PUBLIC RECORD

Dates: 10/08/2026 - 13/08/2026

Doctor:	Dr Farrukh KHAN
GMC reference number:	6068852
Primary medical qualification:	MB BS 2001 University of Punjab (Pakistan)

Type of case	Outcome on facts	Outcome on impairment
New – Misconduct	No facts found proved	Consideration of impairment not reached

Summary of outcome

Case concluded

Tribunal:

Legally Qualified Chair	Mr Phil Rostant
Lay Tribunal Member:	Mr John Kelly
Registrant Tribunal Member:	Dr Deborah Brooke

Tribunal Clerk:	Ms Ciara Fogarty

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Christopher Gillespie, Counsel, instructed by MDDUS
GMC Representative:	Mr Jonathan Lally, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in private.

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 13/08/2026

1. The Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private. This determination will be handed down in private but as this case concerns Dr Khan's alleged misconduct a redacted version will be published at the close of the hearing.

Background

2. Dr Khan qualified in 2001 University of Punjab (Pakistan). Prior to the events which are the subject of the hearing, Dr Khan worked as a GP since 2016. At the time of the events, Dr Khan was practising as a locum GP at the Vista Road Surgery.

3. The allegations that have led to Dr Khan's hearing relate to his conduct. It is alleged by the General Medical Council (GMC) that during a digital rectal examination (DRE) on Patient A, Dr Khan undertook actions which were not clinically indicated and inappropriately continued with the examination despite Patient A asking him to stop.

4. It is further alleged that Dr Khan's conduct was sexually motivated.

The outcome of applications made during the facts stage

5. The Tribunal granted GMC's application, made pursuant to Rule 35(4) of the GMC (Fitness to Practise Rules) 2004 as amended (the Rules), that anonymity be granted to Ms B, the wife of Patient A. The Tribunal's full decision on the application is included at Annex A.

6. The Tribunal granted the GMC's application, made pursuant to Rule 41(2) of the Rules for the entirety of the hearing to be heard in private. The Tribunal's full decision on the application is included at Annex A.

7. The GMC made an application, made pursuant to Rule 17(6), to amend the allegation 1(a) to better reflect the matters alleged. That application was not opposed. The Tribunal considered the application and determined that it should be granted. The Tribunal concluded that granting the application would cause no injustice to Dr Khan and would indeed better reflect the matters alleged against him.

The Allegation and the doctor's response

8. The Allegation made against Dr Khan is as follows:
That being registered under the Medical Act 1983 (as amended):

1. On 11 March 2024 you conducted a prostate examination on Patient A ('the Examination') and you:

    a. ~~inserted your finger into Patient A's anus on more than one occasion;~~ moved your finger back and forth repeatedly, inside the anus of Patient A, in a thrusting and/or forceful motion ***(Amended under Rule 17(6). To be determined***

    b. inappropriately continued with the examination despite Patient A asking you to stop or words to that effect. ***To be determined***

2. Your actions as described at paragraph 1.a were not clinically indicated. ***To be determined***

3. Your conduct at paragraph 1.a. and/or 1.b. was:

    a. carried out without Patient A's consent; ***To be determined***

    b. sexually motivated. ***To be determined***

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

Witness evidence

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

- Patient A, in person. His witness statement was dated 16 July 2025

- Ms B, in person. Her witness statement was dated 29 January 2026

10. Dr Khan provided his own witness statement and also gave oral evidence at the hearing.

11. The Tribunal also received evidence on behalf of Dr Khan in the form of oral evidence from Dr C, GP and XXX. Her statement is dated 3 July 2026.

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

- Ms D, Practice Manager, dated 24 June 2026
- Dr E, GP partner dated 13 July 2026
- Mr F, Practice Manager dated 21 July 2026
- Ms G, Enhanced Access Operations Administrator dated 9 July 2026.

Expert witness evidence

13. The Tribunal received expert evidence from two witnesses. Dr H was instructed by the GMC and Dr I was instructed on behalf of Dr Khan. Dr H provided a supplementary report dated 27 June 2026, and Dr I provided an expert report dated July 2026. The experts also produced a joint report dated 28 July 2026. Their evidence concerned the appropriate procedure for conducting a DRE, whether the examination was clinically indicated and whether Dr Khan's alleged actions fell below, or seriously below, the standard expected. They also addressed the issue of consent. Both experts agreed that it was for the Tribunal to determine the matters disputed between the parties.

14. The experts agreed that a DRE was clinically indicated and appropriate in light of Patient A's presenting symptoms. They also agreed that Patient A initially consented to the examination, although it was for the Tribunal to determine whether that consent was subsequently withdrawn.

15. The experts agreed that, if Dr Khan's account were accepted, he had obtained consent, inserted his finger only once and completed a 360-degree sweep of the rectal cavity. On that account, his conduct was appropriate and did not fall below the standard expected. However, if Patient A's account were accepted, Dr Khan continued the examination and forcibly inserted his finger several times after Patient A had withdrawn consent verbally and physically. On that account, Dr Khan should have stopped the examination and his conduct would have fallen seriously below the standard expected.

16. The experts further agreed that it was appropriate to check perianal sensation before inserting a gloved finger; that a rectal examination would usually be performed using the index finger, although another finger could be used in certain circumstances; that a clinician could return to and re-examine an area of concern; and that, when completing a 360-degree sweep, the finger could be partially withdrawn and reintroduced without being fully removed from the anus. They also agreed that a DRE could be painful for example because of anal spasm or acute prostatitis. Finally, they agreed that whether Dr Khan's actions were sexually motivated was a matter for the Tribunal to determine in light of its findings of fact.

Documentary evidence

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

- Full Medical Records of Patient A
- Patient A's written account dated 12 March 2024
- Police statement of Patient A dated 14 March 2024
- Police and NHS England statement of Dr Khan dated 5 July 2024
- Letter from Patient A to the GMC dated 24 April 2025

The Tribunal's approach

18. In reaching its decision on the facts, the Tribunal will apply the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged. The burden of proof rests with the GMC and it is for the GMC to prove the case. There is no burden on the doctor to prove or disprove anything.

19. The Tribunal will approach fact finding by firstly identifying agreed facts and evidence. To reach a decision on the disputed facts, the Tribunal will assess the evidence in the round. It will consider what conclusions and inferences can be drawn from the documentary evidence. The Tribunal will then consider the available oral evidence and subject that evidence to critical scrutiny against the agreed facts and documentary evidence to consider a witness' reliability and credibility. The Tribunal should not decide reliability and credibility based on the demeanour of a witness alone.

20. The Tribunal was advised that it should assess the evidence of each witness and determine what evidence it accepted as truthful and accurate. Credibility is divisible and, accordingly, the Tribunal may accept or reject some or all of a witness's evidence. Its findings must be based on the evidence before it and not on speculation.

21. The Tribunal was referred to *Dutta v GMC [2020] EWHC 1974 (Admin)* and advised that, when resolving disputed factual issues, the best approach is to base findings on inferences drawn from the documentary evidence and known or probable facts. Demeanour, of itself, is not a reliable indicator of honesty. Similarly, the confident delivery, or otherwise, of a witness's evidence is not a reliable guide as to whether that witness is telling the truth, and vivid or confident recollection should not be treated as a shortcut to decision-making. Honest witnesses may unintentionally form false memories and recollections may fade or change with the passage of time. Where a witness's recollection conflicts with documentary evidence, the Tribunal should carefully assess the objective evidence together with any explanation given for the discrepancy.

22. The Tribunal was also referred to *Roach v GMC [2024] EWHC 1114 (Admin).* At paragraph 29, Ritchie J identified a number of factors relevant to the assessment of the reliability and credibility of a witness's evidence, namely:

- whether the accounts given by each witness have been internally consistent, contradictory or embellished;
- whether the accounts are consistent with external evidence or supported by other witnesses or objective documentary evidence;
- whether the witnesses' behaviours peripheral to the asserted core evidence support that core evidence;
- any available evidence concerning the witnesses' motivations, personality, mental health and past history;
- the witnesses' demeanour and manner of giving live evidence, as one relevant but not determinative factor; and
- the fact that post-event words and actions may be indicative or determinative.

23. The Tribunal was further reminded of Ritchie J's observation in *Roach v GMC [2024] EWHC 1114 (Admin)* that:

"Throughout all of these filters, the Tribunal will take into account that memory is not perfect, it stores only what the witness saw or heard or read, it degrades with time, it may be manipulated quite honestly by the witnesses' desire to be right or justified and it may be manipulated consciously or unconsciously when it is accessed by questioning for the purposes of writing witness statements."

24. The Tribunal was advised that any inconsistencies between a witness's written statement and oral evidence were matters for it to assess when determining the reliability and credibility of that witness. Memory is fluid and may be affected by external influences, although recollections recorded closer in time to the relevant events may be more reliable.

The Tribunal should address discrepancies directly where they are relevant to the Allegation and consider the reliability of witnesses' recollections, including whether the events in question were routine or unusual and whether there was any particular reason why a witness might remember, or conversely forget, a matter.

25. The Tribunal was advised to consider whether any witness had a motive to be untruthful, including what they might gain or lose from the account they had provided. It should also consider whether a witness's evidence may have been influenced by discussions with others or by repeatedly revisiting the events over time.

26. The Tribunal was advised to exercise caution when considering hearsay evidence. Hearsay was defined, by reference to the Civil Procedure Rules, as a statement made otherwise than by a person while giving oral evidence in proceedings which is tendered as evidence of the matters stated. The Tribunal should bear in mind that hearsay evidence is not equivalent to first-hand evidence which has been tested by cross-examination. Hearsay evidence may nevertheless be considered where it is fair and relevant to do so, although the Tribunal should consider what weight can properly be attached to it. A careful balancing exercise should be undertaken, particularly where hearsay evidence is central to a particular allegation.

27. Finally, the Tribunal was advised that Dr Khan's good character should be taken into account and afforded proper weight when assessing both his credibility and the likelihood of him having acted as alleged. A doctor of good character and standing may be more likely to give truthful evidence and less likely to have committed the misconduct alleged. However, the significance of good character evidence should not be overstated. It does not provide a defence to an Allegation in the face of cogent evidence to the contrary and should not detract from the Tribunal's primary focus on the evidence directly relevant to the alleged conduct. The weight to be attached to Dr Khan's good character was ultimately a matter for the Tribunal to determine.

The Tribunal's assessment of the evidence and findings

28. The Tribunal considered each paragraph of the Allegation separately and evaluated the evidence to make its findings on the facts.

29. The Tribunal recognised that there were two materially different and, in significant respects, irreconcilable accounts of the examination. It therefore considered carefully the evidence of Patient A and Dr Khan, together with the contemporaneous documentary evidence, the evidence of the other witnesses, the expert evidence and the surrounding circumstances.

30. The Tribunal first identified a number of matters which were not in dispute between the parties. It was agreed that 11 March 2024 was the first occasion on which Patient A had met Dr Khan. It was also agreed that Patient A attended the practice because he was experiencing rectal pain and that, in those circumstances, a DRE was clinically appropriate.

31. The Tribunal further noted that it was agreed that consent to the examination was sought and obtained before it commenced and that Patient A was offered a chaperone, which he declined. The examination commenced with an examination of the perianal area.

32. The Tribunal noted that it was not disputed that following the examination, Patient A was provided with a treatment plan which included blood and urine tests, an ultrasound examination, and antibiotics. The Tribunal noted that the experts agreed that this was an appropriate treatment plan in light of the diagnosis of acute prostatitis.

33. The Tribunal also had regard to the subsequent ultrasound scan, evident from the medical records and not disputed, which identified slight enlargement of Patient A's prostate and thereby supported Dr Khan's own finding on examination.

34. The Tribunal noted that, shortly after the consultation, Patient A wrote down his account of the examination. He subsequently complained to the head of the practice, Dr J, and made a complaint to the police, to whom he provided a statement.

35. Shortly thereafter Dr Khan made a statement to the police and to the NHS England investigation.

Patient A's evidence

36. The Tribunal considered Patient A's evidence. It recognised that the core of Patient A's account had remained consistent across the various accounts he had provided, namely his description of the nature of the examination and his assertion that he withdrew his consent and asked Dr Khan to stop.

37. However, the Tribunal identified a number of inconsistencies and omissions in Patient A's evidence which caused it concern as to the overall reliability of his recollection.

38. The Tribunal considered, in particular, the different descriptions Patient A had provided as to the manner in which he communicated that he wanted Dr Khan to stop the examination. In his handwritten account Patient A wrote:

''I said it hurts. From past examinations I had never been treated so aggressively… I told him to stop it hurts but he continued. I then shouted time and again to stop".

The Tribunal noted in his police statement, made very shortly after, Patient A detailed: ''… *he has pushed his finger in and out 6 or 7 times while I told him it hurt and asked him to stop.*'' The Tribunal considered that this was a difference of substance rather than nuance.

39. The Tribunal noted that during cross-examination, Patient A demonstrated the manner in which he said he had spoken, raising his voice, but not shouting. The Tribunal considered that there was therefore some internal inconsistency in Patient A's evidence concerning the extent to which he had raised his voice during the examination.

40. The Tribunal did not consider that discrepancy, taken in isolation, was determinative. It recognised that witnesses may describe the same event differently on different occasions. Nevertheless, it considered this to be a relevant factor when assessing Patient A's evidence as a whole.

41. The Tribunal also noted that Patient A stated in his GMC witness statement that Dr Khan had placed his left hand on Patient A's shoulder to help him to thrust with force. That detail did not appear in his handwritten statement or in his police statement, both made much closer to the events.

42. Again, the Tribunal did not consider that omission, of itself, demonstrated that Patient A had been untruthful. However, it considered the addition of that detail relevant when assessing the development and reliability of his recollection over time.

43. Of greater significance to the Tribunal were the concessions Patient A made during cross-examination concerning events surrounding the examination.

44. The Tribunal noted that in his witness statement, Patient A described moving away from Dr Khan, pushing him behind him, being quiet following the examination and going to stand by the door whilst still in shock and pain. The Tribunal considered that Patient A's evidence conveyed the impression that there was very little engagement between himself and Dr Khan following the examination, that being consistent with Patient A's desire to leave the consulting room as quickly as possible.

45. However, during cross-examination, Patient A accepted that his account of the post-examination consultation had not fully reflected what occurred. He accepted that there had been a more substantial discussion between himself and Dr Khan following the examination than his earlier account had suggested.

46. In particular, Patient A accepted elements of the treatment plan recorded within Dr Khan's clinical notes. Although he did not recall collecting or taking antibiotics, he was able to

recall a discussion concerning side effects of those antibiotics. He also recalled being told he should have a blood test. He also accepted that he had been told of the need to have a urine test and undergone both urine and blood tests at the surgery that same day. He further agreed that he had been told that he would be referred for an ultrasound test. None of these matters were referred to in the witness statement.

47. The Tribunal considered that, in cross-examination, Patient A had effectively confirmed the accuracy of significant aspects of Dr Khan's contemporaneous clinical notes concerning the post examination discussion and treatment plan.

48. The Tribunal determined that Patient A's evidence in chief had therefore underplayed the extent and nature of the engagement between himself and Dr Khan during the post-examination phase of the consultation.

49. The Tribunal also considered Patient A's account of events before the examination. His account was that he attended the surgery, explained the issue he was experiencing following which, Dr Khan put on gloves and a chaperone was offered.

50. However, Patient A accepted in cross-examination that there were matters recorded in Dr Khan's clinical notes which he did not independently recall saying but which were accurate. The Tribunal considered that the information recorded in those notes could only realistically have been obtained from Patient A during a consultation which resulted in the decision that a DRE was indicated.

51. A further concern arises from the issue of the perianal examination. It is agreed that this took place and the experts agree that it was clinically indicated. The Tribunal also noted Patient A's assertion that no doctor had examined him in this way before. The impression given in the witness statement is that this part of the examination was already at odds with the norm. However Patient A accepted during cross-examination that the medical records demonstrated that he had undergone previous perianal examinations as a precursor to a DRE, notwithstanding that he had no recollection of those examinations.

52. The Tribunal considered these matters were important when assessing Patient A's reliability. It recognised that Patient A described the examination as an extremely unpleasant experience and that he believed that he had been assaulted.

53. The Tribunal considered that Patient A was able to recall some specific details, including the alleged placement of Dr Khan's hand on his shoulder, while having no recollection of other matters demonstrated by the contemporaneous records to have occurred.

54. The Tribunal reminded itself of the guidance in *Dutta v GMC [2020] EWHC 1974 (Admin)* that an honest witness may nevertheless be mistaken. It determined that the omissions, inconsistencies and concessions in Patient A's evidence meant that it could not regard his recollection of events before and after the examination as wholly reliable.

55. The Tribunal considered that this was relevant when determining what weight it could safely place upon Patient A's recollection of the disputed events during the examination itself.

The evidence of Ms B

56. The Tribunal considered the evidence of Ms B. It noted that Ms B had made clear in her evidence that Patient A was anxious about seeing a doctor and that she generally needed to persuade him to do so.

57. The Tribunal also noted that Patient A's evidence, when he denied any reluctance to attend the doctor, was in conflict with the evidence given by Ms B.

58. The Tribunal found Ms B to be a credible witness and had no reason to doubt her evidence on this issue. The discrepancy provided a further example of Patient A's recollection of the wider circumstances surrounding the consultation differing from other evidence which the Tribunal accepted.

59. However, the Tribunal recognised that Ms B was not present during the examination and could not provide direct evidence as to what occurred between Patient A and Dr Khan in the consultation room. Her account of what Patient A said to her about what had occurred is consistent with Patient A's but is hearsay evidence on that issue and the Tribunal accords it less weight than the accounts of Patient A and Dr Khan.

Dr Khan's evidence

60. The Tribunal next considered Dr Khan's evidence.

61. The Tribunal determined that Dr Khan's account was materially consistent with his statement to the police, his subsequent statement to the GMC and, importantly, his contemporaneous clinical notes concerning the examination.

62. The Tribunal attached particular significance to the contemporaneous clinical notes. Those notes recorded a conventional clinical history taking, examination, findings and treatment plan. The Tribunal noted that the accuracy of a number of aspects of those records was subsequently accepted by Patient A during cross-examination.

63. The Tribunal also considered it significant that the subsequent ultrasound scan identified slight enlargement of Patient A's prostate, which supported Dr Khan's own finding during the examination.

64. The Tribunal considered carefully the principal discrepancy identified in relation to Dr Khan's account, namely that he had not recorded in his clinical notes his passing concern that there might be a thickening of the bowel mucosa.

65. The Tribunal recognised that there was no contemporaneous record of that matter. However, it also noted that neither expert had identified the absence of such a record as a matter of concern or as a failure to comply with Good Medical Practice (GMP) or otherwise accepted clinical practice.

66. Dr Khan explained in his evidence that, in retrospect, he might have taken time at the end of the examination to explain to Patient A what he had done by way of a slightly prolonged examination to check the mucosa. However, he had decided at the time not to do so because the further check had resulted in a negative finding and he did not wish to cause Patient A further concern.

67. The Tribunal found that explanation entirely plausible. In the circumstances, it did not consider the absence of a reference to that further check within the contemporaneous clinical notes to be evidence which materially undermined Dr Khan's reliability.

68. The Tribunal further considered Dr Khan's oral evidence and the challenges made to him on the key aspects of the Allegation. Having done so, the Tribunal found no material reason to doubt his credibility or reliability as a witness.

Dr C's evidence

69. The Tribunal also considered the evidence of [Dr C], who was working within the building as a locum at the relevant time.

70. She stated that she did not hear any cries or sounds of distress coming from the consultation room. The Tribunal found her to be a credible and frank witness.

71. The Tribunal recognised the limitations of that evidence, including that she was not present in the consultation room, the consultation rooms were designed for privacy albeit not fully sound proofed, and that she could not provide direct evidence of the examination itself. It nevertheless considered her evidence as one part of the overall evidential picture.

The Tribunals analysis

72. The Tribunal recognised that there was no way satisfactorily to reconcile the two accounts of the material events given by Patient A and Dr Khan.

73. It considered the fact that Patient A had never met Dr Khan before the consultation and that there was therefore no evidence before it of any pre-existing animosity or other obvious motive for Patient A deliberately to make a false allegation against him. For the GMC Mr Lally submitted that there was no plausible explanation for Patient A's complaint other than the fact that it was true.

74. However, the Tribunal reminded itself that it was not required to identify a motive on Patient A's part before it could determine that his account was unreliable. Nor did it need to conclude that Patient A had deliberately fabricated his account. The burden of proof rested throughout on the GMC.

75. As against that the Tribunal considered the likelihood that Dr Khan had indeed acted as alleged. The Tribunal bore in mind Mr Gillespie's submission that it was inherently improbable that Dr Khan would risk an assault on his first patient of the day, a patient new to him, in a full surgery, which was also new to him, with [Dr C] in a room opposite him. He could not have known how Patient A would react. As Mr Gillespie put it, he could have 'screamed the place down'.

76. The Tribunal also took into account Dr Khan's good character. The Tribunal reminded itself that good character was not a defence to the Allegation and could not outweigh cogent evidence to the contrary. However, it noted that Dr Khan had practised medicine for more than 20 years in the United Kingdom, having previously practised in Pakistan, and that there were no previous adverse findings against him. The Tribunal therefore afforded Dr Khan's good character appropriate weight as part of its overall assessment of the evidence.

77. The Tribunal placed most weight on the contemporaneous clinical records, the consistency of Dr Khan's accounts, the concessions Patient A made concerning the accuracy of matters recorded within Dr Khan's notes, and the fact that aspects of his clinical findings were subsequently supported by the ultrasound scan. This is of particular importance since it was agreed that had Dr Khan's examination been as described by Patient A, it would have been of no diagnostic value at all.

78. The Tribunal also took account of the concerns it had identified regarding Patient A's recollection of events immediately before and after the examination. It considered those concerns relevant when assessing the reliability of his recollection of the examination itself.

79. Standing back and considering the evidence in the round, the Tribunal preferred Dr Khan's account of the examination. It considered his account to be more consistent with the contemporaneous and objective evidence and found no material reason to doubt his credibility or reliability.

80. The Tribunal did not determine that Patient A had deliberately set out to fabricate his account. It accepted that Patient A genuinely believed that he had experienced an inappropriate and distressing examination which had continued despite the removal of consent. However, the Tribunal reminded itself that an honest witness may nevertheless be mistaken.

Paragraph 1(a)

81. The Tribunal considered whether, during the examination, Dr Khan "moved [his] finger back and forth repeatedly, inside the anus of Patient A, in a thrusting and/or forceful motion."

82. For the reasons set out above, the Tribunal was not satisfied on the balance of probabilities that Dr Khan acted in the manner alleged.

83. In particular, the Tribunal preferred Dr Khan's account of the examination, having regard to the consistency of his evidence, the contemporaneous clinical records, the objective evidence concerning his clinical findings, the concerns it had identified regarding the reliability of aspects of Patient A's recollection and Dr Khan's good character.

84. In all the circumstances, the Tribunal determined that the GMC had failed to discharge the burden of proving the disputed conduct on the balance of probabilities.

85. The Tribunal therefore found paragraph 1(a) not proved.

Paragraph 1(b)

86. The Tribunal next considered whether Dr Khan inappropriately continued with the examination despite Patient A asking him to stop, or words to that effect.

87. The Tribunal had regard to Patient A's account that he told Dr Khan it hurt and asked him to stop. It also considered the different descriptions Patient A had provided of having called out, shouted out or otherwise raised his voice.

88. The Tribunal considered Patient A's demonstration during cross-examination of the manner in which he said he had raised his voice together with Dr Khan's evidence.

89. The Tribunal also took into account the evidence of [Dr C] that she had not heard cries or sounds of distress from the consultation room, while recognising the limitations of that evidence.

90. For the reasons already set out in its assessment of the witnesses, the Tribunal was not satisfied that Patient A's recollection was sufficiently reliable for it to conclude, on the balance of probabilities, that he asked Dr Khan to stop and that Dr Khan thereafter inappropriately continued the examination.

91. In all the circumstances, the Tribunal determined that the GMC had failed to discharge the burden of proving the disputed conduct on the balance of probabilities.

92. The Tribunal therefore found paragraph 1(b) not proved.

Paragraph 2

93. Having found the factual conduct alleged at paragraph 1(a) not proved, the Tribunal determined that the factual premise upon which paragraph 2 depended had not been established. It was therefore unnecessary for the Tribunal to go on to determine whether the alleged conduct was clinically indicated.

94. The Tribunal therefore found paragraph 2 not proved.

Paragraph 3(a)

95. The Tribunal had found both paragraphs 1(a) and 1(b) not proved. Accordingly, the factual conduct upon which paragraph 3(a) depended had not been established.

96. The Tribunal therefore found paragraph 3(a) not proved.

Paragraph 3(b)

97. The Tribunal had found the underlying conduct at paragraphs 1(a) and 1(b) not proved. It was therefore unnecessary for the Tribunal to go on to consider whether conduct which had not been established was sexually motivated.

98. The Tribunal therefore found paragraph 3(b) not proved.

The Tribunal's overall determination on the facts

99. The Tribunal has determined the facts as follows:

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

1. On 11 March 2024 you conducted a prostate examination on Patient A ('the Examination') and you:

   a. ~~inserted your finger into Patient A's anus on more than one occasion;~~ moved your finger back and forth repeatedly, inside the anus of Patient A, in a thrusting and/or forceful motion ***(Amended under Rule 17(6). Not proved***

   b. inappropriately continued with the examination despite Patient A asking you to stop or words to that effect. ***Not proved***

2. Your actions as described at paragraph 1.a were not clinically indicated. ***Not proved***

3. Your conduct at paragraph 1.a. and/or 1.b. was:

   c. carried out without Patient A's consent; ***Not proved***

   d. sexually motivated. ***Not proved***

And that by reason of the matters set out above, your fitness to practise is impaired because of your misconduct. ***Not proved***

100. There is no interim order to revoke.

101. That concludes the case.

ANNEX A – 13/08/2026

Application to anonymise a witness

1. This determination will be handed down in private due to the confidential nature of some of the matters heard as evidence. However, as this case concerns Dr Khan's alleged misconduct a redacted version will be published at the close of the hearing.

2. Mr Jonathan Lally, Counsel, on behalf of the GMC, made an application for the wife of the complainant Patient A, Ms B, to be anonymised. He submitted that much of her evidence refers to Patient A in terms of their relationship. Identification of Patient A would be inevitable by way of jigsaw identification, if her evidence was also not subject to an anonymity direction. Failure to order anonymity in respect of her would undermine the order granted in respect of Patient A.

3. Mr Christopher Gillespie, Counsel, on behalf of Dr Khan stated that he did not oppose the GMC's anonymity application.

The Tribunal's Decision on the application to anonymise a witness

4. The Tribunal noted the relationship between Patient A, the complainant, and Ms B. The Tribunal was of the opinion that he could be identified by jigsaw identification. The Tribunal determined that, if Ms B's evidence were not also subject to an anonymity direction, there would be a risk of Patient A being identified. Failure to grant anonymity in respect of Ms B would therefore undermine the anonymity order made in respect of Patient A.

5. Accordingly, the Tribunal granted the application to anonymise the witness, Ms B.

Application for the hearing to heard in private

6. Mr Lally made an application that all of the hearing should be heard in private. He submitted that, due to the nature of the evidence, this would ensure the hearing would proceed in a more efficient manner.

7. Mr Gillespie, Counsel, on behalf of Dr Khan, stated that he did not oppose the GMC's privacy application.

The Tribunal's Decision

8. In making its decision the Tribunal noted Rule 41(2) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), which states:

> *'41(2) The Committee or Medial Practitioners Tribunal may determine that the public shall be excluded from the proceedings or any part of the proceedings, where they consider that the particular circumstances of the case outweigh the public interest in holding the hearing in public.'*

9. The Tribunal noted the general rule that MPTS hearings are held in public, unless the particular circumstances of the case outweigh the public interest in holding the hearing in public. The Tribunal reminded itself that the overriding objective of the MPTS is protection of the public which includes the public interest.

10. The Tribunal was mindful that the allegations in this case relate to alleged sexual assault and the evidence refers extensively to the health of Patient A.

11. The Tribunal was satisfied that the particular exceptional circumstances of the case being heard wholly in private outweigh the public interest in holding the hearing in public.

12. The Tribunal was mindful that as this case concerns Dr Khan's alleged misconduct a redacted version will be published at the close of the hearing.

13. Accordingly, the Tribunal granted the GMC's application pursuant to Rule 41(2) of the Rules for the entirety of the hearing to be heard in private.