FIRST TIER TRIBUNAL CASE NO PHL/15462

HEALTH EDUCATION AND SOCIAL CARECHAMBER

PRIMARY HEALTH LISTS

DR COLIN MARTIN

AND

HAMPSHIRE PRIMARY CARE TRUST

Tribunal

John Burrow – Judge

Dr Elizabeth Walsh – Heggie – Specialist member

Merula Frankel – Lay member

1. The Tribunal sat at the Havant magistrates Court on 10 – 13 and 18 – 20 September 2012. The case concerned an appeal under Regulation 15 of the NHS (Performers List) Regulations 2004 by Dr Martin against his removal from the medical performers list on the ground of unsuitability. Dr Martin was represented by Mr Dennis Matthews instructed by RadcliffesLeBrasseur. The PCT was represented by Michael Mylonas QC instructed by Messrs Weightmans.
2. The bundle ran to some 557 pages containing inter alia legal submissions, witness statements and exhibits, correspondence, expert witness statements and joint expert report, references, police interview, appraisal, Patient notes and statutes. The PCT called 4 Patients who have been initialised in this determination part of the decision –

Patients A-D, and 5 staff members three of whom are complainants and have been initialised E – G. A patient who was a witness for Dr Martin has been initialised as patient H. The PCT's expert witness was Dr Felicity Shaw. Dr Martin gave evidence himself and called Patient H. His expert was Dr Hicks.

Background

3. Dr Martin graduated at Southampton University in 1990 and took postings in Southampton and Winchester Hospitals. After some locum work he started as a GP Registrar in the Health Centre in Alton in 1995. In 1995 he obtained the postgraduate Diploma of the Royal College of Obstetrics and Gynaecology. As well as working as a GP he has undertaken sports medicine and has taught medical students, and worked as a Dermatology Clinical Assistant at St Mary's Hospital in Portsmouth Hospital and other hospitals.
4. In March 1997 he became a partner in Lockswood Surgery, a five partner practice near Southampton. After disagreements with one of the partners, and some personal problems he resigned in March 2007. Dr Heal suggested the partners were not happy with his ability to handle the work load. In November 2007 he joined Bursledon Surgery as a partner. This was a two partner practice where he worked part time for five sessions a week. In November 2007 he joined the Hampshire PCT Medical Performers List (MPL). In 2007 he began work as a locum at Blackthorn Health Centre in Hamble, in a practice known as 'The Centre', for three sessions a week, until 29 March 2011.
5. Sharing the same premises as the Centre Practice was the Fareham Health Centre practice, which also had premises at the Highland Roads Medical Centre. Dr Martin did occasional locum sessions at Fareham Health Centre.
6. On 29 March 2011, a female Patient D made a complaint against Dr Martin to the practice manager of the Blackthorn Surgery concerning alleged inappropriate behaviour during a consultation. This complaint was sent on to the PCT. On the 19th May 2011, the PCT suspended Dr Martin from the MPL, and the matter was referred by the PCT to the police and the GMC.
7. Between 25 May 2011 and October 2011 the PCT were made aware of three further allegations of inappropriate behaviour by Dr Martin with Patients during consultations and three allegations of inappropriate behaviour towards staff members, said to have occurred between 1997 and 2011. These matters also were referred to the police. Statements were taken from a number of the complainants by the police and Dr Martin was interviewed on 28 July 2011. On 18 October 2011 the police confirmed Dr Martin would not be charged with any offence.
8. In June 2011 an incident occurred affecting Dr Martin's health and he was admitted to hospital until early July 2011. On 28 June 2011 the GMC Interim Orders Panel imposed conditions on Dr Martin's practice, including a requirement to be chaperoned

during any consultation with a female Patient. These conditions were confirmed at a subsequent review by the IOP on 7 December 2011.

9. On 17 January 2012 the PCT's Contractor Performance Panel removed Dr Martin from the Medical Performers List pursuant to Regulation 10(4)(c) of the 2004 Regulations on the ground of unsuitability. Owing to solicitors not being notified, Dr Martin was not present or represented at that hearing.
10. On 16 February 2012 Dr Martin appealed under Regulation 15 of the 2004 Regulations against his removal from the Medical Performers List claiming procedural irregularities, and that the PCT was wrong to remove him from the list. The PCT responded to the appeal on 12 March 2012, denying their decision was wrong.

<u>The allegations</u>

11. The allegations, Dr Martin's response to them and the evidence of the experts for the two parties, Dr Hicks and Dr Shaw, are set out below. The allegations are dealt with in chronological order.

<u>Patient A</u>

12. Patient A was a Patient at Lockswood Surgery in August 1997. She was expecting her first child and she attended Dr Martin for her first ante natal consultation on 20 October 1997. After a conversation with her sister she was not expecting any intrusive examination, merely to register with him.
13. Dr Martin informed her he would carry out a breast examination to check for lumps. She said Dr Martin asked her to sit on the examination bed and take her top off, but not her bra. He stood in front of her between her legs. Her bra straps were half way down between shoulder and elbow, but she could not recall who had done this. She thought her breasts were still in her bra, and the cups may have been down a bit, although she couldn't remember details. He put his hand inside her bra feeling one breast and did the same with the other.
14. He was not, as she put it, "prodding" or 'probing' for lumps. She later said she could not recall if he used the flat of his hand. She thought the examination was unusual because she would expect a breast examination to take place when she was lying down, and that the examiner should press around with the flat of his hand. She also felt the examination was too quick. However she also said she had never had a breast examination before. The Patient reported being shocked and later, that she felt uncomfortable and embarrassed. She discussed it with her mother and sister who felt she should not report it and she did not at that time.
15. The Patient developed gestational diabetes and thereafter her pregnancy was managed by the Obstetrics Department at the local hospital. After the birth she became depressed. There were family difficulties including a fear of becoming homeless and her husband had problems with his job. She saw Dr Martin on 3 July 1998, and she

was crying quite a lot. She described Dr Martin as being pleasant and congratulatory about the birth and he explained hormonal changes were occurring. She explained in detail the difficulties with the birth and the baby, although she did not remember discussing marital difficulties at home. She described herself as 'quite distressed.'

16. She said Dr Martin rolled his chair over to her and put one arm around her shoulder while she was crying a lot. He then asked about her relationship with her husband, asking if she still loved him. She thought this question was bizarre and odd, and she left shortly afterwards. She later moved from the area to Staffordshire.
17. After the consultation she spoke with female friends who told her they had not had a breast examination when pregnant. She said she did not have a breast examination during her second pregnancy. In 2011 she heard through a friend of a friend who was still registered at Lockswood Surgery, Patient C, that she had been interviewed by police about an examination by Dr Martin. She subsequently reported the matter to police herself.
18. She said even to this day she does not know if the breast examination was appropriate or necessary, although once she heard of the police involvement she says she thought he took advantage of her, and of the position of trust he was in. She did not think it was appropriate of him to question her about her relationship with her husband or whether he loved her. She also said Dr Martin had failed to diagnose post natal depression, which she says, was only finally diagnosed after she moved to Staffordshire.
19. In cross examination she was taken to her Patient notes, which showed a number of consultations during 1997 and 1998 both before and after the birth. She said she had difficulty remembering definite details. There was no entry in the Lloyd George notes of a breast examination on 20 October 1997. However she thought she may have had a booklet with records of her treatment after the midwife was involved but she was uncertain.
20. The Patient notes show Dr Martin did diagnose post natal depression on 3rd July 1998 after the birth and issued a prescription for Prozac, although she did not remember this. There is an entry for this appointment referring to "husband – work stresses". A repeat prescription was issued, but the Patient said she never took any of the medicines prescribed by Dr Martin. On 11 August 1998 an entry suggested her presentation was better. She did not remember seeing Dr Martin during this period, although she accepted he was pleasant to her and took time with his consultations when he saw her. She also accepted that after the birth in early July 1998, Dr Martin asked how things were at home.
21. She had never subsequently had a doctor put an arm around her or ask about her husband. She said she continued to see Dr Martin after the incidents because she was under stress and quite ill. Her Patient notes indicate that after the move to Stafford she saw her new GP on 21 December 1998. In this entry there is a reference to Prozac 3/12, entered at a point in the notes where the history of the Patient is being considered. This might suggest she had been taking the medicine for 3 months at the time of this appointment.

22. Dr Martin's account was that during training at the Obstetrics –Gynaecology Department at Winchester Hospital he was taught to examine breasts during first pregnancy check-up, as a base line test. Later, some five years ago, advice changed to suggest routine breast examination was no longer necessary. In the period between, he was questioning the necessity of breast examination, and in low risk Patients his examination became quite cursory. He said the examination of Patient A was nearly 15 years ago and with the lapse of time he could no longer remember it. It was his normal practice to have the bra removed, although it was possible he performed a breast examination with the bra on, possibly slipped down a bit.
23. Examination may have been cursory as there was no presenting lump. He normally examined the breast in quadrants with the flat of his hand, and would normally make an entry in the Patient's notes. He performed his breast examinations with the Patient sitting up. There was no record in the Lloyd George notes but where there were no negative findings, a note might not be made or alternatively it might be made in the Patient's own ante natal notes, which they were given to retain themselves in those days after the midwife was involved at the 12th week. The midwife would have been contacted after the appointment on 7th October 1997. Dr Martin denied any sexual motivation for the breast examination.
24. Dr Martin agreed from the Lloyd George Patient notes, he had seen her on four occasions in 1997 and probably seven times in 1998. He did not specifically remember the consultation on 3 July 1998, but he noted the reference to mastitis, crying and "low", and husband work stress, and that he had diagnosed PND. He said in these circumstances it would be appropriate and necessary to ascertain the level of support at home, including her relationship with her husband which might be relevant for diagnosis. It was possible he put an arm around her if she was crying quite a lot, but there was no sexual intent. There were several doctors available at the LOckswood Surgery and Patients could specify which doctor they wished to see.
25. He thought the reference to Prozac 3/12 in the entry of 21.12.98 was to a past history of medication, not a prescription for future treatment, which would be put at the bottom of the entry. Further it would be unlikely Prozac would be prescribed initially for as long as three months as a GP would want to keep the Patient under review. Dr Hicks agreed with this analysis.
26. In cross examination he was asked why if the examination was a base line examination he had not written it in the Lloyd George notes and he accepted that it would have been better if it had been but it might be in the Patient's own notes. The examination was cursory but it would have been more complete if there had been a report of a lump. He said her relationship with her husband including whether he loved her was relevant as he was trying to elicit the correct diagnosis. He also needed to ascertain following the difficult birth of her child, whether she had a good support network at home, including her husband and family members close by to help. He accepted it was inappropriate she had been upset by the question.
27. Dr Hicks and Dr Shaw in their joint report agreed a breast examination should be recorded, and that for proper examination the bra should be removed, although they

accepted that with some bras it may be possible to expose the breast by folding down the bra cups. Dr Hick's researched the literature and found in Obstetrics Illustrated published in 1980, that examination of the breast at the first antenatal examination was advised. In the 'Fundamentals of Obstetrics and Gynaecology' published in 1977 it was said a breast examination will be carried out at the initial examination. In the NICE publication on antenatal care for March 2008 it was said routine breast examination is not recommended.

28. Thus the advice had changed over the years. Dr Hicks said in the 1970s a breast examination was considered appropriate to assess the likely success of breast feeding and to assess risks of breast cancer. This approach was not questioned until 1999 when the Chief Medical Officer advised that GPs should question whether a breast examination was necessary. There was considerable debate on this issue at the time. In 2008 NICE guidelines said a breast examination was <u>not</u> necessary. Dr Shaw accepted these findings in her oral evidence.
29. Both experts agreed that a breast examination should be recorded in the GPs notes or on the Patient's own obstetric notes given by the midwife and carried by the Patient, or on the co–op card kept by the GP with the Lloyd George notes. Both experts agreed a GP should use the flat of the hand to perform a breast examination and prodding or probing was not appropriate. Both experts agreed that if a breast examination was performed it should be performed adequately and not quickly. Both agreed a breast examination can be performed either lying down or sitting up. Both accepted it would be appropriate to ascertain details about family support where a client was emotionally distressed.

<u>Patient B</u>

30. Patient B is a health care support worker who was a Patient at Bursledon Surgery for a number of years. The Bursledon practice has two doctors, one of whom, from November 2007 was Dr Martin. In April 2010 the Patient suffered medical difficulties which placed stress on her. Furthermore she was seeking to have a child, resulting in an ectopic pregnancy and related surgery on 7 July 2010 which was a life threatening incident for her. Her husband had been made redundant and was involved in setting up his own business, restricting the time he had available for support to be given to the Patient.
31. In August 2010 Patient B had an appointment with Dr Martin, at which these matters were discussed. She was crying heavily. At the end of the consultation, when the Patient had calmed down and stopped crying and was about to leave, Dr Martin stood face to face with the Patient and gave her a two-armed hug, one arm at shoulder height and one at lower back height, and a brief kiss to the cheek. The whole incident lasted some two seconds. The Patient shrugged and Dr Martin let go. The Patient said the hug and the kiss had happened at a single consultation.

32. No complaint was made on that day and she said she did not discuss it with anyone, but some two weeks later on 16 August 2010 she reported the incident to the surgery's practice manager. On 17 August she met the practice manager who later that day and the following day made a note of the meeting. That note, which the practice manager told the Tribunal in her evidence was an accurate record, indicates the Patient referred to incidents which happened on two separate consultations, with the hug on the first, and a hug and a kiss on the cheek on the second. She said she had discussed it with her husband. She referred to Dr Martin as a 'brilliant doctor' whom she liked and who had been 'so good with her'. But she said that she was not sure his actions were appropriate and she felt uncomfortable about the incidents.
33. She asked the practice manager (PM) if there had been other similar complaints about him and it was confirmed there had not been. It was agreed the PM would speak to Dr Martin, which she did on 18th August 2010. The Patient said the PM described Dr Martin as tactile and caring. The PM reported Dr Martin as looking embarrassed, shocked and upset that he had upset the Patient. The PM described herself as 'telling off' Dr Martin and that they talked about the actions being inappropriate, and that they could be misinterpreted. Dr Martin said he would call the Patient which he did later that day, the PM having confirmed in the earlier conversation this was acceptable to the Patient.
34. The Patient described Dr Martin as being extremely apologetic, saying he had not intended to make her uncomfortable, merely to console her. The Patient said to Dr Martin that she considered the incident was inappropriate, and could be misinterpreted. As an employee of the NHS herself, she suggested that the question of boundaries should have been drummed into Dr Martin early in his career. She said that he should update his knowledge and for his own protection adjust his practice. If his actions were a mistake he should take steps not to do it again. A handshake was more appropriate. She said in her statement she was confused about the incident. She said he did not challenge anything she had said. During this conversation she asked if it was alright to continue to see him because she wanted continuity of care, and she did continue to see him on a number of occasions.
35. There was some uncertainty about the precise date or dates of the incidents. The Patient notes indicated she saw Dr Martin on 2nd August 2010 when she was 'tearful' and with abdominal pains. Although in her statement she thought Dr Martin had prescribed anti-depressants on that day, the Patient notes showed this was not the case until October 2010. She saw him again on12th August 2010 when she was reported to be feeling better and ready to go back to work. She saw him or spoke by phone subsequently on eight times in 2010 and on further occasions in 2011.
36. In her oral evidence she remained uncertain of the exact date the incidents happened, although she confirmed they had happened during one consultation and not two. She said she was not in fact better by 12 August 2010, but told Dr Martin she was as she felt under pressure to return to work.
37. She accepted Dr Martin always gave her time to talk, but she said that to hug a Patient crossed professional boundaries, although to this day she did not know how to

interpret Dr Martin's actions. She had expected the matter to have been discussed by the practice manager with senior members of staff. She denied saying to the practice manager there were incidents in two separate consultations.

38. Dr Martin said he recalled the consultation, which included long discussions about the ectopic pregnancy and work-related issues. She was upset and intense. She came in with a physical problem, abdominal pain, but it became clear there were emotional difficulties also. It was necessary to ask questions to determine the problem as he did with many Patients. He had no recollection of a kiss on the cheek but accepted in evidence the accuracy of the Patient's description of what happened. He said he had given her time, empathy and advice during the consultation, but denied any sexual intent. In consultations afterwards she continued to discuss personal matters in depth and at length. Patients could select who they wanted to see, although it was only a two partner practice.
39. In cross-examination he accepted he was wrong to have given a hug and a kiss on the cheek. He did not recall the hug as it was not significant to him at the time. He has up to 30 consultations a day and cannot remember how he greets Patients, but he now accepts hugging is inappropriate. He had phoned her shortly afterwards and apologised. He took what she said on board. He did not accept he had lost control with Patient C (another complainant) 5 weeks later, although he accepted he had not met his assurance to Patient B.
40. The experts agreed a two-arm hug and a kiss were inappropriate, and to cause fright, distress and upset by these actions was unacceptable. Dr Hicks said such hugs and a kiss on the cheek should not happen, but it might be a normal human reaction in certain situations. He noted Dr Shaw's quote in her report that a guideline is physical touching should only take place 'at the instigation of, with the permission of and for the benefit of that person.' Dr Hicks said this was not a guideline, merely an opinion. He said the whole point of physical contact was to show empathy with the Patient, and this required spontaneity. To ask first might be insulting.
41. In his report he said while a sexually motivated touch or one for the doctor's benefit can never be appropriate, 'Physical contact and gestures of warmth between doctor and Patient, in which the doctor is attempting to demonstrate empathy, sympathy, comfort or reassurance towards a Patient who is emotionally upset and distressed is a normal human reaction and can be appropriate. He said there is little specific guidance in the area. 'It is always possible for individual Patients to wrongly interpret motives on the part of a doctor who engages in direct physical contact not specifically for the purposes of examination.'

Patient C

42. Patient C was a Patient at Blackthorn Health Centre (also known as The Centre) since 1993. On 21st September 2010 she attended a consultation with Dr Martin for the first time. She asked for a general check-up because of her personal and family history

including blood pressure and cholesterol, but went on to explain about difficult family circumstances she had encountered recently, including the death of her father and brother having been recently diagnosed with cancer and illness of her mother-in-law. She described herself as emotional and anxious, with a family history of cancer. She said Dr Martin showed a caring nature and listened carefully and was very attentive. She was impressed with his demeanour.

43. Dr Martin took her blood pressure, asking her to take her top off. This she did, leaving her vest on. Then he asked how her partner had been during the difficulties and she told him he had not been as supportive as she might have hoped. She thought at that stage he was trying to get the overall picture. Then Dr Martin said, 'So you're looking for a knight in shining armour.' The Patient considered this remark was inappropriate and flirtatious and she replied that she was not, and that that would be out of the frying pan and into the fire so far as she was concerned. She thought he was possibly looking for 'a bit of a relationship'. She then described Dr Martin giving her a pep talk, saying she should not let people put her down and that she was lovely. She thought to herself that she did not need that sort of reassurance, but that possibly he was being holistic.
44. The Patient and Dr Martin then stood up and were quite close and Dr Martin gave her a hug with both arms around her upper back. This lasted for about five seconds. She pulled away without saying anything, but he pulled her back for another hug for 3 – 4 seconds and gave her a peck on the cheek. Again she did not say anything but thought to herself this was a stage too far, and that she was not sure about it. She described it as a bit odd. She did not feel threatened, but felt confused and after the second hug uncomfortable. She thought he was a man who was unhappy with his personal life, possibly giving an illusion of trust, but that if it followed on he might ask her for a date.
45. As she left the surgery Dr Martin said to her, 'I'm concerned about your marriage,' and she said, 'Let me worry about that.' She said she did not consider that as any concern of his. She thought she did not need this type of consolation. She said that after the consultation she was confused and unsure about what happened and that he may have just been kind and attentive. Later she thought he had been manipulative, that he had twisted matters, and the hug was not about her, but about Dr Martin. She could not declare his motive was sexual, but she did not know where it would have gone. The kiss on the cheek tipped it over for her, she did not accept he was merely consoling her. The consultation lasted some 25 minutes. The Patient notes showed she was going through a difficult time. She decided she did not want to see him again.
46. In his evidence Dr Martin accepted the Patient's account of two hugs and a kiss on the cheek although he had no clear memory of it. He had no memory of referring to a knight in shining armour, and if this was said, did not refer to him, nor was it flirtatious. If he had said it, he was merely attempting to be empathetic. He was seeking information as to whether she had a suitable support network.

47. The hugs and the kiss were meant as a sympathetic gesture and were not sexually motivated. He did not know the Patient, but it was necessary in a case such as this to investigate underlying emotional issues, and to obtain a detailed history. He had not made any attempt to follow up or contact the Patient after the consultation.
48. The expert witnesses agree that a second hug and a kiss on the cheek was inappropriate, and that causing upset and distress in this way was not acceptable. The experts agreed that the methodology for taking blood pressure was clinically appropriate.

<u>Patient D</u>

49. Patient D was a Patient at Blackthorn Health Centre for some 13 years. She saw Dr Martin who was a locum at the practice on several occasions and on 29th March 2011 she saw him about varicose veins. This was Dr Martin's last day at the surgery and Patient D was told as much by the receptionist. When the consultation began the Patient made a point of saying she was sorry he was leaving and that it was sad to lose a good doctor. Dr Martin had treated her husband successfully and she said in her statement that he had given him good service. She said in evidence he spent time with his Patients and was impressed with him.
50. Dr Martin also referred to the fact that it was his last day, and that he was feeling emotional. Dr Martin then mentioned he has a surgery in Bursledon, a nearby practice, and that Patient D would be welcome to be his Patient there. She declined saying she was settled, but would bear it in mind. He said there was no pressure and it was just an option. He then inspected her varicose veins in her right leg. He asked her to stand and she rolled up her skirt to her waist to allow him to inspect the affected areas which she said ran from her calf to the back of the knee to the groin area.
51. In her evidence she said he worked his way down the leg. She thought at one stage he was inspecting a part of the leg which did not have varicose veins. At one stage also she said he appeared to be running both hands up her thigh from the top of the knee to the top of her thigh. When his hands were at the top of the thigh he seemed to hold her. She said there was a fleeting moment when he looked up at her 'into her eyes' as she put it. She felt this was inappropriate and not a doctor/Patient situation and she tensed up for a split second. She said other surgeons who had inspected her varicose veins only used one hand.
52. The Patient then described him removing his hands and sitting down at his desk. He inspected her verruca without complaint. The Patient said at this stage she felt she must have imagined things and she felt silly. She stood up to leave and again said she was sorry to see him go and wished him luck. He reminded her that she was welcome to join his surgery and again she declined saying Blackthorn was her local surgery and it was a matter for the PCT. He said it was at the doctor's discretion and he would welcome her. She then reached out her hand to shake his. She then said Dr Martin extended his hand and took her hand in his. She said he was trembling. In cross

examination she said he then 'came forward' and 'came in closer' towards her until they were quite close. She said he raised her hand to about the level of her chin. She believed he was going to kiss her hand, but she cannot recall him doing so. She felt the action of raising the hand to kiss it was inappropriate.

53. Dr Martin then hugged her with both arms around her shoulders. She had her arms bent and fists clenched against his chest, pushing him away. She thought to herself she was married with a husband and she could not do this. She remembered the 'just say no' campaign at school. She thought he was coming on to her, that he was going to kiss her or force himself on her in some way. She said this was her perception although it may have been panic. She said out loud, 'I can't do this,' repeating it several times. She was concerned about difficulties of an escape route, and whether she should scream.
54. Then he let go and went to the corner in the far side of the room. She said, 'I can't emphasise this enough – he looked completely and utterly confused and baffled. He just stood there and looked at me in a bemused fashion.' She said, 'He looked terrified, gobsmacked with big eyes. He didn't have a clue.' Dr Martin said, 'What's the matter? What did I do?' The Patient replied, 'You just frightened me.' Dr Martin said, 'How? What did I do?' She said, 'I wasn't expecting that. I've never been hugged by a doctor before.' He said, 'Really?' and the Patient said, 'Look, I'm sorry but you really frightened me.' He asked what she was frightened of. He didn't seem to understand why what he had done was wrong or why the Patient felt the way she did. The Patient believed he should have known what he had done wrong.
55. Dr Martin then said he was really sad to be leaving the surgery, that he had really enjoyed working there, that the Patient had said such nice things about him when she arrived, and he was feeling very emotional and wanted a hug. The Patient said at this stage he looked 'like a little boy lost'. She said he looked hurt at the suggestion he had frightened her. This had the effect of making the Patient feel guilty for causing this state of mind in him, and that she had misjudged his feelings. She apologised profusely to Dr Martin and said she did not realise he was feeling so emotional, and that she was genuinely sorry.
56. He then hugged her again and she said this second hug was 'totally her doing'. She was effectively begging him for his forgiveness. She believed she had precipitated the second hug by her own response. At this stage she said she was calm and warm and trying to make him feel comfortable and better. She said 'he needed bringing back down in the room.'
57. She said the second hug lasted just seconds and she was not held tightly this time. He put his hands flat on her back and rubbed her back gently. He whispered, 'This is a nice hug.' He let go, the Patient thanked him and wished him good luck and she left. By now she was not happy to be in the surgery. She was upset and 'shaking like a leaf.' She said, 'they had gone from one place to another.' She drove unsteadily out of the car park and went to a neighbour's house because she did not want to be alone, but later went back to her house to change her clothes.

58. Later that day Dr Martin rang her at her home. Dr Martin had intended to refer her to a consultant vascular surgeon for treatment of her varicose veins. This might either be a private consultation, depending on her insurance, or via the NHS. He needed to write a letter of referral and to do this he needed to know the name of the Patient's consultant and the insurance company. She had agreed to come back to the surgery with the information. She had not been back and Dr Martin phoned her for the information. He was described by the Patient as polite and caring, although she was surprised to hear from him. At the time of the phone call she did not have the information available and said she would leave it at the reception. He went on to ask what it was she had been frightened of in the surgery. The Patient thought this was an inappropriate question – he should have known. She did not want to hear from him again.
59. She found the name of the consultant and phoned it through to the surgery reception. About 10 minutes later Dr Martin phoned again, saying he had received the information about the consultant and would write the referral letter that day. He went on to again invite her to join his surgery, and again to ask what had frightened her. He then apologised for frightening her. He was polite and well-mannered. He said he never intended to frighten her, and no one had reacted that way before. He said he was surprised she had never been hugged by a GP before. The call ended soon afterwards and she has not seen or heard from him again.
60. The Patient said she thought the second call in particular was obscure. She felt it was a damage limitation exercise, to avoid the matter being taken further. The Patient said she would not take it further – to end the conversation. She felt he should have done more to reassure her. She said a GP should not put an arm around a Patient. It may have been a chance for him to be close to her, but she may be completely wrong about this. Since the incident she has had anxieties and felt vulnerable and has not wanted to be alone in the house. She was worried he might come to the house, although she said this might just be in her head. She said things are getting better now. She reported the matter to the practice manager at the surgery the following day, and later on 1st April 2011 met the practice manager and a partner of the practice. The incident was subsequently reported by the practice to the PCT by letter dated 8th April 2011. Subsequently on 13th May 2011 the Patient met with the partner, the practice manager and a representative of the PCT where the incident was discussed.
61. Dr Martin described his feelings on 29th March 2011. He was leaving on a high, with Patients having said nice things to him. It was a joyous occasion for him and a surprise lunch had been planned. In his evidence he referred to the Patient notes. It was apparent the Patient had seen him on 18th June 2010, about her varicose veins. This was some 9 months before the incidents of the hugs on 29th March 2011. On 21st June 2010 she was referred to a consultant vascular surgeon for treatment of her varicose veins, but treatment was not proceeded with. He said that on the 29th March 2011 the Patient had referred to continuity of care, that he had treated her and her family well, and that he then mentioned his surgery down the road. The Blackthorn and Bursledon surgeries over lapped geographically, and she could go to either. He

did not remember mentioning the matter again later and denied trying to persuade her to join.

62. He said that an examination for varicose veins required the veins to be palpated along their length using two fingers. This would include investigation of areas where no varicose veins were visible to ascertain the extent of the problem. As he was palpating the vein he would look at the Patient's face to see if there was pain. The examination could be carried out either up or down the leg, normally with one hand, although a second hand may be used to steady and support the leg.
63. On the 29th March 2011, after the examination, he discussed with the Patient whether she had private insurance cover. The NHS was unlikely to provide treatment unless the veins were inflamed or painful. She was uncertain if she had insurance, but said she would provide the information so a referral letter could be drafted. He did not recall taking the Patient's hand intending to kiss it. It was not the sort of gesture he did. He was grateful for the Patient saying nice things about him and it had been an emotional morning. He accepted he gave her a hug, which might have been two handed. He was aghast at the Patient's reaction, and that he had frightened her.
64. He phoned the Patient to ascertain if she had private insurance so he could draft a referral letter that day, tying up loose ends before he left. He heard later she had phoned in with a message that she was privately insured, and Dr Martin dictated a referral letter that afternoon. He said he did sometimes hug Patients. In cross examination it was suggested he had not made an adequate record of the findings of his examination on 29.3.11. Dr Martin said it was enough to write a referral letter on that day when matters were fresh in his mind.
65. It was noted there was no reference to the examination of 29.3.11 in the referral letter. Dr Martin said the letter was adequately detailed for a private referral. The diagnosis of varicose veins was confirmed. The examination on 29.3.11 was essential to exclude treatment options of antibiotics and/or anti-inflammatory tablets and to enable him to prepare the referral. There was a mention in the notes of the examination he had carried out. He denied he was trembling because he was rubbing his hands on her leg, and he denied he was raising her hand to kiss it. He did not recall the Patient declining the suggestion to move surgeries. It was just an offer to change, not that he wanted her to. He had done this with other Patients. He confirmed there were medical reasons for the phone calls and denied it was a damage limitation exercise or that he was trying to get her to agree not to take it further. He knew he had upset the Patient and wanted to apologise. He needed to discuss the protocol for private referral on the second phone call.
66. In cross examination he accepted he had in the past given hugs on occasion to Patients. He said he now understood hugs and kisses on the cheek must never form part of a consultation and regretted giving the hugs to Patient D. The experts jointly agreed that either one or two hands could be used for a varicose veins examination, and that it was appropriate to briefly look at a Patient's face for signs of pain or tenderness. They agreed a two handed hug and an attempt to kiss a hand would be inappropriate. They agreed that the second hug as described by the Patient was

inappropriate. They agreed it could be appropriate for a phone call to be made to ascertain the name of a consultant vascular surgeon, or to ascertain if there was private insurance, although the Patient's distress made it inappropriate in this case. It may have been prudent to discuss the incident with a colleague. It would generally be inappropriate to encourage a Patient to change surgeries to one the GP had a financial interest in, although if the Patient was concerned about continuity of care, providing information about his nearby surgery would not be against the Patient's interest. The distress as described by the Patient was unacceptable.

67. Dr Hicks said it was appropriate for Dr Martin to re-examine a Patient some nine months after an earlier varicose vein examination. This was necessary to reacquaint the GP with the Patient, and to check if the condition had worsened. He said the methodology of the examination carried out by Dr Martin was appropriate to find the extent of the varicosity, inflammation or perforated vein. He considered it was appropriate to examine the Patient from the front. Either one or two hands can be used, and may go up or down the vein, and may be repeated. It was inappropriate for the GP to hug a Patient for his own benefit.
68. Dr Shaw accepted Dr Martin's examination was appropriate, although merely holding a leg with two hands might not be, and standing directly in front of her, between her feet may not be. Palpating where no varicose veins were visible <u>was</u> appropriate. It could be appropriate to look at the Patient's face, although not necessarily gaze throughout the examination. She accepted it can be difficult to get an NHS referral for varicose veins, and she accepted it was not wrong to re-examine after a lapse of nine months. Dr Martin would need to know if it was to be a private or an NHS referral, because a NHS referral required an ultra sound examination. She said if a Patient is complimentary and expresses regret on leaving it would not be against the Patient's interests to let her know he is practising nearby. She said, ' as a guideline a physical touch should only be at the instigation of, with the permission of and for the benefit of that person.' If Dr Martin obtained benefit from a hug, that was inappropriate.

<u>Staff E</u>

69. Staff E was a medical receptionist at Fareham Health Centre starting in March 2007. By December 2007 Dr Martin was working as a locum at The Centre Practice, which shared premises with the Fareham Health Centre. Dr Martin did a few locum appointments at Fareham Health Centre.
70. She said she found conversation with Dr Martin to be probing and continuous with one question leading to another. She felt he was too interested in her family and personal life. She found him to be too intense and he would look into her eyes and stand too close to her invading her personal space. She described him as a pretty chatty person. She compared Dr Martin to work colleagues and employers who acted differently. Of course Dr Martin was neither an employer nor a work colleague. He

followed her into the kitchen (which was quite confined) when she made drinks for her partners. Once or twice she said he stroked her arm which she described as creepy. The interaction with Dr Martin made her feel uncomfortable, but she did not say anything to him personally about it. She said he was too friendly and over-familiar. She saw her practice manager to discuss her concerns but did not take it further at that time.

71. She did not see him for a while, but on 10 October 2007 he came over to her and asked how she was, saying he was worried about her. She went into the kitchen (which was shared by both practices) and he followed. He came up behind her and touched the back of her neck. She described him putting his fingers under her collar and started stroking her neck for some five seconds, which she said made her feel sick. She squirmed away from him.
72. She reported the matter to her practice manager and agreed to make a formal complaint. Later she moved to a different branch of the practice so as not to come into contact with Dr Martin. The practice manger spoke to Dr Martin on the same day. She said he seemed shocked and was very apologetic. She said it was inappropriate and made this perfectly clear. He said he like to socialise with staff and that he was a 'touchy feely' person. He asked if he could apologise to Staff E but the practice manager advised against it, saying she would pass on his apologies. Nothing was said about not repeating the behaviour.
73. Later the same day Dr Martin saw the practice manager again and said the more he thought about it, the more he felt he had not done anything wrong. He said he was getting angry about it. She told him he had made Staff E feel uncomfortable and his physical contact was inappropriate. His personality was over friendly – he wanted to be a friend too quickly. The Fareham Practice decided as a result of the incident not to employ him any further as a locum. The practice manager became aware of the GMC investigation into Dr Martin in 2011, and she contacted Staff E, who later provided a statement for the PCT.
74. Dr Martin said there was often a group of people in the kitchen. He said he would often stop and say hello to the receptionists before starting work. He was busy and did not have much time to talk at length, but he would exchange pleasantries with the GPs, admin staff and the Practice Manager. He denied paying Staff E any more attention than other staff members. He had more contact with the Centre staff with whom he worked.
75. On the 10th October 2007 he had been discussing with Staff E her moving house and decorating her children's bedrooms. He said he may have put an arm around her shoulder or her back but he did not accept he would have rubbed the skin or the back of her neck. If he had done it, it was inadvertent. He denied being sexually motivated in any way. He said he was aghast on hearing of her complaint from the practice manager. He later felt he had done nothing wrong and felt cross although subsequently he has accepted that he should have been more sympathetic if he genuinely upset her. The Centre continued to employ him as a locum and he did not realise he was no longer being used by Fareham Medical Practice.

76. In cross examination he said he did not think he had rubbed her neck but if she said he did he accepted it. He said it was possible if he was busy chatting to her he might have put an arm on her shoulder. He would only do that to someone he knew well. He felt sickened when he heard the complaint first hand in the hearing and it had made him want to change. It was very difficult for him to hear the upset he had caused. This was part of his insight. He said there was no follow on from these events. Everyone continued to be normal with him.
77. At that time he was angry because he looked at it from his point of view and he had got defensive. Dr Houghton has helped him see things from the other's viewpoint. He had a meeting with the practice manager when she told him of Staff E's complaint, but it was not a formal meeting, just a chat between surgeries and lasted less than 15 minutes. It provoked a shock in him. The practice manager was clear the behaviour was inappropriate. He didn't think he had stroked her neck but he accepted he had not said that to the practice manager. He didn't accept his motives were wrong and he didn't understand why he had been misinterpreted. He did not recall any warning about future behaviour with staff. He continued to talk to staff in the Fareham Practice as before and it had not registered with him that Staff E had moved to a different surgery. He discussed the Staff E incident with Dr Houghton.
78. Dr Hicks commented the relationship was between two adults – Dr Martin was not her employer and hardly a work colleague. It was not therefore a power situation. If a doctor received a warning about inappropriately crossing boundaries a repetition might be treated seriously, but it depended on context – which was everything. There were always shades of grey. It could take a period of delay before changes occurred.

<u>Staff F</u>

79. Staff F was employed at Blackthorn Health Centre, joining the practice in 2001. She knew Dr Martin through his locum work at the practice, and she was responsible for payment of his invoices. They had a mutual interest in football which they discussed from time to time, although they did not socialise outside of work. She said prior to 29th March 2011 they got on well and had a pretty good relationship.
80. She was at work at the practice on 29th March 2011, Dr Martin's last day as a locum at the practice, when his contract ended. She attended Dr Martin's farewell lunch party where he was quite chatty. No alcohol was served at the party. After the party Dr Martin continued to see Patients.
81. Later in the afternoon she went to the practice manager's office and as she entered she saw Dr Martin giving her a hug and saying goodbye. In her evidence she said she thought the hug was 'a full on squeeze' and was inappropriate, although she did not say this in her police statement. Dr Martin then turned to her and she said, 'Good luck.' In her police statement made on 1st September 2011 she said, 'I then moved towards Colin by stepping forward intending to give him a kiss on the cheek. As I moved forward Colin turned his head slightly towards me and then kissed me directly onto my lips.' The kiss lasted for a second or two.

82. On 20th March 2012 she made a statement for the GMC. In that statement she said, 'Whilst in the practice manager's office I said goodbye to Dr Martin and wished him good luck. I leaned forward to kiss him on the cheek goodbye and he turned his head totally and kissed me full on the lips.'
83. While giving evidence to the Tribunal, in cross examination she denied trying to kiss Dr Martin. She said after giving the practice manager a hug Dr Martin walked towards her, she said goodbye and she put her face to one side for him to kiss her. She said he then turned his head and kissed her full on the lips. She said she felt her privacy had been invaded and that in her view Dr Martin had intentionally kissed her on the lips. She said she was shocked.
84. The practice manager said Dr Martin had given her a hug and then went over to Staff F and kissed her full on. She was 4 – 5 feet away and had a good view. She said it lasted 3 – 4 seconds. Staff F discussed the incident with the practice manager but did not make a formal complaint at that time. She later heard about the allegation of Patient D and C and was asked by the practice manager if she wanted to make a complaint. No complaint was made by her at this time. She went on holiday and when she returned she found the practice manager had reported the matter to the PCT, and after a delay she gave statements to the police and PCT.
85. Dr Martin said in his statement he had a good working relationship with Staff F. It was a happy two years working in the practice. He saw her once or twice a week, and he always stopped for a chat; subjects included football and Staff F's family health. Dr Martin recalled being in the practice manager's office discussing dates for a leaving dinner. He had no recollection of kissing Staff F on the lips, but said if he did it was inadvertent. He did not deny it happened. He denied any sexual connotation, but was sorry if she was upset. He was mortified when he heard of her complaint. The practice manager was present in the office when he left past Staff F, so she must have seen the incident.

Staff G

86. Staff G was employed at Blackthorn Centre for a number of years prior to 29th March 2011. She said Dr Martin had been employed as a long term locum from 1st May 2009 to 29th March 2011.
87. She attended the lunchtime farewell party for Dr Martin on 29th March 2011. He came into her office at about 2.45 pm. She said Staff F was in her office at that time. She said he kissed Staff F on the lips, then gave her a bear hug. Dr Martin said he was going to miss us all and had enjoyed working with us. She said she and Staff F were shocked by the kiss, but as he was leaving the practice they decided not to 'make a fuss'. No formal complaint was made at that time.
88. She said when she received the complaint from Patient D she spoke to Staff F and asked if she wanted to make a formal complaint. Staff F went on holiday to consider it and during this period heard about the complaint from Patient B. On the return of

Staff F the matter was discussed further. In her evidence Staff G said without prompting she was not sure which came first the hug or the kiss. She denied having discussed the matter with Staff F to resolve a conflict in their evidence. She could not remember if Staff F had walked towards Dr Martin before the kiss. The kiss was too long, some 3-4 seconds.

89. She said he put both arms around her and she felt squashed with her arms pinned. In her evidence she said it was totally inappropriate, although she did not say this in her statement. Dr Martin said the practice manager had said he was the number one person for locum work at the practice. He accepted he probably did hug Staff G and accepted it was a lack of awareness of his non-appreciation of personal space, however she was a practice manager and the situation was different to a Patient. He left on a high. He had discussed holiday destinations with Staff G. He was in a neighbouring practice and expected to stay in contact. But he did not try to contact her or follow this up. She said there is now a chaperoning policy at Blackthorn Surgery which was not in place in 2009.

<u>The case for Dr Martin</u>

<u>Dr Martin</u>

90. He denied acting in an improperly sexually motivated manner. He said he believes he has an empathetic and holistic approach towards treating Patients. Often Patients just want to talk through problems or ask advice about issues in their lives. Instead of just giving prescriptions he tries to listen and give Patients advice and support. He accepts he has provided physical support such as a reassuring arm around the shoulder to a Patient who appears to need comforting or consoling. Many Patients have thanked him for this. He now recognises the risk of misinterpretation of such actions, and he will now avoid such situations. He is concerned about the effect of his actions on Patients.
91. In evidence he said Dr Houghton had helped him to understand boundaries. He now saw different people had different boundaries and different levels of acceptance. What was acceptable to him may not be acceptable to others. In cross examination he said he found the allegations to be devastating and life changing. He was concerned that he had upset Patients and staff, but his actions had been misconstrued. He generally accepted the accounts by the complainants.
92. He now understood the criticisms of him hugging and kissing. Dr Houghton had helped him to understand this and see things from the Patient's point of view. He said his insight was improving all the time. It was put that he had not learnt from the Patient B incident and had been inappropriate with Patient C just 5 weeks later. Dr Martin pointed out that Patient B had continued to see him after the incident, and he knew he had not intended harm. He accepted counselling was proposed by his defence team rather than by him personally but he said his medical history was such that in his mental state he could not himself consider such options. Similarly he

accepted that Patient B had suggested training but he was undergoing a huge stress reaction.

93. He pointed out that his appraisal was on 26 April 2011 and while he accepted he should have dealt with the complaints he was not aware of the Patient D complaints at this time. He first heard of the Patient D complaint on 16 May 2011 and it was an enormous shock.
94. He said he did talk to other doctors about clinical matters although as a locum he did not attend the practice's formal clinical meetings. He was always trying to learn from other doctors. He said his consulting style would change. It would be physically more distant but he would try to achieve a happy medium. He had been examined by two doctors for the GMC proceedings who had not suggested he was unfit to return to work.

Dr Houghton

95. Dr Houghton worked part time as a consultant in public health for a PCT. She also has a firm called The Working Lives Partnership which provides coaching and therapy services. She has various qualifications in neurolinguistic programming (NLP), cognitive behaviour therapy, FIRO and MBTI. She is a member of the BABCP and the Association of Coaching. She has been practising as a behavioural and cognitive coach and CBT therapist for some 10 years. She specialises in supporting health professionals at work and has coached a number of doctors referred by NCAS. She has written a number of publications.
96. She was instructed by Dr Martin's solicitors in June 2012 to see him to consider with Dr Martin the allegations against him, to consider his behaviour against GPs' behaviour in general, to explore with him ways of understanding and avoiding such behaviour, and devise a programme to change his behaviour. Solicitors sent to Dr Houghton inter alia, his police interview, the PCT witness statements, and a summary of allegations.
97. She saw him for the first session for two hours on 12 July 2012 and in her report listed her impressions of Dr Martin which included that he was a caring and committed doctor, that he receives regular positive feedback from Patients and that he was devastated by the initial complaint against him. She described his personal history where hugging was a family trait, where he adopted a role of carer for his mother and where his father, an optician, would hug Patients when they left the clinics he held in the family home.
98. She then considered with Dr Martin the complaint by LR, noting his response when he realised Patient D's distress after the first hug. Using this and other examples, including hugging a male neighbour, Dr Houghton discussed the concept of personal space which, if encroached on, may cause distress. He said he did not experience this himself, but recognised Patients may react differently.

99. Dr Martin's initial response to the various incidents which led to his current situation was that he simply could not understand why any of it happened and what objection there could be to physical gestures of appreciation. However after further discussion he began to understand that his perceptions of normal behaviour – hugging, drove his own behaviour, but that others will have different perceptions of what is normal, depending on their life experiences which will often be different from his own. To hug someone who had grown up in a family where physical conduct was unusual or frowned upon, may cause alarm. A Patient may feel alarmed about being hugged by a GP during a consultation. Dr Houghton believed Dr Martin achieved understanding of this during the consultation, and he was able to see his behaviour from a different perspective.

100. She also concluded that Dr Martin was particularly sensitive to appreciation and criticism, and that this had played a role in Dr Martin's strong reaction to Patient D's praise of him. She also considered he had some difficulties around boundaries and that his distinction between himself and others was blurred. She said an awareness of this difficulty can lead to the resetting of appropriate boundaries. She concluded there was no suggestion of a sexual motivation for the behaviours, rather the origins of his behaviour was to be found in his childhood and upbringing.

101. Dr Houghton saw Martin for a second session on 7th August 2012, when the prime focus was the complaint by TS. He was not aware he had done anything inappropriate and was shocked at the time by her complaint. He was perplexed by it, could not understand at the time what he had done wrong and put it down as a one off inexplicable event and once it was over thought little more about it. The staff and partners in the adjoining practice where he worked remained friendly and gave him more locum work.

102. Dr Houghton analysed his lack of reaction to the incident and its failure to bring about a conscious change in his behaviour as the operation of the 'prejudice model'. This suggests that where a Patient has a belief about himself which is unhelpful and difficult to dislodge, he will tend to interpret new information in such a way as to reinforce the belief. Contrary evidence would have to be consistent or very extreme to begin challenging the belief.

103. She concluded that Dr Martin had long held beliefs that his highly personal interactions with Patients and staff were a positive feature of his professional identity. This was reinforced by positive feedback from Patients and staff. A single complaint would make little difference, and the Staff E incident thus might have little impact. However, a combination of a number of such complaints, coupled with suspension and removal by his PCT, an appearance before the GMC with resulting conditions and an interview by the police, may well be sufficient to initiate change and to start an appreciation that his behaviours were inappropriate. It had been completely shattering for him and seismic in effect. She accepted change would not just concern change in behaviours, or a change in beliefs, but a change in identity, which was difficult, but the seriousness of the events which had befallen him as a result of the complaints, coupled with the counselling which had begun to be provided would enable change to

take place. She believed he would be unlikely to perform inappropriate touching and that Patients would be safe from this in the future.

104. In cross examination it was suggested there had been just three hours of counselling and this was too little to be able to make confident predictions. Dr Houghton accepted there was no absolute certainty but on balance she had no fears of a repetition, or that there was any sexual motivation. She believed the signs were good for change. Patients did achieve what she called an ‘ah ha’ moment within a two hour session. She accepted she had never had a client with Dr Martin’s exact characteristics but he was not unique.

105. It was pointed out to her Dr Martin’s accounts as contained in the instructions were not always accurate or comprehensive. She agreed, but said he had accepted he had done something inappropriate and that he could change. Further it was suggested that he had not been devastated by the Staff E or Patient B complaints at the time, nor had he learnt from them or changed his behaviour. Dr Houghton said this was consistent with the prejudice model where long standing behaviour was difficult to shift. Most people demonstrate the prejudice model to an extent. Once attention is drawn to it change can and does take place.

106. It was suggested that the issue of hugs when young and a desire to protect his mother was commonplace and should not be deployed to justify transgressions of professional boundaries 40 years later. She said personal boundaries were set when very young. The prejudice model suggested an explanation why there may be delay in initiating change.

107. Dr Houghton was asked whether she had considered Dr Martin’s denial of a sexual motive was made merely to preserve his ability to practice his profession. Dr Houghton said she cannot say whether he may or may not be a fantastic liar, but she had determined his motivations to stem from his childhood experiences. Furthermore she was reliant not just on his account, but also on her experience, intuition and his demeanour. Further he had started by saying he did not understand what he had done wrong, rather than seeking to say from the beginning he had changed. Dr Houghton reiterated that in her view the adverse consequences of the complaints were so strong that he now had an association with touching that was almost phobic.

108. It was put that the second hug to Patient D appeared to be for his own benefit by the remark ‘this is a nice hug’. Dr Houghton said the reason for the hug was because he felt warm and emotional towards her, not because he was distressed. Dr Houghton accepted it was important that Dr Martin could determine when a Patient was upset, but he had been able to appreciate that in the case of Patient D. His reaction to her distress was not a picture of a sexual predator. It was put that repeating the behaviour shortly after being warned was not a good indication of change, but Dr Houghton suggested this was merely an indication of some strongly held beliefs. It was suggested she was failing to put sufficient weight on the prior warnings and the subsequent repetition of the inappropriate behaviour but she did not accept this.

109. Two of Dr Houghton's publications concerning bullies and difficult people were put, and parallels were attempted with Dr Martin. Dr Houghton did not accept Dr Martin fell within these categories. Dr Houghton continued to reiterate that she believed she could help Dr Martin because he had the ability to see things differently and she could teach him about how to change. She had led him to understand why he behaved like he did. Something had definitely shifted in his perception of the problem during the consultation. It was not just a matter of developing a copy mechanism to avoid such behaviour in the future, but of developing an understanding of why it was a problem.

110. A future programme of counselling would include increasing understanding, exploring boundaries, increase the sense of self and to find a new way of operating as a doctor, where his special qualities can sit comfortably with appropriate boundaries between himself and his Patients. There could be assessment reports periodically. She believed there would be a successful outcome which would enable him to practise appropriately, despite the fact his initial professional training had not secured change. It would be possible to enable him to distinguish between what was good about his practice as a GP and the way he expresses these matters – that is to preserve his caring nature within appropriate boundaries. His ability to shift his perceptions in a two hour session was a very good sign. She was as sure as she could be there was no sexual motivation, rather that the motivation originated in childhood. Different Patients had different thresholds about a perception of what is 'not right' in a consultation, but she believed Dr Martin could change to avoid inappropriate behaviours.

References

111. There were some 14 references from professional colleagues, fellow GPs, nurses, and practice staff. He was described as punctual, careful to record Patient notes on the computer, conscientious and courteous. One surgery where he was a locum for 6 years said there had never been a complaint against him. He was honest, hardworking with a good rapport and was well liked, warm, caring and sincere. Patients described him as professional and appropriate with impressive medical ability. A female health care assistant who worked with him for 10 years found him to be professional and very competent, very popular and highly regarded. He was friendly with staff and Patients. Other Patients described him as professional and compassionate, kind and sensitive. He had offered a chaperone to one female Patient, which was declined because she felt safe.

112. A senior partner in a practice where he performed locum services for 6 years said he was well liked, personable, polite and a much valued colleague. Nursing staff members found him pleasant, friendly, professional and caring. The nurse never found him to be sexual or provocative. He was caring and compassionate, open and approachable, highly thought of by colleagues and staff. There were some cards sent to him when he finished work at Blackthorn wishing him well and telling him he would be missed. There were a number of letters from Patients at the dermatology

clinic, and various surgeries, thanking him for treatment referred to Dr Martin giving a hug which had been appreciated by the Patient. The referees generally did not know he was accepting the allegations against him. Dr Martin is in a long term relationship. He has a daughter from his former marriage.

113. Julie Howgate, practice manager at Bursledon said there had been no complaints about inappropriate behaviour from either Patients or staff between 2007 and 2010. She said the staff were fond of him. She had got to know him well. She had a very good working relationship with him. Patients could have the choice of GP if they were prepared to wait. He was described as friendly and not standing on ceremony. He was the partner with staff responsibility and all the staff were comfortable to go to him. He was the doctor who was favoured by Patients at the surgery. They wanted to see him before the other partner. He did not rush things. He was tactile and touchy-feely. He put an arm around me on return from holiday and if you were upset he would put an arm around you. She did not believe the KL incident was sexually motivated.

114. Dr Heal a partner at Lockwood Surgery, said Dr Martin had never received a Patient complaint there regarding inappropriate behaviour. This covered the period 1997 – 2007. He resigned due to a breakdown of the relationship with the partners.

115. Staff F said his behaviour to her and other staff was too familiar. He would be very friendly and would offer to make the tea, which was unusual for a GP. She had a pretty good work relationship with Dr Martin. He would talk to anyone. He befriended people and talked to the female staff. He was overfriendly, effusive and touchy-feely. He would touch people when he talked to them, either one to one or when others were present.

Patient H

116. Patient H was a Patient with Dr Martin at the Bursledon practice. She was a nurse with the Royal Navy for a number of years but has now retired. She had a concern about attending doctors because of the possibility of bad new being imparted about her health. She said Dr Martin gave her a hug on three or four occasions when she was distressed or anxious particularly about her husband’s health. She had been crying on occasion. The hugs were one-handed around the shoulder or a double-handed embrace without physical contact. She described it as a comfort and helpful. He had never given her a peck on the cheek, but it would be fine if he had. She described him as acting extremely professionally in removing a mole.

Consideration by the Panel

1. In our findings of fact below we bore in mind that the burden of proving a fact or allegation lies on the party asserting it. Proof is on the balance of probabilities.

Dr Martin

2. We generally found Dr Martin to be a truthful witness. There were a number of incidents of which he had no memory, and he had on occasion not given accounts which were as full as they could be such as to Dr Houghton and in the appraisal . We bore in mind that several of the incidents were a number of years ago and some of them were not brought to his attention at the time they occurred. Further he has been under considerable stress since being informed of the allegations and has had serious health problems requiring treatment by health care professionals. We accepted the evidence from practice managers and others who had worked with him that his character was over familiar and intrusive and that he was prone to touch those he was talking to too readily. These appeared to be indiscriminate habits. We accepted he had boundary difficulties.
3. We also accepted that he was a kind and caring doctor, ready to spend time with Patients, to discuss their problems and lend a sympathetic ear. His many character references and indeed many of the complainants in their evidence reinforced this point. There was little evidence of clinical failings – perhaps some of his record keeping was not as full as it could be - but we were concerned that his recent practice as a locum and in a two partner practice where the doctors worked alternate shifts had left him professionally isolated. We felt this was important in contributing to the effect of the prejudice model where there was little adverse reaction from professional colleagues in bringing misguided behaviour to his attention.
4. We accepted his evidence, supported by Dr Houghton, that he had begun to understand during the counselling sessions with her, why his behaviour was inappropriate. We accepted he understood the importance of the necessity to change and that he was now committed to the process of change. Insight had been delayed but some explanation for this was to be found in the prejudice model which we generally accepted.

<u>Dr Houghton.</u>

5. We accepted Dr Houghton was not a psychiatrist and could not therefore provide a psychiatric assessment of Dr Martin, but we concluded she was an experienced and knowledgeable therapist within the area of health professionals at work and we found her generally to be a helpful and knowledgeable witness.
6. We accepted that during the first consultation, Dr Martin had begun to develop an understanding and insight into his inappropriate behaviour, as described by Dr Houghton. While it was the case that his solicitors, rather than himself, who had brought about the referral to Dr Houghton, we believe she, (and Dr Martin in his evidence) had demonstrated that he was now willing and eager to seek insight, and that he was prepared to change his behaviour.
7. We accepted that there had been delay in the beginning of the development of insight, and that there had been a warning in respect of Patient B and staff member E which had not precipitated insight. However we accepted the applicability of the prejudice model, and that it can take time, persistence and the occurrence of significant events to precipitate change. We accepted that the combination of multiple complaints,

police investigation, GMC involvement, suspension and removal by the PCT, as well as his health issues had combined to establish the necessity for change as compelling for him. We accepted that further consultations with Dr Houghton would be likely to continue to develop and embed the process of insight which Dr Martin is now undergoing.

Dr Hicks and Dr Shaw

8. Dr Hicks has acted as an expert witness since 1994, has a consultancy role with the Health Foundation, was an Associate GP to the Performance Development Team of the NHS and has been a board member of a PCT with responsibility for clinical care along with a number of other appointments.
9. Dr Shaw, in addition to her experience as a GP, served for one year as GP for Practice Based Commissioning in Gosport, and as a Medical Director of a Local Medical Committee. She has been a part time assessor with the GMC for six years.
10. Following directions on 17 May 2012 they produced a joint report setting out areas of agreement and disagreement. We generally accepted their findings where they were jointly agreed.

Patient A

11. We considered the allegations made by Patient A. We noted the allegations were some 14 years old and that she has accepted she had some lapses of memory in respect of them. There had been no contemporaneous complaint, and the first statement made was in July 2011. However, there were contemporaneous Patient notes and Dr Martin did not deny he had performed a breast examination or that he had sought information about her husband or put an arm around her. He generally accepted Patient A's evidence.
12. We accepted the evidence that a breast examination was performed. We accepted the Patient's evidence she considered it to be short. We also noted that she was not expecting an intimate examination and that she believed an examination should take place lying down. We accepted on the balance of probability that the bra was in place during the examination, although we also accepted it was loose with the straps down her arms, allowing an examination of some sort to take place. We accepted that Dr Martin sought information about her family relationships, and asked if she loved her husband.
13. We accepted the joint evidence of the experts, that in 1997 a prenatal examination of the Patient's breasts was clinically appropriate on the first visit. We accepted an examination with the bra on was not wholly appropriate but we noted the debate in the profession about whether an examination was necessary and Dr Martin's explanation that at that time where there were no lumps reported his examination may have been cursory. The joint expert report accepted the examination could be sitting up or lying down. Because of the lapse of time since the incident and the Patient's

inexperience in breast examination, we did not find the methodology of the examination, including its duration and use of the hand had been shown on the balance of probabilities to be inappropriate.

14. We accepted Dr Martin had seen the Patient after the birth, diagnosed post natal depression and prescribed appropriate medication. We did not accept there was sufficient evidence to support the proposition he had failed to record the breast examination. A record may have been made in the Patient's own notes or the co-op notes. We accepted he had put an arm around her shoulder when she was upset and crying.
15. We considered whether there was a sexual motivation by Dr Martin. We concluded there was not. The breast examination was generally clinically appropriate. The precise methodology was uncertain, but leaving a bra in place when it could be taken off, and making the examination short when it could be more prolonged, and carrying out the examination while sitting up when it could be carried out lying down do not in our view provide any support for a sexual motive, indeed rather the reverse.
16. We accepted the evidence of Dr Hicks and both experts that it was appropriate for a treating doctor to investigate the causes of emotional distress and to gather information about support at home. We do not accept there is anything in what Dr Martin asked of the Patient to support a sexual motive.
17. We noted Dr Martin had placed one arm around her shoulders, but this was at a time when she was in distress and crying. We do not find this action to be sexually driven. It was entirely consistent with offering solace and comfort. It was also consistent with Dr Houghton's evidence about Dr Martin's difficulties with boundaries and with the evidence about his touchy feely nature. We agreed with the evidence of Dr Hicks that a normal hug – in this case an arm across the shoulders - at a time of distress is not necessarily inappropriate, and we do not find it to be inappropriate in these circumstances.
18. We concluded Dr Martin diagnosed and treated the Patient entirely appropriately both before and after the consultations of 20th October 1997 and 3rd July 1998. We noted no complaint was made for 15 years after the incident, although we accept she had been advised against it by her family. We noted the Patient continued to see Dr Martin after the incident. We accepted the Patient was upset by her perceptions of what a breast examination should be and what actually took place, and by Dr Martin's questions about her husband, and by the one armed hug, but we do not accept, on the balance of probabilities on the evidence, Dr Martin was driven by a sexual intent during the incident.

Patient B

19. In considering this matter we noted some uncertainty in Patients B's evidence over the dates of the incidents, and some conflict with the practice manager as to how many consultations were involved.

20. However the incident occurred in 2010, there were contemporaneous notes made about the incident by the practice manager and Dr Martin recalled the consultation. He generally accepted in his evidence the account given by Patient B, although he could not remember the kiss on the cheek. We accepted the evidence of a brief two armed hug and a brief peck on the cheek during a consultation in which the Patient had been extremely upset.
21. We considered whether Dr Martin had been sexually motivated during the incident, and concluded he had not been. We reminded ourselves of the evidence about Dr Martin's difficulties with boundaries and about his friendly touchy feely nature. For some, he was over friendly, too ready to invade personal space and touch the person he was talking to. But this was an apparently indiscriminate habit of his with staff and Patients. There was evidence to suggest he hugged other Patients and staff who had not reported the matter and at least one Patient who derived comfort from the hug.
22. We noted also that the hug was given to a Patient who had been distressed, and could therefore have been consistent with offering solace and comfort. There is no suggestion of any other inappropriate behaviour by Dr Martin to the Patient before or after the consultation in question. Also the Patient opted to continue to see Dr Martin on a number of occasions after the incident. Furthermore Dr Martin appeared shocked when first told of the complaint by the practice manager, which might be consistent with Dr Martin not having intended the matter to be taken sexually. The Patient was unsure of the motive for the actions.
23. For all these reasons we concluded on balance of probabilities that the actions were not sexually motivated. However, we agreed with the experts that a two-armed hug, bringing body to body was inappropriate, and accompanied by a kiss on the cheek was also inappropriate. It caused considerable distress to a vulnerable Patient, and Dr Martin should not have performed these actions.

<u>Patient C</u>

24. These events happened in 2010, relatively recently. There was no contemporaneous complaint or note made of them, but the Patient's evidence was largely accepted by Dr Martin, albeit he had little memory of it. Further we found the Patient to be generally a reliable witness in recounting factual matters, and we accepted her description of two brief hugs with both arms and a peck on the cheek. We also accepted her reference to a knight in shining armour, which is a distinctive phrase which a witness might be expected to remember.
25. We considered whether the actions were sexually motivated. We reminded ourselves of Dr Martin's touchy-feely, over familiar nature, and boundary difficulties as set out above. We noted the Patient was distressed at the time, and the actions were consistent with providing comfort and solace. We noted this was the only consultation with Dr Martin – there was no attempt by him to follow up the Patient. We agreed with the expert evidence that the blood pressure examination was appropriate.

26. We accepted that the remark about a knight in shining armour and the reference to being concerned about her marriage had been made by Dr Martin, but in the context of seeking information about the Patient's support at home, which was reasonable and appropriate in the circumstances. The causes of the Patient's distress needed to be investigated by Dr Martin. We fully accepted the Patient had concerns about the nature of the hugs and the peck on the cheek, felt uncomfortable about them, and was concerned that Dr Martin may have been seeking to pursue a relationship, although we note she also felt some confusion and uncertainty about his intentions. We concluded on the balance of probabilities that Dr Martin was not sexually motivated in his behaviour, for the reasons set out above.

Patient D

27. These events occurred recently in March 2011, there was a contemporaneous record, there are Patient notes and the Patient's account is generally accepted by Dr Martin. We accepted Dr Martin had performed an examination for varicose veins and we agreed with the expert witnesses that the examination was appropriate, occurring some 9 months after the previous examination, and was appropriate methodologically including the use of two hands, if that happened, and looking briefly into the Patient's face.
28. We further accepted Dr Martin was feeling more than usually emotional on that day because it was his final day, and because Patients, including Patient D and staff were saying nice things about him. We accepted the Patient's evidence Dr Martin had taken her hand when she stood up to leave, but we did not accept, on the balance of probabilities, that he intended to kiss the hand. We found that we could not dismiss the possibility that the hand had been raised by Dr Martin coming towards the Patient while holding it. Furthermore, the Patient had no recollection of the hand actually being kissed by Dr Martin, even though it might reasonably be expected that such an unusual act would be something that would remain in the memory.
29. We accepted Dr Martin did then give her a two-armed hug, trapping her arms against him. This is now accepted by Dr Martin himself and is consistent with other instances where he did this. We accept also the description of Dr Martin's startled response to being told he had frightened the Patient which is accepted by Dr Martin We accepted a second hug took place and that Dr Martin had said, 'This is a nice hug,' and had stroked the Patient's back. We noted the Patient's belief she had somehow precipitated this second hug.
30. We accepted Dr Martin had invited the Patient to move to Bursleden Surgery twice during the consultation and once during the second phone call. The Patient was very clear and consistent about this. We accepted Dr Martin made two phone calls to the Patient after the consultation. We accepted he had genuine clinical reasons for the calls although we did not accept they were the sole reasons for them. This is considered below.

31. We considered whether the behaviour was sexually motivated. We took into account Dr Martin's personality and boundaries difficulties, as set out above. We noted this behaviour had occurred at an emotional time for him and after the Patient had said some kind words to him. We noted the behaviour complained of -- two hugs – could in our view be consistent with an emotional outburst by Dr Martin. We noted Dr Martin's reaction once he had realised he had upset the Patient, which we concluded, with Dr Houghton, was unlikely to have been the reaction of a person with a sexual motivation. In our view, resistance and a verbal communication of being frightened is unlikely to provoke confusion, bafflement, a 'little boy lost look', bemusement, or terror in a perpetrator who was sexually motivated. It is in our view more likely to be the reaction of a person whose good intentions had been misunderstood and had provoked an adverse reaction.
32. The second hug, which was very brief, is complicated by the Patient's feeling of guilt and belief she had initiated the hug. Whether that feeling was communicated to Dr Martin in any way is unclear, but in the context of his extreme reaction of 'terror' and hurt, we do not believe it is possible to characterise the second hug as sexually motivated. It was, in our view, more likely to have been prompted by a misplaced desire to remedy the fact he had earlier frightened the Patient. He may have been frightened himself, and wanted some consolation, which would be consistent with his remark of it being 'a nice hug.'
33. We fully accept the Patient was extremely upset by Dr Martin's actions, which have had an effect so strong on her it has persisted to some extent today. But for all the reasons above we do not accept on the balance of probability that the behaviour was sexually motivated.
34. We accept there was a clinical reason for the two phone calls after the consultation. However we do not accept this was the only reason for the calls. We accept Dr Martin still did not understand why what he had done was wrong, and was seeking elucidation in the first call. That was consistent with the analysis of Dr Houghton, that at the time he had no insight into these matters, but we accept it was an inappropriate thing for a GP to do.
35. Further, we believe the second phone call did contain an element of damage limitation. He did not want the matter to be taken further. That was the reason for the reminder of the possibility of a move to his surgery, and that was the reason, in our view, why he sought an agreement for the Patient not to take the matter further. He apologised, and this too was at least partly driven by a desire to deescalate the matter. These phone calls were not in or view sexually motivated, but it was inappropriate for him to have attempted a damage limitation exercise with the Patient in this way.

Staff E

36. These events occurred in March 2007. They were the subject of a contemporaneous complaint, and a contemporaneous note was made of the complaint by the practice manager. We accepted Staff E did feel Dr Martin was too familiar and too persistent

in his contacts with her, and we accepted she was very upset by his actions in the kitchen. We accepted there was some touching of the neck. Staff E said that in her view he singled her out for attention, but she admitted she did not know how much Dr Martin interacted with the other staff.

37. We note this complaint is different in several respects to the Patients' complaints as she was not a Patient, she was not an employee of Dr Martin's, and she was not even a work colleague in the normal sense of the word, working for an adjoining practice. Nevertheless we accepted that, for her, his attempts to talk and interact with her were inappropriate and unwanted. Dr Martin should, in our view, have appreciated this sooner and the fact he did not is some indication of his poor communication skills and boundary difficulties.
38. We considered whether, in our view, Dr Martin was sexually motivated in his behaviour to Staff E. We noted his denial that he paid her more attention than other staff members at the two practices. We noted the evidence from various sources that he tends to be over intrusive, and over familiar, has boundary difficulties and is 'touchy feely'. We considered the touching to the back of the neck to be wholly inappropriate, but not wholly inconsistent with an arm being draped over the shoulder and not so overtly sexual in nature as to leave no other interpretation possible, including an inadvertent, not fully appreciated action, as described by Dr Martin. We noted his shocked and apologetic response when the matter was raised by the practice manager. He later displayed anger. On the assumption this was a genuine response, it could be consistent with a non-sexual motivation which had been misinterpreted. We concluded that on the evidence before us, we could not say, on the balance of probabilities that the behaviour was sexually motivated.

<u>Staff F</u>

39. The incidents involving Staff F were recent and we found it surprising there were several different accounts given by her, each exacerbating further the role played by Dr Martin. Because the police statement was given the soonest of the three, we accepted that as accurate, i.e. that she stepped towards him intending to give him a kiss on the cheek and he moved his head slightly, resulting in a kiss on the mouth.
40. We considered whether, on the balance of probabilities, the kiss was sexually motivated. We reminded ourselves of Dr Martin's personality – over familiar and touchy feely. We noted the incident occurred when Dr Martin was leaving the practice, that he was emotional, and was in the process of saying goodbye to his work colleagues. The kiss was done in front of the practice manager, surely a significant disincentive for a sexually motivated predatory kiss. We noted there was no formal complaint until other complaints had been forthcoming. We think it unlikely Dr Martin deliberately turned his head to kiss Staff F on the lips, and in the circumstances of the matter being initiated by her and it all happening very quickly,

we cannot dismiss the possibility of the kiss being inadvertent. We do not find the kiss to be sexually motivated, or inappropriate.

Staff G

41. This single hug was given by Dr Martin to the practice manager as part of his farewells to the staff he had worked with for two years. There was no prior or subsequent inappropriate behaviour towards her. It was done in the sight of staff F. It was very brief. We bore in mind his overfamiliar nature. For all these reasons we do not accept the hug was sexually motivated, and in the circumstances described above, it cannot, in our view, be said to be inappropriate.

Determination

42. We reminded ourselves of our powers. The performer appeals under Regulation 15(1) which states that the appeal is by way of redetermination. Regulation 15(3) of the 2004 Regulations states that the FTT may make any decision which the PCT could make. This would include allowing Dr Martin to remain on the list, removing him or contingently removing him subject to conditions.

Suitability

43. The PCT found Dr Martin to be unsuitable under regulation 10(4)(c) of the 2004 Regulations. We considered whether, in the light of the evidence and the findings we have made in this case, Dr Martin is unsuitable. The issue has to be considered currently.
44. We noted the criteria to which we shall have regard in assessing suitability are set out at Regulation 11(1), (2) and (7). This includes information provided by Dr Martin under Regulation 9 (convictions, regulatory body investigations or findings, etc.), information held by the Secretary of State, the nature of any investigation or incident, the length of time since any investigation or incidents, any action taken by a regulatory body, the relevance of any incident or investigation to his performing relevant primary services and any likely risk to any Patients or to public finances. Also Regulation 11(7) requires that in making any decision under Regulation 10, the PCT shall take into account the overall effect of any relevant incidents and offence relating to the performer of which it is aware. We noted that contingent removal may not be imposed in a suitability case. Removal under 10 (4)(c) is discretionary 'the PCT may remove a performer.'
45. The 2004 guidance document "Delivering Quality in Primary Care" states at paragraph 7.2 that the grounds of efficiency and suitability can overlap. At paragraph 7.10 it states that suitability as a ground for action can be relied on where there is a lack of tangible evidence of a doctors ability to undertake the performer role eg for a lack of experience or essential qualities. Paragraph 7.11says suitability is a term

which is used in its every day meaning and suitability and efficiency overlap and in many cases it may be possible to take action under either ground. At paragraphs 17.12 and 17.13 the Guide mentions the matters to be taken into account as set out in Regulation 11(1), (2) and (7). Paragraph 17.21 states that contingent removal cannot be imposed in a suitability case, and the effect of the law is a doctor is either suitable or unsuitable.

We considered suitability under the relevant heads set out in Regulation 11(2):-

<u>The nature of the incidents - Reg 11.(2)(a)</u>

46. An important aspect of the nature of the incidents was the question of whether the behaviour was sexually motivated. After careful consideration of the evidence we have determined on the balance of probabilities that we have not found that the incidents were sexually driven. Rather we concluded that his behaviour related to issues of his identity and boundaries, as set out in Dr Houghton's report and considered above.
47. In considering the seriousness of the behaviour, we have found it was inappropriate in several instances, and caused appreciable distress to many of the complainants, albeit the behaviour was usually brief and well intentioned by Dr Martin who believed misguidedly he was offering solace.
48. A significant aspect of the incidents is the repetition of the inappropriate behaviour and that in respect of Patient B and staff member E, he was warned about his behaviour yet he repeated similar actions shortly afterwards. He appeared not to have gained insight and understanding until the consultation with Dr Houghton on 12 July 2012. Further he has not yet undertaken any training courses. We accepted the seriousness of this repetition and the delay in achieving insight but we accepted Dr Houghton's application of a "prejudice model" in providing an explanation for the delay. We accepted change would be a difficult process in which persistence and commitment would be required, but that Dr Martin was now fully aware of the need for change and was fully committed to it.

<u>The length of time since the last incident - Reg 11 (2)(b)</u>

49. The last incident was in March 2011. There has been no recurrence since then, but he was suspended as from 19th May 2011 and removed on 17 January 2012.

<u>Offences, incidents or investigations to be considered – Reg 11(2)(d)</u>

50. There are no criminal convictions arising from these matters. On the conclusion of the police investigation he was not charged in any offence. On 28 June 2011 the IOP of the GMC imposed conditions on his practice including the use of chaperones for female Patients. It is not yet clear whether he will be referred to a fitness to practice hearing. The PCT has suspended and then removed him from the Performers List.

<u>Relevance to providing services and risk to Patients Reg 11(2)(e)</u>

51. The inappropriate behaviour was in our view relevant to providing services. Inappropriate touching is distressing to some Patients and clearly impacts on the provision of GP services. Dr Martin would have to change his behaviour in order to practise appropriately but we believe this is possible.
52. We considered the issue of continuing risk to Patients. We accepted that a combination of the adverse effects which have happened to Dr Martin, including GMC, police and PCT involvement, coupled with the counselling by Dr Houghton, and the beginning of the development of insight by Dr Martin, will mean that risk to Patients is significantly reduced, and any remaining risk can, in our view, be removed by the imposition of appropriate conditions

<u>The overall effect of incidents – Reg 11(7)</u>

53. The incidents caused significant upset to a number of the complainants. One in particular remains anxious and concerned about what happened to her, although this condition was said to be improving.
54. We concluded that a GP with boundary difficulties but who now appreciated why his behaviour was inappropriate, was willing to change and could practice safely with appropriate safeguards was not in its every day meaning "unsuitable" for the purposes of Regulation 10(4)(c).

<u>Inefficiency</u>

55. We considered inefficiency under Regulation 10(4)(a). We considered Regulation 11(5) and (6) of the 2004 Regulations which sets out the criteria which we shall consider in removal for an efficiency case. These include information provided by Dr Martin under Regulation 9 (convictions, regulatory body investigations or findings, etc.), information held by the Secretary of State, the nature of any prejudicial incident, the length of time since any investigation or incidents, any action taken by a regulatory body, and any likely risk to Patients. Also Regulation 11(7) requires that in making any decision under Regulation 10, the PCT (and ourselves) shall take into account the overall effect of any relevant incidents and offences relating to the performer of which it is aware. We noted that contingent removal may be imposed in an efficiency case. Removal under 10 (4)(a) is discretionary - 'the PCT <u>may</u> remove a performer.'
56. We also had regard to the 2004 Guidance Document which states at paragraph 7.2 that the grounds of efficiency and suitability can overlap. At paragraph 7.4 it states that efficiency as a ground may be used when the inclusion of a doctor could be prejudicial to the efficiency of the service that is performed. Broadly these are issues of competence and quality of performance. They may relate inter alia to everyday work, inadequate capability, and bad practice. We concluded that issues of poor boundaries and inappropriate touching of Patients fell into these categories.
57. At paragraphs 17.8 and 17.9 the Guide mentions the matters to be taken into account in Regulation 11(5) (6) and (7). Paragraphs 17.15 and 17.16 state that contingent

removal, along with conditions, can be imposed in an efficiency case to address poor performance by requiring additional training or supervision.

We considered 'efficiency' under the relevant criteria in 11(5), (6) and (7) of the 2004 Regulations:-

Information received in accordance with Regulation 9. – Reg 11(5)

58. There are no criminal convictions in this matter.

The nature of the incidents – Reg 11(6) (a)

59. The nature of the incidents has been considered in paragraphs 46 - 48 above. We did not find a sexual intent in the behaviour, but we found the behaviour inappropriate in a number of the incidents. We accepted the significance of the repetition of the behaviour even after warnings were given and that change would require persistence and commitment but that in our view Dr Martin realised the importance of change and was committed to it. We concluded that the inappropriate behaviour was prejudicial to the efficiency of the services, as it caused distress to some Patients.

The length of time since the last incident and action by the regulatory authority - Regulations 11 (6)(b) and 11(6)(c)

60. The last incident was in March 2011. There has been no recurrence since then, but he was suspended by the PCT as from 19th May 2011 and removed on 17 January 2012. On 28 June 2011 the IOP of the GMC imposed conditions on his practice including the use of chaperones for female Patients.

Risk to Patients - Reg 11(6) (d)

61. Risk to Patients was considered above and we concluded that a combination of the adverse effects which have happened to Dr Martin, including GMC, police and PCT involvement, coupled with the counselling by Dr Houghton, and the beginning of the development of insight by Dr Martin, will mean that risk to Patients is significantly reduced, and any remaining risk can, in our view, be removed by the imposition of appropriate conditions.

The overall effect of incidents – Reg 11(7)

62. The incidents caused significant upset to a number of the complainants. One in particular remains anxious and concerned about what happened to her, although this condition was said to be improving.
63. We have concluded that the overall effect of the incidents is that a failure to recognise professional boundaries and to inflict inappropriate behaviour on Patients and cause them distress constitutes, in our view, poor performance amounting to inefficiencies in the provision of services.

64. We therefore find this to be an 'inefficiency' case under Regulation 10(4)(a). However, in our view, Dr Martin has begun to show insight into his inappropriate behaviour, is treating it seriously and has a genuine desire to improve his performance so that he no longer commits this inappropriate behaviour. We further accept that appropriate conditions can be imposed to remove the inefficiency. For these reasons we do not consider complete removal from the list is necessary.

Contingent removal

65. We considered contingent removal under Regulation 12. We noted that in considering contingent removal we must impose conditions with a view to removing any prejudice to the efficiency of the services in question.
66. We considered the 2004 Guidance document. Paragraph 17.16 states that conditions imposed might address poor performance by requiring additional training or supervision.
67. We accepted the analysis of Dr Houghton that in remediating his behaviour, Dr Martin must not just cease his behaviour, but he must understand why the behaviour is inappropriate, and he must change his identity to the extent required. We further noted the delay in Dr Martin understanding the need to change, despite warnings. The remediation process will mean the effect of the prejudice model in ignoring adverse incidents and avoiding change will have to be overcome. We accept in the light of these factors that the process of change will be difficult, may take time, and will require commitment and persistence with rigorous monitoring and assessment processes.
68. We believe Dr Martin has been somewhat isolated in his practice and has, of course, not been practising at all for some time. GP training practices are often concerned with clinical performance but in our view a period of practice in a training surgery in which he can observe on a day to day basis good practice by a GP trainer is necessary and appropriate to develop and embed changes in behaviour. Furthermore this may assist his return to work. We consider, along with the GMC, that a condition should be imposed that all consultations with a female Patient should take place with a chaperone to ensure appropriate Patient treatment is maintained at all times.
69. For these reasons we conclude that Dr Martin should be contingently removed subject to the following conditions which are in our view necessary and proportionate to remove the inefficiency:

1. Six months practise in a GP training practice. This will assist Dr Martin to observe and work with doctors with appropriate boundaries, and who exercise appropriate behaviour in instances of Patient distress. It will also facilitate monitoring and assessment. A report is to be sent to the PCT/PCT successor's which assesses progress to the PCT's/PCT successor's satisfaction at the end of the 6 months period.
2. He is to continue with counselling sessions with Dr Houghton or some other agreed counsellor to continue to develop his insight. A report is to be sent to the PCT after

six months about his progress. Progress is to be to the PCT's/ PCT successor's satisfaction.

3. He is to co-operate with the Deanery to produce a Personal Action Plan to set out learning objectives and how they are to be met.
4. Dr Martin is to arrange an appraisal is to be carried out after six months and make it available to the PCT/PCT's successor body. They must be satisfied as to whether appropriate progress has been made.
5. Save in life threatening emergencies, he must not undertake consultations with female Patients without a chaperone present. The chaperone must be a fully registered medical practitioner, fully registered nurse or midwife or healthcare assistant. He must keep a log of any such consultations, signed by the chaperone.
6. He must notify any post he accepts to the PCT/PCT successor and must agree exchange of information by the PCT/PCT successor with the employing body.
7. He must notify any formal action against him by the GMC to the PCT /PCT successor.

Amended final version

John Burrow

Judge PHT/FTT

7 October 2012