perspective when determining whether the earlier paragraphs (1 to 4) of the Allegation amounted to serious misconduct, and to consider the significant personal and contextual mitigation surrounding those events when assessing current impairment. He maintained that Dr Scott's conduct was, in part, attributable to XXX, that his insight had developed, and that he was now a compliant XXX professional with a previously unblemished 30-year career in the NHS.

The Relevant Legal Principles

28. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

29. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious and then whether the finding of that misconduct which was serious could lead to a finding of impairment.

30. The Tribunal must determine whether Dr Scott's fitness to practise is impaired today, taking into account Dr Scott's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

31. The Tribunal was reminded that there is no statutory definition of impairment in the Medical Act 1983. However, the Tribunal was advised that it should be guided by the guidance provided by Dame Janet Smith in the Fifth Shipman report as adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC* 927 (Admin) ('*Grant*'). In particular, the Tribunal should consider whether its finding of facts showed that Dr Scott's fitness to practise is impaired in the sense that he:

> *"a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. has in the past or is likely in the future to bring the medical profession into disrepute; and/or*
>
> *c. has in the past breached and /or is liable in the future to breach one of the fundamental tenets of the medical profession.*

d. has in the past acted dishonestly and/or is liable to act dishonestly in the future."

32. The Tribunal was advised to the issue of misconduct, noting that if the Tribunal were satisfied that the facts found proved at Stage 1 amounted to a serious departure from the professional standards expected of a registered medical practitioner, it could properly find that the doctor had engaged in misconduct.

33. The Tribunal was referred to the definition of misconduct in *Roylance v General Medical Council (No. 2) [2000] 1 AC 311,* where Lord Clyde stated:

"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."

34. The Tribunal was advised that to amount to serious professional misconduct, the conduct must be a serious departure from the standards set out in GMP. Not every breach of GMP will amount to serious misconduct.

35. In this regard, the Tribunal was reminded that serious professional misconduct has been described in *Meadow v General Medical Council [2006] EWCA Civ 1390* as conduct which would be regarded as "deplorable by fellow practitioners."

36. The Tribunal was reminded that misconduct may arise from behaviour within or outside of the workplace and may include acts or omissions which demonstrate a failure to uphold expected standards of conduct, professionalism, or ethical behaviour.

37. The Tribunal was reminded that, as explained in *Grant*, even where a doctor does not pose a risk of repetition, a finding of impairment may still be required on public interest grounds to uphold confidence in the profession and to maintain proper standards.

38. The Tribunal was also referred to *Yeong v General Medical Council [2009] EWHC 1923 (Admin),* in which the Court held that:

"*Where a panel has found serious misconduct, it must consider not only whether the doctor presents a risk to the public, but also whether a finding of impairment is necessary to maintain public confidence in the profession or to uphold proper standards of conduct."*

The Tribunal's Determination on Impairment

Misconduct

39. In determining whether Dr Scott's fitness to practise is currently impaired, the Tribunal considered whether in the case of each of the matters in the Allegation, the facts found proved amounted to serious misconduct.

Paragraph 1

40. The Tribunal determined that the doctor's actions in forcefully hitting the door of the consultation room, causing genuine alarm to Colleague A, engaged paragraphs 1, 36 and 37 of GMP. The Tribunal accepted Colleague A's evidence that the behaviour was aggressive and alarming. The incident arose in the context of a perceived urgent clinical need, namely, the doctor's desire to obtain an ECG for a patient. In light of the facts found proved and the context in which the incident occurred, the Tribunal found that that misconduct had occurred and referenced GMP.

41. The Tribunal considered the urgency of the situation perceived by Dr Scott and took the view that the issue of whether the situation was in fact urgent was less relevant. Dr Scott's clinical competence was not a matter for determination for this part of the allegation. The Tribunal noted that whilst Colleague A believed that she was under threat from the ferocity of what she perceived to be kicks at her door, the medical context mitigated against this being serious misconduct. The conduct was nonetheless regrettable and fell short of expected professional standards, but did not reach the threshold of being deplorable. Therefore, the Tribunal concluded that whilst paragraph 1 of the Allegation constituted misconduct, it did not amount to serious professional misconduct.

Paragraph 2

42. Turning to paragraph 2 of the Allegation**,** the Tribunal had found the conduct alleged by Colleague A proved. It amounted to backing Colleague A against a wall, shouting in close proximity to her face, failing to respect her personal space, and shouting that he would get rid of her. The Tribunal took the view that this close personal interaction was an escalation of the conduct found proved in paragraph 1. The Tribunal accepted Colleague A's account, and had particular regard to the following in her statement,

> *''He was about a millimetre from my face. All through the day he was telling staff that he was going to report me XXX, on what grounds no one knew. His actions were so premeditated. It appeared to me that he had been thinking about how he could bully me out of the workplace whilst I was on annual leave. He approached me the minute I arrived that morning it was full on aggressive and intimidating behaviour.''*

43. The Tribunal considered that this conduct engaged paragraphs 36 and 37 GMP**.** Doctors are required to treat colleagues with respect and not to abuse their position of power. Whether in fact he was in a position of power was not relevant. Dr Scott's perception that he was entitled to challenge her about her behaviour was relevant. The Tribunal found that he considered himself to be in the position by virtue of the nature of the conversation he had with Colleague A during this incident and the fact that it was found proved that Dr Scott

had said that he would "get rid of" Colleague A. The Tribunal found this to be an unacceptable and aggressive confrontation with Colleague A in the workplace. The Tribunal found that Dr Scott's actions caused Colleague A to fear for her personal safety. The Tribunal considered paragraphs 2(a)–(d) of the Allegation and concluded that, taken together, they demonstrated behaviour that fell seriously below the standard expected and would be regarded as deplorable by fellow practitioners.

44. In conclusion, the Tribunal determined that Dr Scott's conduct found proved in relation to paragraph 2 of the Allegation fell sufficiently short of the standards reasonably to be expected of a doctor as to amount to serious misconduct.

Paragraphs 3 and 4

45. The Tribunal considered paragraphs 3 and 4 of the Allegation in the round.

46. The Tribunal noted that the conduct in question included persistent telephone calls made by Dr Scott to Dr C. The abusive language averred in this aspect of the allegation was found proved. This involved the repeated use of Dr C's name and the personal allegations aimed at XXX. Some of the calls were made during antisocial hours. The nature and number of these calls, as well as their content, were such that they caused Dr C to feel fearful for her personal safety and prompted her to contact the police for advice on that issue. Dr C described feeling terrified and stated that she called the police following the initial calls made on 30 August.

47. The Tribunal was particularly concerned by the repetitive and aggressive use of abusive language during the calls, including the repeated phrase "fuck you" directed at Dr C. The Tribunal found the conduct to be persistent in nature, with multiple calls made in quick succession. The Tribunal considered paragraphs 1, 36, and 37 of GMP to be engaged, and this conduct demonstrated repeated misconduct over a sustained period.

48. The Tribunal was satisfied that the language used, the time of night when the calls were made, and the effect on Dr C were all significant aggravating factors. In assessing the seriousness of the conduct, the Tribunal concluded that it represented a significant departure from the standards expected of a medical professional and amounted to misconduct that is serious.

49. In considering whether Dr Scott's conduct could be explained or mitigated by XXX at the time, the Tribunal acknowledged the evidence from Dr Scott that he was XXX. However, the full extent to which Dr Scott's conduct could be explained fully by XXX remains unclear. Dr C had said that his conduct amounted to a significant departure from what she knew his usual conduct to be which supported the contention that XXX. Dr Scott had also given evidence on the issue of XXX at that time. Dr C was unaware of any XXX at the time of the calls and XXX. She did not know whether his conduct could be attributed to XXX or some combination thereof.

50. The Tribunal further considered whether Dr Scott had demonstrated insight and remediation. It accepted that since the incidents, Dr Scott has been XXX. However, it found that insight into the conduct itself remained limited.

51. The Tribunal noted that whilst there was some evidence of developing insight into XXX, the Tribunal found no specific insight into the behaviour that formed the subject of paragraphs 3 and 4. Nor was there evidence of meaningful remediation prior to the hearing notwithstanding that he had accepted in his oral evidence that the alleged conduct might have happened. The Tribunal concluded that, although Dr Scott's conduct occurred during XXX, this context did not mitigate the seriousness of the behaviour to the extent that it would fall short of serious misconduct.

52. The Tribunal concluded that the conduct was deplorable and had a threatening and intimidating effect on Dr C. It was wholly incompatible with the standards expected of a doctor.

53. In all the circumstances, and having regard to the relevant principles and guidance, the Tribunal determined that the doctor's conduct in relation to Paragraphs 3 and 4 amounted to serious misconduct.

Paragraphs 5 -10

54. In determining whether the conduct found proved in relation to Paragraphs 5 to 10 amount to misconduct that is serious, the Tribunal considered Dr Scott's conduct in relation to the seafarer related examinations, certification, and dishonesty in the round.

55. The conduct in question included issuing seafarer medical certificates whilst operating from unapproved premises, issuing inadequate and falsely endorsed certificates and charging and accepting significant fees over a prolonged period in the context of false certification. It also included serious failures in relation to the assessment certification of two seafarers with diabetes. The Tribunal considered the cumulative nature of this behaviour, as well as its implications for public safety, professional integrity, and the reputation of the profession to amount to serious misconduct.

56. The Tribunal accepted the expert evidence of Dr F that working at sea can pose significant hazards, particularly for individuals with health conditions such as diabetes and those that work with them. The risk to public safety is clear where a doctor fails to conduct proper risk assessments before certifying fitness to work in such an environment. The Tribunal noted that Dr F concluded that Dr Scott's conduct jeopardised the safety of seafarers and the wider public. It had particular regard to the following passage in Dr F's report:

> *''3. Please describe the purpose and usual format of a seafarer assessment, including reference to relevant guidance.*

3.a Working at sea is potentially hazardous:

'Approved Doctors are required to determine a candidate's fitness by reference to the statutory medical and eyesight Standards set out in Annex A of the MARITIME LABOUR CONVENTION, 2006 WORK IN FISHING CONVENTION, 2007 (ILO No. 188) Medical Examination System' MSN 1886 Amendment (1)

The Standards provide for flexibility to reflect relative risk; this enables Approved Doctors to take some account of particular circumstances, such as distance from medical care, and normal duties and requirements for crew members.'

Few ships have medical facilities on board and unless a ship is in port there may be significant delays in receiving medical attention. An Approved Doctor (AD) must consider whether medical conditions might impact on a seafarer's duties and also if there is any likelihood of deterioration.

A Maritime and Coastguard Agency ('MCA') seafarer medical examination provides a standardised assessment of medical fitness to work at sea.

A seafarer examination takes the form of a face-to-face examination. This typically lasts 30-40 minutes. The examination must take place at a venue approved by the MCA as per Annex C MSN 1886 (1)

The seafarer is a asked a series of questions about their health using the ENG2 form. This covers conditions that commonly cause increased risk to safety at sea. The AD does not routinely have access to the seafarers' medical records. Although further information can be requested if significant medical problems become evident at the assessment.

The assessment also consists of a physical examination. This includes assessment of vision (including colour vision), a hearing assessment weight, height, a body mass Index (BMI) calculation (2), urine dipstick analysis and a systems examination.

Although ADs are not dentists they are expected to enquire about dental symptoms.

The examination history and examination findings are recorded on the ENG2 form. This form must be retained in the practice for 10 years in a locked cabinet as per MSN1886(1).

The MCA has recently introduced an online system called ADOS. Medical information is stored on a central database. This was, however not in use during 2020 & 2021.

3.b The expected output from an assessment.

The seafarer is issued with a certificate. The type of certificate issued depends on the category of medical fitness. The seafarer's fitness is assessed according to statutory standards described in MSN 1886. (1) Decisions on fitness are aided by reference to the Approved Doctor's manual. (3) This provides decision aids for most of the common safety critical medical conditions."

57. The Tribunal found that the standards set out in GMP paragraphs 12 and 65 were engaged. Similarly, paragraphs 1 and 68 of GMP were engaged, as well as paragraph 71.

58. The Tribunal noted that the expert report stated unequivocally that Dr Scott was performing seafarer assessments in his role as an MCA-approved doctor. These assessments were subject to strict conditions, including that they be conducted only at an address approved and registered annually by the Maritime and Coastguard Agency. The assessments carried out at an unregistered address therefore represented a clear breach of regulatory requirements. Dishonesty is admitted.

59. The Tribunal also had regard to the evidence from Dr E which confirmed that Dr Scott's conduct had jeopardised the safety of seafarers. The Tribunal accepted that the issue of certificates otherwise in strict compliance with the regulations was an extremely serious breach of trust and professional standards.

60. The Tribunal noted that there was evidence of persistent dishonesty, including a false representation made on 1 July, continuing over a period of 14 months. Although the financial gain obtained caused by this conduct was not specifically part of the Allegation, the Tribunal considered the deception involved, and the financial gain made by Dr Scott over the period, to be relevant. These serious breaches reflected poorly on his motivation and professional judgement.

61. The Tribunal concluded that the repeated nature of the conduct, particularly the dishonesty, elevated the seriousness. The dishonesty was not incidental or isolated; rather, it was sustained over time and related to core responsibilities as a medical practitioner. As such, the Tribunal was satisfied that the conduct amounted to serious misconduct.

62. The Tribunal also considered submissions concerning XXX and noted that he had reflected that XXX may have had an impact on his ability to carry out his duties. However, the Tribunal found that this did not excuse or mitigate the seriousness of the dishonesty admitted.

63. Taking all the above into account, the Tribunal was satisfied that Dr Scott's conduct in relation to Paragraphs 5 to 10 amounted to serious misconduct. It involved clear departures from fundamental tenets of the profession, placed members of the public at risk, and undermined both public confidence in the profession and the integrity of regulatory processes.

64. The Tribunal found that the misconduct breached GMP including paragraphs 1, 12, 65, 68 and 71. In the Tribunal's view Dr Scott's actions departed significantly from these standards.

Impairment

65. Having found that the facts found proved in paragraphs 2- 10 of the Allegation amounted to serious misconduct, the Tribunal went on to consider whether, as a result of that misconduct, Dr Scott's fitness to practise is currently impaired.

66. In reaching its decision, the Tribunal had full regard to the overarching objective, which is the protection of the public. The pursuit of that over-arching objective involves the pursuit of the following elements;

- to protect, promote and maintain the health, safety and well-being of the public;
- to promote and maintain public confidence in the medical profession; and
- to promote and maintain proper professional standards and conduct for members of that profession.
-

67. The Tribunal took account of the guidance in *Grant*.

68. The Tribunal considered that misconduct proved at paragraph 2, taken with paragraphs 3 and 4 of the Allegation involved repeated abusive and threatening communication with another medical professional. The conduct taken as a whole caused significant distress, resulted in the involvement of the police, and posed a risk to the physical and emotional well-being of the recipient. The Tribunal was particularly concerned by the risk this type of behaviour could pose in other contexts if repeated.

69. The misconduct in paragraphs 5 to 10, taken together, involved repeated and prolonged dishonest conduct relating to seafarer medical examinations. These included conducting sub-standard assessments at unauthorised premises, issuing certification without appropriate examination, and charging fees in a dishonest context. The Tribunal found that such actions undermined the safety of seafarers working in inherently hazardous environments and amounted to serious breaches of fundamental professional duties. The dishonesty spanned a period of approximately 14 months and involved deliberate and persistent misrepresentation indicating a pattern rather than an isolated lapse.

70. In assessing whether there had been any evidence of remediation, the Tribunal noted that Dr Scott had made admissions the knowledge attributed to him in paragraphs 6, 7(b) and

8(b) of the Allegation in June 2024 to his dishonest conduct in June 2024 indicating a degree of insight. However, beyond those admissions, the Tribunal received little evidence of meaningful remediation, nor any indication that Dr Scott had taken steps to address his dishonesty or to reflect on its implications for patient safety or professional standards. The Tribunal noted that dishonesty is inherently difficult to remediate and that an absence of full insight or reflection was a significant concern.

71. The Tribunal considered the issue of risk of repetition. Whilst Dr Scott has now been XXX, the Tribunal found that his insight into the misconduct itself remains limited. In particular, his failure to accept responsibility for key aspects of the proven conduct significantly undermined any assurances that such behaviour would not be repeated. There was also a lack of evidence of remediation, particularly in relation to the dishonesty, which the Tribunal considered central to its findings. As such, the Tribunal determined that the risk of repetition remains.

72. Given the breadth and gravity of the misconduct across paragraphs 2-10, The Tribunal concluded that all three limbs of the overarching objective were engaged in each of those paragraphs. The Tribunal concluded that public confidence in the profession would be seriously undermined if a finding of impairment were not made. It was also found that, there is a current and ongoing risk to public protection as referenced in the Tribunal's application of the overarching objective.

73. The Tribunal therefore determined that Dr Scott's fitness to practise is currently impaired by reason of misconduct.

Determination on Sanction - 19/06/2025

148. This determination will be read in private. However, as this case concerns Dr Scott's misconduct, a redacted version will be published at the close of the hearing with those matters relating to XXX removed.

149. Having determined that Dr Scott's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

150. The Tribunal has taken into account evidence received during the earlier stages of the hearing, where relevant, to reaching a decision on sanction.

Submissions

151. On behalf of the GMC, Mr Brook referred the Tribunal to the relevant paragraphs of the *Sanctions Guidance* (2024) (SG) and submitted that the appropriate sanction was erasure.

152. Mr Brook reminded the Tribunal that whilst the GMC's submissions were offered to assist, the decision on sanction was a matter entirely for the Tribunal exercising its own judgment. He observed that there was no XXX before the Tribunal in support of the doctor's position, beyond Dr Scott's own written and oral evidence.

153. XXX

154. Mr Brook submitted that parts of the XXX provided by Dr Scott were based on a letter from Dr G, but Dr Scott had disassociated himself from some of Dr G's evidence under cross-examination. Mr Brook highlighted that there was no XXX.

155. Turning to the facts found proved, Mr Brook summarised the Tribunal's findings in relation to each paragraph of the Allegation. In relation to paragraph 2 of the Allegation, the Tribunal had found that Dr Scott's conduct escalated from that of paragraph 1 and constituted unacceptable and aggressive behaviour towards a colleague, including a threat to "get rid of her". The Tribunal found that this behaviour caused the colleague to fear for her personal safety and that the conduct amounted to serious misconduct, falling seriously below the standards expected of a medical professional.

156. Mr Brook submitted that in respect of paragraphs 3 and 4 of the Allegation, the Tribunal had found that Dr Scott made a series of persistent and abusive telephone calls to another colleague, some during antisocial hours, and that these included personal and XXX remarks. The Tribunal was satisfied that this conduct had a threatening and intimidating effect on Dr C and found it to be wholly incompatible with the standards expected of a doctor. Mr Brook noted that although the Tribunal had acknowledged XXX at the time, it concluded that the extent to which his behaviour could be attributed to XXX remained unclear. The Tribunal further found that Dr Scott had demonstrated only limited insight into the impact of this conduct and that there was no meaningful remediation. Mr Brook reminded the Tribunal that it had concluded that the Doctor's conduct amounted to serious misconduct.

157. Regarding paragraphs 5 to 10 of the Allegation, Mr Brook summarised the Tribunal's findings. Dr Scott had operated from unapproved premises, issued two inadequate medical certificates, falsely endorsed examination certificates with the incorrect address at which they were conducted, falsely endorsed a summary annual examinations (again with the false address), charged significant fees over an extended period, demonstrated serious failings in relation to two seafarers (by failing to have discussions with them concerning hypoglycaemia and failing to conduct risk assessments), failed to issue "conditions letters", and failed to issue appropriate restrictions for them (failing to limit the certification to one year and failing to limit from where the seafarer could operate to "UK near coastal waters").

158. Mr Brook submitted that the Tribunal had found the dishonesty to be persistent and sustained over 14 months and that it related directly to Dr Scott's core responsibilities as a registered medical practitioner. The Tribunal accepted the expert evidence of Dr F, and the

evidence of Dr E, who both highlighted the risks posed to public safety by the Doctor's conduct and the seriousness of the regulatory breaches.

159. Mr Brook further reminded the Tribunal of its findings that whilst Dr Scott accepted some aspects of the Allegation, there was little evidence of reflection or remediation, and no steps had been taken to address the dishonesty or its implications for patient safety or professional standards. The Tribunal had noted that the risk of repetition remained and that Dr Scott's insight into his misconduct was limited.

160. Mr Brook submitted that this presented a case in which all three limbs of the overarching objective were engaged. Further, that neither conditions nor suspension would be sufficient or appropriate in light of the seriousness of the misconduct, the persistent nature of the dishonesty, the lack of insight, and the risk of repetition.

161. Mr Brook submitted that Dr Scott appears to use XXX as an excuse/ mitigating factor for misconduct, which potentially increases the future risk of repetition rather than managing it.

162. Mr Brook directed the Tribunal to the relevant paragraphs of the SG noting that the dishonesty was persistent, it involved professional responsibilities, including certification and financial dealings and it undermined public trust.

163. Mr Brook invited the Tribunal to have regard to paragraphs 108, 109 (a, b, d and h) 120, 124, 125(e) and 128 of the SG:

> *''108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.*
>
> *109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.*
>
> *b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
>
> *d Abuse of position/trust …*
>
> *h Dishonesty, especially where persistent and/or covered up..*

120 Good medical practice states that registered doctors must be honest and trustworthy and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession.

124 Although it may not result in direct harm to patients, dishonesty related to matters outside the doctor's clinical responsibility (e.g. providing false statements or fraudulent claims for monies) is particularly serious. This is because it can undermine the trust the public place in the medical profession. Health authorities should be able to trust the integrity of doctors, and where a doctor undermines that trust there is a risk to public confidence in the profession. Evidence of clinical competence cannot mitigate serious and/or persistent dishonesty.

125 Examples of dishonesty in professional practice could include:

…

e failing to take reasonable steps to make sure that statements made in formal documents are accurate

128 Dishonesty, if persistent and/or covered up, is likely to result in erasure''

164. In conclusion, Mr Brook submitted that erasure from the medical register was necessary to uphold public confidence in the profession, to maintain professional standards, and to protect the public.

165. On behalf of Dr Scott, Mr Brassington reminded the Tribunal that the purpose of sanction was not to be punitive. Rather, it was to serve the statutory overarching statutory objective. He submitted that the public interest must be assessed through the eyes of the well-informed, reasonable member of the public, not one who was vindictive or intemperate, but one who understood the context of the case and approached it with balance.

166. Mr Brassington submitted that the principle of proportionality was engaged at the sanction stage and that the Tribunal was required to impose no more than was necessary to achieve its statutory purpose. To go further would be to punish, and that would be impermissible in regulatory proceedings. Mr Brassington observed that the GMC had placed considerable emphasis on XXX throughout its submissions yet had ultimately invited the Tribunal to disregard it. This contradiction, he submitted, undermined the coherence of the GMC's case.

167. Mr Brassington drew the Tribunal's attention to the GMC's submissions, in which it was suggested that Dr Scott had used XXX as 'an excuse' for misconduct. Mr Brassington submitted such a characterisation was wrong. Dr Scott had never sought to excuse his conduct. Rather, he had advanced XXX as an explanation, a contextual factor which accounted for behaviour that was otherwise out of character, uncharacteristic of his long unblemished professional history, and temporally linked to XXX.

168. Mr Brassington submitted that the GMC's position was inherently inconsistent. It had asked the Tribunal to discount the XXX evidence when assessing seriousness and mitigation, but simultaneously relied on that same evidence to suggest that Dr Scott posed a continuing risk. The same inconsistency, he submitted, was apparent in the Tribunal's impairment determination, which accepted that XXX was relevant to the allegations but failed to analyse its significance in any clear or coherent way.

169. Mr Brassington indicated that evidence of XXX had not been challenged by the GMC in cross-examination. No suggestion had been put to Dr Scott that XXX. Nor had the GMC adduced any contrary evidence concerning XXX. Accordingly, the evidence stood unchallenged, and the Tribunal, Mr Brassington submitted, should accept it.

170. Mr Brassington referred the Tribunal to Dr Scott's statement, in which Dr Scott accepted, on reflection, that XXX at the time of the relevant conduct. He reminded the Tribunal that Dr Scott attributed his behaviour in part to XXX, mistrust of colleagues, and XXX. Further, he stated that he had been XXX, lacking insight and XXX. Mr Brassington reminded the Tribunal that this had not been disputed by the GMC. In fact, parts of XXX had been read into the record by Mr Brook.

171. Mr Brassington submitted, that the XXX evidence had always been before the Tribunal and had been selectively and inconsistently engaged with by the GMC. He invited the Tribunal to not adopt a similarly selective approach submitting that to do so would be to fail to take account of the totality of the evidence.

172. Mr Brassington then turned to the issue of dishonesty. He submitted that the GMC had never alleged financial motivation. This matter had not been put to Dr Scott, nor explored in cross-examination. Accordingly, it would be unfair, and procedurally improper, for the Tribunal to now treat it as an aggravating feature.

173. Mr Brassington reminded the Tribunal of Dr Scott's witness statement, in which Dr Scott explained his confusion, that COVID-19 happening was relevant (Dr Scott set out his intention to assist seafarers in obtaining medical certification when there were pressures in medical practise due to the restrictions in place), and his mistaken belief that his actions would ultimately be approved. Dr Scott had accepted that he had been XXX and that his decision making had been XXX. This evidence, too, had not been challenged in cross-examination. There had been no questions from the Tribunal on the point. It stood uncontradicted.

174. Mr Brassington submitted that it would therefore be quite wrong, at this stage, for the Tribunal to accept the GMC's suggestion that Dr Scott's conduct had been financially motivated, and to allow that suggestion to influence its decision on sanction.

175. In relation to insight, Mr Brassington submitted that Dr Scott had demonstrated insight in a manner consistent with XXX. He had accepted that, at the time, he had no insight,

which was, Mr Brassington submitted, entirely understandable in the context of XXX. Dr Scott now recognised the seriousness of his actions and had taken appropriate steps to ensure that there was no repetition.

176. Mr Brassington reminded the Tribunal that XXX, and had not repeated any behaviour that could be regarded as discreditable. Dr Scott's most recent XXX had taken place shortly before the commencement of the hearing. Mr Brassington submitted these factors were significant in mitigation and spoke to the low risk of repetition.

177. Mr Brassington then turned to the Tribunal's findings at paragraph 68 of its impairment decision. He submitted that the distress caused to Colleague A and Dr C was not the product of any intent on Dr Scott's part. The fact that the impact had been distressing did not, he submitted, significantly increase the seriousness of the misconduct in this context.

178. Mr Brassington reminded the Tribunal that of 39 cases dip-sampled for assessment, only two were found to be substandard. He further reminded the Tribunal that the charging of fees had not been put as the motivation for dishonesty, and that no such allegation had been pursued. He submitted that these matters should not weigh heavily in the Tribunal's assessment of sanction.

179. Mr Brassington accepted that a sanction was plainly required in light of the findings of misconduct and dishonesty. However, he submitted that erasure would be disproportionate. He reminded the Tribunal that Dr Scott had an unblemished record for over 30 years. His conduct arose in the context of XXX. He submitted that Dr Scott had accepted responsibility for his actions, demonstrated insight, and has since XXX. There had been no repetition.

180. Accordingly, Mr Brassington submitted that a period of suspension, followed by a review, would meet the statutory objective. It would mark the gravity of the misconduct, protect patients and the public, and maintain confidence in the profession, without going further than was necessary. To erase Dr Scott, he submitted, would not reflect the reality of the case and would, in the eyes of a fair-minded and well-informed member of the public, amount to punishment for XXX.

The Tribunal's Determination on Sanction

181. The decision as to the appropriate sanction to impose, if any, was a matter for the Tribunal exercising its own judgement. There was no burden or standard of proof at this stage. It recognised that every case will necessarily turn on its own facts.

182. In reaching its decision, the Tribunal had given careful consideration to the SG. It had borne in mind that the purpose of a sanction is not to be punitive although it may have a punitive effect.

183. The Tribunal had borne in mind that in deciding what sanction, if any, to impose, it should consider the sanctions available, starting with the least restrictive.

184. Throughout its deliberations, the Tribunal had taken into account the overarching objective, and applied the principle of proportionality, balancing Dr Scott's interests with the public interest. It would continue to do so.

185. The Tribunal would take into account its earlier determinations on the facts and on impairment, the SG and GMP, the further documentation received through the course of the hearing, the submissions made by Mr Brook on behalf of the GMC, and Mr Brassington on behalf of Dr Scott.

Aggravating and Mitigating Factors

Aggravating Factors

186. The Tribunal noted several aggravating features. It noted that the dishonesty was persistent. It had taken place for over a year. Each time that Dr Scott either stamped a certificate or made the annual return, he would be reminded of his obligations regarding the premises where examinations were authorised to take place. He chose to ignore them. He had received letters from the MCA every year since 2008 reminding him categorically of the importance to conduct examinations only at approved premises. The Tribunal noted that the dishonesty spanned over 13 months and included a false declaration in December 2020. The dishonest conduct had persisted until the MCA notified him to stop his conduct immediately over concerns for the safety of the seafarers. The dishonesty had occurred within the context of the Doctor's professional role. The dishonesty had the potential to affect patient care and also the safety of the public when taking account of the potential consequences of the certification of the seafarers. The conduct had undermined the integrity of the MCA system designed to protect seafarers and the wider public.

187. The Tribunal regarded this as persistent dishonesty and considered paragraphs 32–33 of the SG to be engaged:

> *"32 However, there are some cases where a doctor's failings are difficult to remediate. This is because they are so serious that despite steps subsequently taken, there remains a current and ongoing risk to public protection and action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients and should have taken steps earlier to prevent this.*
>
> *33 In such serious cases, the tribunal must fully and clearly explain:*
>
> *a The extent to which the issues can be remediated*
>
> *b The steps the doctor has taken*

c How the seriousness of the findings – including the doctor's failure to take steps earlier – justifies the tribunal taking action, notwithstanding the steps subsequently taken.''

188. The Tribunal noted that Dr Scott's behaviour regarding parts 2, 3 and 4 of the Allegation involved two separate colleagues and included repeated acts of intimidation. Whilst the Tribunal found that paragraph 1 of the Allegation amounted to misconduct, it had found the behaviour was the context for the serious misconduct set out in paragraph 2. Dr Scott's behaviour towards Colleague A had escalated. Dr Scott had said that at the time of the conduct in 2018 he did not think XXX.

189. The conduct averred in paragraphs 3 and 4 of the Allegation included making telephone calls often during antisocial hours to XXX (Dr C). He had persistently sworn at her and repeated her name in a way that made her fearful. He made XXX allegations against XXX. He referred to his conversations with her on social media. He accused her of conspiring against him with other members of staff at his surgery XXX. The Tribunal viewed this as escalating and persisting conduct. The Tribunal referred to the impact on the victim, noting in particular that Dr C felt so threatened she contacted the police for assistance with her personal safety, and that this behaviour posed a risk to her emotional wellbeing.

Mitigating Factors

190. The Tribunal identified several factors that mitigated the seriousness of Dr Scott's conduct. It accepted that Dr Scott had previously enjoyed an unblemished medical career spanning more than 30 years, and that until the events in question, he had maintained his good character. The Tribunal also noted the significant passage of time. Paragraph 2 occurred seven years ago and there was a three-year gap to the next allegations involving threatening and intimidating conduct. It considered this relevant in assessing the current risk posed by the Doctor to the public. In addition, Dr Scott had made partial admissions during the course of the hearing, which the Tribunal regarded as a mitigating factor.

191. The Tribunal further considered as mitigating that Dr Scott had experienced significant XXX. It referred to the submissions made by Mr Brassington to consider the context that XXX provided in the case. It reminded itself of its findings in paragraphs 49 and 50 of the impairment determination. Dr Scott's XXX, coupled with the absence of any repetition of misconduct since that time, and found that this provided context and mitigation.

192. The Tribunal considered that XXX could impact on behaviour and the Doctor's averred behaviour had to be contrasted with previous good conduct to provide context. This was particularly relevant to the course of threatening and intimidating conduct directed towards Dr C. The Tribunal considered the limited evidence as to any impact of XXX on his dishonest behaviour. The Tribunal exercised its judgment solely on the facts and evidence before it and determined that the context of XXX could not be reconciled with his dishonest conduct. Whilst his business decisions might have been affected and XXX to a degree, that could not

explain adequately the period over which the dishonesty occurred, the number of seafarer assessments or the fact that the conduct continued until the dishonesty was discovered and the Doctor told to desist. The Tribunal found that the evidence of XXX contextualised Dr Scott's actions only to a limited degree. Although insight into the misconduct itself remained absent, the Tribunal accepted that Dr Scott had shown some insight into XXX.

193. In considering Dr Scott's dishonesty, the Tribunal did not exclude the possibility that XXX, that appeared relevant in August 2021, may have affected his earlier decision making. The Tribunal reminded itself of its findings at the impairment stage, which addressed the relationship between XXX and his actions but found that such context did not reduce the gravity or extent of the dishonesty. The Tribunal concluded that XXX could provide some contextual background particularly in relation to paragraphs 3 and 4. However, they could not explain Dr Scott's dishonest behaviour.

194. The Tribunal remained cautious in its assessment of XXX as a mitigating or aggravating factor and preferred Mr Brassington's suggested approach that it provided context. It accepted that anyone could XXX and behave out of character. However, the Tribunal found that Dr Scott had not demonstrated significant insight into XXX, and much less into his misconduct. Although there was acceptance of XXX, he had shown little awareness of whether and to what extent they contributed to his dishonest behaviour. It noted that in the GMC's submissions, it was observed that Dr Scott appeared to attribute the entirety of his behaviour to XXX, which the Tribunal viewed as a failure to take personal responsibility. Whilst XXX could contextualise the conduct, the Tribunal did not accept that XXX accounted for his dishonesty.

195. The Tribunal considered Dr Scott's explanation for his dishonesty. It noted that Dr Scott had said that he acted out of a sense of public duty during the COVID-19 pandemic, stating that he believed seafarers would otherwise struggle to obtain certification. The Tribunal therefore had regard to *'Supplementary guidance on assessing the risk to public protection posed by a doctor where the information relates to their practice during the Covid-19 pandemic.'* This was guidance issued to Tribunals in September 2020. Whilst the Tribunal accepted that the pandemic caused significant disruption, and that medical practitioners might look for innovative ways to provide a service during the COVID-19 restrictions period, it found that this context did not explain the persistence of Dr Scott's dishonest conduct. The conduct had persisted beyond the COVID restrictions in place at that time. The conduct was wholly undermining of the MCA system designed to protect the public. It was found by the Tribunal that if Dr Scott's intentions were to provide a service, that could not explain his on-going dishonesty and could not explain the extent to which his behaviour created a real and separate risk to public health.

196. The Tribunal further reviewed the evidence from 14 April 2020, including a letter that followed a meeting on 7 April 2020 in which his suspension from the Brae practice was confirmed. The Tribunal was concerned that, despite being suspended, Dr Scott submitted many certificates and an annual return in December 2020, falsely stating that he was

operating out of the Brae Practice. The Tribunal found that Dr Scott's dishonest course of conduct in 2020 and 2021 was not driven by altruism.

197. In reviewing the clinical impact of Dr Scott's conduct, the Tribunal noted that of approximately 400 seafarers' assessments conducted by Dr Scott, 39 were dip-sampled and reviewed, and two were found to be substandard. Both involved issues concerning diabetes. It considered this significant, given the potentially serious implications of improperly conducted assessments for maritime safety. The Tribunal accepted the evidence of the expert witness concerning the importance of such examinations being carried out in strict compliance with regulations. He had used uncertified premises and falsely declared that the examinations were conducted at the approved site. The Tribunal regarded this as a serious undermining of a system designed to protect the public. The MCA had issued repeated guidance and warnings and highlighted the importance of adherence to the rules. Dr Scott continued regardless.

198. When considering insight and remediation, the Tribunal found no evidence that Dr Scott had undertaken any steps to remediate his dishonest conduct. Although he had demonstrated some limited insight into XXX, he had not acknowledged the gravity of his dishonesty. There was no written reflection, CPD undertaken, remediation plans, or expressions of remorse.

199. Beyond Dr C's comments about Dr Scott's good character, no testimonials were provided. The Tribunal noted that Dr Scott admitted dishonesty, but that this admission came only after a sustained course of misconduct and under the scrutiny of regulatory proceedings. The Tribunal had regard to paragraph 47 of the SG:

> *"47 The tribunal should be aware that cultural differences and the doctor's circumstances […] could affect how they express insight. For example, how they frame and communicate an apology or regret."*

The Tribunal considered that, although XXX provided some contextual background, they did not displace the obligation to demonstrate insight, nor did they explain the totality of the misconduct.

200. The Tribunal noted paragraphs 52(c) and 53 of the SG:

> *"52 A doctor is likely to lack insight if they:*
>
> *…*
>
> *c do not demonstrate the timely development of insight*
>
> *53 The tribunal should be aware however that cultural differences and the doctor's […] could affect how they express insight…"*

201. The Tribunal reminded itself of its findings on Dr Scott's insight as set out in its impairment determination. It concluded that whilst XXX could contextualise the absence of insight it could not sufficiently explain his failure to develop insight.

202. The Tribunal considered whether the conduct alleged under paragraphs 2, 3, and 4 of the Allegation was capable of remediation. It accepted that, in principle, such behaviour could be remediated. However, at the present time, there was no evidence that Dr Scott had made any meaningful attempt to remediate. The Tribunal bore in mind that the conduct had been denied. The contextual factor advanced for paragraphs 3 and 4 was XXX.

203. The Tribunal considered this context carefully it found that it was the persistent dishonesty that was the matter that caused the most concern and the issue that was the most serious. It considered that the dishonesty, combined with the absence of remediation or insight, posed a continued risk to public confidence and patient safety, amounted to a serious failure to adhere to professional standards, and weighed heavily in the Tribunal's assessment of sanction.

204. The Tribunal went on to consider sanction in order of the least serious first.

No action

205. In reaching its decision as to the appropriate sanction, if any, to impose in Dr Scott's case, the Tribunal first considered whether to conclude the case by taking no action. Taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

206. The Tribunal determined that the seriousness of its findings required the imposition of a sanction. It determined that there were no 'exceptional circumstances' in this case and it would not therefore be sufficient, proportionate or in the public interest to conclude this case by taking no action.

Conditions

207. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Scott's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable.

208. It had regard to paragraph 81 of the SG which states:
"81 Conditions might be most appropriate in cases:

a *[…]*

b *involving issues around the doctor's performance*

c where there is evidence of shortcomings in a specific area or areas of the doctor's practice

d where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision."

209. Whilst the Tribunal recognised that paragraph 81 did not exhaustively limit the circumstances in which conditions might be appropriate, it considered that the dishonesty in this case elevated the seriousness to one in which conditions would be neither appropriate, proportionate nor, indeed, workable.

210. The Tribunal considered that conditions would also be inappropriate and insufficient to meet the public interest and to maintain proper professional standards of conduct for members of the profession. Accordingly, the Tribunal determined not to impose conditions on Dr Scott's registration.

Suspension

211. The Tribunal next considered whether it would be appropriate to impose a period of suspension on Dr Scott's registration. In doing so, it had regard to the paragraphs 91, 92 and 93 of the SG:

"91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e. for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions."

212. The Tribunal considered that Dr Scott's conduct represented a serious departure from the principles set out in *GMP*, particularly those concerning honesty, integrity, and the maintenance of public trust. However, the Tribunal determined that the paragraphs of SG set

out above concerning suspension, did not adequately reflect the overarching objective in the context in this case.

213. In assessing whether suspension was sufficient, the Tribunal considered paragraphs 97(e) and 97(g) of the SG.

> *"97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> *…*
>
> *e No evidence that demonstrates remediation is unlikely to be successful, e.g. because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> *g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.*

214. It found that there was not sufficient evidence that Dr Scott had demonstrated insight into his dishonest behaviour, and that there had been no significant steps taken to remediate the misconduct. While it was noted that there had been no repetition of the dishonesty since the events in question, the Tribunal considered that this fact alone was not sufficient, particularly in the absence of any evidence of sufficient reflection and remorse.

215. The Tribunal acknowledged that Dr Scott had addressed XXX and had continued to XXX. However, it concluded that XXX did not explain the persistent dishonesty over an extended period, and that the XXX context did not mitigate the gravity of the misconduct. The Tribunal also noted that, despite partial admissions during the proceedings, Dr Scott had not demonstrated insight into the impact of his behaviour on public trust, nor had he provided any evidence of steps taken to ensure there would be no recurrence.

216. Having carefully considered the relevant factors, the Tribunal determined that although suspension may, in other circumstances, be an appropriate response to serious misconduct, the absence of insight, the lack of remediation, and the persistent nature of the dishonesty weighed against it in this case. The Tribunal therefore concluded that it was necessary to consider whether erasure was required in order to satisfy the overarching objective.

Erasure

217. The Tribunal had regard to the relevant paragraphs of the SG, beginning at paragraph 108. The Tribunal noted that the misconduct in this case involved persistent dishonesty over an extended period and concluded that the guidance at paragraph 109(a) was engaged. Dr Scott had submitted a false declaration in December 2020, stating that he was conducting seafarer examinations at an approved practice, when he knew that was not the case. This occurred approximately eight months after the first dishonest act and was followed by further acts of dishonesty for some months, demonstrating a sustained course of

misconduct. The MCA regulations had been deliberately by-passed for reasons that were not explained by Dr Scott.

218. The Tribunal also considered paragraph 109(j), which notes that XXX may be a relevant contextual factor. The Tribunal accepted that Dr Scott had XXX during the relevant period, and that this provided some context to his behaviour. However, it concluded that XXX did not adequately explain the repeated and deliberate acts of dishonesty, nor did they provide a justification for submitting false documentation or circumventing safety-critical procedures.

219. The Tribunal had regard to paragraphs 120 to 128 of the SG. It had particular regard to paragraphs 120, 125(e), and 128, as above, and considered they were engaged in this case.

220. The Tribunal had particular regard to the importance of the seafarer certification process, which exists to protect public and maritime safety. It found that Dr Scott's conduct had undermined that regulatory framework and had the potential to place both individual seafarers and the wider public at risk. Dr Scott's dishonest behaviour represents a serious breach of trust seriously undermined public confidence in the profession.

221. While the Tribunal gave appropriate weight to Dr Scott's previously unblemished record of over 30 years, it found that this mitigating factor did not outweigh the seriousness of the misconduct. The Tribunal could not establish a motivation for Dr Scott's behaviour. It considered that the persistence and deliberateness of the dishonest conduct, together with the lack of insight, rendered the dishonest conduct incompatible with continued registration.

222. The Tribunal was satisfied that erasure was necessary and the only proportionate sanction which would uphold the overarching objective, specifically to maintain public confidence in the profession and to promote and uphold proper professional standards and conduct.

223. Accordingly, the Tribunal determined that Dr Scott's name should be erased from the Medical Register.

Determination on Immediate Order - 19/06/2025

224. Having determined that Dr Scott's name be erased from the Medical Register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

225. On behalf of the GMC, Mr Brook referred the Tribunal to paragraphs 172 and 173 of the Sanction Guidance (the SG). He submitted that an immediate order is necessary to protect the public, weighing the public interest against the interests of Dr Scott.

226. On behalf of Dr Scott, Ms Claire Raftery stated that she did not oppose an immediate order.

The Tribunal's Determination

227. In making its decision the Tribunal had regard to the SG, including paragraphs 172, 173 and 178:

> *'172. The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173. An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> *178. Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'*

228. The Tribunal has considered its findings at the impairment stage with regard to the risk of repetition that Dr Scott poses to potential patients and to the wider public interest.

229. In all the circumstances, the Tribunal determined to impose an immediate order of suspension on Dr Scott's registration. The Tribunal concluded that this was appropriate and necessary and was required to protect the public, maintain public confidence and uphold proper standards of conduct and behaviour.

230. This means that Dr Scott's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

231. That concludes this case.

SCHEDULE 1

Schedule 1 Item number	Certificate Serial number	Date	XXX
1	XXX	4/5/20	XXX
2	XXX	6/5/20	XXX
3	XXX	3/6/20	XXX
4	XXX	3/6/20	XXX
5	XXX	3/7/20	XXX
6	XXX	3/7/20	XXX
7	XXX	3/8/20	XXX
8	XXX	3/8/20	XXX
9	XXX	1/9/20	XXX
10	XXX	1/9/20	XXX
11	XXX	1/10/20	XXX
12	XXX	1/10/20	XXX
13	XXX	2/11/20	XXX
14	XXX	3/11/20	XXX
15	XXX	1/12/20	XXX
16	XXX	1/12/20	XXX
17	XXX	7/1/21	XXX
18	XXX	15/1/21	XXX
19	XXX	1/7/21	XXX
20	XXX	4/2/21	XXX
21	XXX	5/3/21	XXX
22	XXX	3/3/21	XXX
23	XXX	10/5/21	XXX
24	XXX	2/5/21	XXX
25	XXX	2/4/21	XXX
26	XXX	2/4/21	XXX
27	XXX	10/3/21	XXX
28	XXX	15/12/20	XXX
29	XXX	26/2/21	XXX
30	XXX	15/12/20	XXX
31	XXX	17/2/21	XXX
32	XXX	18/12/20	XXX
33	XXX	9/2/21	XXX