Neutral Citation Number: [2026] EWHC 2226 (Admin)

Case Nos: AC-2025-LON-000876

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28/08/2026

Before :

THE HONOURABLE MR JUSTICE MORRIS

- -

Between :

THE GENERAL MEDICAL COUNCIL — **Appellant**

- and -

DR ALI SHOKOUH-AMIRI — **Respondent**

- -
- -

Jenni Richards KC (instructed by General Medical Council) for the Appellant
Ben Rich (instructed by MDDUS) for the Respondent

Hearing dates: 8th, 9th & 10th October & 1st December 2025

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Approved Judgment

This judgment was handed down remotely at 10.30am on Friday 28 August 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

Mr Justice Morris :

Introduction

1. This is an appeal brought by the General Medical Council ("the GMC") from a decision ("the Determination") of the Medical Practitioners Tribunal ("the Tribunal") dated 14 February 2025 made in respect of Dr Ali Shokouh-Amiri ("the Respondent"). By the Determination, whilst finding that in some respects he was guilty of misconduct, the Tribunal determined that the Respondent's fitness to practise is not impaired, and decided not to make any direction.

2. The appeal is brought by the GMC under section 40A of the Medical Act 1983 and is in respect of some of the Tribunal's findings of fact and its decision on fitness to practise. The Respondent is the respondent to the appeal.

3. In summary the GMC contends that the Determination is not sufficient for the protection of the public (see section 40A(3) of the Medical Act). It advances four grounds of appeal as follows:

    (1) The Tribunal erred in finding the allegation in relation to Patient B not proved;

    (2) The Tribunal erred in finding a number of allegations in relation to Patient F not proved;

    (3) The Tribunal's approach to cross-admissibility was flawed, affecting its approach to the allegations relating to the Respondent's treatment of Patients A, D and F;

    (4) The Tribunal was wrong to conclude (on the basis of the allegations which it found proved) that the Respondent's fitness to practise is not impaired.

4. The Respondent contends that the decisions on facts, misconduct, impairment and warning of the Tribunal were sufficient to protect the public. Further, they were not wrong, nor should they be quashed as unjust due to a serious procedural or other error in the Tribunal's proceedings.

5. My conclusions are set out in paragraph 259 below. Grounds 1 and 2 succeed. Grounds 3 and 4 fail.

Some Factual background

6. At the time of the relevant events between October 2017 and January 2019, the Respondent was working as a consultant gynaecologist in Guernsey. He was head of Gynaecological Oncology at the Princess Elizabeth Hospital. The allegations against the Respondent related to six patients under his care: Patients A to F. There were specific allegations regarding poor clinical treatment in relation to Patient B, Patient C, Patient D and Patient E; these allegations included, in the case of Patient C, the removal of her ovaries without consent, and, in the case of Patient D, the removal of her ovaries without consent and without any clinical indication for their removal. There were multiple allegations of sexually motivated and/or inappropriate behaviour in relation to Patient A, Patient D, Patient E and Patient F. There were allegations of a failure to have a chaperone present when conducting intimate examinations in relation to Patient A, Patient C, Patient D, Patient E and Patient F. There were two allegations of dishonesty, arising out of the treatment of Patient D and Patient F.

Finally, there was an allegation that the Respondent wrongly retained clinical information on his personal mobile telephone.

7. Some of the allegations relating to poor clinical treatment (including both allegations regarding the removal of patients' ovaries without consent) were admitted by the Respondent. He also admitted that some intimate examinations were conducted without a chaperone when one ought to have been present. Most of the allegations, however, were denied. The Tribunal's findings in relation to each Patient are summarised at paragraphs 49 to 54 below.

The Legislative Framework and relevant legal principles

8. The statutory framework for the GMC and the Tribunal is to be found in the Medical Act 1983, as amended ("the Act"), and the General Medical Council (Fitness to Practise) Rules 2004, made under the Act ("the FTP Rules"). Other relevant material is to be found in certain case law.

The GMC and the Medical Practitioners Tribunal

9. Section 1(1A) of the Act provides that "the overarching objective of the General Council in exercising their functions is the protection of the public". Section 1(1B) expands on this, providing that: "the pursuit by the General Council of the overarching objective involves the pursuit of the following objectives (a) to protect promote and maintain the health safety and well-being of the public; (b) to promote and maintain public confidence in the medical profession, and (c) to promote and maintain proper professional standards and conduct for members of that profession".

Fitness to practise proceedings

10. The procedure for determination of "fitness to practise" is divided into two stages: an investigation stage and then reference to, and consideration and determination by, the Tribunal. Section 35C(2) of the Act provides that: "a person's fitness to practise shall be regarded as impaired for the purposes of this Act by reason only of – (a) misconduct…". It is well established that under section 35C the determination of impairment of fitness to practise involves a two-stage process. First the issue of whether there has been misconduct (or other grounds) and, second, whether as a result of such misconduct (or other ground), fitness to practise is impaired. By section 35D(2), where the tribunal find that the person's fitness to practise is impaired they may order erasure from the register, suspension of registration or the placing of conditions upon registration with such requirements so specified as the tribunal think fit to impose for the protection of members of the public or in his interests. By section 35D(3) where the tribunal find that the person's fitness to practise is *not* impaired they may nevertheless give him a warning regarding his future conduct or performance.

11. Rule 17 of the FTP Rules provides for the "Procedure before a Medical Practitioners Tribunal", setting out the different stages of the proceedings at the hearing. Rule 17(2) (j) and (l) each provides that when announcing both its findings of fact and then its findings on the impairment of fitness to practise, the tribunal "shall give its reasons for that decision". There is thus a statutory duty to give reasons.

12. The General Medical Council (Legal Assessors and Legally Qualified Persons) Rules 2015 ("the 2015 Rules") set out rules dealing with the role of a legal assessor in Tribunal proceedings. Rule 6 provides as follows

"**Advice of legally qualified persons**

> 6. Where, at hearing of a Tribunal, a legal assessor has not been appointed under paragraph 7(1B) of Schedule 4 to the Act, and the Chair as a legally qualified person advises the Tribunal on any question of law as to evidence or procedure, the Chair shall—
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> (a) so advise in the presence of every party, or person representing a party, in attendance at the hearing; or
>
> (b) if the advice is tendered after the Tribunal has begun to deliberate on any decision during the course of the proceedings, include the advice so given in the Tribunal decision, unless the Chair considers it necessary to advise in the presence of every party, or person representing a party, in attendance at the hearing.)" (emphasis added)

There is no difficulty in principle with the legally qualified chair tendering advice to other members of the Tribunal after the Tribunal has begun to deliberate, provided that the chair does not raise any new point of law. However a new point must be raised in the presence of the parties, who are to be given an opportunity to make submissions: see *R (British Medical Association) v General Medical Council* [2018] 4 WLR 31 at §§35 to 41.

Appeals

13. Section 40A of the Act makes provision for appeals by the GMC to, inter alia, this Court against a "relevant decision" of the Tribunal, if the GMC consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public. By section 40A(4), consideration of whether a decision is sufficient for public protection involves consideration of whether it is sufficient in respect of each of the three objectives set out in section 1(1B).

14. A "relevant decision" includes a decision not to give a direction under section 35D of the Act: section 40A(1)(d). This includes a decision not to make a direction because the Tribunal has found that the practitioner's fitness to practise is not impaired. Under s.40A(6), this Court's powers on appeal include the power to dismiss the appeal, to allow the appeal and quash the relevant decision, to substitute for the relevant decision any other decision which could have been made by the Tribunal, or to remit the case to the MPTS (the Medical Practitioners Tribunal Service) for them to arrange for a tribunal to dispose of the case in accordance with the Court's directions.

15. On appeal, the question for the Court is whether the decision of the Tribunal was wrong, or unjust because of a serious procedural or other irregularity: see CPR 52.21(3). Under the terms of CPR 52.21(3) in order to establish a basis for an appeal, a procedural irregularity must have been "serious" and must have rendered the decision "unjust". i.e. caused injustice *Hussain v General Pharmaceutical Council* [2018] EWCA Civ 22 at §§35 and 36. Further, an appeal under s.40A is by way of review (rather than by way of re-hearing): *Sastry v General Medical Council [*2021] EWCA Civ 623 §98.

What is the target of the appeal and what is "wrong" etc

16. In the present case the "relevant decision" is the decision not to make a direction (and, effectively, the decision to find that fitness to practise was not impaired). That is the decision which is said to be either "wrong" or "unjust because of a serious procedural

or other irregularity". Strictly the individual findings in relation to each allegation (found not proven) are not what I am being asked to find were "wrong" or "unjust because of a serious irregularity". Thus, if I were to find that any one or more of the individual findings in relation to any of the allegations concerning Patient B or Patient F are "wrong" or "unjust", then that would infect the conclusion that fitness to practise was not impaired and in turn the decision not to make a direction. It would then follow that the Determination as a whole would fall to be quashed, but subject to any particular directions upon remittal back to the MPTS.

The approach to appeals on findings of fact

17. I heard substantial argument on the correct approach of the Court on an appeal from a decision of the Tribunal on the facts. This raised a number of particular issues, which I address in the following paragraphs.

Findings of primary fact

18. There are many authorities on the correct approach on appeal to findings of fact by a regulatory tribunal. I addressed this issue in my judgment in *Byrne v General Medical Council* [2021] EWHC 2237 (Admin). In that case, after identifying at §10 almost 20 authorities, I summarised the principles from the authorities as follows. (It is common ground that this is a fair summary):

> "11. The issue is as to the circumstances in which an appeal court will interfere with findings of fact made by the court or decision maker below. This is an issue which has been the subject of detailed judicial analysis in a substantial number of authorities and where the formulation of the test to be applied has not been uniform; the differences between formulations are fine. I do not propose to go over this ground again in detail, but rather seek to synthesise the principles and to draw together from these authorities a number of propositions.
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> 12. First, the degree of deference shown to the court below will differ depending on the nature of the issue below; namely whether the issue is one of primary fact, of secondary fact, or rather an evaluative judgment of many factors: *Assicurazioni Generali* at §§16 to 20…
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> 13. Secondly, the governing principle remains that set out in Gupta §10 referring to Thomas v Thomas. The starting point is that the appeal court will be very slow to interfere with findings of primary fact of the court below. The reasons for this are that the court below has had the advantage of having seen and heard the witnesses, and more generally has total familiarity with the evidence in the case. A further reason for this approach is the trial judge's more general expertise in making determinations of fact: see *Gupta*, and *McGraddie v McGraddie* at §§3 to 4. I accept that the most recent Supreme Court cases interpreting Thomas v Thomas (namely *McGraddie* and *Henderson v Foxworth*) are relevant. Even though they were cases of "review" rather than "rehearing", there is little distinction between the two types of cases for present purposes [(see paragraph 16 below)].
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> 14. Thirdly, in exceptional circumstances, the appeal court will interfere with findings of primary fact below. (However the reference to "virtually unassailable" in *Southall* at §47 is not to be read as meaning "practically impossible", for the reasons given in *Dutta* at §22.)

> 15. Fourthly, the circumstances in which the appeal court will interfere with primary findings of fact have been formulated in a number of different ways, as follows:
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> - where "*any advantage enjoyed by the trial judge by reason, of having seen and heard the witnesses could not be sufficient to explain or justify the trial judge's conclusions*": per Lord Thankerton in *Thomas v Thomas* approved in *Gupta*;
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> - findings "*sufficiently out of the tune with the evidence to indicate with reasonable certainty that the evidence had been misread*" per Lord Hailsham in *Libman*;
>
> - findings "*plainly wrong or so out of tune with the evidence properly read as to unreasonable*" per…*Casey* at §6 and Warby J (as he then was) in *Dutta* at §21(7);
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> - where there is "*no evidence to support a ... finding of fact or the trial judge's finding was one which no reasonable judge could have reached*": per Lord Briggs in *Perry* after analysis of *McGraddie* and *Henderson*.
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> In my judgment, the distinction between these last two formulations is a fine one. To the extent that there is a difference, I will adopt, in the Appellant's favour, the former …"

In the present case, I make no relevant distinction between these two formulations.

19. At §16 in *Byrne*, I concluded that, on the balance of authority there is little or no relevant distinction to be drawn between "review" and "rehearing", when considering the degree of deference to be shown to findings of primary fact. Authority supports the proposition that there may be a relevant difference when the court is considering findings of evaluative judgment or secondary or inferential findings of fact, where the court will show less deference on a rehearing than on a review.

Other findings of fact

20. As indicated in *Byrne* §12 above, there are findings of fact (other than primary fact): findings of inferential (or secondary) fact, being findings of fact based on inferences from primary fact; and findings of "evaluative judgment". Evaluative judgments involve findings which take into account a number of factors, and include (but are not limited to), in particular, findings of fact based on the application of a legal standard: for example, a finding of negligence: see *Assicurazioni Generali* §§16 to 18. As regards findings of secondary or inferential fact, as stated expressly in CPR 52.21(4), and pointed out in *Jagjivan* §40 (iv) (see paragraph 27 below), the appeal court may draw any inferences of fact which it considers justified on the evidence. The degree of deference shown to the court below will vary depending on the nature and basis of the findings of underlying primary fact. As regards findings of evaluative judgment, the approach will vary depending on nature of the evaluation. In general the appeal court will not interfere unless satisfied that the conclusion below lay outside the bounds within which reasonable disagreement is possible. See *Sayer v General Osteopathic Council* [2021] EWHC 370 Admin at §§16, 18, 19 and 22 and *R (on the application of Dutta) v General Medical Council* [2020] EWHC 1974 (Admin) at §21(6).

21. In the present case, one further issue arose, where there is a finding of primary fact that something did - or did not - happen. If a tribunal finds that something happened (or did not happen) and its reasons for so finding make no sense or are factually wrong then the Court on appeal is entitled to say that the finding of fact is wrong, but without necessarily finding that that something did not happen (or vice versa).

Assessment of general credibility of witnesses

22. In many cases the Court has emphasised that a tribunal should include an assessment of relevant witnesses' general credibility and reliability, taking all relevant factors into account: see *Hindle v Nursing and Midwifery Council* [2025] EWHC 373 (Admin) §8 and 58. This is particularly so in cases where there is a primary dispute of fact with competing factual witness accounts, as to whether something did or did not happen. See also *James v General Medical Council* [2025] EWHC 2049 (Admin) at §§63, 69 and 77.

23. In *Byrne* at §§17 to 20 I addressed the issue of credibility of witnesses and corroborating evidence, stating in particular at §§19 and 20:

> "19. Thirdly, corroborating documentary evidence is not always required or indeed available. There may not be much or any such documentary evidence. In a case where the evidence consists of conflicting oral accounts, the court may properly place substantial reliance upon the oral evidence of the complainant (in preference to that of the defendant/appellant): … . There is no rule that corroboration of a patient complainant's evidence is required…
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> 20. Fourthly, in a case where the complainant provides an oral account, and there is a flat denial from the other person concerned, and little or no independent evidence, it is commonplace for there to be inconsistency and confusion in some of the detail. Nevertheless the task of the court below is to consider whether the core allegations are true: … .

Approach to multiple allegations and more than one complainant

24. Where there are a number of allegations and evidence from more than one complainant, the tribunal should stand back and consider the whole picture. It should not solely consider the allegations "on an individual charge-by-charge basis, effectively in silos": *Hindle*, supra at §11. However this principle is distinct from the principle of cross-admissibility: see paragraphs 211 et seq below.

25. Where an allegation is based on factual accounts asserted by certain witnesses which are directly contradicted by the person facing the allegation or by other witnesses, the Tribunal will need to carry out a careful and thorough forensic analysis for deciding whether the burden of proof is satisfied. Such an analysis should seek to draw upon all available relevant indicators as to whether each witness's account is reliable. Those indicators will often include the tribunal's overall impression of the witnesses it has seen giving oral evidence. In such a case, it is not sufficient for the tribunal to simply consider each charge individually (i.e. in isolation from the other charges and allegations on which the witnesses have given testimony), briefly summarise the witnesses' competing narratives relevant to that charge, and then say, "*We prefer the evidence of [name of witness(es)] and therefore find this charge proved*". See *Hindle* supra, at §§52 and 53.

26. In *James*, supra, Hill J (at §§65 to 67, 76 and 77 and 88) found that the Tribunal had fallen into error, by not resolving or making findings on key sub-issues of fact; and did not explain which of the various accounts it accepted and why. No explanation was given as to why evidence was not accepted and such reasons as were given had to be rational including assessment of relevant witnesses' general credibility and reliability. She concluded that the finding made by the tribunal was *wrong*.

Approach to appeals on misconduct, impairment and sanction

27. In this regard I have been referred to the following principal authorities: *General Medical Council v Jagjivan* [2017] EWHC 1247 (Admin) at §§39 to 40 and *Bawa-Garba v General Medical Council* [2019] 1 WLR 1929 at §67. The following principles apply:

    (1) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence: *Jagjivan* §40(v).

    (2) However there may be matters, such as dishonesty or sexual misconduct, where the court "is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal". The appellate court "will afford an appropriate measure of respect of the judgment in the Tribunal … but the [appellate court] will not defer to the Tribunal's judgment more than is warranted by the circumstances". *Jagjivan* §40(vi).

    (3) Where the decision under challenge is an evaluative one (such as a decision on impaired fitness to practise, or a decision as to which sanction to impose), the appeal court should interfere only if there was an error of principle in carrying out the evaluation, or the evaluation was wrong, being a decision that fell outside the bounds of what the tribunal could properly and reasonably decide: *Bawa-Garba* §67;

28. Impairment of fitness to practise is not limited to a consideration of the practitioner and likelihood of him repeating the misconduct in the future. The assessment of impairment is forward looking and public confidence in the regulatory regime is relevant to that assessment, even where the practitioner in question is unlikely to repeat the misconduct: see *General Medical Council v Armstrong* [2021] EWHC 1658 (Admin) at §52.

The duty to give reasons

29. In the present case, Rule 17(2) of the FTP Rules required the Tribunal to give reasons. The general principle is that when a statute requires a public body to give reasons for a decision, the reasons given must be proper, adequate, and intelligible and must deal with the substantial points that have been raised. They should not disclose errors of reasoning. See *Westminster City Council v Great Portland Estates* [1985] 1 AC 661 at 673 D-E and *General Medical Council v Lamming* [2017] EWHC 3309 Admin at §64 and 65 (also citing and approving (at §§67 and 68) *English v Emery Reimbold* [2002] 1 WLR 2409).

30. In *Byrne* (at §§23 to 27) I also considered the extent of the duty to give reasons, including reasons regarding the credibility of witnesses. I there identified, as the leading authority, *Southall v General Medical Council* [2010] EWCA Civ 407 which cited in detail earlier leading cases and in particular *English*, supra. The judgment in *Byrne* continued:

> "24. …[In *Southal*l] At §54, Leveson LJ (citing Phipps) confirmed that the purpose of such a duty to give reasons is to enable the losing party to know why he has lost and to allow him to consider whether to appeal. It will be satisfied if, having regard to the issues and the nature and content of the evidence, the reasons for the decision are plain, either because they are set out in terms or because they can be readily inferred from the overall form and content of the decision. It is not necessary for them to be expressly stated, when they are otherwise plain or obvious. Leveson LJ then continued as follows:
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> > "55. For my part, I have no difficulty in concluding that, in straightforward cases, setting out the facts to be proved (as is the present practice of the GMC) and finding them proved or not proved will generally be sufficient both to demonstrate to the parties why they won or lost and to explain to any appellate tribunal the facts found . In most cases, particularly those concerned with comparatively simple conflicts of factual evidence, it will be obvious whose evidence has been rejected and why. In that regard, I echo and respectfully endorse the observations of Sir Mark Potter. [in Phipps]
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> > 56. When, however, the case is not straightforward and can properly be described as exceptional, the position is and will be different. Thus, although it is said that this case is no more than a simple issue of fact (namely, did Dr Southall use the words set out in the charge?), the true picture is far more complex. First, underlying the case for Dr Southall was the acceptance that Mrs M might perfectly justifiably have perceived herself as accused of murder with the result that the analysis of contemporaneous material some eight years later is of real importance: that the evidence which touched upon this conversation took over five days is testament to that complexity. Furthermore it cannot be said that the contemporaneous material was all one way: Dr Corfield's note (and, indeed, her evidence) supported the case that it was (or at least could have been) Mrs M's perception alone. Ms Salem's note (accepted by Mrs M as 100% accurate so far as it went) did not support the accusation and her evidence was that if those words had been said, she would have recorded them. I am not suggesting that a lengthy judgment was required but, in the circumstances of this case, a few sentences dealing with the salient issues was essential: this was an exceptional case and, I have no doubt, perceived to be so by the GMC, Dr Southall and the panel.
> > …
> >
> > 59. Further, once providing some reasons, in my judgment, the panel did have to say something about Dr Southall who gave evidence on this topic for some days. If (as must have been the case) they disbelieved him, in the context of this case and his defence, he was entitled to know why even if only by reference to his demeanour, his attitude or his approach to specific questions. In relation to Ms Salem,

> the position was worse: to say that the panel "did not find her evidence to be wholly convincing" is not good enough. If she did not make a note of the specific challenge of murder (which she said she would have done), it must have been the panel's view that she decided, at the time of the interview, that she would not do so and so have entered into an implicit agreement with Dr Southall to cover up an overly oppressive interview. That is nothing to do with not being wholly convincing: it is about honesty and integrity and if the panel were impugning her in these regards, it should have said so. (emphasis added)

25. As made clear at §56, the factual issue in *Southall* was not "a simple issue of fact" of whether the doctor did or did not use particular words; rather it was particularly complex. §56 of *Southall* is not authority for the proposition that specific reasons for disbelieving a practitioner are required in every case where his defence is rejected. The references to "the circumstances of this case" and "in the context of this case and his defence" in §§56 and 59 imply that there will be cases where such reasons will not be required.

Reasons and credibility

26. As regards reasons concerning the credibility of witnesses

(1) Where there is a dispute of fact involving a choice as to the credibility of competing accounts of two witnesses, the adequacy of reasons given will vary. In *English v Emery*, Lord Phillips stated that "*it may be enough to say that one witness was preferred to another, because the one manifestly had a clearer recollection of the material facts or the other give answers which demonstrated that his recollection could not be relied upon*". On the other hand, *Southall* at §55, and *Gupta* at §13 and 14 suggest that even such limited reasons are not necessarily required in every case.

(2) Secondly, whilst Mr Mant accepted that it is a common practice in Tribunal decisions on fact, there is no requirement for the disciplinary body to make, at the outset of its determination, a general comparative assessment of the credibility of the principal witnesses. Indeed such a practice, undertaken without reference to the specific allegations, has been the subject of recent criticism in *Dutta* at §42 and *Khan* at §§106 and 107. In my judgment, consideration of credibility by reference to the specific allegations made is an approach which is, at least, equally appropriate.

27. Finally, an appeal court will not allow an appeal on grounds of inadequacy of reasons, unless, even with the benefit of knowledge of the evidence and submissions made below, it is not possible for the appeal court to understand why the judge below had reached the decision it did reach. It is appropriate for the appeal court to look at the underlying material before the judge to seek to understand the judge's reasoning and to "identify reasons for the judge's conclusions which cogently justify" the judge's decision, even if the judge did not himself clearly identify all those reasons: see *English v Emery Reimbold* §§89 and 118.

31. As to the issue of whether, even if reasons are not adequate, the court can tell from the evidence what the Tribunal's reasons must have been or why it reached that conclusion (or even why it could have reached that conclusion) and so the decision should be upheld, Ms Richards KC submits that §27 of *Byrne* did not represent the correct legal position. In particular she submits that there is an inquisitorial duty upon a panel hearing a professional regulatory matter in the public interest. The panel is under a more proactive role than a judge presiding over a criminal trial: *The Professional Standards Authority for Health and Social Care v General Medical Council and Lingam* [2023] EWHC 967 Admin ("*Lingam*") at §16. Further, less deference to the panel is shown where there is a serious procedural or other irregularity: *Lingam* §17. She submits that, because of this inquisitorial duty, this placed upon the panel an enhanced duty to give reasons, relying on §18 *Lingam* (which cites earlier cases of *GMC and PSA v Bramhall* [2021] EWHC 2210 (Admin) at §§36 and 42 and *PSA and GOC v Rose* [2021] EWHC 2888 (Admin) at §82.) As a result she submits that the approach in *English*, upon which §27 *Byrne* is based, does not apply to professional regulatory proceedings.

32. I do not accept this. *Southall*, the leading authority on reasons in regulatory proceedings expressly relies upon the earlier regulatory cases of *Gupta* and *Phipps;* and in turn *Phipps* itself is based upon, and endorses, the principles drawn from *English*: see *Southall* §§52 and 54. I note that each of the more recent cases relied upon by Ms Richards (*Lingam, Rose* and *Bramhall*) concerned decisions on sanction and public confidence. It does not follow that the analysis there readily reads across to findings of fact.

33. However I do accept that some caution is required here. In *Southall* in his first judgment (referred to in paragraph 30 above) Leveson LJ found that the decision was wrong because of a failure to give reasons. Written submissions were then invited as to the appropriate consequential order. The GMC submitted that the complaint should be remitted for amplification of reasons. In his further judgment ([2010] EWCA Civ 484 at §4) Leveson LJ held that, whilst the court had jurisdiction to remit a decision to a panel for further reasons, nevertheless, in the circumstances of that case, it would not be right to do so, for the following reasons:

> "Given the issues between the parties, the process of reaching a decision – the reasoning – is itself important and although I recognise that there was material upon which the panel could reach the decision that it did, that is not the same as saying that, <u>if approached from the correct analytical position</u>, it would *necessarily* have done so" (<u>emphasis</u> added)

Thus, where, from the decision, it is not easy to ascertain what has been decided and why, it is permissible to look at the underlying material and conclude that that was what the tribunal was referring to and what it was meaning. That is a legitimate exercise to understand better the decision under challenge. However what is not permissible, by relying on underlying material, is either to speculate what the decision process might have been or to say that there is material upon which the tribunal *could* have found in a particular way.

Consequences of failure to give reasons

34. A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the Tribunal's decision unjust: see *Southall* §§55 to 56 and *Jagjivan* §40(viii). The question arises as to whether reasoning which is flawed or which does not stand up is also a ground for finding that a decision is *wrong* (under CPR

52.21(3)). In *Lingam* Foster J held (at §13) that failure to provide adequate reasons constituted a serious irregularity. On the facts she found (at §§74 and 75) that the panel's reasoning on sanction evinced a serous procedural error in relation to the reasoning process. There was a clear failure of reasoning, possibly concealing failures of analysis and she quashed the decision on the basis only of procedural error: §§74 and 75. The reasoning must expose the relevant analysis so the reader understands what the principal issues were and what the panel made of them (§81).

35. Moreover deficiency in reasoning also indicates (or may indicate) that the decision on a finding of fact is *wrong*. Examination of the reasons may lead to the conclusion that the underlying substantive decision is wrong. In *Lamming*, supra, Julian Knowles J, after citing (at §§63 to 68) the relevant authorities on the duty to give reasons, found (at §94) the tribunal's reasons to be legally inadequate, to have failed to address the issue and for that reason the decision was *wrong*.

The background facts in more detail

36. The Respondent qualified as a doctor in January 2005 and received his medical licence from Copenhagen University. After the successful completion of his specialist training, he achieved board certification in Obstetrics and Gynaecology, and pursued advanced training in Gynaecological Oncology, Robotic Surgery, and Colposcopy in Denmark from January 2007 to December 2012. He relocated to the UK in 2013. After various placements in the UK he moved to Guernsey in November 2016 to take up the post of Consultant Obstetrician and Gynaecologist and Head of Gynaecological Oncology, Colposcopy Endometriosis and Minimal Access Surgery. He also had an honorary contract with the Cancer Hub, specialising in Gynaecological Oncology surgery, at Southampton University Hospitals NHS Trust. At the time of the events that form the subject of this case the Respondent was the head of Gynaecological Oncology, based at the Princess Elizabeth Hospital, Guernsey. He was employed in that capacity by an entity called the Medical Specialists Group (MSG), and he became a partner of MSG in 2017. He resigned from MSG in August 2019. At the time of the Determination Dr Shokouh-Amiri had been working as a Consultant in Obstetrics & Gynaecology at Mid and South Essex University Hospital NHS Foundation Trust, as from November 2022.

37. In relation to the allegations the subject of the Determination, the chronology in outline is as follows. On 3 July 2017 the Respondent treated Patient C without a chaperone. On 28 November 2017 he treated both Patient A and Patient C without a chaperone. On 24 January 2018 and again on 13 March 2018 he treated Patient A without a chaperone.

38. As regards Patient B, the Respondent conducted surgery upon her on 30 May 2018. The procedure was a total laparoscopic hysterectomy and a bilateral salpingectomy. On 1 June 2018 Patient B attended A & E with abdominal bloating. On 10 June 2018 a CT scan revealed injury to Patient B's ureter. Patient B underwent repair surgery to this in July and August 2018.

39. On 23 October 2018 the Respondent treated Patient C without a chaperone and on 2 November 2018 he treated Patient D without a chaperone. On 12 November 2018 he treated Patient E without a chaperone and there were other failures. On 29 November 2018, Patient D had her ovaries removed in the course of an operation.

40. On 4 December 2018, Patient F attended a consultation with the Respondent. She alleges that in the course of this consultation he acted inappropriately with her; this forms the basis of the allegations 17 a to e. On 7 December 2018, Patient F attended a

further consultation with the Respondent. She alleged that in the course of this consultation he acted inappropriately with her; this forms the basis of the allegation 18. Further details of the facts relating to Patient F are set out in paragraphs 98 to 101 below.

The Tribunal proceedings

The allegations

41. There were 22 allegations. These are set out in full in the Annex to this judgment (together with the Tribunal's finding in relation to each). The specific allegations in respect of Patient B and F are set out below.

The hearing and the evidence

42. The hearing before the Tribunal took place between 16 and 29 January 2025, when the evidence concluded. On 30 January 2025 (day 9 of the hearing) there was legal advice on the facts from the Chair and written and oral closing. A more specific chronology of the closing stages of the hearing is set out in paragraphs 224 to 231 below, in relation to Ground 3.

43. The Tribunal received written and oral evidence from Patient A, Person X (Patient A's husband), Patient D, Patient E, Patient F. The Respondent gave oral evidence and provided a witness statement dated 16 November 2024. The Tribunal also received written and oral evidence from an expert witness, Mr Paul Wood., a consultant in obstetrics and gynaecology. He provided four written reports (dated 14 August 2022, 5 June 2023, 4 July 2023 and 25 July 2024) and gave oral evidence at the hearing by video link. His evidence provided opinions on all aspects of the evidence in the case. Additional documentary evidence considered by the Tribunal included medical records, records of police interviews, transcripts and testimonials, phone call logs, messages between Patients A, D and F, MSG investigation reports and expert statements.

44. I have considered in detail all the written witness statements of the complainants and of the Respondent and the transcripts of the oral evidence given by each of them. The Respondent's essential case is that he denied all the allegations; certain of the events did not happen at all; others happened in different and innocent circumstances.

45. On 11 February 2025 the Tribunal handed down its Determination on the facts. On 12 February 2025 the Tribunal then proceeded to hear the submissions of the parties in relation to stage 2, namely misconduct and impairment. At that stage the Respondent gave further oral evidence relevant to these issues. On 14 February 2025 the Tribunal announced its determination on impairment.

The Determination

Summary of The Determination

Determination on the facts

46. In its determination on the facts, the Tribunal set out its "approach" in at §§17 to 26. After directing itself as to the burden and standard of proof, the law on dishonesty and as to good character, the Determination continued:

> "20. In relation to assessment of witnesses the LQC advised care must be taken when assessing all witnesses and demeanour may not be a good guide. The approach to credibility was recently addressed in Khan v GMC [2021] EWHC 374 per Knowles J quoting with approval from Dutta v GMC [2020] EWHC 1974 (Admin) per Warby: …
>
> 21. …
>
> > *… "42 … It is an error of principle to ask, 'do we believe her?' before considering the documents … Reliance on a witness's confident demeanour is a discredited method of judicial decision making …"*
>
> 22. The LQC advised that the term 'sexually motivated' is defined in the case of Basson v GMC [2018] EWHC 505 (Admin) as:
>
> > *'Acting with sexual motivation is defined as conduct done either in pursuit of sexual gratification or in pursuit of a future sexual relationship'.*
>
> 23. The Tribunal must be satisfied on the evidence that there was a specific intent.
>
> 24. The Tribunal must consider whether there is a plausible alternative explanation before determining if the conduct was sexually motivated.
>
> 25. The Tribunal reminded itself it must form it so own judgment about the evidence presented to it.
>
> 26. The Tribunal accepted the LQC's advice on cross admissibility and propensity." (emphasis added)

47. Then, under a heading "The Tribunal's Analysis of the Evidence and Findings", the Tribunal made some general observations regarding the evidence in §§27-30. In particular, at §30 of the Determination, the Tribunal stated:

> "The Tribunal noted that Patient F was the first complainant to go to the police. She alleged that the Respondent engaged in inappropriate sexual talk and also inappropriate conduct during gynaecological examinations on multiple occasions. It also noted that Patients D and A came into contact by telephone and message. Patient D's belief is that Dr Shokouh-Amiri had deliberately removed her ovaries, precipitating her into a premature menopause. Patient A's belief is that the Respondent had ruined her life through negligent medical treatment including the removal of her left ovary without consent. The Tribunal noted that phone records obtained by the police showed that Patient D had substantial contact with Patient A prior to both A and D reporting matters to the police. Patient D had some contact and a number of pre-existing casual connections with Patient F. "

48. From §31 to §174 of the Determination, the Tribunal proceeded to consider the allegations in relation to each patient in turn. In summary the Tribunal made the following findings.

Patient A

49. In relation to Patient A (at §§31 to 80)), the Tribunal found proved the allegation that the Respondent had rubbed and/or touched her leg (§40)). The allegation that the Respondent hugged her was admitted and thus found proved, as was the allegation that he performed intimate examinations without a chaperone on three dates (28 November 2017, 24 January 2018 and 13 March 2018). The remainder of the allegations relating to Patient A, which related to inappropriate and/or sexually motivated conduct, were found not proved. In this appeal, the GMC does not directly challenge those findings of "not proved". However Ground 3 and the issue of cross-admissibility may be relevant to those findings.

Patient B

50. In relation to Patient B (§§81 to 85), the Tribunal found not proved the allegation relating to substandard care (which arose out of surgery performed on Patient B on 30 May 2018).

Patient C

51. The allegations in relation to Patient C – the removal of her ovaries without consent and the undertaking of intimate examinations on three occasions (3 July 2017, 28 November 2017 and 23 October 2018) without a chaperone - were admitted and thus found proved.

Patient D

52. In relation to Patient D (§§87 to 111), the allegation that the Respondent removed her ovaries without consent on 29 November 2018 and with no clinical indication was admitted and found proved, as was the allegation of failure to have a chaperone present when conducting an intimate examination on 2 November 2018. An allegation that the Respondent touched Patient D's clitoris during that examination was found proved, but the Tribunal concluded that this was inadvertent (§§91 to 92). The allegation that he wiped her vaginal area following the examination was admitted but found to be acceptable in the context of that examination (§§106 to 108). The remainder of the allegations relating to Patient D, which related to inappropriate and/or sexually motivated conduct, and to an instance of dishonest conduct, were found not proved. As in the case of Patient A, in this appeal the GMC does not directly challenge those findings of "not proved".

Patient E

53. The allegations that at a consultation on 13 November 2018 with Patient E the Respondent failed to arrange investigations for her heavy irregular periods, failed to arrange treatment for an endometrial polyp and failed to have a chaperone present during an intimate examination were admitted and found proved (§§112 to 115). The Tribunal found proved the allegation that the Respondent suggested to Patient E that she join him in the gym.

Patient F

54. In relation to Patient F (§§116 to 169), allegations of undertaking an intimate examination without a chaperone were admitted and found proved in respect of consultations on 21 November 2018 and 7 December 2018. The Tribunal found proved the allegations that the Respondent hugged and kissed Patient F at consultations on 4 December 2018 and 7 December 2018. The remainder of the

allegations regarding Patient F, which related to inappropriate and/or sexually motivated conduct, and to an instance of dishonest conduct, were found not proved.

Other allegations

55. The allegations relating to the retention of clinical information on the Respondent's personal mobile telephone were found not proved, on the basis that the phone was both a work and personal one and that records were accessed with the consent and approval of his employer (§§170 to174). At §175 the Tribunal then summarised its findings of fact in respect of each of the 22 numbered allegations, identifying those admitted and found proved, those determined and found proved and those not proved.

Determination on impairment

56. The Tribunal's determination on impairment on 14 February 2025 is set out at §§176 to 316 of the Determination. First, in relation to misconduct itself, the Tribunal found that the rubbing/touching of Patient A's leg and hugging her, although inappropriate behaviour, did not amount to misconduct (§§268 to 270); it found also that hugging and kissing Patient F did not amount to misconduct (§294). The failure to have chaperones present on each occasion that was found proved constituted misconduct (§§272, 278, 285, 291, 293), as did the removal of the ovaries of Patients C and D (§§277 and 284). The substandard care delivered to Patient E was held to amount to misconduct (§§288 and 290), as was the Respondent's suggestion to Patient E that she join him in the gym (§ 292).

57. At §§295 onwards, the Tribunal considered impairment to practise in the light of those aspects found to have constituted misconduct. Having considered issues of insight and remediation, the Tribunal decided that there was a low risk of the Respondent putting patients at a risk of unwarranted harm (§§306 to 312). It concluded that a finding of impairment was not necessary in order to uphold proper professional standards or to maintain public confidence in the profession, and concluded that the Respondent's fitness to practise *"is not currently impaired by reason of misconduct"*. (§§313 to 316). In particular the Tribunal stated:

> "313. The Tribunal had regard to whether a finding of impairment was necessary on public interest and patient safety grounds in order to uphold proper professional standards. It reminded itself of the finding it had made in relation to misconduct and the fact that these issues had been the subject of regulatory proceedings. The Tribunal considered this finding of misconduct, and these proceedings are sufficient to highlight to the wider profession that Dr Shokouh-Amiri's conduct was unacceptable.
>
> 314. The Tribunal also noted its finding that Dr Shokouh-Amiri's misconduct was serious and had the potential to affect the public's confidence in the profession. However, the Tribunal reminded itself of the significant level of insight, remorse and remediation demonstrated by Dr Shokouh-Amiri and his acceptance of responsibility from the outset of the regulatory process and admissions at this hearing. He fully engaged and participated with the GMC procedures since the start. It noted again that these factors indicated to the Tribunal that there was a low risk of repetition. It concluded that a fully informed member of the public, made aware of these factors would be sufficiently satisfied and reassured that Dr Shokouh-Amiri's responses were appropriate to offset concerns prompted by his misconduct.

> 315. Therefore, the Tribunal determined that public confidence in the medical profession would not be undermined if a finding of impairment was not made in the particular circumstances of this case."

58. Accordingly, no question of sanction arose, although the Tribunal did decide to issue a warning under section 35D(3) of the 1983 Act.

The Appeal in summary

The grounds of appeal

59. The grounds of appeal are set out in paragraph 3 above. Before turning to each of the four grounds, I make some general observations about the Determination.

Some general observations about the Determination

60. First the Determination contains no distinct assessment (whether at the outset or otherwise) of general credibility of the witnesses, and in particular of the complainants and the Respondent. In particular there is no such assessment of the credibility of Patient F. In these circumstances any advantage of seeing witnesses is not a weighty factor because the Tribunal failed to make any assessment of that advantage. Secondly, whilst there was a lot of ground to cover and multiple allegations (and sub-allegations), nevertheless the Tribunal's reasoning is at times very brief and at other times makes little sense. It also contains certain errors of drafting or detail. Thirdly, in the case of Patient F at least, the Tribunal was faced with detailed evidence from her on the one hand, and, on the other hand, bare denials from the Respondent: see paragraph 24 above. Finally, some of the Tribunal's findings were of primary fact (e.g. whether or not a specific event or conduct happened). Some of the findings were of secondary (or inferential) fact or were evaluative judgments (e.g. whether or not certain conduct was inappropriate).

Ground 1: Patient B

Allegation 7

61. Allegation 7: In relation to Patient B, the Respondent was charged that "On 30 May 2018 you performed surgery on Patient B at the Hospital and you failed to check the ureters at the time of the procedure"

Evidence

62. The background to events concerning Patient B and the surgical procedure is set out in paragraph 38 above. There was no reference in her medical records to ureters. On 1 June 2018 Patient B was in the emergency department with abdominal bloating, increased pain and a raised temperature. The CT scan on 10 June revealed a ureteric injury with leakage of urine and the presence of a large urinoma.

Mr Wood's evidence

63. In summary Mr Wood's evidence was that the ureters should be checked in all cases, and, further, that any failure to have checked the ureters at the time will have been seriously below the expected standard.

64. In his second report dated 5 June 2023, in relation to Patient B, Mr Wood stated:

> ". … It is probable that there was a direct transection injury to the left ureter at the time of the hysterectomy given the subsequent clinical course including early symptoms requiring readmission the day after discharge and just two days after surgery and the imaging that followed [10 June]"

In his fourth report dated 25 July 2024, Mr Wood stated that:

> "it is most probable that the injury occurred during the surgery on 30 May 2018 given the apparent absence of anything to indicate such an injury prior to the operation, the extent of the significant pathology encountered intraoperatively, the difficulty with the surgery and the timing of the readmission within 48 hours and subsequent diagnosis of the fistula and left ureteric injury with leakage of urine".

In that report, he was asked, if the injury had occurred on 30 May and if the Respondent had examined the ureters, what the likelihood was that he would have noticed the injury. He replied:

> "In this case the evidence indicates that there was a direct left ureteric injury during the index surgery resulting in leakage of urine as a result of a complete transection of the ureter (as also concluded by the Trust's External Assessor). On balance had the ureters been checked during the operation then the ureteric injury should and would probably have been positively identified with a complete transection and drainage of urine and help summoned"

65. Subsequently in an email dated 26 November 2024 sent in response to the Respondent's explanation, Mr Wood stated that his opinion has been that it is most probable that the ureteric injury actually occurred directly during the surgery on 30 May 2018. The evidence indicated that on a balance of probability there was a direct left ureteric injury during the surgery resulting in leakage of urine. That was also the view of the Trust's own independent external assessor. Their conclusion was that the injury was not a subtle thermal injury with delayed presentation. He maintained the view expressed in the second report (paragraph 64 above). This was a laparoscopic case. At readmission on 1 June the patient was unwell and there was left-sided free fluid along with a grossly elevated CRP level. That was in keeping with a direct ureteric transection at the time of surgery.

66. Mr Wood then referred to an article which suggests that if there is a direct injury in most cases blood in urine can be seen. He said that tissue damage as a result of indirect heat transmission tends to result in tissue necrosis leading to leakage of urine, but this would not tend to become manifest as soon as less than 48 hours after the injury. The presence of left sided free fluid as early as when the patient was readmitted on 1 June was in keeping with urine draining from the left ureter. Indirect thermal tissue damage would not have had to have been immediately obvious.

67. In *examination in chief*, Mr Wood said that if there is a direct injury, you could expect to see one or two things – first, the cut ureter and secondly, spontaneous passage of urine from the area that had just been cut. Not all ureteric injuries are identified at the time of surgery but, certainly, a direct injury such as this, where you would actually see the ureter being cut and/or see urine draining should have alerted the surgeon to the fact, if there was a direct injury to the ureter. His evidence continued:

> "Q: Is that something which requires a specific check of the ureter to see a direct injury or would it be obvious without such a specific check being made?
> A No. If you have made incision and you have damaged the ureter, you would expect to see the edge of the cut ureter and you would expect to see urine.
> Q Okay. But would that require the surgeon to specifically check the ureters to see that or would it just be obvious regardless?
> A It could be obvious regardless but there is a duty for the surgeon to check the position of the ureters and their integrity, and that is all the more important in such a complex case such as this where the ovary was densely adherent to the side wall of the pelvis.
> Q Is that because of the potential risk of a direct injury?
> A Yes."

By contrast an indirect thermal injury, would not necessarily be identified during the course of the procedure because of the nature of the injury. The indirect injuries tend to present after a week and so one would not expect an indirect injury to present before that period of time.

68. He was then asked what the notes and records from 1 June showed.

> "There are a number of symptoms and signs which all indicate that, in fact, there had already been urinary leakage as early as 48 hours following the surgery. [First], she was sufficiently symptomatic to return to the unit the day after she was discharged. She was in pain, she was distressed, and there was a particularly raised inflammatory marker, called a CRP level which was significantly raised and much higher than would be expected after surgery when it does rise, but not as much as that. Then the imaging identified some fluid localised to the left side of the pelvis and he believed, on balance, that this was urine that was identified. So the symptoms, the signs and the investigations were all indicative of a direct injury to the ureter at the time of the index surgery.
> …
> That [i.e. the imaging] was very important because the fact that it was localised to the left side, which is where the difficult surgery had been, where the dense adhesions had been, should all have alerted the clinicians to a ureteric injury, instead of which it seems that there was more concern that there might have been a bowel injury and then they decided that that probably wasn't the case, which was correct, and Patient A was then treated with intravenous antibiotics on the basis that this was purely infection. Now, as I say, I think there is enough evidence – there is not one, two, but there is more than a couple of factors which indicate that the ureter had already been damaged within 48 hours.
> …
>
> Q Okay. Now, you have already listed those but I am interested to know why you think the liquid that could be seen on the left side in the ultrasound scan was urine as opposed to anything else. What is your basis for concluding that?
> A Well, the localisation of the fluid is the most important factor here. If there had been a collection of blood, then because of gravity, one would expect that to be central. This was very clearly described as being left-

> sided and that really is the nub of the finding, that it was localised to the area where the ureter was injured." (emphasis added)

69. In *cross-examination*, Mr Wood said that any surgeon should have known that there was a real and increased risk of ureteric injury in this particular case. His evidence continued:

> "Q Indeed. So if you cut the ureter, I am going to suggest to you that that would be very obvious to the surgeon.
> A It would be obvious to the surgeon, yes, if the surgery is carried out competently.
> Q Yes. So you are saying that not seeing the cut end of the ureter and/or the urine leaking into the operating field is a kind of gross failure to see something that is basically in front of your face?
> A The fact that there was a real and present danger of a ureteric injury meant that it was imperative to reassure yourself as the lead surgeon that there was no injury to the ureter, and doing that would involve identifying the ureter, checking its function, ensuring its integrity, and if it has been transected, it should have been obvious to the surgeon, to the competent surgeon." (emphasis added)

70. He addressed this issue of "obviousness" again a little later in his cross-examination. He confirmed that "with a competent examination, [the transection] should have been obvious". He added that you would have seen the cut end of the ureter, "if you looked". It would not have been easily obvious. It would have been obvious with a competent examination which may have been challenging because of the degree of scarring. In answer to a question from a panel member, Mr Wood said that the surgery was challenging and there would have had to have been a thorough examination, but that did not detract from the ability to recognise a direct injury to the ureter at the time.

71. Earlier in his cross-examination, he stated:

> "What is important is the presentation on 1 June when, a few days after surgery, she presents with a combination of symptoms and signs amongst which was a CRP level that was far higher than would be expected after a routine operation, and that should and could not have been ignored and more crucially would support the contention that there was a direct injury to the ureter the previous 48 hours".

It was put to him in cross-examination that Patient B presented, on later occasions, with three of the things she presented with on 1 June, and he was asked whether that affected his view of the significance of those signs on 1 June. He replied that there was "no doubt that the combination of symptoms and signs on 1 June were indicative of a ureteric injury having occurred at the time of the surgery on the balance of probability".

72. Thus, at the centre of his evidence in chief and in cross examination was how Patient B presented on1 June and his view that those presentations were indicative of ureteric injury having occurred at the time of the surgery, of a direct injury

The Respondent's evidence

73. In his witness statement, the Respondent denied the allegations and stated as set out in §82 of the Determination (see paragraph 77 below).

74. In oral evidence in cross examination, he said that the symptoms on 1 June were consistent, but not diagnosed on the day, because it wasn't obviously a ureteric injury. She was reviewed following her admission but no concerns were raised about a ureteric injury.

The parties' submissions to the Tribunal

75. In opening *the GMC* characterised the issue as "whether that injury was caused by direct contact between the tools that were being used to carry out the hysterectomy, or whether it was indirect damage – again caused by the tools but what is called as a thermal injury. The tools use heat to cauterise and effectively stop blood loss and it is a recognised complication that that can cause thermal injuries". If it had been an indirect injury, she would not have been presenting with the ureteric injury on 1 June. The Respondent did not check, because if he had done so, he would have seen the injury which was a direct injury. Thus, the issue was whether it was a direct injury or indirect injury. In closing the GMC submitted that the key issue was Patient B's presentation on 1 June 2018. If that presentation was due to a ureteric injury, it was a direct injury. The issue turned largely on how Patient B presented on 1 June. She was clearly suffering from a urinoma, leaking urine in the left side of the body. The GMC relied on the three indications of that referred to by Mr Wood in his evidence. The GMC submitted

> "The final piece in the jigsaw, and perhaps the most significant, is that the ultrasound scan shows her to have fluid on the left side, where you would expect to find fluid if she has a ureteric injury. Okay, there may be other causes of fluid, albeit it would be surprising. But none of the other causes – and it was really only the wash-out, which is sucked out in any event, I'm going to suggest to a point that would be fairly negligible – that would not explain the other symptoms. That's why you have to look at each of the pieces in total. You know that there is an issue, because of the pain and the CRP reading, and you can see that there is a physical symptom of fluid at the site, or where you would expect the fluid to be collected. This was an injury.
>
> If that is an urinoma, it must be because there was a direct injury to the left ureter and, if there was a direct injury to the left ureter, then Mr Amiri cannot have checked it. Although that is a process of deduction, it's an entirely sound, logical process of deduction and one that would allow you to find Allegation 7 proved."

76. *The Respondent*, in written closing, submitted that Mr Wood had admitted that many of the signs and symptoms on 1 June could have other explanations. Whilst initially Mr Wood had said that a cut ureter would have been very obvious, later he toned that down to suggest it might not be that obvious. He realised that, as a consequence of saying it would be obvious, that made it considerably less likely that it had happened. As he was considering whether or not the surgeon was competent, he could not factor in the important point that the very obviousness of this sort of injury is the strongest argument that it did not happen. He submitted that it was not suggested that the Respondent was not in general terms a competent surgeon. Because the question Mr Wood had to answer was about the competence of the surgeon the fact that the injury would be obvious was treated as a factor to assess the level of failure, rather than considered as part of the probability that it had happened in the first place. A direct injury would be difficult to miss and therefore it was intrinsically unlikely that the injury would be missed by the surgeon during the procedure. The patient did re-

present within a timetable that was consistent with, but not diagnostic of, direct injury. In his written closing the Respondent addressed at some length this issue of the presentation on 1 June, setting out 13 distinct factors which it was said were more suggestive that it was *not* a direct injury. Overall the factors provided a mixed picture, not finely diagnostic one way or the other. He submitted that it is at this point that the sheer unlikelihood of the surgeon missing the cut ureter had to be factored in to decide whether, on balance, this was a failure of ureter checking or alternatively an indirect injury that could not have been detected.

The Tribunal's decision

77. The Tribunal addressed this allegation at Determination §§82 to 86 as follows:

> "82. In determining this paragraph the Tribunal took into account Dr Shokouh-Amiri's evidence:
>
> *'I did check the ureters during the surgery on 30 May 2018. It is my usual surgical routine to visualise the ureters. If I could not visualise the ureters then I would have changed the technique I used. I have a background in gynaecology oncology, and I would have looked further and ensured I had identified the ureters before continued with the surgery. I would not have removed the ovaries without having visualised the ureters…. I do not accept that the ureters were cut during the surgery on 30 May 2018. If I had directly damaged Patient's B's ureters then it would have become immediately obvious during the surgery. Patient B would have suffered, haematuria intraoperatively, which she did not'.*
>
> 83. The Tribunal noted that Dr Shokouh-Amiri. is an experienced surgeon and in his oral evidence highlighted his careful approach to identify the ureter during surgery by opening the retroperitoneal area. He explained the complexity associated of the surgical procedure of this patient because of extensive adhesions on the left side of the pelvis. He therefore took particular care throughout the procedure.
>
> 84. The Tribunal noted from Mr Wood's oral and written evidence that a ureteric injury caused at the time is known as a direct transection. This injury would be difficult to miss because the cut ends would be visible in the surgical field, and urine from the cut into the surgical field. It was accepted that the evidence presented supported the fact that Dr Shokouh-Amiri checked throughout the procedure. Both Dr Shokouh-Amiri and Mr Wood agreed that the injury would be obvious, and that any competent surgeon would see it. From Mr Wood's evidence the Tribunal understood that an indirect thermal injury would develop over time and not be detectable at the time.
>
> 85. The Tribunal determined that it was unlikely that an experienced surgeon such as Dr Shokouh-Amiri would miss a direct injury to the ureter given the description given by the expert. The Tribunal accepted that Dr Shokouh-Amiri checked the ureter.
>
> 86. Therefore, the Tribunal finds paragraph 7 not proved."
>
> (emphasis added)

The Parties' submissions

The GMC case

78. The GMC's case is that the Respondent did not do the check that would have been expected of a competent surgeon. Its essential case is that the injury was a direct injury caused at the time of the operation on 30 May; and that it follows that the Respondent failed to check the ureters on that date because if he had checked he would have noticed the injury, given that it is a direct injury. It submits that, crucially. the Tribunal did not address at all the central issue about Patient B's presentation on 1 June. The GMC's case is to start by looking at the medical records and in particular what had happened on 1 June. There was a complete and utter failure to address the issue of what the 1 June presentation indicated. That was central to the expert's view that, on the balance of probability, it meant that there had been a direct injury. It was common ground that this was a key issue; yet there was no finding on that issue by the Tribunal. The public cannot be reassured that the Tribunal engaged with the evidence where there is no reference to that evidence in the Determination. The decision is wrong because of the failure to address that issue.

79. Moreover the Tribunal's reasoning about him being an experienced surgeon is facile. To the Tribunal's knowledge, the Respondent had admitted to ethical and clinical errors. On that basis the Tribunal were wrong to simply assert glibly that it was unlikely that he, as an experienced surgeon, would miss a direct injury.

The Respondent's case

80. The Respondent's case and his evidence is that he did check the ureters on 30 May. When he checked he did not notice anything, because the injury was indirect. If he had checked and the injury had been direct he would have noticed the injury. If a direct injury, it would have been obvious.

81. It was further submitted that even if he had not checked, urine would have leaked into the operating area and he would have noticed. Thus the absence of urine demonstrates that the injury cannot have been a direct injury. Further lack of blood in urine indicated it was not a direct injury.

82. The Respondent accepted in argument that the central dispute related to the presentation on 1 June. As regards that presentation, the symptoms were not symptoms of a ureter injury. They were consistent with, but not diagnostic of a direct injury. The Tribunal came down against the suggestion that the 1 June symptoms were decisive. It is inconceivable that the Tribunal did not have regard to the clinical issues. It was disputed that fluid in the abdomen could only have been caused by direct injury. There was fluid in the abdomen but this could have been caused by thermal indirect injury. If it had been an indirect injury, it would have caused fluid, but not urine.

83. The Tribunal was correct to concentrate on the obviousness of a direct injury and that factor trumps the evidence of signs and symptoms on 1 June relied upon by the GMC. There was no reference at all in the Determination to the presentation on 1 June because Mr Wood agreed that a direct injury would have been obvious and the Tribunal decided the issue on "obviousness".

Discussion

84. The allegation here is that the Respondent did not check the ureters on 30 May. Whilst ultimately that was a question of primary fact, the underlying issues here raised questions of inferential fact, evaluative judgment and medical expertise and opinion.

85. The essential reasoning of the Tribunal appears to be as follows: the Tribunal found that the injury to the ureter would have been obvious at the time of the operation on 30 May (to a competent surgeon). The Respondent is such a competent surgeon and because he did not notice any injury at the time, the injury cannot have been and, was not, a direct injury but rather (implicitly) an indirect injury which emerged only later.

86. At the heart of the issue in relation to Patient B is whether the injury (which had emerged by 10 June) was a direct injury caused by a cutting of the ureter during the operation or, alternatively, an "indirect injury" which may have been caused by the heat of instruments.

87. It is common ground that there was an injury to Patient B's ureters which occurred during the operation on 30 May. Moreover that injury had emerged by 10 June and by that time it was too late to tell whether it was a direct injury or an indirect injury. Further, it is common ground that if that ureter injury had been diagnosed on 1 June, it would have had to have been a direct injury because indirect injury would not have emerged by 1 June.

88. Furthermore, in this connection, a (if not the) central issue was what inference could be drawn from Patient B's presentation on 1 June and whether it could be inferred from that presentation that it was a direct injury and thus that the ureter cannot have been checked on 30 May. On this issue, there were forceful and detailed submission from both sides. Mr Wood was consistently of the view (and did not alter his view) that the presentation on 1 June indicated, on balance, a direct injury. The Respondent argued to the contrary; referring to a number of aspects to show that the symptoms on 1 June were not diagnostic of a direct ureteric injury.

89. However, and despite the case presented to it by the GMC (and with which the Respondent joined issue), in the Determination the Tribunal made no reference at all to the issue of the presentation on 1 June. It made no finding on this issue; indeed it did not refer to the 1 June presentation at all anywhere in the Determination. It did not explain why it did not accept the extensive and consistent evidence of the expert, Mr Wood. The Tribunal failed to resolve this central issue.

90. §§84 and 85 of the Determination seem to be an inference that the Tribunal found that the injury was indirect. However this is not stated expressly and it is not clear. As regards the statement in §84 of the Determination "it was accepted that the evidence presented supported the fact that [the Respondent] checked throughout the procedure", it is not clear what is meant by this. It was not accepted by the GMC or by Mr Wood. The statement therefore must mean that the Tribunal "accepted that the evidence" showed this. Yet there is no reference at all to Mr Wood's evidence to the contrary.

91. As to the contention that the Tribunal was entitled to decide the allegation on the basis of "obviousness" without making any reference to the presentation on 1 June and that, in any event, obviousness "trumps" the 1 June presentation, I do not consider that this is well founded. If, as the GMC contended, and as Mr Wood's evidence said, the 1 June presentation did in fact indicate that the injury was a direct injury, then the issue

of obviousness is irrelevant. In my judgment, both because of this and because of the evidence and arguments presented, the Tribunal was required to reach a conclusion on this specific issue.

92. First Mr Wood's evidence was that the injury was not easily obvious, but would have been obvious with a competent examination and "if you looked". Moreover, in concluding that the Respondent was an experienced surgeon who took particular care throughout the procedure the Tribunal failed to take into account the fact that in relation to Patients C and D he had removed the ovaries of two patients without their consent and, in one case, without any proper clinical indication.

93. The question then arises as to whether, with the benefit of knowledge of the evidence and submissions made below, it is possible to understand why the Tribunal reached the decision it did.

94. The Tribunal could have meant as follows. Whilst it was Mr Wood's evidence that on balance the symptoms on 1 June indicated a direct injury, there were a number of factors which were suggestive of indirect injury. The Tribunal was therefore entitled to conclude that it was not satisfied that the presentation on 1 June clearly indicated a direct injury. If that is right, it was then entitled to look at the issue of obviousness. It concluded that, on the evidence from Mr Wood, a direct injury would be obvious (at least to a competent surgeon). There was no reason to think that the Respondent was not a competent surgeon and therefore it would have been obvious to him; and because it was not seen, it must have been an indirect injury. Therefore there was no reason to disbelieve him when he said he checked the ureter.

95. In my judgment it is pure speculation that the Tribunal *did* analyse the matter on this basis. It simply did not address at all the central question of the presentation on 1 June**.** It is not possible to understand their reasons for rejecting (as it must have done) Mr Wood's central evidence. The alternative possibility is that it may simply have overlooked that evidence and this issue.

96. Finally, there is an element of circularity in the Tribunal's analysis. It assumes the very answer to the question which is posed by Allegation 7; i.e. did the Respondent check the ureters on 30 May? The Tribunal's analysis appears to be as follows. On 30 May the Respondent says he checked the ureters. He did not see any injury. He would have seen such an injury, because it would have been obvious. Therefore at that time there was no direct injury; therefore he must have checked on 30 May.

Conclusion on Ground 1

97. I conclude that the Tribunal failed to consider, understand or resolve the central issue and evidence relevant to this allegation. The finding of not proved was therefore wrong. Alternatively the reasons given by the Tribunal were not intelligible and did not deal with the substantial points that were raised and failed to address the issue or set out findings. There was a breach of the duty to give reasons and this amounts to a serious irregularity causing injustice. Ground 1 therefore succeeds.

Ground 2: Patient F

Some background

98. This relates to events in consultations between the Respondent and Patient F on 4 and 7 December 2018.

99. On 21 November 2018, Patient F underwent a procedure for the removal of her coil, and without a chaperone present. On 4 December 2018, Patient F attended a consultation with the Respondent. She alleges that in the course of this consultation he acted inappropriately with her; this forms the basis of the allegations 17 a to e. On 5 December 2018, the Respondent sent a letter (dictated on 4 December) to Patient F's GP explaining that he had seen her for a routine follow up about rectal bleeding. They had discussed contraception. He had added Patient F to his waiting list for adhesiolysis of the vulva, insertion of a coil and cervical cautery under general anaesthetic. (Adhesiolysis is a procedure to address the condition of Lichen Sclerosus.) The letter stated that the pros and cons of the procedure "have been discussed" and a written consent had been obtained. It is not clear from the letter whether that "discussion" took place at the 4 December consultation or had occurred earlier. Moreover, in fact, that written consent had not been obtained at that point, and indeed was the reason for the further appointment on 7 December, because the Respondent's secretary considered that the consent should be given in his presence. Both in her police interview on 12 December 2018 and her statement to the GMC on 18 April 2020, Patient F explained how initially the Respondent had suggested she should come in to sign the consent form, but that on the next day, the secretary had called her, and that as a result of that call, a further appointment would be made with the Respondent so that he could go through the consent form with Patient F.

100. On 7 December 2018, Patient F attended a further consultation with the Respondent. She alleged that in the course of this consultation he acted inappropriately with her; this forms the basis of the allegations at paragraph 18. On 7 December 2018 the Respondent dictated a letter to Patient F's GP (sent on 18 December) stating that she had come to consent for the procedures referred to in the 5 December letter. This later letter referred to her complaining about vulva soreness along with some iliac fossa discomfort.

101. On 8 December 2018, Patient F reported matters to the police. Patient F's evidence before the Tribunal comprised the recorded accounts she gave to the police on 12 December 2018 and then on 29 January 2019; the account she gave to the GMC on 18 April 2020 and the oral evidence she gave to the Tribunal at the hearing on 23 January 2025. In what follows I set out in relation to each allegation those parts of that evidence which relate directly to that allegation - extracting passages from the overall narrative account.

102. Before turning to the particular allegations, I make the following observations in relation to Patient F's evidence. First, Patient F gave her first account to the police a matter of days after the relevant events; the account was detailed. Much of the detail was highly specific and had "the ring of truth" about it. She gave that account before having any contact with Patients A and D. Her subsequent accounts in January 2019, April 2020 and before the Tribunal itself were consistent. She had no reason to make untrue allegations against the Respondent and none have been suggested.

103. Secondly, the Tribunal did not make any general assessment of Patient F. It made no real assessment of the credibility of Patient F as a witness or the reliability of her evidence, either at the outset of the Determination or in the course of considering allegations 17 and 18 (save in relation to one specific allegation – Allegation 18 b v). There was no proper evaluation of her oral and written evidence. It did not find her to be a not credible witness. As appears from below, the Tribunal clearly accepted much of her evidence about the facts which occurred.

104. Thirdly, the Respondent contends that the Tribunal considered the 7 December allegations (Allegation 18) first, found her to be not credible in relation to those and then worked backwards to consider the 4 December allegations, having found her not to be credible. I do not accept this contention. There is no evidence to suggest that this was the Tribunal's approach.

105. Fourthly, the Respondent contends that Patient F was, in general, "confabulating". I address this at paragraph 182 below. Her evidence is clear that she had no doubts as to what had happened.

4 December: Paragraph 17

Paragraph 17 c

Allegation

106. Allegation 17 c: In relation to Patient F, the Respondent was charged that "On 4 December 2018, during a consultation at MSG, you behaved inappropriately in that you asked intimate details about Patient F's sex life".

Evidence

107. Patient F's evidence was as follows. In her police interview on 12 December 2018, she explained that she had a routine appointment arranged for 29 November. That was initially cancelled, but on Friday 30 November it was re-arranged for 4 December because she was feeling uncomfortable. On Sunday 2 December she experienced bowel bleeding and the Respondent said she was coming to see him on the Tuesday and he would do a rectal examination. (I note however that in her statement to the GMC on 18 April 2020, she said that in fact the 4 December appointment was not made until, at the earliest, Sunday 2 December and due to the rectal bleeding issue.)

108. Her evidence in the 12 December police interview continued:

> "Erm so I went in .. . so yeah that was, he asked me how I'd been and he said I'll do a rectal examination and I'll put your mind at rest because I'm sure it's just haemorrhoids and I said okay. Erm and then he said so we really need to start off the health anxiety thing so he said oh tell me about your what you think might have triggered it off
> …
>
> "He then went on to ask me how many times me and my partner have sex and I said oh I'm not sure I said it's not that often and he said no tell me how many times a week do you and your partner have sex. So I said probably 2 or 3 times a month and he said are you happy are you comfortable with that, and I said well we have had arguments about it and he said yeah yeah I can see that. Erm he said I think your problem is is that you don't know how to love yourself, you don't know how to be comfortable with yourself and you're constantly seeking for other people's approval. And he said I can see that with your partner if he doesn't fulfil sexual needs you're going to doubt yourself, you're going to think there's something wrong with you, he's going to think that you're gonna think there's something wrong with your appearance. Erm and he said that that's not the case he said you're a very attractive woman he said your body is very well put together he said you're articulate, you're well dressed and you need erm someone to make you kind of realise that through sex."

109. In her statement to the GMC on 18 April 2020 she stated:

> "Mr Shokouh-Amiri then asked me how many times per week we have sex. I felt a little uncomfortable about this question, but I knew it wasn't completely out of context to talk about sex in a gynaecologist appointment, so I answered him. I advised that myself and my partner have sex approximately 2 or 3 times a month. He said that was not enough and looked shocked. He asked why we didn't have sex more regularly and I said that my partner has a lower sex drive and I thought that may have been down to him being older than me."

110. Mr Wood in his first report dated 14 August 2022, asked to comment on this allegation, said that asking her about her sex life with her partner "would only be relevant in the context of the gynaecological history and accompanying symptoms such as bleeding after intercourse or painful sex. …The exploration of more intimate details about sex life as described by Patient F would be inappropriate and seriously below the expected standard". (emphasis added)

111. The Respondent in his written statement denied this allegation. In his oral evidence in cross examination, asked about this allegation, he denied it with a simple "No". The alleged conduct did not happen.

The Tribunal's decision

112. The Tribunal addressed this allegation at Determination §§124 to 126 as follows:

> "124. With regards to paragraph 17c, the Tribunal finds that to an extent a gynaecological doctor has to ask the patient about intimate details when carrying out an examination. It noted the evidence of Mr Wood:
>
> > *'This would only be relevant in the context of the gynaecological history and accompanying symptoms such as bleeding after intercourse or painful sex'.*
>
> 125. The patient was reporting that she was sore, and the Tribunal considered that questioning the patient about sex was not inappropriate in the context of the examination and the condition she presented with. It also noted that Patient F offered information about her sex life:
>
> > *'He then went on to ask me how many times me and my partner have sex and I said oh I'm not sure I said it's not that often and he said no tell me how many times a week do you and your partner have sex. So I said probably 2 or 3 times a month and he said are you happy are you comfortable with that, and I said well we have had arguments about it'*
>
> 126. The Tribunal accepts the doctor responded to her concerns and asked Patient F further intimate details about her sex life. However, it was not inappropriate in the context of this gynaecological examination. Therefore, the Tribunal finds paragraph 17c, not proved."
>
> (emphasis added)

The Parties' submissions

The GMC case

113. The GMC submits that the Tribunal did not reject Patient F's account of the conversation. The Tribunal failed to realise that the consultation on 4 December 2018 was not about a gynaecological condition nor was there a gynaecological examination. It was about a rectal condition and Patient F's health anxiety. The Tribunal confused the 4 December consultation with the 7 December consultation. It was wrong to suggest that Patient F "offered" information about her sex life. Further the Tribunal failed to take account of the entirety of Mr Wood's evidence that such a conversation was inappropriate. The conclusion that the Respondent's questioning as described in the evidence was not inappropriate is extraordinary and not one reasonably open to a tribunal.

The Respondent's case

114. The Respondent submits that Patient F's sex life and gynaecological issues were a topic during the consultation on 4 December, as evidenced by the letter of 5 December. She told the Respondent about contraception and her vaginal condition was discussed. It was always a consultation about vulva and contraception. Secondly, the Tribunal's reference to Patient F "offering" information does not suggest that the Respondent was not asking questions, which she answered willingly about contraception and vaginal condition. Her sex life was therefore properly discussed.

Discussion

115. First, the Tribunal found that the conversation about her sex life did take place on 4 December; it therefore must have rejected the Respondent's evidence that it did *not* take place at all. He did not put forward any positive account about what happened at that consultation. It also accepted that the conversation was as described by Patient F in her police interview. There is no suggestion that she was lying or exaggerating or misunderstood what had happened. It did not reject her account.

116. Secondly, and critically, the Tribunal erred in finding that on 4 December, the *examination* which took place was gynaecological. There is no evidence that there was gynaecological examination on 4 December. There was rectal examination. Moreover it is also far from clear that Patient F was "presenting" with a gynaecological *condition* on that day. The immediate issue was her concern about rectal bleeding. There was no evidence of any psychological or psychosexual discussion or issue. I note that in her April evidence, Patient F described the appointment as with a gynaecologist and not as a gynaecological appointment. The immediate issue for the 4 December consultation was that Patient F had been suffering from rectal bleeding when she had a bowel movement over the weekend. That was not a gynaecological issue. As regards the Tribunal's reference to "soreness", there is no evidence that any "soreness" she mentioned related to a gynaecological issue. In her evidence, relating to 4 December, she referred to "soreness" arising from the rectal bleeding condition and not to a gynaecological condition. It is possible that the Tribunal confused this with the soreness from gynaecological issues which is referred to in the letter of 7 December following the 7 December consultation. Her evidence was that on arrival at the consultation the Respondent said that he would do a rectal examination and that he thought it was haemorrhoids. This is confirmed by the letter dated 5 December. There was reference in that letter to a discussion about contraception. The letter also referred to being added to a waiting list for an operation for gynaecological issues. However this letter does not evidence that those issues were discussed *at the 4 December consultation*, nor more pertinently that there was any gynaecological examination at that consultation. See paragraph 99 above.

117. Thirdly, and in any event, the ultimate conclusion was that the conversation which took place as described by Patient F was "not inappropriate". This was an evaluative finding and appeared to be based on Mr Wood's evidence. However the Tribunal reference, in §124 of the Determination to Mr Wood's evidence was selective, partial and misleading. First, he said that sex life would *only* be relevant in the context of gynaecological history – there is no evidence of gynaecological history being discussed. Secondly, and more importantly, the Tribunal omitted reference to the second sentence of Mr Wood's evidence (paragraph 110 above), where he said, of this very conversation, "the exploration of *more* intimate details about her sex life as *described by Patient F* would be inappropriate and seriously below the expected standard". This was a serious omission by the Tribunal.

118. I conclude therefore that the Tribunal's conclusion that a conversation in these terms in the context of the consultations on these issues was not inappropriate is not one reasonably open to a tribunal and was so out of tune with the evidence properly read as to be unreasonable. The conclusion was wrong.

Paragraph 17 d

Allegation

119. Allegation 17 d: In relation to Patient F, the Respondent was charged that "On 4 December 2018, during a consultation at MSG, you behaved inappropriately in that you said words to the effect of "you need to find someone outside of the family unit that you can go to and you have a sexual relationship with them so it fulfils your needs"

Evidence

120. Patient F's evidence was as follows. In her police interview on 12 December 2018, she stated:

> "Erm and he said so you need to find somebody he said outside of the family unit he said I don't know what sort of thing you're into but you need to find somebody out of the family unit that you can go to and you have a sexual relationship with them so it fulfils your needs. And I ended up getting a little bit confused at that because I didn't quite understand why he was saying that and he said it's a little bit like if your partner doesn't like going to the cinema erm you may have a friend that does like going to the cinema so you've got a friend there to do the things that you enjoy that your partner doesn't enjoy." (emphasis added)

121. A little later in the statement, in relation to the content of the 4 December consultation, she said:

> …
>
> "Erm oh I also that day as well after I saw Mr Amiri in the morning I went to go and see my partner and I told him about all of these conversations that I'd had with him and I think we just thought this is just a little bit odd. Erm this, these aren't sort of normal questions I've been asked before but again didn't think anything major of it because he's a doctor and there must've been a reason why he'd asked me them."

122. In her statement to the GMC on 18 April 2020 she stated:

> "He reassured me by telling me that I was an attractive woman with a good body. Mr Shokouh-Amiri suggested that if I was comfortable enough, I should try to find someone to have sex with, other than my partner, as this would make up for what I was missing in my relationship. He said that if my partner did not like going to the cinema, then I should find a friend who does like going to the cinema and go with them instead. At the time, I thought that was a literal statement and did not take it as an analogy. It was only at a later date that realised that it was an analogy for having sex with someone other than my partner. (emphasis added)
>
> …
>
> That afternoon, I visited my partner at work to tell him about my appointment with Mr Shokouh-Amiri. We both laughed about it, as we felt as though he was asking extremely personal questions. However, we did not question that there was an ulterior motive and trusted that there was a good reason for him asking what he did (about sex and masturbation)."

123. The Respondent in his written statement denied this allegation. In his oral evidence in cross examination, asked about this allegation, he denied it with a simple "No". He added that such conversation "is totally inappropriate. Never can find myself to say something to a patient". The alleged conduct did not happen.

The Tribunal's decision

124. The Tribunal addressed this allegation at Determination §§127 to 134 as follows:

> "127. In determining this paragraph the Tribunal noted the police statement of Patient F
>
> > *'He said that if my partner did not like going to the cinema, then I should find a friend who does like going to the cinema and go with them instead. At the time, I thought that was a literal statement and did not take it as an analogy. It was only at a later date that I realised that it was an analogy for having sex with someone other than my partner.'*
>
> 128. The Tribunal notes that she thought it was a literal statement, and it was only at a later date that she changed her mind and, 'realised that it was an analogy of having sex with someone other than her partner'. The Tribunal noted that Patient F did not tell the police that Dr Shokouh-Amiri had directly used the words as alleged in paragraph 17d. Instead, she had reported interpreting his comments about a trip to the cinema as comments about having sex with someone else - she states she only thought this 'at a later date'.
>
> 129. Patient F also states in evidence to the police and GMC that she visited her partner at work directly after the appointment:
>
> > '*That afternoon, I visited my partner at work to tell him about my appointment with Dr Shokouh-Amiri. We both laughed about it, as we felt as though he was asking extremely personal questions. However, we did not question that there was an ulterior motive and trusted that there was a good reason for him asking what he did (about sex and masturbation).''*

> 130. Patient F has stated she changed her view of the conversation 'sometime later'. The Tribunal finds it highly unlikely that she would laugh about such a comment with her partner in the immediate aftermath, words as alleged or the effect of. [sic]
>
> 131. The Tribunal noted that Patient F had continued to request appointments with Dr Shokouh-Amiri after the alleged comment.
>
> 132. The Tribunal noted that Dr Shokouh Amiri denies this allegation.
>
> 133. In conclusion, the Tribunal finds that Dr Shokouh-Amiri had not made this comment or words to that effect, in the appointment. It noted that it was sometime later and after conversations with Patient A and D, that Patient F changed her view of the conversation and thought it was an analogy, rather than taking it as a literal statement. It also noted that Patient F asked to see Dr Shokouh-Amiri several times after that alleged comment was made, she also laughed about the appointment afterwards with her partner, which supports the finding that such words were not used.
>
> 134. The Tribunal therefore finds that Dr Shokouh-Amiri did not make any comment as alleged and found it not proved." (emphasis added)

The Parties' Submissions

The GMC case

125. The GMC submits that §128 of the Determination is a wholly inadequate basis to reject Patient F's account. The Tribunal's reasoning was flawed and/or based on a misunderstanding and/or failed to have proper regard to the relevant evidence.

126. First, the Tribunal misunderstood or ignored key parts of Patient F's evidence in respect of this allegation. Secondly, the Tribunal failed to consider the many reasons why a person who had been subject to sexually inappropriate behaviour might laugh. Thirdly the Tribunal erred in fact when it stated that Patient F continued to request appointments; she did not.

The Respondent's case

127. The Respondent submits that there was only one conversation and that concerned going to the cinema. Patient F was confused. She wrongly thought that by this conversation the Respondent meant having sex with a friend. The Tribunal could reasonably have inferred that it could not have been said by the Respondent as two separate things. It is inconceivable that if these two things had been mentioned as she described it, she would not have realised that the reference to going to the cinema was *not* an analogy. Secondly, the reference, at §131 of the Determination, to further appointments was badly expressed; nevertheless however the point remains that Patient F was not showing any reluctance to see the Respondent again.

Discussion

128. First, contrary to the Tribunal's conclusion, Patient F's actual evidence was that the Respondent made two comments to her: the first a statement about having sex with someone else and the second an analogy about going to the cinema.

129. As regards the passage of Patient F's evidence cited at §127 of the Determination, the Tribunal wrongly identifies this as being part of her "*police* statement". It is not. It is part of her evidence in her *April 2020 GMC* statement. More significantly the citation wholly omits the first half of that passage of her statement where she expressly and distinctly refers to "*finding someone to have sex with*": see paragraph 122 above. Furthermore, the Tribunal makes no reference to what she said earlier in the 12 December police interview, where she referred - even more clearly - to two distinct matters: having sex with somebody "outside of the family unit" and going to the cinema with a friend. This is made clear by the words in that passage "and he said it's a bit like…". Her consistent evidence is that two distinct things were said. Furthermore the Tribunal's statement at §128 that "she did not tell the police that Dr Shokouh-Amiri had directly used the words alleged" is wrong. In the police interview on 12 December she used those exact words: see paragraph 120 above. Finally, I note that the suggestion that the cinema analogy was only thing that was actually said was never put to Patient F in the course of her oral evidence (either by the Respondent's counsel or by the Tribunal itself).

130. For this reason alone, the Tribunal's conclusion was so out of tune with the evidence properly read as to be unreasonable and wrong. Moreover the Tribunal's reasons were inadequate and failed to deal with the evidence and substantial points which had been raised.

131. Secondly, as regards §§129 and 130 and the evidence about Patient F laughing, I accept the GMC's submission that the Tribunal failed to consider why someone in this position as alleged might respond by laughter; the conclusion that this was highly unlikely was superficial. (I note too, in passing, that the final words of §130 do not make sense - there appears to have been a drafting error.)

132. Thirdly, the Tribunal placed some significant reliance (both at §131 and §133) upon the fact that Patient F requested further appointments with the Respondent. This conclusion was based on factual error. First there was only one further appointment - on 7 December; and secondly, that appointment was not made at the behest of Patient F, but rather as a result of a request from the Respondent's secretary to sign a consent form in the presence of the Respondent.

133. I conclude therefore that the conclusion that the Respondent did not make any comment as alleged failed to take account of the relevant evidence, was based on a misunderstanding of evidence and contained clear factual errors; it was therefore so out of tune with the evidence as to be unreasonable and therefore wrong. Furthermore the Tribunal's reasons were inadequate.

Paragraph 17 e

Allegation

134. Allegation 17 e: In relation to Patient F, the Respondent was charged that "On 4 December 2018, during a consultation at MSG, you behaved inappropriately in that you discussed masturbation with Patient F."

Evidence

135. Patient F's evidence was as follows. In her police interview on 12 December 2018, she stated:

> "So at which point I'm just kind of just listening to him thinking I don't know where this is going erm and then he said do you masturbate to which I said yes and he said how many times a week do you masturbate and I started to get quite uncomfortable. But I kind of thought he's a doctor there must be a reason why he's asking this, this isn't just a random question so I answered him and I said oh probably a couple of times a week erm and he said oh I'm really happy to hear that because it's important that you kind of you have your own self appreciation, your own time on your own. And erm it's that peace and quiet to leam to love ·yourself and he said and it's that release that you need and he said and you need to see if you can try and do that more even though I understand that's difficult he said even if it's twice a day you need to try and fit that in more. I thought okay. And then he said well what do you think about when you masturbate and I just said oh my partner and he said okay that's fine and then and then I think I was in there for a good 45 minutes"

136. In her statement to the GMC on 18 April 2020 she stated:

> "Mr Shokouh-Amiri then asked me whether I masturbated and I said yes. He asked how many times per week and what I thought about during masturbation. I said a few times per week. He said that he was happy to hear that. He said that he wanted me to try and do it more often. He said it was important for me to find time to myself to try and let go and explore my body to find out what I liked. He said that I would learn to love myself by doing this."

137. Mr Wood in his report dated 14 August 2022, asked to comment on this allegation, said that, if accepted by the Tribunal, this was inappropriate and unrelated to the circumstances of the gynaecological consultation. This was seriously below the expected standard of care. In his oral evidence in chief Mr Wood stated

> "So there is no appropriate circumstance where one would specifically ask about masturbation in the context of a consultation unless this is something that the patient brings up herself spontaneously. In terms of providing medical advice, masturbation does not come under the remit of the standard gynaecological examination and history."

In cross-examination (about Patient A), Mr Wood said that he had never in his career had a patient asking him about masturbation. He accepted that masturbation might come up in a physical examination, where the patient has a problem with sexual arousal, although that was very much in the realms of psychosexual medicine.

138. The Respondent in his written statement denied this allegation. In his police interviews he categorically denied ever discussing masturbation. In his oral evidence in cross examination, asked about this allegation, he denied it with a simple "No". He added that such conversation "is totally inappropriate. Never can find myself to say something to a patient". The alleged conduct did not happen.

The Tribunal's decision

139. The Tribunal addressed this allegation at Determination §§135 to 136 as follows:

> "135. The Tribunal noted i Dr Shokouh-Amiri denies discussion masturbation with Patient F. He explained that he had a clinical reason to ask patients about intimate details during gynaecological examinations.

> During the consultation Patient F spoke about her difficulties her sex life including various factors such as soreness. In response Dr Shokouh-Amiri advised her on the management of Lichen Sclerosus more likely he further talked about way to deal with her concerns including masturbation. The GMC has not proved on the balance of probability that Dr Shokouh-Amiri has asked about masturbation in an inappropriate way.
>
> 136. Therefore find paragraph 17e not proved." (emphasis added)

The Parties' submissions

The GMC case

140. The GMC submits that the single paragraph decision here makes no sense and/or is based on a misunderstanding of the relevant evidence. In particular the sentence about management of Lichen Sclerosus make no sense. There was no gynaecological examination on 4 December and the Tribunal confused the reference to "soreness" – which was in fact mentioned at the 7 December consultation. Secondly, the Tribunal's conclusion was contrary to the evidence of both Mr Wood and the Respondent himself; his evidence was that there was no conversation about masturbation at all.

The Respondent's case

141. The Respondent submits that, despite the Respondent's evidence that it did not take place, given the Tribunal's conclusion that Patient F's sex life was discussed at this consultation, it was open to the Tribunal to accept that masturbation was part of it. The Tribunal was correct to find that the Respondent advised about Lichen Sclerosis. This is reflected in the letter of 5 December and this was a gynaecological consultation. Mr Wood accepted in evidence that masturbation might come up in a physical examination. A gynaecologist might have to ask a patient about whether they can arouse themselves in order to try and find if there was a physical problem or a psychological problem.

Discussion

142. The Tribunal's reasoning here is very brief.

143. First, the Respondent's case was that he did not discuss masturbation at all. The Tribunal rejected his evidence and found that he *did* ask about masturbation; but went on to find that it was not in an inappropriate way. This finding therefore suggests that the Tribunal accepted Patient F's evidence about the fact (and the content) of the discussion.

144. Secondly, as with paragraph 17 c, the Tribunal's conclusion that the discussion was not inappropriate was based wholly on the factual foundation that in the course of the 4 December consultation there was a gynaecological examination, that Patient F spoke about soreness ("down there") and that the Respondent advised her about Lichen Sclerosus. However as pointed out at paragraph 116 above, the evidence does not support this factual foundation. Patient F (whose factual account of the conversation was accepted) makes no reference to these facts in relation to 4 December. Moreover the letter of 5 December does not clearly provide evidence to support this.

145. Thirdly, the Tribunal's conclusions are contrary to the Respondent's own evidence. Not only does he deny such a conversation having taken place and deny that he would ever have such a conversation, but said that any such discussion would be totally inappropriate. Further its conclusions are contrary to Mr Wood's evidence on this issue of discussion of masturbation: see paragraph 137 above. There is no suggestion that any issue about sexual arousal came up in the consultation.

146. In these circumstances, it is hard to see how the Tribunal could have reached the conclusion which it did. I conclude that there was no evidential basis upon which the Tribunal could rationally have concluded that the conversation (which did happen) was not inappropriate. The Tribunal's conclusion is so out of tune with the evidence properly read as to be unreasonable and wrong.

7 December: Paragraph 18

147. As regards the consultation on 7 December generally, it is common ground that there was a gynaecological examination on that date. As regards what may have happened in that consultation, a central issue is the Respondent's case that Patient F's account was confabulation and that her recollection was distorted. This appears to have been accepted by the Tribunal, particular in relation to allegation 18 b v. I address this issue when dealing with that allegation: see paragraph 182 below.

Paragraph 18 b iii

Allegation

148. Allegation 18 b iii: In relation to Patient F, the Respondent was charged that: "On 7 December 2018, during a consultation at MSG you behaved inappropriately in that you discussed masturbation with Patient F"

Evidence

149. Patient F's evidence was as follows. In her police interview on 12 December 2018, she stated:

> "And then he went straight into, he said, have you masturbated since I last, saw you on Tuesday and I said yes and he said oh really why, what made you do that. Erm and I said oh I just took into account what you said about making time for myself and thought I would just see whether or not that would help. And he said oh that's good, he said his words were 'did you cum' and I said 'no' and he said why not and I said because I generally feel really uncomfortable down there and I said I feel like my skin down there is stinging and obviously with all the haemorrhoids and everything I'm not particularly in the mood to do that."

150. In her statement to the GMC on 18 April 2020 she stated:

> "He did not ask any other questions on the matter and went on to ask me if I had masturbated since I last saw him. I said yes and he asked what had made me do this. I said that he's made me think at the last appointment and that I wanted to try and make more time for myself in this way, as he had suggested. He asked if I had come and I said no and he wanted to know why. I said that I felt uncomfortable and sore down there, so I stopped."

151. The Respondent in his written statement denied this allegation. In his oral evidence in cross examination, asked about this allegation, he denied it with a simple "No". Again this conduct did not happen.

The Tribunal's decision

152. The Tribunal addressed this allegation at Determination §§141 to 142 as follows:

> "141. The Tribunal noted it was the view of Dr Shokouh-Amiri that he had a clinical reason to ask patients about intimate details. During the consultation the patient had concerns about her sex life. In response to her concern, the Tribunal did not consider it to be inappropriate in the context of a clinical appointment for Dr Shokouh-Amiri to ask a patient about their sex life but the GMC has not proved on the balance of probability that Dr Shokouh-Amiri has asked about masturbation in an inappropriate way.
>
> 142. Therefore, the Tribunal finds paragraph 18 b iii not proved."

The Parties' submissions

The GMC case

153. The GMC submits that it is unclear what actual findings the Tribunal was making or purporting to make on this allegation. Patient F's account, given only five days after, was that having first asked about the rectal bleeding he went straight into saying "have you masturbated?". The Respondent denied he had asked her about masturbation. It was not his evidence that he asked questions which led to an appropriate discussion about masturbation. There was a primary dispute of fact as to whether masturbation had been discussed. It is not possible to tell from the decision what conclusion the Tribunal reached that issue.

154. Insofar as the Tribunal decided that masturbation was discussed, but in an appropriate way, that conclusion was not open to it either on Patient F's evidence or on the case advanced by the Respondent. Further the Tribunal failed to take into account the evidence of the expert Mr Wood who said that in no circumstances would such conversation be appropriate. The decision failed to address that evidence. Furthermore the Tribunal's brief reasoning suggests that it mischaracterised the evidence so as to suggest that it was Patient F who initiated the discussion regarding her sex life and masturbation

The Respondent's case

155. The Respondent makes no specific submission on this allegation. Rather he submits that, in general, the Tribunal did not accept Patient F's account of the events on 7 December. The Tribunal made overall findings that her account lacked credibility. Patient A was "confabulating". The evidence shows that she had doubts that she had made it all up. The Respondent relies upon the submissions it made to the Tribunal setting out the sequence of events.

Discussion

156. This allegation involved initially a primary dispute of fact. Was there or was there not a discussion about masturbation? Patient F's evidence was that there was such a discussion. The Respondent's evidence was that there was no such discussion (and any such discussion would always be inappropriate). The Tribunal is not entirely

clear as to its conclusion on this primary dispute of fact. Its finding of "not proved" is, at best, ambiguous. Even if, which might be the case, it found that the discussion took place, but was not inappropriate, this was contrary to the Respondent's own evidence and case and contrary to Mr Wood's evidence. Moreover on this allegation it must have found Patient F's factual account to have been credible. I agree with the GMC there is no evidence that it was or could have been "appropriate" to discuss masturbation. Further the relevant paragraphs of the Determination did not address at all Patient F's evidence. As explained in paragraph 182 below, I do not accept that this evidence given by Patient F amounted to confabulation. The doubts were not about whether she had invented or made something up, rather her doubts appeared to be whether what she said had happened was wrong.

157. The Tribunal's conclusion that this allegation was not proved failed to take account of the relevant evidence and was based on a misunderstanding of evidence; it was therefore so out of tune with the evidence as to be unreasonable and therefore wrong. Furthermore, the Tribunal's reasons were inadequate.

Paragraph 18 b iv

Allegation

158. Allegation 18 b iv: In relation to Patient F, the Respondent was charged that: "On 7 December 2018, during a consultation at MSG you behaved inappropriately in that you asked intimate details about Patient F's sex life".

Evidence

159. Patient F's evidence was as follows. In her police interview on 12 December 2018, in a passage which followed on from her evidence about masturbation (paragraph 149 above), she stated:

> "And he said alright oh that's not good then he asked about whether erm me and my partner are having sex at the moment and again I said no because I just generally don't really feel I'm in the mood to do it. And he said well are you doing anything, are you doing oral sex or anything like that and I just said no nothing I said and I'm tired and that."

160. In her statement to the GMC on 18 April 2020 she stated:

> "Mr Shokuh-Amiri then asked if me and my partner were having sex at the moment. I said no, and he asked if we were doing anything, such as oral sex. I said no and that neither of us were in the mood to do that at the moment. I said that I had spoken to my partner about what we had discussed in our last appointment, about needing to have sex more. Mr Shokouh-Amiri asked why I had told him that. I said that I thought it was important to be honest with him in order to try and improve the situation and our sex life. He didn't respond to this."

161. Mr Wood's evidence in relation to this issue is set out at paragraph 137 above.

162. The Respondent in his written statement denied this allegation. In his oral evidence in cross examination, asked about this allegation, he denied it with a simple "No". Again this conduct did not happen.

The Tribunal's decision

163. The Tribunal addressed this allegation at Determination §§143 to 144 as follows:

> 143. With regards to paragraph 18b iv, the Tribunal finds that to an extent a gynaecological doctor has to ask the patient about intimate details when carrying out an examination. It noted the evidence of Mr Wood:
>
> > *'This would only be relevant in the context of the gynaecological history and accompanying symptoms such as bleeding after intercourse or painful sex'.*
>
> 144. The Tribunal accepts the doctor responded to Patient F's concerns and did progress the conversation further and asked the Patient intimate details about her sex life. However, it was not inappropriate in the context of this gynaecological examination. Therefore, the Tribunal finds paragraph 18 (b) iv, not proved." (emphasis added)

The Parties' submissions

The GMC case

164. The GMC submits, again, that there was a primary dispute of fact as to whether the conversation about Patient F's intimate sex life took place or not and that, again, the Tribunal did not resolve that factual issue. Secondly, the Tribunal failed to take account of Mr Wood's evidence as a whole; its citation of his evidence was selective. Thirdly, the Tribunal's reasoning suggests that Patient F was herself responsible for introducing the topic of her intimate sex life.

The Respondent's case

165. The Respondent relies upon his case that Patient F's account of what occurred on 7 December was not credible and not believed by the Tribunal, for the reasons set out above. He makes no specific points about this specific allegation and the Tribunal's decision on it.

Discussion

166. The issue under this allegation was another dispute of primary fact: what conversation took place and what questions were asked. The Tribunal's finding was that the Respondent *did* ask about intimate details and thereby rejected the Respondent's own evidence. (To that extent, I do not agree with the GMC's submission). But the Tribunal went on to find that this conversation was "not inappropriate".

167. Overall the Tribunal's analysis here was extremely brief. First the Tribunal fails to refer to Patient F's own evidence about how the conversation came about; nor did it consider the precise content of the conversation. Her evidence was that it was the Respondent who raised the issue of her sex life with her partner, and that this followed on straight from the conversation about masturbation (which he initiated). There is no finding as to whether or not the Tribunal accepted Patient F's detailed evidence. Patient F's own evidence was that it was not asked in response to any concerns which she had raised. Thus there is no evidential foundation for the Tribunal's statement in §144 that the Respondent "responded to Patient F's concerns". Patient F does not refer to any specific concerns which led to this part of the conversation; and, of course, the Respondent denied the entire conversation.

168. Furthermore, and again, the Tribunal's reliance upon Mr Wood's evidence (at §143) is selective and as a result misleading. See paragraphs 110 and 117 above. His evidence was that the exploration of more intimate details about sex life … would be inappropriate and seriously below the expected standard". There was no suggestion of discussion, at the 7 December consultation, of bleeding after intercourse or painful sex.

169. Ultimately, based upon this evidence, the conclusion that the conversation was not inappropriate was an evaluative finding made by the Tribunal and in my judgment was one which on the material could not reasonably be made. It was so out of tune with the evidence properly read as to be unreasonable and wrong. Furthermore the Tribunal's reasons were so brief as to be inadequate.

Paragraph 18 b v

Allegation

170. Allegation 18 b v: In relation to Patient F, the Respondent was charged that: "On 7 December 2018, during a consultation at MSG you behaved inappropriately in that you said words to the effect of:

1. "are you feeling in the mood now?";

2."are you feeling horny now?";

3."is this conversation making you horny?";

4."oh I can see it in your face, you are, you're getting horny";

5.Patient F should go on the internet on a dating website where no one knows her so Patient F can have sexual conversations with them;

6."you need to find somebody that you can trust that can do things to you to make you feel good. It's up to you whether or not you want to do anything back to them, that's completely up to you, but you need to find somebody that can do all these acts to you";

7."it's important that you don't share this conversation with anybody because it's private and it's important that you keep all of this information personal so that you can kind of grow as a person and grow in confidence and if you start telling other people they won't understand all of that".

Evidence

171. Patient F's evidence was as follows. In her police interview on 12 December 2018, she stated:

> "And then I said to him oh but I have spoken to my partner about our conversation that we had on Tuesday and he said why did you tell him and I said oh because I thought it was important to share it with him I said because we spoke about mine and his sex life and I said it was I thought we normally argue about the subject and I thought it would be best just to bring it up to him outside of the situation so we can discuss it properly without it going into an argument. And he was like okay oh before that when he asked me about erm masturbation he said are you feeling in the mood now and I

> kind of went what, and he said, and his words were 'are you feeling horny now' and I just went well no I'm just really uncomfortable and he said 'no no no in your head is this conversation making you feel horny' and I kind of just laughed 'cos I didn't know what to say erm and at which point I ended up getting really, bad timing, I ended up getting really really warm. And I think it was feeling uncomfortable and I'd obviously gone bright red in the face and he said 'oh I can see it in your face, he said, you are, you're getting horny' and he said 'oh that's good, that's a sign that your body has got the correct sex hormones'. So again I kind of even though I was really uncomfortable about his comments he justified It by saying he wanted to make sure I had the correct sex hormones. So I took my coat off and he just went that's good he said cool down 'cos he said I can see you're getting a little bit worked up.
>
> …
>
> Oh no sorry before that, before the examination when we're still chatting he mentioned that I needed to go on the internet on some sort of like a dating website he said go on the internet where nobody knows you and you can talk to people in the UK and he said and you can have sexual conversations with them. So if you can kind of explore and become more sexually confident you'll love yourself more and he said and you won't, you won't need to be afraid about what you say because these people won't know you and you can say whatever you want. …
>
> …
>
> Oh sorry going back to when, before the examination when he said, I can't remember when it was said if I'm honest, but it was definitely during that appointment and I know he was having a conversation with me while I was getting dressed about needing to find somebody to have sex with. And he said erm you to need to find somebody that you can trust that can do things to you to make you feel good. He said and It's up to you whether or not you want to do anything back to them, that's completely up to you, but you need to find somebody that can do all of these acts to you. Erm and he said and all you have to do you just need to find somebody that you really really trust and ask them and they will say yes because they will know how important it is to you that you feel appreciated and loved. And I kind of just went okay and he said and also it's important that you don't share this conversation with anybody erm because it's private and obviously it's private to you and it's Important that you keep all of this information personal so that you can kind of grow as a person and grow in confidence and if you start telling other people they won't understand and all of that." (emphasis added)

172. In her statement to the GMC on 18 April 2020 she stated:

> "He asked if the conversation was making me in the mood. I gave him a puzzled look and he repeated the question, but asked if I was starting to feel horny. I said that I was generally feeling uncomfortable and he laughed. He repeated the question and said that he meant, in my head. I just laughed and said 'I don't know.' I went bright red at this point and started to feel a bit too warm so I took off my coat. He took this as a sign of me getting aroused

> and said that he was pleased to see this as it showed that I had the right hormones to give me a sex drive.
>
> He then suggested that I go online and talk to people in a sexual manner. He said that you have to be careful on a small island like Guernsey. Talking to people online meant that I could talk to people in this manner, who didn't know who I was."

173. On the specific issue of confabulation, Patient F's evidence was as follows. In her police interview on 29 January 2019 she stated:

> "Erm and I was worried that nobody would believe me. That's hit me quite hard that I am scared that its it's just me and him we were the only two people in that room and, at the end of the day, he's a specialist consultant I know professionally as in his job that he does he's quite high up in things and I know he's probably got money. He probably can get whatever legal thing In place and what have I got, I haven't, it's my word against his and that's what I just thought I can't. I didn't, I struggled with that that. I am terrified of not being believed. Erm anyway when I went to the Police I just thought all I'm going to do is just tell people the facts not put any emotion into it and just say this is exactly what was said, this is what's happened and leave it to somebody else to decide whether or not it's right or wrong.
>
> …
>
> I did struggle an awful lot that I felt as though, as I said before, gone against his trust. Erm and I just I felt really bad for that. That he asked me not to tell anybody about our conversations and I had done and I felt very, l did feel bad about that. Erm but as time has, oh also the other feeling that I had straight afterwards and I don't know whether how to explain this properly because I knew what had happened and I knew I wasn't comfortable and I'd made this, this is going further with the Police I had a fair idea that what had happened wasn't right and shouldn't have happened and I was starting to question my own sanity for quite a while.
>
> Erm of, in my line of work I deal with extra care em, the extra care development on the Island, and I deal with people who have kind of auditory hallucinations and visual hallucinations and you can talk to them and to them what has happened or happening to them is real but you know that it's not. And I started questioning my sanity as to what happened, what happens if it's me that's having these hallucinations and what I've said is just going to get somebody in trouble and all of this is going & to be just is me that's not right, it's me that's not very sane. And I ended up going through whatever happened Just constantly in my head reliving it all the time in order to get clarity for myself that this had happened. And also I was scared of forgetting something or misinterpreting something. That feeling went after I did the Police interview because I felt as though all the information I had in my head had gone and I didn't need to keep thinking about it. And I know that what happened has happened because if you turn round to me now and said okay Patient F if you're not too sure we'll drop it. No, no 'cos I know what happened and I do know that what happened and what he said is all real but it was that feeling that I was losing my sanity because what had happened shouldn't have happened so therefore the only logical explanation to me is that it didn't happen." (emphasis added)

174. Later in her statement to the GMC of 18 April 2020, she said:

> "Over the following weeks, the Police put me in touch with Victim Support and I attended several sessions with them. I was struggling to get my head around things. I seemed to forget that other women had come forward and I continued to feel guilty for reporting Mr Shokouh-Amiri to the Police. I also still didn't believe that he acted out of line and that there would be a medical explanation for why he acted in the manner that he did. When I did come to terms with the fact that what he did was wrong, I felt as though it couldn't have been true and that a medical professional would not do something out of turn. Mr Shokouh—Amiri seemed like such a knowledgeable and charming professional, who cared about me, I couldn't believe that he would have done something to jeopardize his career. I would get a lot of flash backs of what happened and even though I could remember everything so clearly (as I can today), I questioned my own sanity and whether I had unknowingly made everything up."

175. In oral cross-examination, what she had said in 18 April 2020 statement was put to her, and it was suggested that she was unsure about whether or not she had made it up. She responded firmly:

> "No; no, no. At that point, when I went to the police, I just stated what had happened. I knew what had happened and I stated it. It was afterwards that I started questioning my own sanity because I was in such a heightened state of needing to remember exactly what had happened, in the exact way, not putting anything to it but making sure that I told my truth, the truth, and it was for the police to determine whether or not it was right or wrong. It was after that that I started to really question things because I didn't believe that a doctor would have done something that wrong." (emphasis added)

176. The Respondent in his written statement denied this allegation. In his oral evidence in cross examination, asked about this allegation, he denied it with a simple "No". Again this conduct did not happen.

The Tribunal's decision

177. The Tribunal addressed this allegation at Determination §§145 to 153 as follows:

> "145. The Tribunal noted that Patient F said to Dr Shokouh-Amiri that she had told her partner what happened at her appointment on 4 December 2018. When she attended the appointment on the 7 December 2018 she said:
>
> > *'And then I said to him(Dr Shokouh-Amiri) oh but I have spoken to my partner about our conversation that we had on Tuesday and he said why did you tell him and I said oh because I thought it was important to share it with him I said because we spoke about mine and his sex life and I said it was I thought we normally argue about the subject and I thought it would be best just to bring it up to him outside of the situation so we can discuss it properly without it going into an argument'*
>
> 146. The Tribunal also noted an element of self-doubt in Patient F in her police statement a year after the consultation:

> '*I was struggling to get my head around things. I seemed to forget that other women had come forward and I continued to feel guilty for reporting Dr Shokouh-Amiri to the Police. I also still didn't believe that he acted out of line and that there would be a medical explanation for why he acted in the manner that he did.'*

147. The Tribunal finds that Patient F had convinced herself she had become confused over the details of the consultation. Generally, she said that although she could remember everything clearly, she "questioned her own sanity and whether I had unknowingly made everything up". It noted that Patient F reported suffering from health anxiety and having problems with her memory. The Tribunal noted that there had been hugs, kisses, and a discussion of intimate details with Patient F. It accepted that there had been a blurring of boundaries by Dr Shokouh-Amiri and straying by him into psychosexual areas.

148. The inherent probability of Dr Shokouh-Amiri acting in the way alleged in an appointment where Patient F flagged that she was speaking to her partner about the appointments was also considered by the Tribunal.

149. The primary evidence in relation to this allegation come from Patient F and Dr Shokouh-Amiri. The Tribunal noted that other people, including her partner, had been spoken to by the police, however, the Tribunal do not have evidence before it from those individuals mentioned in her statement, to support Patient F's account. It noted the evidence of Patient F:

> *'My phone was taken, and data taken off it, to be used as evidence. My partner's phone was also taken. He was interviewed, along with my closest family and friends, who I had told. My parents do not live in Guernsey, yet the Police also travelled to interview them. As I had to tell my boss at work about what had happened, I also had Police coming into my place of work to interview my boss. On top of all of this, I trusted Mr Shokouh-Amiri with my inner most thoughts and discussed with him things that I wouldn't necessarily talk to my partner about.'*

150. The Tribunal had regard for Dr Shokouh-Amiri's evidence in which he denies this allegation.

151. The Tribunal finds that it was inherently improbable that Dr Shokouh-Amiri, having been told that Patient F was discussing matters with her partner including the allegation of a conversation about finding another sexual partner, would then escalate matters and continue to make inappropriate comments to Patient F.

152. The Tribunal reminded itself that it is for the GMC to prove its case. It's also reminded itself of the need for careful scrutiny of the evidence before it. In the absence of sufficient evidence and due to the inherent improbability, the Tribunal could not be satisfied that Dr Shokouh-Amiri had acted inappropriately towards Patient F as set out in allegations 18 (b) iii-v.

153. Therefore, the Tribunal finds paragraph 18 (b) v 1 to 7, not proved." (emphasis added)

The Parties' submissions

The GMC case

178. The GMC submits that the Tribunal must have rejected Patient F's evidence, although it did not refer to her evidence given to police on 12 December. The Tribunal gave no consideration to the fact that the day after Patient F went to the police and gave a detailed account and was not remotely confused on 12 December. The conclusion that Patient F was confused (§147) is not a fair reflection of her evidence as a whole. She had no doubt as to what had happened. As regard inherent improbability, it was also inherently improbable that a patient with no axe to grind and no communication at that stage with any of the other complainants would go to the police and provide a detailed account if she was making it up. The Tribunal effectively finds that it disbelieved her and that she must be making it up with the police. However the Tribunal make no reference to her evidence on 29 January 2019 where she sets out how she dealt with her emotions in going to the police.

179. The Tribunal's analysis based on telling the Respondent she had told her partner (at §§148 and 151) contains a leap of reasoning; it demonstrates a naïve approach. Doctors may abuse their professional position and act outside the rules in the belief that they would not get caught because it's one person's word against another. In any event, some of the comments the subject of this Allegation were made *before* Patient F had told the Respondent about having told her partner.

The Respondent's case

180. The Respondents submits that the Tribunal explained adequately why it had rejected Patient F's account, based on a number of factors. First Patient F's general self-doubt about whether these events had really happened and her health anxiety and memory issues (§§146 and 147). Secondly, the Respondent's blurring of boundaries by straying into psychosexual areas which had contributed to confusion in her mind (§147). Thirdly, the absence of corroboration. Fourthly Patient F's phone provided no support for Patient F's account of events, Patient F and the Respondent provided the only accounts of the consultation (§149). The Tribunal was entitled to give significant weight to the inherent improbability of the Respondent making inappropriate comments to Patient F after she had told him that she had discussed with her partner inappropriate conduct on 4 December. This was the central finding at §§ 148, 151 and 152 of the Determination.

Discussion

181. The Tribunal's analysis of this allegation is based on two central points: Patient F's confusion (or confabulation) (§§146 and 147) and the inherent improbability of the Respondent continuing with, and escalating, his inappropriate conduct, once Patient F had told him that she had told her partner about what had happened on 4 December.

182. As to the first point – confabulation – Patient F's evidence was not confused. On the contrary, it was consistent and detailed (as set out in paragraph 102 above). Patient F went to the police the day after the 7 December consultation. She then gave a detailed account to the police on 12 December, in which she expressed no doubt as to what had happened. At that point she was willing to support a complaint and police investigation, saying she knew that what happened was not right. She had no doubt

that it had happened. In January 2019 she confirmed "I knew what had happened" see below. On careful analysis those passages where she refers to doubts and doubting her sanity did not evidence that she had doubts about the facts of what had happened. Rather her doubts were as to why a doctor would do such things or her doubts were as to whether that conduct from a doctor she trusted was wrong. When this was put to her in cross-examination, she responded robustly that she had no such doubts as to the events: see paragraph 175 above. The Tribunal makes no reference to this evidence in §147.

183. As to the second point, first, the Tribunal's view that it was inherently improbable that the Respondent continued to make inappropriate comment does not take into account the possibility that a doctor may feel he is not going to be found out, particularly since, on her account, the Respondent had told her to keep it to herself**.** More importantly, in my judgment, is the fact that, of the seven identified statements (in allegation 18 b v (1 to 7), on any view four of them (including questions about "feeling horny") would have been made *before* Patient F had told the Respondent about her conversation with her partner. It is clear, when she says "before that when he asked about masturbation", that these remarks about "horny" were made before she had mentioned to the Respondent that she had discussed it with her partner. It follows that the Tribunal's reasoning at §§148, 151 and 152 cannot apply to those allegations at all. The reliance by the Tribunal on the fact that Patient F told the Respondent that she had told her partner about what had happened on 4 December is central to the Tribunal's decision on this point. However, critically, it is clear that some of the conduct alleged under this allegation happened at a time before Patient F had informed the Respondent of that conversation with her partner. In other words she told the Respondent of the conversation with her partner *after* the Respondent had asked intimate details about her sex life.

184. The Tribunal's conclusions on this allegation were based on failure to take account of all the evidence relevant to the issue of "confusion" and to the issue of "inherent improbability". In my judgment, these errors rendered the conclusions so out of tune with the evidence properly read as to be unreasonable and wrong.

Paragraph 18 b vi to ix

Allegation

185. Allegation 18 b vi to ix: In relation to Patient F, the Respondent was charged that: "On 7 December 2018, during a consultation at MSG you behaved inappropriately in that you

vi. on one or more occasion used your finger/s to stimulate Patient F's clitoris;

vii. moved your finger/s around the outside of Patient F's vagina;

viii. moved your finger/s around Patient F's rectum;

ix. during your actions as set out at paragraph 18b vi-viii above, you said words to the effect of:

1. "see, that feels good doesn't it?";
2. "I can see that you're reacting to that, that that feels good";
3. "did you enjoy that?";
4. "I bet you wanted me to carry on"."

Evidence

186. Patient F's evidence was as follows. In her police interview on 12 December 2018, she stated:

> "So sorry going back to the examination so I got undressed and I'm on the table with my legs in the stirrups and he's kind of checking everything over and he said oh it doesn't look like there are any cuts or anything and I said oh it does sting a bit. And then he said what do you do to masturbate, how do you do it. And I said oh I use toys and he said no don't use toys because it'll be too dry you need to use lubrication and your hands. And he said you need to use KY Jelly and at that point he went to get the KY Jelly, and he put the KY Jelly on his finger, and erm he physically used his finger to stimulate my clitoris and said this is what you need to do. Does that feel uncomfortable and I said no that doesn't hurt.
>
> He didn't do it for very long but he did that and then he said also you need to find your other erogenous zones and he said you've got an erogenous zone, and he used his finger, and he said round the outside of your vagina. And he used his finger to show me how that would feel and he said, also kind of the rectum as well, and he used his finger to kind of go around the outside of my rectum to show me that that was also an erogenous zone. Erm 'cos I remember at that point, and this is probably a really daft thing to think in the situation 'cos I was just completely baffled and I definitely know that he did that around the back, because I remember thinking well I hope you're not going to then touch me again there because I know that with that's not that's not right 'cos I know that infection can pass. And I know that's a really daft thing to think but I did think about kind of infection.
>
> Erm and then he went back to kind of my clitoris area and did that and he said 'see that feels good doesn't it' and I remember saying it doesn't hurt 'cos I didn't know what to say. And he said no no no, he said I can tell, I can see that you're reacting to that, that that feels good. And then he said right we'll do an internal examination with the ultrasound, he's never done this before so I don't know, I don't know what the purpose of doing it but he, so he got the Internal ultrasound stick thing so he's stood next to me and he put the condom on the top of the ultrasound stick and he said 'did you enjoy that', and again J said it doesn't hurt. And he said 'no that's not what I asked I said did you enjoy that' erm and I, I can't remember, I think I laughed because I didn't know what I was meant to say. 916 And erm and he said oh I bet you wanted me to carry on. Erm and again I laughed and he said oh I can be your sex therapist.",

187. In her police interview on 29 January 2019 she stated:

> "Erm and then after that that's how I felt, that night wasn't nice, and then I tried to text Sarah Craske who's my psychotherapist that J do see about my health anxiety. And I'd mentioned it to actually, I think the Tuesday, no it wasn't erm it was whenever he said he was gonna help me with my health anxiety so maybe that first appointment I'd mentioned it to that he said he was going to help me and she didn't comment and but I could see the look on her face was a kind of a mmmm not quite sure whether or not if she agrees with that but she didn't comment. So I text Sarah Craske on the Friday and just said can I come and see you because I said to my partner I

> need to speak to somebody medical to see whether or not what he's done Is right because I don't, I don't want to get somebody in trouble if I've misinterpreted this wrong or blown things out of proportion. And anyway she called me in the morning and that's when she said no you need to go to the Police straight away."

188. In her statement to the GMC on 18 April 2020 she stated:

> "Mr Shokouh-Amiri then got wet paper towels and cleaned me up, whilst I lay on the examination bed with my legs in stirrups. He checked my Lichen Sclerosis and said it looked fine. He then asked what I did to masturbate. I said that I used sex toys. He advised that this was not good for my skin and that I needed to use my fingers with lubricant. At that point, he had a tube of KY Jelly on the table next to him and he put it on his fingers. He then proceeded to massage my clitoris in order to show me how I should do it successfully. He then went on to show me with his fingers, where the sensitive areas were on the outside of my vagina and massaged that area for a few seconds. He then went on to show me that I could also massage around my anus area, again, he showed me this with his fingers. He then went on to continue massaging my clitoris. I remember this part extremely clearly as I remember thinking that would cause infection (after he touched my anal area). He then asked me if what he was doing felt nice. I laughed and said that it didn't hurt. He laughed and said that it wasn't what he asked. At this point, I remember not wanting to say anything negative to him, but just wanting to give fairly general answers, without denying or confirming anything.
>
> He then went on to do an internal ultrasound examination. At this point, he was standing near my head and he was putting the condom over the ultrasound instrument. Whilst doing this, he asked if I enjoyed that. I laughed again and he asked a second time. I said it was 'alright' and he laughed and said 'just alright?' He then asked me if I wanted him to carry on with what he was doing previously and I laughed again. He said that he could be my sex therapist.
>
> Mr Shokouh-Amiri then went on to do the internal ultrasound examination. Throughout this, he was very professional and spoke about my ovaries and general medical observations. When he pulled the ultrasound device out, I bleed all over the table (period). I went to get up to find something to clean myself up with.
>
> I got off the bed and went to get dressed. The curtain to the changing room was open whilst I was getting dressed and Mr Shokouh-Amiri stood in front of me whilst cleaning himself up and washing his hands. Whilst I was getting dressed, he asked me not to tell anyone about our conversations, as it was important that everything stayed between the two of us, in order for my anxiety to improve. He then spoke again about finding someone who I could trust to have sex with, outside of my relationship. He said that I just needed to find that person who I could trust and ask them. He said that they would say yes as they understand what I need."

189. The Respondent in his written statement denied this allegation. In his oral evidence in cross examination, asked about this allegation, he denied it with a simple "No". Again this conduct did not happen.

The Tribunal's decision

190. The Tribunal addressed this allegation at Determination §§154 to 156 as follows:

> "154. The Tribunal had regard to the matters set out above in relation to Patient F regarding her evidence and in particular the flagging up to Dr Shokouh-Amiri, that she had discussed with her partner inappropriate comments allegedly made at a previous examination on the 4th December 2018 by Dr Shokouh-Amiri.
>
> 155. Having regard to the considerations above, the Tribunal finds that it was inherently improbable that Dr Shokouh-Amiri, having been told that Patient F was discussing matters with her partner including the allegation of a conversation about finding another sexual partner, would then escalate matters to commit what would amount to serious sexual assaults. The Tribunal also had regard to the fact that Patient F had expressed doubts to the police and others about her recollection of the alleged events and only reported matters to the police having spoken to her psychotherapist.
>
> 156. Therefore, the Tribunal finds paragraph 18 vi to ix not proved."

The Parties' submissions

The GMC case

191. The GMC submits that Patient F gave a very detailed account of what had happened. Yet the Tribunal conducted no evaluation of that account and why, as it must have found, she had made it up. Essentially the Tribunal relied upon the same reasoning as in relation to allegation 18 b v; that reasoning was wrong for the reasons already given, The Tribunal makes the additional point (at the end of §155) that she only reported the matter to the police having spoken to her psychotherapist, but there is no explanation about why that might undermine her account.

The Respondent's case

192. The Respondent submits that the Tribunal was, again, entitled to rely on the fact that the alleged sexual touching had happened after Patient F had told the Respondent that she had told her partner about earlier events. The Tribunal correctly referred to the fact that these allegations amounted to escalation to serious sexual assaults. Secondly the fact that Patient F went to her psychotherapist shows that she had some doubts about whether these events had happened at all. The Tribunal's conclusion at §155 was neither irrational nor inadequate reasoning.

Discussion

193. Essentially these are the allegations of sexual touching. First, the account which Patient F gave to the police, within five days of the consultation, contains very specific details: for example: references to sex toys, to KY Jelly, to erogenous zones, her own "daft thoughts" about infection, and the specific detail of the internal ultrasound stick and putting a condom on top of it. In my judgment, these details give the account "the ring of truth". The Tribunal undertook no assessment of the account and contained no explanation of how and why she had come to make this all up – which must have been its conclusion. To this extent, the Tribunal's reasons for its conclusion are inadequate.

194. Secondly, the Tribunal's reliance on the two same points as made in respect of allegation 18 b v - her own doubts and inherent improbability - is unfounded for the reasons in paragraphs 182 and 183 above. (Although in this case, the conduct appears to have happened after Patient F had told the Respondent about the conversation with her partner).

195. Thirdly, as to the Tribunal's additional reliance upon the fact that Patient F only reported the matter after having spoken to her psychotherapist, the Tribunal does not explain why this might undermine the truth of her account. It is common ground that there is no suggestion that the psychotherapist put Patient F up to it – or that as result of that meeting, Patient F made up her account. Moreover Patient F contacted her immediately after 7 December (the next day) and before she went to the police. This is not a case of seeing a psychotherapist some considerable time after the events in question where there might be an implication of recovering a false memory. In my judgment, this additional reason has no underlying basis and was not rationally relevant.

196. For these reasons, I find therefore that the Tribunal's conclusions on this allegation were based on a failure to take account of all the evidence. In my judgment, this failure rendered the conclusions so out of tune with the evidence properly read as to be unreasonable and wrong. In addition, the Tribunal's reasons were inadequate and/or not intelligible and did not deal with the relevant evidence and the points raised.

Paragraphs 18 c to e

Allegations

197. Allegation 18 c to e: In relation to Patient F, the Respondent was charged that: "On 7 December 2018, during a consultation at MSG, you

c. circled 'yes' on a stamp in Patient F's medical records next to 'chaperone offered', which was untrue;

d. circled 'yes' on a stamp in Patient F's medical records next to 'chaperone declined', which was untrue;

e. you knew:

i. you had not offered Patient F a chaperone;

ii. Patient F had not declined a chaperone.

Evidence

198. Patient F's evidence was that she was never offered a chaperone on 7 December. Her evidence was as follows. In her police interview on 12 December 2018, she stated:

> "and then I noticed in the book, they've got a stamp where it says was a chaperone offered, and he circled yes and was a chaperone declined and he circled yes and I sat there and I looked at that sticker, stamp, and I thought he hasn't, he's not offered that in the slightest. But I just got to the point where I wanted to leave without being kind of making things weird or uncomfortable"

199. In her statement to the GMC on 18 April 2020 she stated:

> "I saw Mr Shokouh-Amiri put a stamp in my medical records to say that he had offered a chaperone, but I had declined it. I remember wondering why he had lied about this. He did not ask me if I wanted a chaperone and I certainly wouldn't have felt comfortable enough to ask for one, as I did not want him to think that I didn't trust him."

200. The Respondent's evidence in his witness statement was that he denied these allegations. In that statement, he set out the general position as follows:

> "Whenever I needed to perform an intimate examination, I always asked my patients if they would like a chaperone. However, at MSG, chaperoning wasn't a dedicated role, and chaperones were not present for the entire consultation. If a patient requested one, I had to step out of the consultation room to find someone who could assist. Unfortunately, there were often few staff members available, such as personal assistants, who had only completed a brief, one-hour chaperone course.
>
> …
>
> A stamp was used in patient notes to indicate whether a chaperone had been offered and whether the patient accepted or declined. If a chaperone was present, their name would also be recorded. While I was generally diligent in documenting this, there were occasional instances when I failed to record it. This typically occurred if the stamp wasn't available in the room, such as when it had been moved by the cleaner or borrowed by a colleague, or simply due to a moment of human oversight."

201. His evidence therefore was that he always asked patients if they would like a chaperone. In cross-examination, he said that he had put in the stamps on that occasion**.**

The Tribunal's decision

202. The Tribunal addressed this allegation at Determination §§157 to 161 as follows:

> "157. The Tribunal noted the statement of Dr Shokouh-Amiri:
>
> > *'Whenever I needed to perform an intimate examination, I always asked my patients if they would like a chaperone. However, at MSG, chaperoning wasn't a dedicated role, and chaperones were not present for the entire consultation. If a patient requested one, I had to step out of the consultation room to find someone who could assist. Unfortunately, there were often few staff members available, such as personal assistants, who had only completed a brief, one-hour chaperone course.''*
>
> 158. The Tribunal also noted that Dr Shokouh-Amiri had been generally discouraged from offering patients a chaperone. It noted there were difficulties with availability of chaperones at MSG at the time. When Dr Shokouh-Amiri first joined he was told about a locum whose contract had been terminated due to the fact he insisted on a chaperone at appointments. Patient F stated she was never offered one.

> 159. The Tribunal noted that for this allegation to be proved, the GMC would need to satisfy it that, Dr Shokouh-Amiri made a false entry in the medical records in front of Patient F, by circling 'yes' on a stamp within Patient F's medical records. It noted that there is no evidence beyond that of Dr Shokouh-Amiri and Patient F as to whether a chaperone was offered and declined on this occasion.
>
> 160. It also noted that Dr Shokouh-Amiri has admitted in previous paragraphs of the allegation that he failed to provide a chaperone, but was adamant on this particular occasion that he did offer a chaperone.
>
> 161. Taking everything into account, the Tribunal finds that there is not sufficient evidence to prove this allegation, therefore, Paragraphs 18c, 18d, 18e are not proved." (emphasis added)

The Parties' submissions

203. *The GMC* submits that these allegations turned on whether the Respondent offered her a chaperone and she declined it. Patient F's evidence was that she was not offered a chaperone; the Respondent's evidence was that she was. Contrary to the Tribunal's finding at §161, Patient F's evidence was "sufficient" to prove the allegation. If, as appears to be the case, the Tribunal disbelieved Patient F's evidence on this issue, it failed to give adequate reasons for that finding and that finding must have influenced by its erroneous approach to Patient F's evidence in general. The *Respondent* made no specific submissions on this issue.

Discussion

204. It was common ground and admitted (allegation 18 a) that the Respondent failed to have a chaperone present during the examination on 7 December 2018. The issue is whether a chaperone was offered and refused; or not offered at all. It is common ground that Patient F's medical records were stamped in the way that they were stamped. Patient F addressed this issue specifically and directly and gave a consistent account of a clear recollection. On the other hand, the Respondent gave no specific explanation as to how the records came to be stamped in the way that they were. The Tribunal refers at §157 to some of the Respondent's general evidence about chaperones and their availability at MSG, but does not refer to the fact that his response to this specific allegation was a bare assertion without any recollection or indeed any response to Patient Fs own evidence. Patient F's evidence, had it been accepted, would be sufficient to establish the allegation. The Tribunal therefore must have rejected her evidence. However it gave no reasons for so rejecting her evidence. As regards §159, given the situation in the consultation, it is inherently unlikely that there would be evidence beyond that of the Respondent and Patent F. In my judgment, taking account of the Tribunal's erroneous approach to the credibility of Patient F's evidence more generally, in my judgment, the Tribunal's reasons for rejecting Patient F's evidence on this allegation are inadequate.

Paragraphs 19, 20 and 21

Allegations

205. Allegation 19 to 21: In relation to Patient F, the Respondent was charged that:

> 19. Your actions at paragraphs 16b and c, 17a and b, 18bi and ii and 18bvi-viii were carried out without Patient F's consent.

20. Your actions at paragraphs 16-18b were sexually motivated.

21. Your actions at paragraph 18c-d were dishonest by reason of paragraph 18e.

The Tribunal's decision

206. The Tribunal addressed this allegation at Determination §§ 162 to 169 as follows:

"**Paragraph 19**

162. Your actions at paragraphs 16b and c, 17a and b, 18bi and ii and 18bvi-viii were carried out without Patient F's consent. To be determined

163. With regards to paragraph 16b and c the Tribunal had regard to Patients F's police statement

> *'Erm and then at that point I left he held his arms out to give me a hug erm and he gave me a hug and a kiss on the cheek and said that erm we'll sort it out. So I said oh okay great thank you and again I walked out thinking he's just a lovely caring man and he's gonna help me'.*

164. The Tribunal noted the way in which Patient F said that Dr Shokouh-Amiri held out his arms out to Patient F. It appears on the balance of probabilities it was with consent on this occasion due to the description given by Patient F in relation to this hug and kiss. However, with regards to 17a and b, 18b i and b ii the Tribunal finds the hugs and kisses were carried out as a reassurance to Patient F but without consent.

165. The Tribunal therefore finds the hugs and kisses as stated in paragraph 17 a and b, 18bi and bii were not with consent, therefore it finds these paragraphs proved in relation to paragraph 19.

Paragraph 20

20. Your actions at paragraphs 16-18b were sexually motivated. To be determined

166. In relation to paragraphs 16a and b and 17a and b and 18 bi and bii. The Tribunal noted that Patient F saw the hugs and kisses as reassuring. The Tribunal noted that no evidence of any sexual element in relation to the hugs and kisses was advanced by Patient F. The Tribunal taking the views of Patient F into account and noting the absence of any other persuasive evidence, The Tribunal determined that Dr Shokouh-Amiri's actions were not sexually motivated even when as the Tribunal finds, the hugs and kisses on two occasions were not done with the patient's consent.

167. Therefore the Tribunal finds paragraph 20 not proved.

Paragraph 21

21 Your actions at paragraph 18c-d were dishonest by reason of paragraph 18e. To be determined

> 168. The Tribunal accepted that Dr Shokouh-Amiri was discouraged from offering chaperones at MSG, Dr Shokouh-Amiri in his evidence accepted he should have been more persistent in this area.
>
> 169. Given the Tribunal's findings in relation to paragraphs 18c, d and e, and that the Tribunal had finds these allegations not proved. The Tribunal therefore finds paragraph 21 not proved."

The Parties' submissions

207. *The GMC* submits that the Tribunal's conclusions in relation to allegations 19, 20 and 21 were based, in large measure, on its erroneous approach to the evidence regarding the consultations and were therefore wrong for the same reasons. Whilst it found that the Respondent hugged and kissed Patient F on 4 and 7 December without consent, it found that these were *"carried out as a reassurance to Patient F*" (§164) and were not sexually motivated (§166). Had the Tribunal found proved the central parts of allegations 17 and 18, as it should have done on the evidence before it, that would, in all likelihood, have led to a different conclusion regarding sexual motivation in relation to allegation 20. *The Respondent* made no specific submissions on this issue.

Discussion

208. These allegations relate to sexual motivation and, in one case, dishonesty. In the light of my conclusions in relation to allegations 17 c to e and 18 b iii to ix, the foundations for the conclusions of the Tribunal on allegations 19 to 21 are undermined and those conclusions can no longer stand. It follows that these allegations will have to be reconsidered following reconsideration of allegations 17 and 18.

Conclusion on Ground 2

209. Overall in its Determination concerning these allegations by Patient F, the Tribunal, at various points, made clear errors of fact, failed to consider important evidence, did not explain why it did not believe Patient F's evidence, and made statements which contradicted the evidence (and at times statements which did not make sense).

210. In the light of my conclusions in paragraphs 118, 133, 146, 157, 169, 184, 196, 204 and 208 above, the Tribunal's findings in respect of allegations 17 c to e and 18 b iii to ix, and c to e are wrong and/or in breach of its duty to give reasons and thus unjust by reason of serious procedural irregularity. To this extent, Ground 2 succeeds.

Ground 3: Cross-admissibility

211. The GMC contends that the Tribunal committed a serious procedural irregularity by either (a) failing to give itself a legal direction on cross-admissibility or (b) by giving itself only private advice on cross-admissibility in breach of Rule 6(b) of the 2015 Rules (set out in paragraph 12 above). The issue arises in connection with §26 of the Determination, stating that "the Tribunal accepted the LQC's advice on cross-admissibility and propensity."

The law on cross-admissibility

212. The leading recent case on cross-admissibility in the context of Tribunal proceedings is *Professional Standard Authority for Health and Social Care v General Medical Council and another* [2025] EWHC 318 (Admin). In that case, the PSA appealed on the sole ground that the Tribunal wrongly directed itself in relation to cross-

admissibility of evidence. There were two complainants who were vulnerable female patients who alleged that the Respondent had behaved in an inappropriate manner towards them. The two complainants had no prior connection and there was no evidence of collusion or contamination of their evidence.

213. After summarising the authorities and their effect in §§35-41, MacDonald J, at §47 of the judgment, explained as follows:

> " i) There are two primary grounds on which evidence may be cross-admissible. Namely (a) where it may establish propensity to commit that kind of conduct and/or (b) where it may rebut coincidence. …
> ii) The tribunal will need to decide on which ground or grounds (propensity, coincidence or both) it is being asked to cross admit the evidence and advise itself accordingly.
> iii) The tribunal will need to take care to distinguish clearly between the grounds and not advise itself on the other ground if only one is applicable, in order to avoid confusion.
> iv) The tribunal will need to consider whether the evidence is capable of being cross-admitted, by evaluating whether there is a sufficient connection and similarity between the facts of the allegations.
> v) Where the evidence is cross-admitted to prove propensity, the tribunal will need to be satisfied to the required standard that the first allegation took place before relying on evidence in respect of the first allegation to deduce propensity from the second allegation.
> vi) Where the evidence is admitted to rebut coincidence, the tribunal will need to advise itself that (i) it must exclude collusion or contamination as an explanation for the similarity, (ii) if that is excluded, considering the evidence as a whole, the fact of two patients making such allegations reduces the likelihood of there being an innocent explanation for them, and (iii) it is not necessary to find one allegation proved before relying on the evidence in respect of that allegation in support of the other."

214. MacDonald J found that the tribunal in the case before him had not directed itself correctly as to the applicable principles and that it failed properly to apply the principles regarding cross-admissibility to rebut coincidence (§§57 to 58). He concluded (§64) that:

> "had the Tribunal directed itself correctly on the issue of cross-admissibility I am satisfied that it may have reached a different conclusion on whether, in determining the allegations before the Tribunal, it should consider the evidence as a whole, whether the fact of two patients making allegations against the Respondent strengthened the case relating to the other and reduced the likelihood of there being an innocent explanation for them and whether the allegations relied on by the GMC were made out."

The case was remitted for hearing by a differently constituted tribunal with a direction that the tribunal come to a fresh decision applying the correct legal approach to cross-admissibility.

215. These principles on cross-admissibility are drawn from criminal law: see *R v Brennand* [2023] EWCA Crim 1384; [2024] 1 Cr. App. R. 14 at §§35 and 36 (referred to by MacDonald J in *PSA* case). Whether, in an individual case raising issues of cross-admissibility, directions on propensity and/or coincidence are required is for the trial judge to determine on the facts of the case. There is no legal principle that should

preclude a judge, in an appropriate case, giving both directions. The decision as to the appropriate directions to give depends upon the facts of the particular case. In some cases, where there are several complainants and a number of complaints, the judge may properly consider that no direction on either propensity or coincidence is appropriate and that jury should simply be given the separate consideration direction. In others, where issues of cross-admissibility do arise, a direction on propensity but not coincidence may be appropriate. In others again, a direction on coincidence but not propensity may be appropriate; and there may be yet others where a direction both as to propensity and as to coincidence will be appropriate.

The relevant background facts

216. By this appeal, the GMC is not challenging the Tribunal's findings in relation to the allegations concerning Patient A and Patient D which were found not proved. This was expressly accepted by Ms Richards in oral submissions. (This is in marked contrast to the GMC's detailed challenges (in Grounds 1 and 2) to the Tribunal's findings in relation to Patient B and Patient F).

217. In the following paragraphs, I summarise the Tribunal's findings in relation to Patient A and Patient D and the evidence of contact between Patients A, D and F. I then address how the issue of cross-admissibility was dealt with at the hearing before the Tribunal.

(1) Summary of findings in relation to Patient A and Patient D.

218. In relation to Patient A, the allegation was of inappropriate sexual conduct between 17 October 2017 and 2 August 2018. The Tribunal did not accept Patient A's evidence and found the allegations not proved; in particular because they did not find her evidence to be credible, plausible or consistent and because of further discrepancies. I refer, in particular, to, but do not set out here, §§43, 44, 52 and 55 and 56 of the Determination. The Tribunal found Patient A's claims about sexual misconduct not credible, especially given that they were supposed to have happened in front of her grandmother and other healthcare staff. Her evidence was inconsistent in important respects. There was no support for her account from other alleged witnesses to it, or contemporaneous or near contemporaneous documentary sources. Her account was further undermined by the fact that it was only when she went to the police (and after contacts with Patient D who had been in contact with Patient F) that she reported any sexual misconduct. She had a motive to attack the Respondent as she believed (wrongly) that his treatment had ruined her health and her life.

219. In relation to Patient D, the allegations were of touching during intimate examinations between 2 November 2018 and 1 December 2018. The core sexual allegation made by Patient D was Allegation 13 which alleged that the Respondent, while examining Patient D for blood loss in hospital on 1 December 2018, had touched her vagina and clitoris. There was also Allegation 10 relating to an intimate examination on 2 November 2018 which alleged that the Respondent touched the Patient's clitoris and wiped her vaginal area. Allegation 14 alleged that these actions, and a failure to have a chaperone present on each of these occasions, were sexually motivated. Allegation 10 was dealt with by the Tribunal in §§88 to 92 of the Determination. The Tribunal found that the vagueness of her description of what occurred, together with the evidence of Mr Wood (and the account given by the Respondent), led it to the conclusion that contact with the clitoris was an inadvertent by-product of a clinically-indicated examination and not sexually motivated. With regard to Allegations 13a-13e, the vagueness and confusing nature of Patient D's evidence was again a

significant factor for the Tribunal in determining that these allegations were not proved: see §§98 to 105 Determination, and in particular its findings at §§98, 100, 101, 102 where it referred, variously, to the absence of evidence, no documentary evidence, and to Patient D's evidence being vague and unsure, confused, not consistent, and/or not reliable.

(2) Summary of evidence of collusion and/or contamination through contact between Patients A, D and F.

220. There was significant evidence of contact between these three complainants, giving rise to the possibility of collusion and/or contamination. There was no evidence that Patient F colluded with Patient A and Patient D prior to her going to the police, but Patient F then gave an account of what she said she had experienced to Patient D, and there was extensive contact between Patients D and A about the Respondent before either of them made sexual allegations. Patient A's allegations were similar to Patient F's, although Patient D's allegations were different.

221. Patient F was separate and independent when she first went to the police. However that was not the case for either of Patient D or Patient A when they made their complaints. The Tribunal heard extensive evidence, oral and documentary, about the number and content of communications between the complainants, and the place of that communication within a chronology of when the various complaints were made.

222. The Tribunal had before it documentary evidence of contacts between the complainant patients. Patient F admitted to police and in cross-examination that she had passed a number of key details about what she was alleging to Patient D. The Tribunal also knew that Patient D was talking to Patient A about the events, including the involvement of Patient F. Patient A made no sexual allegations before she went to the police, and until after she had had extensive contact with Patient D about the allegations. Patient D's allegations were tentative, unclear and she did not appear to regard them as sexual in nature until after her contacts with Patients F and A.

223. The Tribunal had this evidence in mind. In §30 of the Determination the contacts are mentioned three times – twice in relation to Patients D and A specifically, and once relating to Patients D and F. At §§39 and 43, in relation to Patient A, the Tribunal referred specifically to her contacts with Patient D and other complainants, prior to her police interview and her descriptions of her complaints. By contrast, in relation to Patient E, the Tribunal expressly observed that she did *not* talk to any other patients and thus there was no evidence of collusion: §114 Determination.

(3) The issue of cross-admissibility at the Tribunal hearing in January 2025

224. As regards the treatment, before the Tribunal, of the issue of cross-admissibility, the relevant sequence of events is as follows.

225. Oral evidence concluded on 29 January 2025. At some point before the start of the hearing on 30 January 2025 the Tribunal circulated written directions, in the Chair's document entitled "Legal Advice on the Facts". That document made no reference to issues of cross-admissibility or propensity. It covered the burden and standard of proof, good character, focus on precise wording of allegations, dishonesty and assessment of witnesses. The Legal Advice on the Facts is reflected in the terms of §§17 to 25 of the Determination (see paragraph 46 above). By contrast, §26 of the Determination is not to be found in the Legal Advice on the Facts.

226. The parties submitted their written closing arguments. In the course of its written closing, the GMC referred to cross-admissibility stating:

> "The principle of cross-admissibility can be applied in one of two ways: 1) unlikelihood of coincidence and 2) propensity. In this instance, the GMC rely on propensity. In essence, if you conclude, that Dr SA acted in a sexually motivated way towards one complainant, you should then go on to consider whether Dr SA had a tendency to behave in a sexually motivated manner towards other patients. If you do consider that he had such a tendency, then you can take that into account in determining whether he behaved in a sexually motivated way towards the other complainants. Bear in mind however that even if a person has a tendency to commit a particular way, it does not follow that they are bound to do so. So, if you find that SA does have a tendency to behave in the manner alleged, this is only part of the evidence against SA, and you must not make findings against SA wholly or mainly on the strength of it. See Crown Court Compendium July 2024, para. 13-6" (emphasis added)

Under an entirely separate heading in the written closing, the GMC submitted:

> a. Consider each individual's testimony –…
>
> …
>
> b. Then step back and consider overall picture. GMC say these are 3 patients who are truthful, credible and – contrary to SA's assertions - have no reason to persist in malicious lies towards SA over a period of years."

However this was not a reference to "rebutting coincidence".

227. Then on the next day, 30 January, the parties made their oral closing arguments. The GMC made the same point on cross-admissibility. The following exchange ensued. It is clear from this exchange that what was being discussed was a direction on propensity alone.

228. The GMC sought a direction on propensity alone, submitting:

> "In short – and I'm going in due course invite you to approach this – is to consider each individual case. But if you conclude in respect of any one of them that Mr Amiri has behaved in the way alleged, i.e. has touched patients, spoken to patients in a sexually motivated way, you can then go on to the next stage, if you like, and decide if you think that means he has a tendency – sometimes put as a propensity – to behave in that way."

The Chair responded:

> "I'll just double-check. I think it's a case called Re T, which I think says the panel must consider each piece of evidence in the context of all the other evidence, which I think is in effect what you're saying."

Counsel for the Respondent then stated:

> " Yes. Equally, you can't put the cart before the horse, to use that phrase. You have to start by first of all making that individual evidential assessment".

The Chair responded:

> "Yes. They don't fall like dominoes. In effect, they're individual.

Counsel for the GMC responded:

> "But once you do make that evidential conclusion, you can then consider: does he have a tendency?" (emphasis added)

229. At a later point in his oral closing counsel for the GMC re-iterated the separate point made in written closing, saying:

> "You need to consider each individual allegation and, in particular, each individual complainant on their own. Once you have done so, step back and consider the overall picture, albeit in the light of what you know about the communication that took place between A, D and F, which obviously I will deal with. The fact that you have here three patients who are all to an extent saying the same thing, but also the fact that you have here three patients who, six years down the line, are still saying it."

230. At the end of oral closing submissions, the Chair referred to the Legal Advice on the Facts which had been given to the parties in writing "to give them the chance to respond" and explained that there was no need to read it out, as there were no members of the public or press present. He pointed out that it had also been sent to the panel, who could ask him any question of it. This oral statement therefore appears to have taken the place of actually incorporating the legal directions into the transcript, either by orally repeating them or stating that they are to be incorporated.

231. The Tribunal then had a private session after the close of the hearing. Finally, §26 of the Determination then states that "The Tribunal accepted the LQC's advice on cross-admissibility and propensity."

The Parties' submissions

The GMC case

232. The GMC submits that the statement at §26 of the Determination means that the Chair must have given his advice in private. It was not repeated in public and not included in the Determination itself. On that basis there was a breach of Rule 6(b). Alternatively no consideration was given to cross-admissibility at all. On either basis this was a serious procedural irregularity. Moreover, the Tribunal should have given a direction on cross-admissibility in relation to rebuttal of coincidence (even of its own motion).

233. The failure to consider cross-admissibility properly could have led to a different conclusion in relation to the allegations regarding Patients A, D and F. The Tribunal's findings in relation to Patients A, D and F, where found not proved, should be quashed on grounds of failure to give proper directions as to cross-admissibility alone. In relation to "rebuttal of coincidence" the evidence of Patient D and Patient F was relevant to the allegations made by Patient A and was to be weighed in the balance. Whilst the evidence in relation to Patient D and Patient F could not be determinative of Patient A, however the Tribunal "may have reached a different conclusion". In relation to propensity, first there were relevant factual findings in relation to Patient F (17 c and e) and those findings were relevant to Patient A and Patient D. In addition if Ground 2 succeeds then potentially additional findings in relation to Patient F (on

remittal) would be cross-admissible on propensity for Patient A and Patient D. The Court cannot be satisfied that, had the Tribunal taken a proper approach to cross-admissibility, it would not have made any material difference.

The Respondent's case

234. The Respondent submits that, as regards the legal advice on propensity, the most credible interpretation of §26 of the Determination is that it is a reference to the oral exchanges between the Chair and counsel on 30 January and no further advice was given privately. Alternatively, if the advice was given privately, there was no evidence that it differed materially from the discussion on propensity in the oral exchanges; it was therefore not "new" advice and so there was no breach of Rule 6(b). In any event, even if there was a breach of Rule 6(b), this was not a serious procedural irregularity rendering the decision unjust. What was said was present on the transcript.

235. Secondly there was no failure to give a legal direction in relation to rebutting coincidence. The Chair was under no obligation to give such a direction. He was not invited to consider such a direction. As the GMC itself submitted, this was a propensity case. It was not a coincidence case. The application of the coincidence limb would have required the Tribunal to exclude the possibility of collusion, or contamination of evidence. In the face of the evidence of substantial contacts between the complainants, collusion and/or contamination could not have been excluded. This means that a coincidence direction was not appropriate in the circumstances of the case, and if (wrongly) given would not have had any effect. This was obvious in the circumstances of this case, and it explains why the GMC was explicit that it was relying only on propensity. The Tribunal had no obligation further to consider the coincidence limb, and it cannot be any kind of procedural or other irregularity that it did not.

236. Even if the allegations relating to Patient F had been found proved, the problems with the evidence provided by Patients A and D were so significant that the additional consideration of propensity could not have led to them being found proved. Even if the Court quashes the findings on some or all of the unproven allegations relating to Patient F, it does not imply that the decisions on Patients A and D are also wrong, or unjust because of a serious irregularity. The GMC has not made any criticism whatsoever of the specific reasoning which led to the sexual allegations made by Patients A and D being found not proved. Evidence used for cross-admissibility is bad character evidence and, in criminal cases, bad character propensity evidence should not be used to *"bolster a weak case"*. This applies to the regulatory jurisdiction and to this case. It should be part of any consideration of whether propensity evidence (had the Patient F allegations been found proved) could properly have led to a different decision on Patients A and D. The Respondent submits that it could not.

Discussion

237. First, by way of background to this issue, the Tribunal made detailed findings in relation to the allegations concerning Patient A and Patient D. It found the key allegations not proved, on the basis that the evidence of each Patient was weak and not ultimately credible. Mr Rich for the Respondent took the Court through that material (both the findings and the underlying evidence) in considerable detail to support that conclusion. It is highly pertinent that the GMC, as it accepted, did not challenge those findings of the Tribunal as being wrong. Moreover, there was substantial evidence of relevant contact between Patients F, D and A, which – again –

Mr Burn went through in considerable detail. In the Determination, the Tribunal noted that contact as being relevant, in a number of places.

238. Secondly, turning to events at the hearing, the GMC sought a direction on cross-admissibility on propensity alone. It did not seek - in written or closing argument - a direction on rebutting coincidence. This is clear from the fact that in its written closing it drew attention to the fact that cross-admissibility in principle has two limbs, but that the present case was one of propensity only. The direction the GMC sought – in both closings - about "stepping back" and considering the overall picture - was *not* a request for a rebutting coincidence direction. In the light of the GMC submissions to it, I find that the Tribunal understood that it was not being invited to consider or make a rebuttal of coincidence direction. Further §30 of the Determination does not amount to such a direction.

239. Furthermore, what was said *by the Chair* in the course of oral argument (see paragraph 228 above) was not his "advice" on cross-admissibility (on a propensity basis or otherwise). Nor was what counsel said in that exchange capable of constituting advice *by the Chair.* The "advice" referred to in §26 of the Determination was either given in private or not given at all. I assume the former. That advice was not repeated in public and not included in the Determination itself. Moreover I do not accept that the advice had already been given (and was therefore not "new"). The approach in the *BMA* case (referred to in paragraph 12 above) does not therefore apply. Accordingly the advice given was not included "in the Tribunal decision", and thus I find that there was a breach of Rule 6(b) of the 2015 Rules. This was, at the least, a procedural irregularity

240. Thirdly, on the basis that there was a direction given on propensity, but not on rebutting coincidence, it was a matter for the Tribunal to decide whether to give itself the latter direction. It could have done so of its own motion, even though it was not invited to do so. However, in my judgment, the Tribunal was not in error in not giving itself such a direction, in view of the significant evidence of contact between Patients F, D and A giving rise to the strong possibility of either deliberate collusion or innocent contamination. Indeed, given this level of contact, had it considered rebuttal of coincidence, the Tribunal would have been justified in not directing itself to draw any conclusions rebutting coincidence. Given this level of contact, it might be regarded as unsurprising that the GMC positively refrained from inviting or considering such a direction.

241. Finally, as regards the consequences of the breach of Rule 6(b) and/or the failure otherwise to direct itself properly in respect of *propensity*, first, this irregularity did not make any difference to the outcome because the Tribunal found that the principal allegations of *inappropriate* sexual conduct in respect of Patient A, Patient D and Patient F were not proved. Moreover the findings on Allegations 17 a and b and 18 b i and ii found proved in relation to Patient F did not arguably establish a propensity to commit acts of the more serious nature alleged by Patient A and Patient D.

242. Further as regards the position if the findings in relation to Patient F on the remaining allegations 17 and 18 (the subject of Ground 2) were wrong, and if the Tribunal should have found those facts proved, then it is argued that a direction on propensity would have been relevant to the allegations in respect of Patient A and D. The GMC contends that, for that reason, and in the event that it is successful on Ground 2 (which it is), the Tribunal's determination in respect of Patient A and D should also be quashed, because had the Tribunal directed itself properly, it *may have* reached different conclusions in respect of those allegations.

243. I do not accede to this argument. The Tribunal found those allegations to be not proved, with clear detailed reasons. It found serious deficiencies in the evidence of the two Patients, such that their evidence was not credible. The GMC does not challenge those findings or those deficiencies, which will remain. The case in respect of those allegations was found to be weak. The findings on Patient A and Patient D were not finely balanced. Even if the allegations in relation to Patient F are proved, I do not accept that they alone could have tipped the balance in relation to Patient A and Patient D. Any propensity arising from findings in relation to Patient F should not be permitted to bolster those weak (and unchallenged) cases. As the GMC itself submitted (and as made clear in the Crown Court Compendium) findings against the Respondent in respect of Patient A and Patient D must not be made "wholly or mainly on the strength of" that propensity/tendency. To quash those findings and remit them on this basis, would run the risk of such an outcome.

244. Finally, as regards the GMC's contention based on the case of *Hindle* (see paragraph 24 above) in so far as it seemed to merge with a submission on cross-admissibility to rebut coincidence, for the reasons given above, such a submission was unfounded. Secondly, the Chair was aware of the need to consider each piece of evidence in the context of all the other evidence (and had the benefit of the GMC's written and oral submissions to "step back"). Thirdly, *Hindle* was principally concerned with the assessment of the general credibility of each complainant, where it had found that a complainant was not reliable on one topic. In that case, the panel had not taken that concern across to other topics where the credibility of that witness might be in question. In the present case, the Tribunal did not consider each individual allegation made by each complainant "on a charge-by-charge basis". For, for example, in respect of Patient A the Tribunal considered some of the most serious the allegations "collectively" and because it found them to be implausible and not credible: see Determination §§42 and 43.

Conclusion on Ground 3

245. Thus, even if the Tribunal's conduct in relation to a direction as to cross-admissibility relating to *propensity* constituted a serious procedural irregularity, I conclude that the Tribunal's decision, in so far as it found not proved allegations in respect of Patient A and Patient D, was not unjust. For these reasons Ground 3 fails.

Ground 4

246. By Ground 4 the GMC contends the Tribunal was wrong to conclude (on the basis of the allegations which it found *proved*) that the Respondent's fitness to practise was not impaired. In particular the GMC challenges, first, three findings that certain conduct did not amount to misconduct, and secondly, the Tribunal's overall decision on impairment.

Background

247. In relation to those facts which were admitted and/or proved, the Tribunal found some to amount to misconduct and others not to amount to misconduct. Those it found not to amount to misconduct included touching Patient A's leg, and hugging Patient A (Allegations 1 a and b) and kissing and hugging Patient F (Allegations 17 a and b, and 18 b i and ii) and an inadvertent touch on Patient D's clitoris, and the act of wiping her after an intimate examination (Allegations 10 a and b). Aspects which the Tribunal found to amount to misconduct were eight allegations of failure to have a chaperone present, the removal of Patient C's ovaries and of Patient D's ovaries; and in respect of Patient E two allegations of failure to arrange further

investigation/treatment and suggesting she join him in the gym (Allegations 15 a to d). (In respect of those matters it found to be proved, the Tribunal found them not to be sexually motivated.) The Tribunal went on to find that the Respondent was not currently impaired for a combination of reasons including the fact that he had continued in practice for around six years since the index events without any further problems, and a mix of CPD, changes of practice and other specific remediation.

The Parties' submissions

The GMC case

248. The GMC submits, first, and in relation to misconduct, that the Tribunal's conclusions (at §§268 to 270 and 294 of the Determination) that touching Patient A's leg and kissing/ hugging Patient A and Patient F were not misconduct that was serious was wrong. The Tribunal failed to consider the fact that these acts occurred in the context of the conduct of intimate examinations, and in the absence of a chaperone in respect of Patient F. If (as found in §292 Determination) suggesting a patient join him in the gym (Patient E allegation 15 d) is misconduct because it was a serious crossing of the patient/doctor boundary, then so too is hugging and kissing a patient.

249. In relation to impairment, the GMC submits, first, that when considering impairment, the Tribunal addressed only the removal of Patient D's ovaries and failed to consider the removal of Patient C's ovaries without consent. Secondly and more generally, the decision that a finding of impairment was not necessary in order to maintain public confidence in the profession or uphold proper professional standards of behaviour and conduct was wrong and inadequately reasoned. A finding of impairment was needed in order to uphold the statutory overarching objective in circumstances where: a consultant removed the ovaries from two different patients without their consent; crossed patient/doctor boundaries through inappropriately over familiar conduct; and repeatedly failed to ensure the presence of a chaperone in clear contravention of the applicable standards and guidance. The Tribunal was wrong to focus its analysis almost exclusively on insight, remediation and the risk of repetition. The Tribunal appears to have conflated public confidence in the profession with public confidence in the Respondent's remediation. Even on the basis of the misconduct which the Tribunal did find, a finding of impairment was needed in order to uphold public confidence in the medical profession and in order to uphold proper professional standards

The Respondent's case

250. The Respondent submits that Determinations on misconduct and impairment are evaluative decisions where a specialist tribunal is at a distinct advantage over an appeal court. As regards the issue of misconduct, the Tribunal accepted (Determination at §§270 and 294), and was entitled to rely on, the opinions of Mr Wood of the conduct being not seriously below the expected standard. Secondly, as regards impairment, the GMC does not challenge the Tribunal's findings that the Respondent had good insight and had taken extensive remedial steps and represented a low risk of repetition. Further the Tribunal did consider the public interest and its decision was well within the range of reasonable decisions.

Discussion

251. Ground 4 is advanced specifically on the basis that Grounds 1 to 3 do not succeed. However I have found that Grounds 1 and 2 succeed; and as explained in paragraph 260 below, the relevant "decision" will be quashed. Nevertheless, subject to further

submissions from counsel, it may well be that certain findings of the Tribunal will remain unaffected by the quashing order; in particular, freestanding conclusions of the Tribunal that facts it found to have been proved nevertheless did *not* amount to misconduct.

252. As regards impairment, in the light of my conclusions on Grounds 1 and 2, the Tribunal's Determination on impairment will be quashed in any event, and considered by a fresh tribunal on remittal, in the light of any further findings of fact proved. Nevertheless I express my brief conclusions on this issue, if, contrary to my conclusions, Grounds 1 and 2 had failed.

253. The relevant principles to be applied by this Court to findings of misconduct and impairment are set out in paragraph 27 above. The Court will only interfere with such finding where there was an error of principle in carrying out the evaluation, or the decision fell outside the bounds of what the tribunal could properly and reasonably decide.

254. As regards the GMC challenge in relation to misconduct (i.e. to §§268 to 270 and 294 of the Determination) I accept the Respondent's submissions. The Tribunal relied on the expert opinion of Mr Wood as to the boundaries of appropriate conduct. Mr Wood differentiated as to degrees of seriousness – as between kissing and hugging, one the one hand, and offering to exercise in the gym, on the other. In my judgment, the Tribunal was entitled to rely on that expert evidence to inform its own view, reached as the specialist tribunal, of professional standards. In my judgment, there was no error of principle in its assessment; nor did its conclusion here fall outside the bounds of what the Tribunal could properly and reasonably decide. This part of the challenge fails.

255. As regards the issue of impairment, first it is the case that, when considering impairment, the Tribunal only referred expressly to the removal of Patient D's ovaries and did not address expressly the removal of Patient C's ovaries. However the former instance, which was considered, was the more serious of the two (and the Tribunal had found the removal of Patient C's ovaries to be serious misconduct (§277)). This omission does not affect my conclusion on this issue.

256. Secondly, and more generally, I accept the submission that, even if a doctor is fit to practise, both in relation to his competencies and his attitude and remediation conduct, nevertheless that doctor may still be not fit to practice and/or that doctor's fitness to practice may still be impaired on the basis that the public will not have confidence in that doctor because of his past misdeeds. In other words public confidence in the profession is relevant to the issue of impairment of fitness to practise (as well as to issues of sanction). There is a need to have regard to the wider public interest in determining questions of impairment.

257. In the present case, it is the case that, at §§306 to 312 of the Determination, the Tribunal focussed, in considerable detail, upon the Respondent's personal insight and remediation, and thus upon the lack of risk of patient harm in the future. Nevertheless at §§313 to 315, the Tribunal did address the wider issues of public interest and in particular public confidence in the profession. Whilst this Court might not have placed so much emphasis on Respondent's personal position and might have reached a different conclusion balancing these factors, I recognise the Tribunal's expertise and approach its assessment with diffidence. Accordingly I conclude that the Tribunal did not err in principle and further that its decision in this regard did not fall outside the bounds of what the tribunal could properly and reasonably decide.

Conclusion on Ground 4

258. For these reasons, (and to the extent that it arises in the light of my conclusions on Grounds 1 and 2), Ground 4 fails.

Conclusions and consequences

259. In the light of my conclusions at paragraph 97 and 210 above, Grounds 1 and 2 succeed. In the light of my conclusions at paragraphs 245 and 258 above, Grounds 3 and 4 fail.

260. As explained in paragraph 16 above, the relevant "decision" in the present case is the decision not to make a direction (and, effectively, the decision to find that fitness to practice was not impaired). Having found one or more of the individual findings in relation to any of the allegations concerning Patient B or Patient F to be "wrong" or "unjust", that then infects the Tribunal's conclusion that the Respondent's fitness to practice was not impaired and in turn the decision not to make a direction. For that reasons the "relevant decision" will be quashed.

261. I will hear the parties further on the precise terms of the order. My provisional view is as follows

(1) The Tribunal's conclusions in relation to the following allegations are wrong or unjust by reason of serious procedural irregularity: Allegations 7, 17 c to e, and 18 b iii to ix, c to e and relevant parts of 19 to 21.

(2) The Tribunal's decision not to make a direction will be quashed.

(3) The finding of no impairment (at §316 of the Determination) will be quashed.

(4) The case is to be remitted to the MPTS for them to arrange for a differently constituted tribunal to dispose of the case with a direction to re-decide only those allegations of fact, the Tribunal's findings on which this Court has found to be wrong and/or unjust, and to re-decide issue of impairment.

262. Finally I am grateful to counsel for their assistance and for the detail and quality of the analysis and argument placed before the Court.

Annex

The allegations

Patient A

1. On one or more occasions between 17 October 2017 - 2 August 2018, whilst working at The Medical Specialist Group ('MSG'), you behaved inappropriately toward Patient A in that you:

a. rubbed and/or touched Patient A's leg**; Determined and found proved**

b. hugged Patient A following a consultation; **Admitted and find proved**

c. touched Patient A's genitalia saying that is what she should be feeling, or words to that effect**; Not proved**

d. touched Patient A's genitalia and asked "how does that feel?", or words to that effect; **Not proved**

e. told Patient A she should be trying to have sex, or words to that effect; **Not proved**

f. said "this is how you should be feeling when you sexually arouse yourself, how your husband should arouse you and if not then you're doing it wrong", or words to that effect; **Not proved**

g. advised Patient A to use sex toys to orgasm, or words to that effect; **Not proved**

h. advised Patient A to use her fingers to get herself to orgasm, or words to that effect; **Not proved**

i. said "play with yourself, give yourself a sexual arousement, use toys, it's all about the woman, pleasuring themselves before introducing a man" or words to that effect; **Not proved**

j. asked Patient A whether she had sexually aroused herself (since the last appointment), or words to that effect; **Not proved**

k. demonstrated intercourse using the internal probe on Patient A, by moving it back and forth inside her vagina; **Not proved**

l. said words to the effect of:

i. "if this doesn't hurt then it shouldn't be a problem with your husband"; **Not proved**

ii. "if you can handle this pain then you should be able to handle having sex"; **Not proved**

iii. if Patient A didn't reach orgasm by doing what he was doing then she was doing it wrong; **Not proved**

iv. you were a good person for advice on sex and that you would sort Patient A's sex life out. **Not proved**

2. On the following dates you performed intimate examinations on Patient A and failed to have a chaperone present:

a. 17 October 2017; **Not proved**

b. 28 November 2017; **Admitted and found proved**

c. 19 December 2017; **Not proved**

d. 24 January 2018; **Admitted and found proved**

e. 13 March 2018; **Admitted and found proved**

f. 24 April 2018. **Not proved**

3. On or around 19 December 2017 you said to Patient A, in reference to her husband's penis,:

a. "it must be too big", or words to that effect; **Not proved**

b. "he is not doing the right thing", or words to that effect. **Not proved**

4. On or around 8 February 2018 whilst Patient A was admitted to the Princess Elizabeth Hospital ('the Hospital') you made the following comments to Patient A's husband:

a. "oh did you do this with your big penis again", or words to that effect; **Not proved**

b. "did you cause this again with your big willy, maybe you might have to take your trousers down so we can have a look at the size", or words to that effect; **Not proved**

c. "we need to measure the size of your penis to see what damage it is causing", or words to that effect. **Not proved**

5. Your actions at paragraph 1a-d and k were carried out without Patient A's consent.

Found proved in relation to 1a and 1b, **found not proved** in relation to 1c, d and k

6. Your actions at paragraph 1- 2 were sexually motivated. **Not proved**

Patient B

7. On 30 May 2018 you performed surgery on Patient B at the Hospital and you failed to check the ureters at the time of the procedure. **Not proved**

Patient C

8. On 4 September 2018 you performed surgery on Patient C at the Hospital and you removed her ovaries when she did not consent to this. **Admitted and found proved**

9. On the following dates you undertook intimate examinations on Patient C and you failed to have a chaperone present:

a. 3 July 2017; **Admitted and found proved**

b. 28 November 2017; **Admitted and found proved**

c. 23 October 2018. **Admitted and found proved**

Patient D

10. On 2 November 2018 you conducted an intimate examination on Patient D at MSG and you:

a. touched Patient D's clitoris; **Determined and found proved**

b. wiped Patient D's vaginal area following examination; **Admitted and found proved**

c. failed to have a chaperone present; **Admitted and found proved**

d. dictated a letter to D's GP stating you had used a speculum which was untrue;

Not proved

e. knew you had not used a speculum in the examination. **Not proved**

11. Your actions at paragraph 10d were dishonest by reason of paragraph 10e**. Not proved**

12. On 29 November 2018, you operated on Patient D at the Hospital and inappropriately removed both ovaries:

a. when she did not consent to this; **Admitted and found proved**

b. when there was no clinical indication for their removal. **Admitted and found proved**

13. On or around 1 December 2018, you examined Patient D at the Hospital for blood loss and you:

a. touched patient D's vagina; **Not proved**

b. touched Patient D's clitoris; **Not proved**

c. kept your hand on Patient D's underwear in her genital area while talking to her; **Not proved**

d. failed to have a chaperone present; **Not proved**

e. said to Patient D "you are a very beautiful girl", or words to that effect. **Not proved**

14. Your actions at paragraphs 10a-c and 13 were sexually motivated. **Not proved**

Patient E

15. On 13 November 2018 you had a consultation with Patient E at MSG and you failed to:

a. arrange investigations for Patient E's heavy irregular periods; **Admitted and found proved**

b. arrange treatment for an endometrial polyp; **Admitted and found proved**

c. have a chaperone present during an intimate examination; **Admitted and found proved**

d. appropriately communicate with Patient E in that you suggested she join you in the gym, or words to that effect. **Determined and found proved**

Patient F

16. On 21 November 2018, during a consultation at MSG you:

a. undertook an intimate examination on Patient F and failed to have a chaperone present; **Admitted and found proved**

b. hugged Patient F; **Not proved**

c. kissed Patient F. **Not proved**

17. On 4 December 2018, during a consultation at MSG, you behaved inappropriately toward Patient F in that you:

a. hugged Patient F**; Determined and found proved**

b. kissed Patient F; **Determined and found proved**

c. asked intimate details about Patient F's sex life; **Not proved**

d. said words to the effect of "you need to find someone outside of the family unit that you can go to and you have a sexual relationship with them so it fulfils your needs"; **Not proved**

e. discussed masturbation with Patient F. **Not proved**

18. On 7 December 2018, during a consultation at MSG, you:

a. failed to have a chaperone present during an intimate examination of Patient F; **Admitted and found proved**

b. behaved inappropriately toward Patient F in that you:

i. hugged Patient F; **Determined and found proved**

ii. kissed Patient F; **Determined and found proved**

iii. discussed masturbation with Patient F**; Not proved**

iv. asked intimate details about Patient F's sex life**; Not proved**

v. said words to the effect of:

1. "are you feeling in the mood now?"; **Not proved**

2. "are you feeling horny now?"; **Not proved**

3."is this conversation making you horny?"; **Not proved**

4. "oh I can see it in your face, you are, you're getting horny**"; Not proved**

5. Patient F should go on the internet on a dating website where no one knows her so Patient F can have sexual conversations with them; **Not proved**

6."you need to find somebody that you can trust that can do things to you to make you feel good. It's up to you whether or not you want to do anything back to them, that's completely up to you, but you need to find somebody that can do all these acts to you"; **Not proved**

7."it's important that you don't share this conversation with anybody because it's private and it's important that you keep all of this information personal so that you can kind of grow as a person and grow in confidence and if you start telling other people they won't understand all of that". **Not proved**

vi. on one or more occasion used your finger/s to stimulate Patient F's clitoris; **Not proved**

vii. moved your finger/s around the outside of Patient F's vagina; **Not proved**

viii. moved your finger/s around Patient F's rectum; **Not proved**

ix. during your actions as set out at paragraph 18bvi-viii above, you said words to the effect of:

1. "see, that feels good doesn't it?"; **Not proved**
2. "I can see that you're reacting to that, that that feels good"; **Not proved**
3. "did you enjoy that?"; **Not proved**
4. "I bet you wanted me to carry on". **Not proved**

c. circled 'yes' on a stamp in Patient F's medical records next to 'chaperone offered', which was untrue; **Not proved**

d. circled 'yes' on a stamp in Patient F's medical records next to 'chaperone declined', which was untrue; **Not proved**

e. you knew:

i. you had not offered Patient F a chaperone; **Not proved**

ii. Patient F had not declined a chaperone. **Not proved**

19. Your actions at paragraphs 16b and c, 17a and b, 18bi and ii and 18bvi-viii were carried out without Patient F's consent. **Not proved**

20. Your actions at paragraphs 16-18b were sexually motivated. **Not proved**

21. Your actions at paragraph 18c-d were dishonest by reason of paragraph 18e. **Not proved**

Data protection

22. Between 1 September 2016 and 25 January 2019 you retained on your personal mobile telephone:

a. clinical documents for 272 patients; **Not proved**

b. clinical photographs of:

i. Patient G; **Not proved**

ii. Patient H**. Not proved**