BEFORE THE FAMILY HEALTH SERVICES APPEAL AUTHORITY
IN THE MATTER OF DR PAUL HIRSCHOWITZ

AN APPEAL FROM A DECISION OF THE NORTH YORKSHIRE AND YORK PRIMARY CARE TRUST

BETWEEN:

DR PAUL HIRSCHOWITCH

APPELLANT

And

NORTH YORKSHIRE & YORK PCT

RESPONDENT

DECISION & REASONS APPEAL

1. This is an Appeal by Dr Paul Hirschowitch (Dr H) against the Decision by North Yorkshire & York Primary Care Trust (the PCT) communicated by letter dated 15th January 2008 to remove him from its Performers List (the List) under Regulation 10(4)A and 10(4)B of the National Health Service (Performers' List) Regulation 2004 as amended by the Regulations of 2005 and 2006 on the grounds that his continued inclusion in the List would be prejudicial to the efficiency of the service and safety of its patients and that he is unsuitable to be included on the List.

2. The Appeal was heard over three days from 19th – 21st May 2008 at the FHSAA Headquarters in Harrogate. Dr H was represented by Mr Giles Colin of Counsel instructed by Radcliffes LeBrasseur, Solicitors, and the PCT by Miss Fenella Morris of Counsel, instructed by Hansons Solicitors.

DECISION

3. Our unanimous decision is to dismiss the Appeal and direct removal of Dr H's name from the Performers List of the PCT.

REASONS

<u>The PCT Decision under Appeal</u>

4. Following an Oral Hearing which took place on 27th November 2007 and 7th January 2008 the PCT gave its formal decision and reasons by letter dated 15th January 2008. Its decision set out in paragraph 1 above was stated to be in respect of the following allegations:

   (i) On 29th March 2005 during a consultation with patient W at Norwood House Surgery you sat so close to this patient whilst examining her so as to make her feel uncomfortable such that when she saw your Partner Dr Barron on her next visit to the Surgery, patient W commented that she did not wish to see you again as you were "creepy". This view of patient W did not change as a result of your examinations of her at the Surgery on 9th February 2007 and 28th February 2007.

(ii) On 22nd January 2005, during a consultation with patient H at Norwood House Surgery, you examined this patient's breasts without first offering a chaperone and without arranging the attendance of a chaperone during the intimate examination.

(iii) On the same occasion you offered this patient an internal examination despite an internal examination having been performed by your Partner Dr Barron shortly before on 17th June 2006.

(iv) On the same occasion you said to this patient "you've a nice arse and if I saw you down the street.." or words to that effect and at this time you rubbed yourself.

(v) On the same occasion as patient H left the consultation room you called her back saying "hey" and drew her attention to your rubbing yourself in your genital area.

(vi) By December 2006 you had established an inappropriate relationship with patient S such that you had stroked her hand, touched her face and placed loose hair behind her ear, an unusual feature of consultations with her of a cuddle on her leaving the consultation room.

(vii) On 14th March 2007 you examined at Norwood House patient S including the touching of a breast of the patient without first offering a chaperone and without the knowledge of a chaperone during this intimate examination.

(viii) On 14th March 2007 during a consultation with patient S at the Norwood House Surgery:

i. you touched her hand and you touched her face;

ii. on this patient standing up to leave you had hold of her hand and pulled her down so that she sat on your knee;

iii. after this patient was sitting on your knee you said "some things happen to men when they have a woman sat on their knee" or words to that effect and drew this patient's attention to your erection at the time.

(ix) You failed to make a note of the consultation with patient S that took place on 14th March 2007.

5. The Panel found allegations (i) to (viii) proven to the criminal standard and in respect of allegation (ix) that a clinical note had been made for the consultation with patient S which took place on 14th March 2007, however the Panel found the note to be inadequate and misleading in that it did not detail the incident with patient S which was a serious professional matter.

6. The Panel, having considered the evidence before it as set out above, concluded that Dr H should be removed from its List on the grounds of efficiency and unsuitability.

<u>The Grounds of Appeal</u>

7. By Notice of Appeal dated 30th January 2008 Dr H set out his grounds of appeal or matters of complaint.

i) The application of an inappropriate standard of proof indicative of the approach that the Panel were taking to the Hearing. Namely that the test was to the criminal standard having careful regard to patient safety and public interest. This demonstrated a clear bias which could not be determined by the Panel stating at the conclusion of the Hearing

that the standard being applied was the criminal standard i.e. beyond all reasonable doubt.

ii) The late and piecemeal disclosure of medical records relating to patients W, H and S. This was in breach of the regulations for the Hearing which required disclosure of information at least 28 days before the Hearing commenced.

iii) Patient W who is the subject of Allegation 1 did not attend the Hearing nor give oral evidence. Dr H was therefore denied the opportunity to cross-examine the witness and test out the evidence as set out in her statement. This left significant doubt as to whether the allegation could be so proven to the criminal standard.

iv) Reliance upon the GMC Guidance Document "Maintaining Boundaries" November 2006 in relation to allegations which pre-dated the guidance, for example Allegation 1.

v) The PCT amended the charges in the Decision without any formal application being made at the Hearing.

vi) The letter of Dr Sleaman was relied upon as evidence consistent with the allegations made even though there was no formal enquiry in relation to the issues that he discussed or findings on those issues.

vii) Dr Geddes gave expert evidence. As Medical Director of the Trust and the witness who gives recommendations to the Panel, this was inappropriate and questioned his independence as an expert.

viii) The Panel relied on similar fact evidence, this was not appropriate and each allegation should have been considered on an individual basis and proven to the criminal standard on the basis of the evidence called.

ix) Too much attention and reliance is placed upon the "state of patient S" as evidence of proof of her allegations.

x) Disproportionate amount of time considering the allegations when compared to the time for which the evidence was heard. The Panel heard almost two days of evidence and submissions yet only took less than one hour to reach their determination.

xi) The appearance was the decisions had been reached before evidence was heard.

xii) The inappropriate use of Regulation 10(4)A and 10(4)C as the reasons for removal. The regulations are for removal in the case of either efficiency or suitability and not both.

xiii) In all the circumstances the Panel's decision was unfair, unreasonable and disproportionate and Dr H was not given a fair hearing.

8. With regard to the allegations of procedural unfairness, both parties accept that this Appeal proceeds by way of a re-determination, in which the burden lay on the PCT to prove its case and therefore any grounds of Appeal in respect of procedural unfairness were not pursued.

9. Dr H submitted that it was open to the FHSAA Panel (hereinafter called "the Panel") to find that this was an efficiency case and could be dealt with by way of contingencies i.e. that Dr H could be removed on the ground of efficiency and a contingent removal would be appropriate with various conditions.

10. Written Directions were issued by the Panel providing witness statements to be filed in respect of all witnesses upon whom either Party intended to rely and further that skeleton arguments should be filed by both Parties in respect of the issue of the attendance of the PCT witnesses, such witnesses having already given oral evidence at the Hearing in November 2007 and January 2008.

11. At the outset of the Hearing there was an issue in respect of Directions which had been given by the Panel dated 14th April 2008 and in particular Direction 2 which read "all witnesses who will be relied upon will be expected to attend the Final Hearing". The Respondent sought a variation to that Directions as follows:

Save for patients S and H who gave evidence at the North Yorkshire and York PCT Hearing in this matter. The APPELLANT did not seek a variation.

12. The Panel directed that this would be dealt with as a discrete issue at the commencement of the Hearing on the 19th May 2008. Written reasons were given to the Parties after hearing submissions from both the APPELLANT and the Respondent.

13. The Panel considered overall that it was not disproportionate to re-hear oral evidence in the case and directed, after consideration of the papers, that all witnesses upon whom either party intended to rely should attend the Final Hearing, the Panel saw no reason to vary that Direction.

14. Also at the outset of the Hearing, in accordance with the points raised by the Parties, the Panel confirmed that the standard of proof which they intended to apply would be the criminal standard following Doshi -v-Southend-on-Sea PCT 2007 EWHC1361(Admin).

<u>The Relevant Law</u>

15. (i) This Appeal proceeds by way of a re-determination of the PCT'S decision (Section 49M(3) and Regulation 15(1) of the 2004 Regulation).

(ii) This Panel can make any decision which the PCT could have made (Section 49M(4) National Health Services Act 1977 and Regulation 15(3) of the 2004 Regulation).

(iii) By Regulation 10(3) of the 2004 Regulations a Performer may be removed from the list where any of the conditions set out in paragraph (4) is satisfied including:

(a) his continued inclusion in its Performers' List would be prejudicial to the efficiency of the services which those included in the relevant Performers' List perform ("an efficiency case");

(b) he is unsuitable to be included in that Performers' List ("an unsuitability case").

(iv) Regulation 11 sets out the criteria which have to be taken into account in determining either an unsuitability case or an efficiency case.

(v) The burden of proof falls upon the PCT.

(vi) The standard of proof as outlined at the beginning of the Hearing is the criminal standard.

(vii) In the event that the Panel find that this is an efficiency case the Panel may decide to contingently remove the APPELLANT under Regulation 12(1) of the Regulations.

(viii) By Regulation 12(2), if (the Panel) so decides it must impose conditions as it may decide on his inclusion in its Performers' List with a view to:

(a) removing any prejudice to the efficiency of the services in question (in an efficiency case).

Preliminary Issues and Documentary Evidence Available

16. At the start of the Hearing the Panel directed that all witnesses should be available for the purposes of cross-examination and therefore on the basis that patient W had not given oral evidence previously nor was she available to give evidence before this Hearing, Allegation 1 was not to be considered by this Panel. Her evidence was excluded. The other evidence was included and the documents available and taken into account by the Panel were as follows:

1. Hearing Bundle paginated from 1 – 355
2. Statement and Transcript Bundle
3. Medical Records

17. The Panel also agreed to include witness statements which were received during the course of the Hearing from Dr Judith Dawes and Dr Jeremy John Coppack on the basis that there was no prejudice to the Appellant by the inclusion of the late filing of that evidence.

Background

18. Dr H qualified from the University of Newcastle in 1996. Prior to undertaking his medical training he worked as a fully trained combat paramedic in the Israeli Defence Force. In February 2003 he commenced his G.P. Registrar Placement at The Eastfield Surgery in Scarborough. In February 2004 his final G.P. Registrar Placement was at The Derwent Surgery in Moreton. This was completed in August 2004 at which time he joined Norwood House Surgery as a General Practitioner. He continued practice until he was suspended on 2nd April 2007 and thereafter removed on 15th January 2008.

19. Around 16th March 2007 the Practice became aware of a letter which had been sent by patient S to Dr H which raised questions on the part of patient S and the Practice about what had happened during a consultation.

20. In the letter patient S stated that they had both crossed the patient/doctor line and that she had liked sitting on Dr H's knee and wanted to meet to talk about what had happened. A meeting took place between Dr H and Dr Barron and at the meeting it was noted that:

(i) description of events as recorded by Dr H differed from the patient's version;

(ii) there was no documentation of the consultation in the patient's case notes;

(iii) Dr H had not sought to discuss what had happened with any G.P. colleagues;

(iv) the patient had not made a formal complaint.

21. The Practice recalled two earlier instances where young female patients had raised concern about their experience of consultations with Dr H and in view of the earlier cases the Practice referred the matter to the PCT. An investigation was undertaken by Amanda Brown together with Dr Sian Gilcrist who was asked to provide clinical support in respect of the interview process. During the course of the investigation the investigating officer interviewed patient H, patient W and patient S. A statement was provided on behalf of the three patients which formed the basis of the allegations 1 – 9.

22. During the course of the investigation Dr H was requested to nominate five G.P. referees. The purpose of contacting the G.Ps was to consider whether there was a history of previous complaints or concerns of a similar nature that would indicate a pattern of behaviour. Dr Sleaman, a G.P. trainer at Derwent Surgery, said that his attention had been drawn to matters in respect of the issue of behaviour towards female colleagues and patients on two separate occasions, one in respect of a Staff Nurse who reported an encounter with Dr H following the successful resuscitation of a patient in the Casualty Department when a hug was given in congratulations and, secondly, a female patient who said that Dr H had put a congratulatory arm around the patient at the end of the consultation which she felt was inappropriate. Dr Sleaman stated that he had arranged a meeting with Dr H to discuss the issues and following that meeting there were no other reports of any incidents with Dr Sleaman concluding that a lesson had been learned. He expressed his disappointment that allegations had now been made by patients at Norwood House Surgery. The other referees all confirmed that Dr H was a professional and conscientious colleague who gave no cause for concern.

23. The investigating officer also arranged a referral to the Occupational Health Service for an assessment including a hearing test with the agreement of Dr H, due to the fact that Dr H had suggested that one of the complaints, namely that he would sit too close to patients, was due to his having to lean in to be sure that he heard what the patients were saying. Dr Fraser carried out a pure tone audiogram which confirmed a degree of hearing impairment which Dr Fraser felt may account for the problems to which Dr H related. He stated that in his opinion it was credible that his hearing difficulties would have meant that he had to be closer than average to a softly spoken patient. He did not have any other medical problems including mental health problems, other than some psychological symptoms related to his war service which had not impacted upon his work. Dr Fraser concluded that Dr H was medically fit for his duties as a G.P and no additional professional support to Dr H or care was recommended.

24. On 27th November 2007 the PCT held an Oral Hearing following the result of the investigation. Dr H was represented by Mr Giles Colin of Counsel the PCT were represented by Miss Fenella Morris of Counsel. A full transcript of that Hearing was available to the Panel. Patient S gave evidence and indicated that Dr H had undergone a breast examination without a chaperone being present and without a chaperone being offered. That he had requested that she call him Paul and then began hugging her during the course of the consultation. He would stroke her hand and in March 2007 she was pulled into an embrace and sat upon Dr H's knee. Patient S gave evidence that he sort of scooped her up, she was trying to remember how it happened, it

was just quick. Patient S then went on to say that Dr H had said "some things happen to men when women sit on their knees". As she left the consultation she had to look back because he had said it and it was ringing in her head and she noticed an erection. She left the room and said goodbye saying that she would see him on Monday. Subsequent to that consultation she said that she made her mind up as she was leaving the Surgery that she was never going to go back for the letter, she thought "stuff it, the letter is not that important any more and Dr H needed to know that this has gone on above a level i.e. the boundary had been crossed". She wrote the letter out with help of her friend.

25. She changed her Surgery two days after the letter and did not attend a meeting with Dr Barron and Dr Koppack.

26. Under cross-examination patient S maintained her position, patient H gave evidence to the Panel and confirmed at an appointment on 22nd June 2005 she was offered an internal examination by Dr H and further that Dr H took her bra strap down and examined her breast. She was not offered a chaperone nor was she asked whether her breasts could be examined. Patient H then gave evidence to say that Dr H said "you have got a nice arse" that she was a good looking girl and if he was down in the street …. Patient H said that Dr H was rubbing himself as well which made her feel anxious and nervous. As she left the consultation Dr H shouted "hey", so patient H looked back and Dr H was rubbing himself.

27. Patient H confirmed that she had an appointment with the Practice Nurse a few days later and the notes as written by the Practice Nurse in respect of the incident.

28. Under cross-examination patient H maintained her position. When asked for an explanation as to why the Practice Nurse had recorded in her notes that the breast examination had taken place on top of her clothing, patient H confirmed that she did not write down the incident as it happened, it was recorded after she had left the Surgery. She spoke to Dr Koppack on the telephone but did not go in for a further appointment due to the fact that she was ill.

29. Dr H gave evidence to the Panel, he initially dealt with the letter from Dr Fraser confirming that he had attended an Occupational Health Physician and had been prescribed two hearing aids.

30. In respect of patient H, Dr H confirmed that he had undertaken a breast examination without a chaperone. The reason being that patient H, with her right hand, removed her top and bra to one side and exposed her breast. Dr H said he was nervous and flustered and it was a relatively quick examination asking her to re-dress and felt uncomfortable afterwards. With regard to the internal examination he advised her that the only physical examination which could be undertaken in an early pregnancy setting, which could give any information, was bi-manual examination. Patient H had advised him that she had already had one and at that stage Dr H scrolled back through the screen due to the fact that Dr Barron's previous examination notes were not on the screen. When he noticed that he advised patient H there would be no need for any further examinations to take place. He denied neither that he had made any comment to patient H nor that he had rubbed himself.

31. In respect of patient S, he said that he had not examined her breast because he could examine a rash without shifting any intimate garment which he had actually asked prior to undertaking the examination. He accepted that he had touched her hand on 14th March, to get her a tissue as she was crying. In respect of the incident concerning patient S sitting on his knee, he stated that he was checking the screen to see who was in the waiting room, how long they had been there for and whether he needed to move his clinic on, on the basis that if there was nobody waiting he would have given patient S more time. Whilst his attention was diverted patient S initiated the contact by sitting on his lap. He stood up which caused patient S to stand up as well and he was surprised. He had not put any entries in her medical notes on the basis that he thought he would deal with it at the end of the day. He did not have anybody to speak to at the end of that day so he discussed the situation with his wife when he went home.

32. Incidents overtook him at that stage because prior to him being able to discuss anything with Dr Koppock the letter had been received and a meeting was called. Dr H said that Dr Koppack and he sat down planning how they would remedy the situation and Dr Koppack decided that Dr H would see patient S to try and ascertain exactly what her motives were, if it was accidental to try and re-establish professional boundaries and if it was not accidental and she had some feelings for Dr H then to sever the relationship professionally and ask her either to see another doctor within the Practice or remove herself from the patient list. Patient S did not show up for the appointment on Monday.

33. With regard to any further allegations he maintained he had not given her a cuddle, he had not had any physical contact, not stroked patient S's face, that he had not said the words to patient S advanced in her evidence.

34. Under cross-examination Dr H maintained his position, he accepted that there was no clinical reason for examining patient H's breast and that he would have gained no hard clinical information from performing that examination. In respect of patient S, Dr H said that he failed to be aware that patient S was developing a relationship with him. He did not actively encourage or understand that there was a relationship. The only time that he would have touched her face was to move hair if it was clinically indicated and he did say to patient S when she sat on his lap "that's the first time an adult has ever sat on my knee". He said there was no further conversation between them and that he had not made a note in the consultation notes afterwards. He maintained under cross-examination that Dr Koppack had advised him to see patient S and whilst he was quite scared of the possible outcomes he was swayed by Dr Koppack's argument because he was a G.P. of significant seniority to himself and was his senior Partner.

<u>Oral Evidence</u>

35. The PCT did not call evidence from patient S and patient H who attended on the basis that the transcript was available which would stand as their evidence in chief. Both patient S and patient H were cross-examined. Patient H said in respect of the consultation on 22nd June 2005 under

cross-examination that Dr H was making her drip with sweat due to the fact that she was not feeling OK. She was sick which was why she attended the Surgery. She maintained that Dr H had said to her that she was a very pretty girl and he understood why she did not want the baby. There was no way that she had exposed her right breast. The breast was examined, Dr H took her strap down and her top. He examined both breasts in his consultation room. Dr H also asked if she wanted an internal examination and it was offered to her.

36. Patient H stated that Dr H said she had a nice arse and that he was rubbing himself in his crotch area. She maintained that she had advised the Practice Nurse that the consultation was not right and that she felt uncomfortable. She raised with the Practice Nurse that she had been offered an internal examination although Dr H knew that she had already undergone such an examination previously. The Practice Nurse did not write down the notes at the time, the notes must have been written afterwards. Patient H said that she did not mention the comments that Dr H said, she may have said that he rubbed himself, she was just not sure. She was very shaky when she was waiting to see the Practice Nurse in case Dr H came out of the Surgery. She maintained that she had spoken to Dr Koppack twice on the telephone about it but was too ill to attend. She had not exaggerated or misconstrued any of the consultation.

37. Dr Koppack gave evidence next and confirmed the content of his statement which dealt with patient S. Dr Koppack's evidence was that he was very clear Dr H should not see patient S again at the Surgery and that if she attended she would be directed to one of the other Partners.

38. Under cross-examination Dr Koppack advised that he had written to patient H but had not kept a complaint file. The information given to him was from the Practice Nurse. Patient H did not come into the surgery, she was unable to attend because of illness. He could recall one conversation but had not recorded details of the conversation.

39. In respect of the Practice Nurse's notes, he would be very surprised if the Practice Nurse had not documented an allegation that Dr H was rubbing his crotch if that information was given to her.

40. With regard to the incident of patient S's letter, he had received the letter from the Practice Director. He noted the contents and decided to approach Dr H at lunch time. Dr H had said that patient S sat on his knee and he terminated the consultation at that point. Both Dr H and Dr Koppack had discussed how to deal with the situation. Dr H had said that he would contact the patient to explain there had been a misconstruction and that he did not intend to form a relationship. Dr Koppack's advice was that there should be no further contact and that her attendance this afternoon would be dealt with by another G.P. He then approached Dr Barron, told her about the meeting and the letter and Dr Barron had agreed to stay back, as it was her half day, to see patient S, who did not attend.

41. With regard to Dr H's allegations that his consultation notes were looked at, Dr Koppack denied that this was the position and that they would only be looked at in respect of future consultations. There was a good working relationship between him and Dr H.

42. Amanda Brown gave evidence, she was the investigating officer who made contact with the patients and took the notes to prepare the statements. She maintained that they had stuck to the interview plan as far as they could but that the notes were not recorded verbatim.

43. Dr Healey gave evidence then on behalf of the Appellant due to the fact that patient S was not available to give evidence until the following day. Dealing with patient H, it was his opinion that as patient H had been in five days previously he would query why she was coming back. She was obviously anxious and the simplest and best way was to start from square one. He would not criticise the doctor for offering an internal examination. Scans were not available for 24 hours and this would put her mind at rest immediately.

44. Dr Healey accepted that a lady's breasts should not be examined without a chaperone being present. It however happened to all G.Ps that women expose their breasts, it causes less embarrassment to the patient to deal with it there and then. He submitted that it happened to every G.P. in the land.

45. In respect of patient S, that she was obviously upset, disturbed and distressed. It was known over the Christmas period that she had attempted to take an overdose. Dr H had quite rightly referred her to a Counsellor and he would not criticise him. Patients did form attachments with G.Ps. It was not a sexual attachment. Dr Healey did not see anything wrong in that. He did say that you would need to remove yourself from the patient if it became sexual.

46. If the allegations on 14th March 2007 were proven, one would have to accept it and Dr Healey would not condone the behaviour. A note should have been taken but it was not.

47. In respect of Patient S being prescribed benzodiazepines, 5% could exhibit or imagine things which were not there. Various things had happened to patient S and it was his opinion that her mental notes should be looked at in detail.

48. Under cross-examination Dr Healey said in respect of patient H, it was reasonable to offer her an internal, it would have been reasonable to offer a scan but it would only increase her anxiety and it is not what most G.Ps would do. They would offer a bi-manual examination. In respect of the NICE guidance, he said that you had to take the situation as you found it. Patient H was anxious. He was aware of the NICE guide lines but you had to take the guidance with a pinch of salt.

49. He submitted that breasts should be examined if they were presented as lumpy and misshapen. He would always examine a person's breasts if that complaint was presented. He maintained that it should be recorded on the notes, both the examination and the findings should be recorded. There was a clinical obligation to do that and it was also a requirement that a chaperone be offered.

In respect of patient S, he said that he believed a psychological assessment was important and that he needed to see any psychological assessment of her. He would expect a General Practitioner to record the incident on 14th March 2007. If a patient came up with an extraordinary

statement such as that he would raise a query. Not to make a note of her sitting on his knee was a failing.

Dr. Healey did not regard inspection as part of the examination and thus felt that a chaperone was not required. Dr Sharma, on behalf of the Panel, put questions to Dr Healey and asked him to describe various parts of an examination, he could not recall them off hand.

50. In respect of the position of the hydatidiform mole which Dr H suggested could be a reason for patient H's complaint, he accepted that a blood test was the only basis upon which that could be clinically proven, although initially he only suggested a diluted urine test.

51. With regard to the bi-manual test, he said that patient H could be reassured immediately however he would still have to undergo a scan to make the clinical findings. He accepted that patient H would not be reassured without a scan. It was a failing not to record the breast examination and a major omission.

52. Similarly with regard to patient S, it was understandable that Dr H was completely shocked. It should have been recorded and this also was a major omission. He also submitted that one would expect Dr H to tell a partner and the MDU over an incident such as that.

53. Patient S gave evidence the following day, under cross-examination she said in respect of the incident on 14th March 2007 that she had initially gone in to ask for a letter. Dr H asked her how she was feeling and when he mentioned some things to her she started to cry. He made a further appointment for her to collect the letter and as she went to leave he pulled her into him. He said that some things happen to men when women sat on their knees. She had said "oh right", stood up and noticed that Dr H had his hand in his pocket and there was a bulge. She was upset, angry, confused and shocked. With regard to the letter which she had written, she did a draft letter first because she was dyslexic and asked a friend how to write the letter. She stated that she was being polite when she said she liked sitting on his knee, she was completely confused and did not know why she had put that in the letter. She said it was odd but it was not often that you found yourself in that situation. She had not developed an attachment or an attraction to Dr H. She had wanted him to clarify why he had done what he had done, which is why she wrote the letter. She did not think about reporting him due to the fact that she had already made a decision to leave the Surgery. She had transferred to Prospect Surgery on 15th March and was not going to return to that Surgery. She had no intention of going back to collect the letter.

54. She denied that her hair needed to be pushed back for the purposes of an examination as she always wore her hair back to make it feel secure. This was when Dr H touched her face. She maintained that she was cuddled, which started on probably the second or third time that she saw him. She also maintained that Dr H had said "call me Paul".

55. With regard to the examination, she maintained that there was a rash on the right side of her breast. She said that she was asked if she wanted a chaperone. She accepted she refused the

chaperone but agreed that he undertake the examination of her breast. She said that Dr H needed to compare it with the other breast and asked her to lift her bra up.

56. Dr H confirmed both the contents of his statement and the contents of the oral hearing. In respect of patient H he maintained that the patient had exposed her right breast before he anticipated she would and before he had the chance to offer her a chaperone. He offered her an internal examination as she felt that she may be further along even though she had a termination booked for 4th July 2005. Patient H had asked if there was anything that she could do in the clinic that day. He had advised her that the only physical examination was a bi-manual and only when she advised him that she had had an examination previously did he scroll back and see the entry from Dr Barron. He said he offered her an ultra-sound and did not either rub his crotch or state that she had a nice arse.

57. In respect of patient S he did not stroke her hand or touch her face, if he did put her hair behind her ear it was only to undertake an examination of her ear. He had not cuddled her and did not establish an inappropriate relationship with her.

58. With regard to the incident on 14th March, she had attended with upset and stress. She had told him that her second marriage had broken down and she wanted to be relocated. He said that he was going to help her relocate and offered her a tissue because she was stressed. As he checked his computer patient S sat on his knee. He arose quickly, it was an unpleasant experience. He did say that that was the first time an adult had sat on his knee. He ushered her to the door. He had not made a note of the consultation due to the fact that there were five people waiting and he wanted to give some thought and plan what to do. He was the last person in the Practice and decided that he would go home and talk to his wife. He said he was isolated in the Practice.

59. With regard to the incident in February concerning the examination of her breast, he said that he did not touch her breast, there was no need to. He did not expose her breast, it was not an intimate examination and therefore there was no need for a chaperone.

60. Under cross-examination in respect of patient H he maintained that she had asked if there was any examination she could do on that day in respect of what her dates were. He accepted an ultra-sound could be arranged the following day but patient H had not asked for one. He said that he did not offer the patient an ultra-sound. He maintained that on looking at the clinical notes you could not see the previous notes from Dr Barron. He could only see a previous entry from Dr Koppack.

61. He accepted that the breast examination should have been recorded and that was a mistake on his part. The breast examination occurred after he had completed the notes and he planned to go back later and add it. It was just a matter of style. Dr H maintained that patient H had exposed her breast whilst sitting down. He had asked her whether she wanted an examination and she said yes.

62. Dr H accepted that the examination was of no purpose and it would not give him any clinical assistance.

63. In respect of patient S, he accepted that patient S was vulnerable. He did not encourage any relationship but he was oblivious to what was happening. He maintained that patient S had to share some of the blame. He did not think at any point that she was forming an attachment or a dependence to him. With regard to the incident concerning the rash, there had been a recorded incident in the medical notes on 5th March 2006 which stated 'mild skin cracking, perinostril' With regard to most rashes on the skin he would have to make contact to see whether it was scaly, raised, moist and what the temperature was. He would have touched the rash where it appeared elsewhere, he did not need to expose her breast as it was readily apparent and noticeable.

64. He said it was Dr Koppack's idea that he saw patient S on her own.

65. He said that all of the staff had advised him that his notes were looked at and he would not put it past his Partners to try and arrange his self-destruction. He said that he wished to return to work as a G.P. He had addressed his physical side with regard to his hearing loss such that patient proximity would not now be a problem. He would be more wary of watching situations develop and would insist on a chaperone with regard to any female consultations. He accepted that a period of training would help him and the public.

66. Dr Sharma, on behalf of the Panel put some questions to Dr H. He said he could not answer why his notes were being looked at by the other doctors. Meetings were called to which he was not asked to attend. He had watched the G.P s professionally destroy a Nurse and that his wife had been pushing him for two years to resign, she had actually been proven right. He said that in respect of patient S, he thought that he could see her and sort it out such that they could re-draw the professional boundary. He had not spoken to anyone over the weekend because he was too busy. The decision to speak to patient S was his alone.

67. He said that Dr Koppack came in with the letter after Surgery, he felt isolated and did not know who to tell. He accepted he could have gone to the Health Care Assistant in the Practice but he had not spoken to her either.

68. Dr H accepted that the Practice had an EMIS system with regard to the consultation notes. He accepted that with patient S the screen would be similar to that on page 98 of the bundle.

69. Dr Sleaman's statement was agreed. Dr Sleaman dealt with the two incidents with regard to the Staff Nurse and the patients. He maintained that Dr H was a caring and competent General Practitioner. The actions which were brought to his attention were innocent and unfortunately misinterpreted by a patient also by a staff nurse, and were made as a result of cultural differences rather than being motivated by any sexual intention.

SUBMISSIONS

70. The closing submissions on behalf of the PCT submit that patient H's evidence supported the allegation. She had no reason to lie, there was no possible advantage to her giving evidence and submitting to cross-examination twice. She had disclosed the incident shortly afterwards at an appointment with the Practice Nurse. The Practice Nurse's note of the disclosure was not contemporaneous but made after the disclosure. The fact that the note suggested an examination of the breasts was through patient H's clothes was neither here nor there since both patient H and Dr H accept that the examination was of her naked breasts.

71. Patient H's evidence was consistent both throughout the PCT and the FHSAA process.

72. The internal examination which took place did not provide any clinically useful information. It was not accepted that Dr H would not have seen the previous internal examination, as the screen on page 98 suggested it would be visible to him. The failure to record the breast examination tended to support a hypothesis that the examination was for an improper i.e. sexual, purpose. It was accepted that Dr H himself stated he did not carry out a clinically useful or appropriate examination of patient H's breasts. The credibility of Dr H's account was doubtful, he introduced the suggestion that patient H had told him she knew an ultra-sound was available but did not want it, only after the suitability of an ultra-sound rather than an internal examination was raised at the Hearing before the Panel. This had not been raised before.

73. In respect of patient S, she presented a picture of a vulnerable patient in respect of forming an attachment to Dr H through repeated consultations, disclosures and an escalating pattern of inappropriate physical contact. She had given a clear account of the touching of her hand, face, hair, breasts, cuddling and then the incident in respect of his lap.

74. Patient S was credible because she had no reason to lie and clearly suffered considerably a result of being required to give evidence and submit to cross-examination twice. Dr H had accepted that patient S was not less likely to tell the truth because of the history of depression, there was no evidence to support a finding of lack of credibility in her records. She had been repeatedly prescribed benzo-diazapines without reports of adverse effect. It was Dr H's responsibility to draw the boundary and it was not credible or attractive to blame patient S for the incident. Her evidence was consistent throughout the PCT and FHSAA process.

75. The credibility of Dr H's evidence was doubtful. His account of not touching patient S's breast to examine the rash was not credible. His earlier evidence was that he had to touch the rash, secondly he described it as easily palpable which implies that he touched it. His failure to make a note of the incident in March 2007 over a period of several days tended to suggest that he wished to cover it up. His evidence was contradicted both by Drs Barron and Koppack.

76. The hearing problems do not explain the allegations nor do exuberance or Dr H's personality. Dr H received guidance from trainers, his Partners and written guidance was available from the GMC. He knew at the material time that the keeping of proper medical records was a simple requirement imposed on all doctors by the GMC for sound clinical reasons.

77. The PCT submit that Dr H accepts that if sexualised behaviour is found then he is unsuitable and must be removed from the Performers' List. If the Panel were to consider contingent removal the PCT submitted the conditions must be imposed.

78. The written submissions on behalf of the Appellant submit that on the basis of the evidence that the Panel has seen, heard and read, it cannot be so satisfied. The Appellant has to prove nothing, although he gave evidence before the Panel and submitted to cross-examination. Dr Fraser confirmed that pure tone audiogram demonstrated a degree of hearing impairment. In Dr Fraser's opinion it was credible that hearing difficulties would have meant that he would have to be closer than average to a softly spoken patient in the consulting room. The observation explained how easy it was for the Appellant's actions to be misunderstood.

79. The Appellant has addressed this issue by consulting with an Ear, Nose & Throat Surgeon and obtaining hearing aids which have now been fitted to both ears.

80. The evidence of patient H was neither credible, reliable nor consistent. It was significant that the account patient H gave to the Practice Nurse differed to the account presented to the FHSAA and as set out in her witness statement. It was significant that the Practice Nurse's note was silent in respect of the allegation that the Appellant was rubbing his crotch during the consultation or that he made comments of a sexual nature. When patient H was asked about the inconsistencies in her evidence she said 'I might have said that, I am not sure whether I said it or not'. Dr Koppack was clear that if patient H had made a complaint to the Practice Nurse of the nature now suggested he would have expected her to record it. She was a professional colleague who was reliable.

81. The FHSAA cannot simply dismiss the evidence of Dr Healey.

82. The Appellant, in respect of patient H, was clear and consistent in his evidence. The credibility of his account cannot be dismissed as doubtful. His account remained the same in his witness statement in the course of his evidence before the PCT Panel and before the FHSAA. He did not comment on patient H's looks. It is the Appellant's case that patient H was seated in a chair talking about how she felt sick and that her breasts were over-sized when suddenly and unexpectedly she exposed her right breast. He had offered the information with regard to a bi-manual examination of the uterus when patient H was concerned about her dates. He did not offer to perform the examination. He was adamant and unshakable in his evidence.

83. It is inconceivable that Dr H would behave in the manner alleged by patient H in respect of rubbing his crotch or genital area on the basis that events occurred in the manner stated by the Appellant, Dr Healey was supportive of the manner of Dr. H's consultation in the circumstances.

84. Patient S was neither credible, reliable nor consistent. It was submitted that the actions of Dr H with regard to seeing patient S on a number of occasions were those of a kind and caring General Practitioner and nothing more.

85. The Appellant submitted that he did not wish to seek to blame patient S for the incidents. It is submitted that at its highest, the only criticism that could be levelled is that the Appellant did not see that an attachment had developed. He accepted that criticism.

86. With regard to the letter dated 16th March 2007, the Panel was asked to carefully consider the letter:

(a) Such a letter was not consistent with the upset, shock, anger and confusion as patient S indicated.

(b) It was not consistent with her evidence that she was hopelessly in love with her husband. She was attracted to the Appellant.

(c) The letter was indicative of patient S having developed an attachment and was inconsistent with her oral evidence.

87. The Appellant denies having developed anything other than a professional doctor/patient relationship with patient S. There was physical contact in that he welcomed her with a hand shake and offered her tissues when she was crying. If he had examined patient S's face he may have touched her face for a reason of looking at skin lesions, it was only this type of condition that would have necessitated touching her face. An examination of the ears was the only clinical context where it is conceivable that a lock of hair needed to be brushed away. He had not given a cuddle to a patient. It was a matter of record that patient S had taken an overdose. For this reason the Appellant started rationing her medication and would make the appointments himself whilst at the computer. It was clear from patient S's medical records that there were cases when she was offered a chaperone and this was declined. The Appellant acquiesced and he accepts that he should not have done so. The Appellant maintained that he did not need to expose or touch the breast, in February 2007 he was able to examine it without doing so. With regard to the consultation on 14th March the Appellant states that patient S had attended regarding a housing situation and psychological problems; the Appellant agreed to write to the Housing Department and at the end of the consultation in a split second patient S turned and sat on his knee. The Appellant denied that he took patient S's hand and pulled her onto his lap as was alleged. At no point did the Appellant make the comments alleged or referred to his genitals. The Appellant made a note of the consultation in patient S's medical records but accepted some fault for lack of documentation. He felt isolated within the Practice such that he felt paralysed.

88. He had never sought a relationship with patient S and had empathised with her only on one occasion, detailing his past problems.

89. It was submitted on behalf of the Appellant that there could be no doubt as to the honest credibility of the Appellant in terms of his consultation with patient S. On the basis that the events occurred in the manner stated by the Appellant, Dr Healey was supportive of his case.

90. The allegations were entirely without foundation and merit, the Applicant has not satisfied the Panel to the standard required in relation to allegations 2 – 9. If the FHSAA find allegations 2 – 9 to have been proved to the requisite standard, namely that the FHSAA is satisfied so that it is

sure, then the Appellant is unsuitable to be included in the Performers' List and therefore must be removed.

91. If the FHSAA finds that this is an efficiency case and the words, deeds and actions of the Appellant have been misconstrued and/or misinterpreted, then it is asked to consider contingent removal. The Appellant agrees that any conditions must include:

(a) training and assessment;

(b) assessment by the respondent to its satisfaction that the Appellant has full insight, sufficient good and reliable record keeping and appropriate consultation style, fully addressing his hearing difficulties and appropriate insight and understanding of the needs of chaperones and the ability to implement a chaperone policy, a full understanding of the GMC and NICE guidelines, up to date knowledge and skills in the management of ante-natal care and patients complaining of breast symptoms and only on completion of the training and assessment a return to the General Practice for an initial period under full time clinical supervision by an experienced G.P. trainer.

92. The Appellant contends that a requirement that he sees no female patients without a chaperone is simply unworkable and if concern existed in relation to the aspect of this case that would be covered by the conditions.

FINDINGS

Allegation 1

Both Patient H and Dr H accept that a breast examination took place without either the offer of a chaperone or a chaperone being present.

The Panel note that the breast examination was not recorded in Patient H's notes.

Patient H's evidence was that the examination took place by Dr H removing her bra strap and exposing her breast. Dr H's evidence was that she suddenly and unexpectedly exposed her right breast and he had been therefore unable to offer a chaperone to her.

Patient H complained on 27th June 2005 to the Practice Nurse and stated that an examination had taken place on top of her clothing.

The Panel note that there is a discrepancy in the evidence but on the basis that both the Patient and Dr H accept the examination took place unclothed the Panel believe that the Practice Nurse had misinterpreted Patient H's comments.

Dr Healey, the medical expert on behalf of the Appellant suggested that a breast examination was justified. If the Patient's statement was correct then that behaviour could not be condoned, if the Doctor's statement was correct it was understandable. Dr Healey accepted that Dr H should have recorded the breast examination.

Dr H accepted under cross-examination that the examination was not complete and that he should have offered a chaperone and that examining one right breast on the chair was not of clinical value and that it should in any event, even if negative, have been recorded.

The Panel find that Patient H was a credible and willing witness and that her evidence as to the circumstances of the breast examination was found to be true.

This allegation is proven to the criminal standard.

Allegation 2

Both the Patient and Dr H accept that Dr H offered internal investigation on the same date.

Dr H stated that the Patient requested confirmation as to the dates of her pregnancy and how far she was on in view of her impending termination. He advised her that a bi-manual examination of the Uterus could give a reasonable estimate of dates.

Patient H stated that Dr H asked her if she wanted an internal and she said no, she had already had one.

The Panel note that there is no evidence of this examination being offered and/or declined contained within the medical notes.

Dr H said in oral evidence "she asked me if there was anything I could do to confirm her dates in the clinic". After having been told that Patient H had had an internal five days previously, Dr H agreed with her that she did not need another internal examination and accepted Dr Barron's estimate of the dates.

Under examination in chief, Dr H said that he offered Patient H a scan. Under cross-examination he stated he did not offer Patient H an ultra sound scan because she was aware of the ability to obtain one but stated that she did not want one and wanted an immediate answer in respect of her dates, which was why he offered the bi-manual examination of her Uterus.

Dr Healey stated that Patient H was anxious and needed urgent reassurance and the only way that the immediate reassurance could have been given was to perform the bi-manual examination of her Uterus.

Dr Geddes, medical director of the PCT, confirmed that a bi-manual examination would only give a rough estimate and that the only way to obtain accurate dates was to undergo an ultra sound scan which would be available in 24 hours and therefore questioned why there was any pressing need to determine gestation.

Other queries were raised in respect of incorrect diagnosis of dates as to why Patient H believed her symptoms were further advanced. All of those queries could only have been ascertained by undergoing an ultra sound scan.

Dr H stated in evidence that he could not see the previous entry of Dr Barron on the computer screen.

Dr H confirmed that he was not aware of the NICE guidelines in respect of bi-manual examinations to determine gestation.

The Panel do not accept that Dr H would not have seen the previous entry of Dr Barron. The printout on page 98 of the Bundle clearly shows the entry five days previously and reads "no pregnancy per abdomen – per vaginal not less than six weeks".

The Panel find that if the pregnancy was more than twelve weeks it would have been felt through the abdomen and therefore there was no clinical reason to offer a further bi-manual examination. Any further investigation, if warranted, should have been made by way of a referral for an ultra sound scan.

The Panel believe that the inconsistencies of Dr H's evidence, in particular the fact of raising that Patient H asked for an answer in respect of her dates that day in clinic and the offering/refusal of the ultra sound scan were only raised in evidence before this Panel when no evidence of that nature had been offered by Dr H before, either in written form or at the Oral Hearing over two days, call into doubt his version of events and the Panel find that Patient H's evidence is to be preferred.

The Panel find, in accordance with Dr H's position under cross-examination that a bi-manual examination of this patient would not have offered any clinically useful information.

The Panel find this allegation proven to the criminal standard.

Allegations 4 & 5

Patient H states that Dr H said "you have a nice arse and if I saw you down the street ……", Dr H rubbed himself, and called her back saying "hey". Dr H denied the allegations.
The Panel believe that due to the credibility of the witness, although it is likely this incident did occur as alleged by Patient H, they are not sure to the criminal standard.

Allegation 6 – Patient S

Patient's S's evidence is one of a progressing relationship which included, stroking her hand, tucking her hair behind her ear and cuddling her at the end of consultations. Patient S stated in evidence that her hair was always tied back. Dr H's evidence was that he would only touch her hand if he gave her a tissue or shook her hand initially or at the end of a consultation. He may, although he denied it, have had cause to move a lock of her hair to undergo an examination of her ear and he vehemently denied any cuddles, touching her face would only be to palpate a rash.
Dr Healey stated that if there was inappropriate touching it could not be condoned but he would not criticise Dr H's practices in respect of touching her face or moving her hair. In respect of the inappropriate relationship, Dr Healey said under cross-examination that a sexual relationship could not be condoned but an emotional relationship by way of the Doctor appearing to be friendly often helped the patient. However it was up to the General Practitioner to recognise that attachment forming.
Dr Healey suggested that the attachment could be in the patient's mind due to her reliance upon benzodiazepines. Although accepted under cross-examination that in fact it was less than 5% of patients who suffered delusions of this nature, Dr Healey maintained his position.
Patient S had written a letter to Dr H which provided details of a relationship which is clearly evidenced in that letter.

Dr H did not accept there was a relationship or, if there was, it was not of his instigation and that he had not noticed it developing.
The letter which Patient S wrote is a contemporaneous note and the Panel believe that this letter of itself provides evidence of an inappropriate relationship.
The phrase in the letter "we have crossed the patient/doctor line" stands out as did the evidence of Patient S when she blamed herself for the incident on 14th March and the fact that she herself withdrew from the Practice on 15th March.
The Panel note that there are no entries in the medical records of any investigations in respect of Patient S's ears. It would also be unusual for any General Practitioner to continue to make follow up appointments for his patients during consultation periods as suggested by Dr H. That point was supported by Dr Koppack.
The Panel do not accept that Patient S suffered from "florid eczema" as the only note in the medical records confirms mild skin cracking perinostril.
Although the Panel accept it would be acceptable to touch a patient's face to palpate a rash, it would only take a matter of seconds.
Patient S was credible in her evidence and the Panel believe that these incidents, i.e. touching her face, moving her hair, stroking hands and cuddling will have happened on occasions. In isolation these incidents may have been linked to medical matters but overall it is evidence of inappropriate physical behaviour, the cumulative effect of which led to the development of an inappropriate relationship.
The Panel find that there was an inappropriate relationship between Patient S and Dr H and that allegation is found to the criminal standard.

Allegation 7 – Patient S

Patient S suggests that on the 10th February 2006 Dr H examined a rash both on her back, shoulder and breast and that he did so with no chaperone being offered.

Dr Healey suggested that it was not an examination as Dr H had only looked. The medical notes confirm that there was a rash on the left shoulder and side. The rash appeared fungal.

Dr H said that he did not need to expose the breast as it was readily apparent on the back.

Dr Healey could not identify the different stages of an examination and stated initially inspection was not an examination and as such did not require a chaperone. After cross-examination by the Panel, Dr Healey accepted that an inspection did form part of the examination but stated that Patient S did not need a chaperone as it was only her back and shoulder that were being examined and not her breast.

The Panel found Patient S to be a credible witness and find that the examination of Patient S's breast will have taken place without a chaperone.

This allegation is proven to the criminal standard.

Allegation 8 and 9 – Patient S 14.03.2007

The medical records confirm that there is no proper computer entry which was made in respect of this consultation. There is a partial note although the Panel find to the criminal standard that the note is incomplete and inadequate.

There was no evidence by Patient S that Dr H touched her hands or her face on this occasion. As Patient S went to leave the Surgery, Dr H pulled her down onto his lap.

She then said, Dr H stated, "some things happen to men when women sit on their knees". As Patient S left the consultation room she stated that she looked back and believed that Dr H had an erection.

Dr H's evidence was that he was checking his computer screen to see how many patients were waiting to see him, when Patient S sat on his lap. Dr H said that he stood up and said "that's the first time an adult has sat on my lap". Dr H said that Patient S was upset from the outset, wanted to talk to him and needed help to relocate. He stated that he had finished late that evening and had not been able to talk about the incident to any of his Partners as they had left the Practice for the day. Dr H stated that he did not record the incident in the medical notes for the following reasons:

(i) The G.Ps in the Practice were perusing his notes;

(ii) It was late;

(iii) He did not know what to write.

Over Thursday and Friday, the two days immediately following the appointment, Dr H stated that he did not speak to anyone but his wife, who suggested that he speak to a G.P. colleague over the weekend. He stated that he was too busy over the weekend.

On Monday morning Dr Koppack showed Dr H the letter, Dr H confirmed in evidence that Dr K agreed he should see Patient S to ascertain what her motives were, if accidental to re-establish professional boundaries and if not to sever the relationship.

Dr Koppack gave evidence and stated that having received the letter he discussed the contents with Dr H who did suggest that he would see her on his own and that they would try and sort out the situation. Dr Koppack stated that there should be no further contact.

Dr Healey stated that such an extraordinary statement such as Patient S had made raised a query in respect of her mental health. If Patient S was to be believed it could not be condoned but if Dr H was to

be believed then he was to be defended most vigorously. Dr Healey accepted that the incident should have been written in the patient's medical notes.

Dr H, when asked about Dr Koppack's evidence, suggested that the Partners were out to get him by reading his notes and he would not put it past them to try and arrange his self-destruction.

i. Touching the hands and face: The panel can find no evidence to support this allegation.

ii. It is accepted that there was an incident which involved Patient S sitting on Dr H's lap. The Panel prefer Patient S's evidence for the following reasons:

i) For Patient S to sit upon Dr H's lap would have been difficult, even more so when he was in a position of power and she was vulnerable. The Panel believe that Patient S did not have the inner strength to do that and it would just not ring true;

ii) For Patient S to sit upon Dr H's lap whilst he was looking at a computer screen would be difficult as he would have been facing away from her;

(iii) For Patient S to slip or faint into Dr H's lap would also be difficult for the same reason;

(iv) It is likely that Dr H pulled Patient S onto his lap as the force required is slight and Dr H would have been prepared;

(v) The fact that Dr H did not make a full consultation note, even though he had time to write the letter which Patient S requested, gives credence to Patient S's version of events.

(vi) Dr H did not discuss this with any of his colleagues or members of staff from Wednesday evening until Monday morning when he was presented with the letter written by Patient S. The Panel believe that there is a doubt as to whether Dr H would have raised the position at all if the letter had not been intercepted.

(vii) Dr H did not refer the matter to a professional body or other G.P. colleagues as suggested by his wife.

(viii) Dr Koppack's evidence that Patient S should not be seen by Dr H is fundamentally the position that any G.P. would take in these circumstances. The Panel find it incredulous that any G.P. would suggest that Dr H would see the patient again on his own in the light of the contents of the letter.

The Panel find that this allegation is proven to the criminal standard.

iii. The Panel believe that something was said and the fact that both Patient S and Dr H confirmed similar wording, lead the Panel to believe that words of that nature were spoken but the Panel do not find that allegation proven to the criminal standard.

iv. Patient S confirms that she looked back and saw a bulge. Dr H denies that he had an erection.

The Panel find that this is not proven.

Overall Conclusion

The Panel find that there are 2 instances on breast examinations being conducted without a chaperone, neither of which were recorded in either if the Patient's medical notes. One of which was both unnecessary and incomplete, further would not have given any clinical value.

The Panel find that there was an offer of an unnecessary internal examination.

The Panel find that there was an inappropriate relationship between Dr. H and Patient S which included an element of touching and hugging. The Panel believe that Dr. H's behaviour was insidious which led to the incident on the 14th March when Dr. H pulled Patient S on to his knee during a consultation.

The Panel find that there is an element of non recording in each of the Patient's notes which is concerning when the examinations were of an intimate nature.

In the light of the above finding the Panel find that Dr. H is unsuitable to be included in the Performers List.

The Panel intend to consider National Disqualification and invite the parties to provide submissions on the same.

Finally, in accordance with Rule 42 (5) of the Rules we hereby notify that a party to these proceedings c+an appeal this decision under Sec 11 Tribunals & Inquiries Act 1992 by lodging notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days from receipt of this decision