PUBLIC RECORD

Dates: 22/03/2021 – 30/03/2021, 26/04/2021, 13/05/2021, 07/06/2021, 11/06/2021 & 18/06/2021

Medical Practitioner's name:	Dr Gordon COX
GMC reference number:	3541708
Primary medical qualification:	MB BS 1991 University of London

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

Summary of outcome
Erasure

Tribunal:

Legally Qualified Chair	Mr Stephen Killen
Lay Tribunal Member:	Mr Geoffrey Brighton
Medical Tribunal Member:	Dr Ann Smalldridge

Tribunal Clerk:	Ms Olivia Moy 22/03/2021 – 30/03/2021 Ms Chloe Ainsworth 26/04/2021 & 13/05/2021 Miss Kanwal Rizvi 07/06/2021 Mrs Lorraine Cheetham 11/06/2021 Ms Jeanette Close 18/06/2021

Attendance and Representation:

Medical Practitioner:	Present on some days but represented throughout

Medical Practitioner's Representative:	Mr Anthony Haycroft, Counsel, instructed by RadcliffesLeBrasseur
GMC Representative:	Mr Carlo Breen, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 13/05/2021

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

Overarching Objective

2. Throughout the decision-making process the Tribunal has borne in mind the statutory overarching objective as set out in section 1 of the Medical Act 1983 ('the 1983 Act') to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the medical profession; and to promote and maintain proper professional standards and conduct for members of that profession.

Background

3. Dr Cox trained at the Royal Free Hospital in London from 1984 to 1991, when he received his MBBS from the University of London. He worked at the Ulster Hospital in Northern Ireland and then in Bristol before commencing GP training in August 1996. He obtained membership of the Royal College of General Practitioners and JCGTGP in 1997. Dr Cox then worked as a GP in Northern Ireland and various other places before continuing to obtain postgraduate qualifications at the Entabeni Hospital in Durban, South Africa.

4. Dr Cox subsequently worked as a GP between 2004 and 2017 at a number of different practices, both as a GP partner and as a locum. At the time of the events which are the subject of this hearing, Dr Cox was employed as a locum GP at the Quintin Medical Centre, Hailsham ('the Practice'). He left the practice in July 2017 following suspension by the GMC.

5. On 24 May 2017, Patient A attended the Practice and consulted for the first time with Dr Cox. During the consultation Dr Cox examined Patient A's chest and back. On leaving the examination room, Patient A spoke to a nurse at the Practice and stated that she believed that Dr Cox had masturbated behind her back during the consultation. She subsequently made a verbal statement to police that evening in respect of this allegation, and then signed a written statement prepared for her by a police officer on 21 June 2017, which read as follows:

> *"… I attended the surgery for an appointment at 3.30pm with Dr Cox, I have not seen this doctor before. On entering the consulting room, Dr Cox was standing by his desk and I sat in a chair that was close to the desk. I know this because I was able to lean on the desk. I believe the chairs were black with a metal frame and there was blood pressure equipment on the desk.*
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> *My appointment was to discuss* [REDACTED]. *Dr Cox checked my blood pressure and* [REDACTED]. *He then picked up his stethoscope to listen to my chest. I would describe myself as having a large chest and on this particular day I was wearing a vest top but no bra and a waist coat. At this time Dr Cox was standing directly in front of me and I was still seated. He placed the stethoscope over my breasts about four times. He then leant me forward so my head was near his crotch and used the stethoscope on my back. I mentioned to Dr Cox that I was suffering from a stiff neck* [REDACTED]. *He asked me to stand up and he then positioned himself behind me. I removed my waist coat prior to Dr Cox examining my back. Dr Cox put both of his hands under my top against the skin on my back. I could initially feel both of his hands on my back but then I became aware that he had removed his right hand. His left hand stayed on my back but remained fairly still. I could then feel jerking motions behind me and what I would describe as quiet, controlled laboured breathing. I remember thinking to myself I hope he is not doing what I think he is doing but I did not look around because you don't really expect that sort of thing to be happening. As soon as Dr Cox removed his left hand from my back he said 'Oh sorry, I'll just wipe you off'. He then proceeded to wipe my lower back with what I believe were tissues. I wondered what he needed to wipe but he was wiping the bottom half of my top and also my shorts. I cannot recall whether or not he wiped my actual skin or if it was purely my clothing. When Dr Cox initially placed both of his hands on my back he had lifted my top up so the lower half of my back was exposed. When he removed his right hand I believe the right hand side of my top was pulled down slightly at the same time but a small section of my back was still exposed.*
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> *Once Dr Cox had wiped my back I stepped slightly to the side in order to sit back down and as I looked down I could see seven or eight drops of a milky coloured liquid on the floor that I believed was semen. Dr Cox noticed me looking at the floor and immediately leaned over and grabbed a handful of the paper that is used to line the examination couch. He wrapped this around his arm in order to rip some from the roll. Dr Cox then used this tissue to wipe the floor where I had noticed the drops of what I*

believed to be semen. I do not remember actually seeing Dr Cox place the tissue in the bin but I heard the sound of metal and think this was the lid of a bin closing. I remember there was a bin on the other side of the room to the desk. Dr Cox was trying to act normally but he appeared flustered. I also saw a small wet spot on his trousers, right in the middle of his fly area. I did not see his penis at any time or see him do his trousers up. I felt totally confused about what had happened but could not think of any other explanation for what Dr Cox had done. The only logical thing I can think of is that Dr Cox masturbated behind my back during my examination.

When I left Dr Cox's room I was a bit shocked and I went to speak to a nurse in the surgery by the name of [REDACTED]. *I explained my concerns to her and she said she did not disbelieve me but doubted the doctor would have done this especially as I could have looked around at any time. She said the jerking motion I felt could have been the doctor using the hand gel dispenser.* [REDACTED] *even dripped a few drops of the gel onto the floor to demonstrate her theory. This liquid was clear though and definitely not the same milky colour of the liquid I saw on the floor in Dr Cox's room. I do not believe the hand gel was the liquid I saw on the floor and I cannot think of any reason why Dr Cox would have used hand gel in the middle of my examination.*

I left the nurse's room and returned home where I removed my top and had a close look at it. I believe I could smell semen on my top as it has a distinctive odour.

I spoke to a couple of my friends about what had happened and they advised me to contact the police. The more I think about what happened the more convinced I am that Dr Cox masturbated behind my back. Dr Cox was wearing beige/sand coloured trousers … I would also like to mention that at 1927 hours on the same evening I missed a call on my mobile phone from number [REDACTED]. *I tried to call this number back but it was a voicemail regarding 101 for medical advice. …"*

6. On 2 June 2017, the nurse to whom Patient A had spoken following her consultation with Dr Cox made a statement to police which read as follows:

"I am employed as a [REDACTED] *at* [the Practice]. *On Wednesday 24th May in the afternoon a patient named* [REDACTED] *disclosed an allegation of sexual abuse. Her words were "I can't believe what's just happened to me, I think that Doctor has just had a 'wank' behind my back" I understood that to mean he had been masturbating. I said 'That is a serious allegation",* [Patient A] *then said "I heard hand movements behind my back and liquid fell on the floor". At this point* [Patient A] *was making hand gestures, rubbing her hands up and down. I asked her if she saw the Doctor's penis and she said "No, I didn't turn round". I then said "Could it have been the Doctor rubbing hand gel into his hands and a bit of gel falling on the floor?" I demonstrated putting hand gel onto my own hands and rubbed them together. I then asked her if that was what she thought it could be.* [Patient A] *said "yes, that's probably what it was".* [Patient A] *implied that she felt reassured after telling me. I asked whether she wanted me to disclose this information and she said "No".* [Patient A] *then said "I*

wouldn't mind, I'm quite open minded if he had of done that, but I just worry about other people". I did ask her again if she was sure that she didn't want me to speak to anyone and she again said that she didn't want me to. The Doctor that [Patient A] *had just seen was Doctor Gordon Cox. I struggled for two days to come forward about this serious allegation towards the Doctor. From a safeguarding point of view, I believe the patient was not in any serious harm or danger. On the 26th May 2017 I submitted a report to my Practice Manager."*

7. As a result of the allegations made by Patient A, as referred to at paragraph 2(c) of the Allegation, below, Dr Cox was interviewed by police on 4 July 2017. He gave "*no comment"* answers to the questions put, but provided two handwritten statements. The first read as follows:

"… I understand that an allegation of sexual assault has been made against me by one of my patients, [Patient A]*, following a consultation on 24th May 2017. I have a recollection of the consultation but I do not now have access to my records and therefore cannot give precise details. What I can say is that* [Patient A] *came to see me for* [REDACTED]. *I can recall that during the course of the consultation she told me that she had been suffering from* [REDACTED] *and I therefore asked her to stand up so that I could palpate her spine. I routinely do this using both hands pressing on each vertebrae in turn and asking if this caused any pain.* [Patient A] *slightly lifted up her top at the back to allow me to do this.*

As I was pressing down the back I saw some fluid on [Patient A's] *waistband and looking around I saw some fluid on the floor as well. I took one hand off her back to pull some tissue paper off the examination couch to wipe her clothes. I then removed both hands to pull some further pieces of tissue off the roll to wipe the floor. Because I had taken my hands away from her back, I assume she thought the examination had finished and she sat back down. I threw the tissue in the bin and then continued the consultation. When the police came to the Practice later that evening and seized the contents of my bins, I assumed that whatever allegation had been made, it was most likely to have been made by* [Patient A]*. I tried to call her home number and her mobile to try and clear up any misunderstanding but both went to voice mail. I did not do so again and have had no further contact with her since. I categorically deny that I assaulted* [Patient A] *as she has suggested, or at all."*

8. The second handwritten statement then read as follows:

"Having listened to the questions put to me at interview today, I would like to attempt to address them.

I can recall [Patient A] *is middle aged and she is a large lady. As I have said in my previous statement, I do not have access to the GP records for the consultation and I am therefore unable to say with certainty exactly how the consultation ran. I believe that prior to mentioning her* [REDACTED]*, I had listened to her chest.*

My usual practice for cardiac sound auscultation is to stand next to the patient, place my hand on the right shoulder clade and my stethoscope against the patient's chest at the front on both sides. When paying particular attention to heart sounds, I ask the patient to lean forward and to breathe in and out, and to hold their breath. It is my recollection that I was particularly keen to listen to [Patient A's] *heart because of some* [REDACTED]. *I would, therefore, have asked her to lean forward as I listened to her chest.*

I think, though I cannot now be sure, that it was the leaning motion that prompted [Patient A] *to mention her* [REDACTED] *and this led to the back examination that I have already described.*

I should mention that before [Patient A] *had come into my room, I had had a small gap between patients and, having had a stressful day up to that point, I had ill-advisedly taken the opportunity to masturbate whilst alone in my consulting room as a means of relief. Having done so, I wiped myself with tissues and then, having done up my flies, I called the next patient in, which happened to be* [Patient A].

When I saw the mark on her waistband during the back examination and I saw the drops of fluid on the floor, I suddenly feared that the spots of fluid were my ejaculate because I had been acting in such a hurry, it was for this reason, and because the thought filled me with a sense of shame and panic, that I tried to wipe the fluid with tissue from the roll over the couch without saying anything to [Patient A]. *The roll of tissue on the examination couch is wide and quite difficult to tear with one hand. This may have been the jerking feeling that* [Patient A] *described, but this is only speculation.*

I have been asked why, when I was informed of a complaint of sexual assault that evening, I assumed it was [Patient A]. *The reason that the consultation stuck in my mind was because of what had preceded it and the horror of seeing the fluid on* [Patient A] *and the floor.*

It has been suggested that I was told on the evening that they came to the practice that I should not contact or speak to anyone about the allegation. I have no recollection of being told this at the time; only on the following day with DC Reilly called me. I had no intent in calling [Patient A] *other than to attempt to clear up a misunderstanding."*

9. Dr Cox was subsequently charged with sexual assault, contrary to section 3 of the Sexual Offences Act 2003. A Crown Court trial commenced on 24 September 2018, at the conclusion of which on 28 September 2018, Dr Cox was acquitted of the charge by the jury.

10. On investigation by the General Medical Council ('GMC'), in addition to the matters relating to the allegation of sexual assault, a number of alleged clinical failings in relation to

the manner in which the consultation was conducted by Dr Cox were identified, as contained within the Allegation below.

The Allegation and the Doctor's Response

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

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

1. On 24 May 2017 you consulted with Patient A (the 'Consultation') and you failed to:
    a. obtain an adequate medical history from patient A in that you did not:
        i. review the actions already taken to assess Patient A's hypertension to identify any outstanding issues;
        Admitted and found proved
        ii. consider the blood results, including elevated lipid levels;
        To be determined
    b. obtain Patient A's verbal consent prior to examining her chest;
    To be determined
    c. carry out and/or arrange for:
        i. a cardiovascular risk assessment using a validated screening tool;
        Admitted and found proved
        ii. a urine analysis for protein and blood;
        Admitted and found proved
        iii. blood tests covering:
            1. fasting lipid profile; **Admitted and found proved**
            2. fasting blood glucose; **Admitted and found proved**
            3. liver function test; **Admitted and found proved**
            4. thyroid function test; **Admitted and found proved**
    d. action within one to two weeks of the consultation:
        i. a referral to Cardiology; **Admitted and found proved**

ii. repeat blood tests to check renal function;
Admitted and found proved

e. review Patient A's understanding of the diagnosis of hypertension and the implications in terms of lifelong treatment and monitoring;
To be determined

f. advise Patient A on the:

i. nature and purpose of the additional drug treatment you prescribed;
To be determined

ii. requirement for blood testing to check kidney function after initiation;
To be determined

iii. need to follow 'sick day rules' to avoid acute kidney injury; Admitted and found proved

iv. need for a cardiology referral for further assessment of patient A's raised BNP level; To be determined

v. modifiable cardiovascular risk factors. To be determined

g. record:

i. the outstanding actions needed to complete the assessment of hypertension; Admitted and found proved

ii. a history of recurrent chest infections; To be determined

iii. the reasons for carrying out a chest examination;
Admitted and found proved

iv. your findings from the examination of Patient A's chest; Admitted and found proved

v. elevated lipid levels in Patient A's blood test results;
Admitted and found proved

vi. having carried out the actions set out in paragraph 1.a – c, 1.e, 1.f.
Admitted and found proved

h. seek Patient A's consent to make a referral to Cardiology.
To be determined

2. During the Consultation you inappropriately examined Patient A in that you:

    a. failed to:

        i. offer a chaperone; To be determined

        ii. use an appropriate method of holding a stethoscope.
        To be determined

    b. made excessive contact with patient A's breasts on one or more occasions as a result of your inappropriate stethoscope technique;
    To be determined

    c. masturbated behind the back of Patient A while carrying out the examination.
    To be determined

3. In the alternative to paragraph 2.c you masturbated in your GP surgery before the Consultation. To be determined

4. Your actions as described at paragraph 2 and/or 3 were sexually motivated. To be determined in relation to paragraph 2
Admitted and found proved in relation to paragraph 3

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

The Admitted Facts

12. At the outset of these proceedings, through his barrister Mr Haycroft, Dr Cox made admissions to the paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with rule 17(2)(d) of the Rules. In addition, Dr Cox admitted the alternative allegation at paragraph 3 of the Allegation; and he admitted paragraph 4 as it related to paragraph 3. In accordance with rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation (save for paragraphs 3 and 4) as admitted and found proved.

The Facts to be Determined

13. In light of Dr Cox's response to the Allegation made against him, the Tribunal was required to determine whether Dr Cox failed to consider the blood results, failed to obtain Patient A's verbal consent prior to examining her chest and failed to review Patient A's understanding of the diagnosis of hypertension and the implications in terms of lifelong treatment and monitoring.

14. The Tribunal was also required to determine whether Dr Cox failed to advise Patient A on the nature and purpose of the additional drug treatment he prescribed; the requirement for blood testing to check kidney function; the need for a cardiology referral; or of the modifiable cardiovascular risk factors. Furthermore, the Tribunal was required to determine whether Dr Cox failed to record a history of recurrent chest infections and whether he failed to seek Patient A's consent to make a referral to Cardiology.

15. Additionally, the Tribunal was required to determine whether Dr Cox failed to offer a chaperone; whether during the consultation, Dr Cox inappropriately examined Patient A; whether Dr Cox masturbated behind Patient A's back; and whether Dr Cox's actions were sexually motivated.

Evidence

Witness evidence adduced by the GMC

16. The Tribunal received a written statement dated 5 April 2019 and heard oral evidence from Patient A. It received a written witness statement dated 13 September 2019 from Ms H, Practice Manager at the Practice which exhibited a number of photographs.

17. The Tribunal also received an expert report dated 5 November 2019 from Dr F, General Practitioner. Dr F also gave oral evidence.

Witness evidence adduced by Dr Cox

18. Dr Cox provided his own witness statement dated 16 February 2021 and gave oral evidence.

Documentary Evidence

19. The Tribunal had regard to the documentary evidence provided by the parties, which included but was not limited to:

- Patient A's police witness statement
- Dr Cox's handwritten statements submitted to police during interview
- Transcript of the examination and cross examination of Patient A during the Crown Court trial
- Transcript of agreed facts from the Crown Court trial
- Transcript of the examination and cross examination of Dr Cox during the Crown Court trial
- Certificate of acquittal
- Relevant photographs
- Medical records of Patient A
- Police Statement of the Practice Nurse dated 2 June 2017

XXX

20. XXX.

The Tribunal's Approach

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

22. The Tribunal noted that these proceedings concern serious allegations, and that the utmost care must be taken when assessing the evidence. The Tribunal noted that it must give due consideration to any inherent improbability of such serious circumstances arising as alleged. It noted that there is a need for cogent evidence and that the full circumstances must be considered. The Tribunal reminded itself that Dr Cox had been acquitted of criminal charges arising from the non-clinical facts alleged in this case, and there is therefore a need to proceed with greater caution if differing from the jury's conclusions.

23. The Tribunal noted that some of the evidence had been presented without formal proof and had, therefore, not been subject to cross examination or questioning. It reminded itself that, when considering the weight to attach to such evidence, this should be taken into account.

24. The Tribunal was mindful that it must form its own judgment about the evidence. It noted that it must decide whether to accept or reject such evidence, and where it is accepted, what weight to attach to it.

25. The Tribunal also bore in mind that it should assess and determine each paragraph and sub-paragraph of the Allegation separately. It noted that while it can draw inferences from the evidence, it must not speculate as to any further evidence that has not come before it.

26. The Tribunal reminded itself that it must consider any inconsistencies in the evidence and whether such inconsistencies impact upon the reliability of the evidence or the credibility of the person providing that evidence. It also noted that an allowance should be made in its assessment for the passage of time and the impact that this may have on memories etc.

27. The Tribunal took account of the requirement to give sufficient and clear reasons for its determination.

Previous Fitness to Practise Proceedings / Character

28. The Tribunal noted that it had received in the GMC's cross examination of Dr Cox, evidence of previous Fitness to Practise proceedings involving matters of both a clinical and sexual nature. It noted that a registrant's previous fitness to practise history may potentially be relevant to his credibility and such evidence may be illustrative of a registrant's propensity to act as alleged.

29. The Tribunal noted that Mr Haycroft sought to distinguish the facts of the previous case from those under consideration in this hearing. He stated that, although the previous proceedings related to matters of a sexual nature, the acts involved were entirely consensual in the previous case and they were not similar to those alleged in this instance.

30. In considering this matter, the Tribunal reminded itself that it has not been presented with the full facts of the previous proceedings, the context to the allegations or the findings of the previous Tribunal. From the very limited information it has been given, and as Mr Haycroft has outlined, the issue of consent was not a factor in the previous proceedings and the allegations and findings do not appear to be directly analogous to those in this case. In the circumstances, particularly in light of the limited information given, the Tribunal did not consider that the evidence presented was sufficient to show propensity on the part of Dr Cox to act in the manner alleged in this case.

31. The Tribunal noted that Mr Haycroft submitted that Dr Cox is a person of 'good character'. It reminded itself that evidence of good character is not a defence to an allegation, but it may assist a Tribunal when considering whether the alleged conduct is more likely than not to have occurred.

32. The Tribunal again noted that Dr Cox has had previous fitness to practice proceedings, which had resulted in adverse findings made against him arising from both admissions and contested allegations. Those matters related to both clinical and misconduct matters. The misconduct matters related to sexual impropriety with a patient in a consulting room. In the circumstances as they have been made known to the Tribunal, the Tribunal considered that it was difficult to consider Dr Cox to be a registrant of previous 'good character' for the purposes of these proceedings.

33. However, it reminded itself again that, whereas Dr Cox has previously been found to have committed misconduct of a sexual nature, he has not previously been found to have acted in the manner, or indeed similar manner, to that alleged in this case. In the previous case, the patient was said to have consented to engage in sexual acts with Dr Cox, whereas in this case, Dr Cox is alleged to have masturbated behind Patient A's back. It also reminded itself that Dr Cox has been a qualified doctor for many years, and that the previous allegations are now quite historic, with a significant intervening time lapse during which no further proceedings or findings have occurred. Accordingly, the Tribunal did not consider that it could attach much weight to the issue of character in this case.

The Tribunal's Analysis of the Evidence and Findings

Paragraph 1(a)ii of the Allegation

"1. On 24 May 2017 you consulted with Patient A (the 'Consultation') and you failed to:

a. obtain an adequate medical history from patient A in that you did not:

ii. consider the blood results, including elevated lipid levels;"

34. The Tribunal noted that, in his expert report, Dr F stated:

"The blood tests showed an elevated level of BNP (this may be a feature of cardiac failure) and an elevated level of blood lipids (a risk factor for cardiovascular disease). Dr Cox noted the raised BNP level in his record of the consultation on 24.05.17 and made a referral to cardiology on 27.06.17. My opinion is that this was appropriate. However, Dr Cox did not mention the elevated lipid levels and my opinion is that this falls below the standard expected because lipid levels are a contributor to cardiovascular risk, and elevated levels should be assessed and managed (NICE, 2014). Clinical guidance (NICE, 2014) is that patients with hyperlipidaemia should have blood tests (fasting lipid profile, fasting blood glucose, liver function tests and thyroid function tests), a cardiovascular risk assessment using a formal risk assessment tool, and be given advice on modifiable risk factors (such as smoking and obesity). My opinion is that failure to arrange for these actions to be taken was below the standard expected because cardiovascular risk is medically important."

35. In his oral evidence, Dr F stated that it was incumbent upon Dr Cox to properly review the preceding assessments to include the blood results and to note the elevated lipid levels. He stated that although this was an ongoing matter, it should have been identified by Dr Cox. The Tribunal did not receive any evidence that Dr Cox was not under such a duty. It therefore accepted Dr F's expert opinion that Dr Cox was under an obligation to consider the blood results, including the elevated lipid levels.

36. The Tribunal reminded itself that, at this stage, the Tribunal is not considering whether Dr Cox's actions fell below the standard required of a reasonably competent doctor, only whether a fact as alleged is proved.

37. The Tribunal noted that Dr Cox denies this allegation and stated that he did consider the raised lipid levels. In his written statement, he said the following:

"While I had considered Patient A's medical records and her elevated BP and blood results (noting her lipids were abnormal) I did not obtain an adequate medical history from Patient A. Patient A's consultation with me was part of an ongoing matter. Her high blood pressure had been identified and when someone has already been seen before about a concern, my experience was that they would be unhappy if asked to repeatedly explain the history to their problem. My practice was led by my experience of patient expectations that you will have read and familiarised yourself with their

recent history and that you will then add to it, rather than rehearse what had gone before. I was conscious that I was only part of the longer-term process of reviewing concerns around her high blood pressure."

38. The Tribunal noted that Dr Cox had admitted that he failed to obtain an adequate medical history in that he did not review the actions already taken to assess Patient A's hypertension to identify outstanding issues. It noted the absence of any entry in the notes and records of having considered Patient A's blood levels, to include the elevated lipid levels, as referred to by Dr F. It noted that Dr Cox did not mention elevated lipid levels in the referral to cardiology on 27 June 2017.

39. Taking the available evidence into account, to include Dr Cox's admissions that he failed to obtain an adequate history in other associated respects; the absence of a record having been made; and the fact that raised lipid levels were not mentioned in the referral, the Tribunal considered that it is more likely than not that Dr Cox did fail to consider the blood results, including the elevated lipid levels. Accordingly, it found this paragraph proved.

Paragraph 1(b) of the Allegation

"1. On 24 May 2017 you consulted with Patient A (the 'Consultation') and you failed to:

b. obtain Patient A's verbal consent prior to examining her chest;"

40. The Tribunal accepted Dr F's evidence that Dr Cox was under a duty to obtain Patient A's verbal consent prior to performing a chest examination. It considered that such a duty is self-evident and that Dr Cox himself agreed that this is a well-known and understood requirement of a GP in conducting such examinations.

41. In reaching a conclusion on whether Dr Cox failed to obtain verbal consent, the Tribunal noted that Patient A did not in her evidence dispute that Dr Cox obtained her consent prior to examining her chest and she stated that she understood the examination to be conducted and she permitted it to proceed without hesitation. On the basis that Patient A understood the examination to be conducted and was content for Dr Cox to proceed, the Tribunal considered it more likely than not that Dr Cox had explained his intention and obtained verbal consent to proceed.

42. Accordingly, the Tribunal therefore found paragraph 1(b) not proved.

Paragraphs 1(e) of the Allegation

"1. On 24 May 2017 you consulted with Patient A (the 'Consultation') and you failed to:

e. review Patient A's understanding of the diagnosis of hypertension and the implications in terms of lifelong treatment and monitoring;"

43. The Tribunal considered firstly whether Dr Cox was under a duty to act in the manner in which it was alleged he had failed. It had regard to the oral evidence of Dr F where he stated that reviewing a patient's understanding of diagnosis should be a *'team approach'* which is *'normally done over a series of appointments'*.

44. The Tribunal noted that this was the first occasion on which Dr Cox had encountered Patient A and that she had already been under ongoing care and investigations or treatment in respect of hypertension. It noted that this was a standard 10-minute appointment slot and that Dr Cox was working as a locum.

45. The Tribunal considered that, whilst the Practice was under a duty to ensure Patient A had a clear understanding of the diagnosis of hypertension and the implications in terms of lifelong treatment and monitoring, in the context of Dr Cox's one-off appointment as a locum GP working as part of a wider team, Dr Cox himself was not under a duty that day to ensure understanding in the precise terms of this paragraph of the Allegation.

46. In addition, and although the Tribunal concluded that Dr Cox was not under a duty in relation to paragraph 1(e), it noted the contents of Dr Cox's statement in relation to this paragraph of the Allegation, in which he stated:

> *"I did speak with Patient A about the implications of a diagnosis of hypertension. I discussed with her that her BP was still up and that the tablets she had been taking to date had failed to reduce it. I spoke to her about seeing a Cardiologist and that in the meantime I would provide her with a prescription for some alternative tablets (Losartan and hydrochlorothiazide), that work in different way, given her hypertension.*
>
> *I also discussed with Patient A the importance of exercise and a healthy diet.*
>
> *I explained to Patient A that she would need to continue taking the tablets and that she would continue to be reviewed to check whether they were having an impact. I said to Patient A that she would need to return and see her usual doctor (the senior partner, I was a locum) for monitoring.*
>
> *I did not specifically use the term lifelong, but I did explain to Patient A that she would be under continuing treatment and reviews. I was mindful that by the time the patient had seen me she had been started on treatment for hypertension already, and considered it likely that at the time of instigation of that treatment matters would have been explained to her. I advised her of the planned referral to a cardiologist and in those circumstances it would have been premature to speak to the patient in terms of lifelong treatment. I would not have wanted to overwhelm the patient, but ensure she was on the right path (by referring her) and that she had the right support as she progressed. This was not her final appointment. The patient was to be reviewed and monitored and I was satisfied that she was complying with her treatment. It would therefore have been premature, before the referral, to speak to the patient in terms of*

lifelong treatment and I would have spoken in terms of 'ongoing' treatment and monitoring. This was a conversation to be had, but after Patient A had seen the consultant."

47. The Tribunal considered that, from the available documentary evidence, it is clear that Dr Cox prescribed medication to Patient A and recommended monitoring within one month. The Tribunal therefore accepted that Dr Cox recognised the need for ongoing monitoring and it accepted that it was more likely than not that he would have conferred some information in this respect to Patient A.

48. Taking the available evidence into account, in the overall context of the circumstances prevailing at the time, the Tribunal therefore found paragraph 1(e) of the Allegation not proved.

Paragraph 1(f)i of the Allegation

"1. On 24 May 2017 you consulted with Patient A (the 'Consultation') and you failed to:
f. advise Patient A on the:

i. nature and purpose of the additional drug treatment you prescribed;"

49. The Tribunal accepted Dr F's evidence that Dr Cox was under a duty to advise Patient A on the nature and purpose of the additional drug treatment he prescribed. Indeed, Dr Cox in his evidence agreed that this was the case. Dr Cox stated that he did so advise Patient A.

50. The Tribunal noted that Patient A stated that she cannot remember what Dr Cox said to her regarding the nature and purpose of the additional drug treatment provided. It noted that her recollection of specific discussions during the consultation is not entirely clear, however she did state that the consultation included discussion regarding medications.

51. The Tribunal noted that Dr Cox made an entry in Patient A's notes and records which stated the nature and purpose of the additional drug treatment and he arranged a follow up.

52. In the circumstances, and noting the specific entry in Patient A's notes and records, the Tribunal accepted Dr Cox's evidence. It considered it to be more likely than not that Dr Cox did advise Patient A on the nature and purpose of the additional drug treatment prescribed. Accordingly, it found this paragraph not proved.

Paragraph 1(f)ii of the Allegation

"1. On 24 May 2017 you consulted with Patient A (the 'Consultation') and you failed to:
f. advise Patient A on the:

i. requirement for blood testing to check kidney function after initiation;"

53. The Tribunal had regard to the expert report of Dr F where he states:

> *"Dr Cox's record of the consultation includes the statement "review one month". My opinion is that this was an acceptable arrangement that would allow for review of Patient A's blood pressure and cardiovascular risk factors. Patient A also needed a cardiology referral because of her raised BNP, and a repeat blood test (to check renal function) because of starting ARB treatment. Neither of these is included in the record of the consultation on 24.05.17, but the cardiology referral is actioned by Dr Cox on 27.06.17, and a telephone call is made to Patient by surgery staff on 30.06.17 advising of the need for a blood test. My opinion is that the delay in actioning the referral and the blood tests was below the standard expected because a reasonably competent GP should have actioned these matters within 1-2 weeks."*

54. On the basis of Dr F's evidence, and the fact that arrangements were ultimately made by the Practice to have additional blood testing, the Tribunal accepted that Dr Cox was under a duty to advise Patient A on the requirement for blood testing to check kidney function after initiation of the new medication. The obligation to take such action did not appear to the Tribunal to be contradicted by Dr Cox.

55. In her oral evidence, Patient A said that Dr Cox did not advise her of the need for further blood tests following initiation. She did accept that he had talked to her about new medication.

56. The Tribunal noted that, in his written statement, Dr Cox stated the following in relation to paragraphs 1(f)(i) – (v) of the Allegation:

> *"I accept this allegation. I believe I explained to Patient A the purpose of the additional drug treatment and that she would require testing to see that there was no damage to her liver function.*
>
> *I also discussed with Patient A risk factors including lifestyle factors; her weight, diet and smoking and advised her of the need for a cardiology referral in view of her raised BNP level. I did not mention the sick day rules to Patient A.*
>
> *I therefore accept that I did not explain all of the matters in sub-paragraphs i – v and I acknowledge that because of the way the back examination concluded, Patient A may not have taken on board the details of the advice that I did provide to her. I was doing my best to steer the consultation to safer ground i.e. provide the patient with advice (to avoid having to explain why I needed to wipe her waistband/the floor). However, I was flustered and I accept that any explanation I provided at that time may not have been sufficiently clear for Patient A."*

57. The Tribunal noted that the additional blood testing was not arranged at the time of the consultation or in the two weeks thereafter, which Dr F stated was the period within

which such testing should have been conducted. It noted that the necessary additional testing was not arranged until some five weeks after Patient A's appointment.

58. Taking the available evidence into account, to include the absence of any contemporaneous entry in Patient A's notes and records and the late arrangements for testing, the Tribunal considered that, although Patient A's recollection of the specifics of discussions regarding medication was not always entirely clear, it was more likely than not that Dr Cox did fail to advise Patient A on the requirement for blood testing to check kidney function after initiation.

59. The Tribunal therefore found paragraph 1(f)ii of the Allegation proved.

Paragraph 1(f)iv of the Allegation

"1. On 24 May 2017 you consulted with Patient A (the 'Consultation') and you failed to:

f. advise Patient A on the:

iv. need for a cardiology referral for further assessment of patient A's raised BNP level;"

60. The Tribunal accepted Dr F's evidence that Dr Cox was duty bound to advise Patient A of the need for a cardiology referral for further assessment of her raised BNP level. Indeed, Dr Cox did not dispute that he was under such a duty.

61. Patient A stated that she was shocked to receive a letter informing her of a referral to cardiology; and she telephoned the Practice to enquire as to whether this was a mistake. She stated that she does not recall any conversation about such a referral.

62. Dr Cox stated that he did advise Patient A but that he did not record the need for a referral or his discussion with Patient A in her notes. He stated that he was flustered after the incident which relates to the allegation at paragraph 2(c) / 3; that his notes were not as comprehensive as they ought to have been; and that he made a memo to himself to make the referral at a later time.

63. The Tribunal noted that a referral to Cardiology was not, in the event, made by Dr Cox until 27 June 2017 following the consultation on 24 May 2017.

64. The Tribunal considered that Dr Cox's explanation for this, being that he did not know whether he should do anything further in relation to Patient A following her allegations and until he discussed the matter with a senior partner, to lack credibility. Had Dr Cox felt that he could take no further steps in relation to Patient A, there was no reason why he could not ask another doctor to make the necessary referral. No satisfactory reason was given by Dr Cox for not discussing the referral with the senior partner until he ultimately made the referral at

the end of June. The Tribunal accepted Patient A's evidence that she was shocked by the referral and telephoned the Practice to see if there had been a mistake.

65. The Tribunal was not provided with a copy of the contemporaneous memo which Dr Cox stated he had made.

66. Taking the available evidence into account, to include the significant time lapse between consultation and referral and the absence of a contemporaneous record, the Tribunal considered that it was more likely than not that Dr Cox failed to advise Patient A on the need for a referral to Cardiology.

67. The Tribunal therefore found paragraph 1(f)iv of the Allegation proved.

Paragraph 1(f)v of the Allegation

"1. On 24 May 2017 you consulted with Patient A (the 'Consultation') and you failed to:

f. advise Patient A on the:

v. modifiable cardiovascular risk factors."

68. The Tribunal accepted Dr F's evidence that Dr Cox was obliged to advise Patient A on the modifiable cardiovascular risk factors. It noted that Dr Cox stated in his evidence that he did discuss modifiable cardiovascular risk factors with Patient A and such factors had been referred to in Patient A's notes and records.

69. The Tribunal had regard to Dr F's expert report where he states:

> *"My opinion is that Dr Cox's treatment plan was broadly in line with clinical guidance on the management of hypertension (NICE, 2011) in that he noted the presence of multiple cardiovascular risk factors (hypertension, obesity, smoking, exercise) and gave appropriate lifestyle advice."*

70. The Tribunal noted that Patient A's recollection of specific discussions was not entirely clear and she appeared to accept during cross examination that discussions regarding lifestyle may have occurred.

71. Taking the available evidence into account, in particular the entries in the notes and records which refer to these matters, the Tribunal felt it reasonable to infer that it is more likely than not that Dr Cox did not fail to advise Patient A on the modifiable cardiovascular risk factors. It therefore found paragraph 1(f)v of the Allegation not proved.

Paragraph 1(g)ii of the Allegation

"1. On 24 May 2017 you consulted with Patient A (the 'Consultation') and you failed to:

g. record:

ii. a history of recurrent chest infections;"

72. The Tribunal noted that the primary reasons for Patient A's attendance at the consultation with Dr Cox did not relate to recurrent chest infections. Patient A stated, however, that she did mention that she suffered from recurrent chest infections because she was aware that certain medications which may be prescribed for hypertension can aggravate chest problems.

73. No record was made in Patient A's notes and records regarding this matter.

74. In his witness statement, Dr Cox said the following in relation to paragraphs 1(g)i-vi of the Allegation:

> *"I note that in her witness statement for the GMC that Patient A has said that she had endless chest infections and colds, which is what led to me performing a chest examination. Patient A may have advised me that she had recurrent chest infections, I do not recall."*
>
> *"Admitted. I have failed to make a record of the above matters in the patient's medical notes. I am not clear that I was advised by Patient A of a history of recurrent chest infections and this may explain the absence of it in my note. I was advised of back and neck pain by Patient A and noted she was a hairdresser, which she advised to me when informing me of her back and neck pain. This was information that she volunteered.*
>
> *I accept that my note of this consultation is deficient in a number of respects."*

75. Although paragraph 1(g)ii initially appeared to be admitted by Dr Cox, Mr Haycroft clarified that on the basis that Dr Cox stated that he was not clear that Patient A advised him of a history of recurrent chest infections and because he had no recollection of this, the paragraph was denied.

76. The Tribunal accepted the evidence of Dr F that, if Patient A disclosed this information to Dr Cox during the consultation, he ought to have recorded it in her notes. In his report, Dr F stated:

> *"It is also my opinion that, if the account of the consultation given by Patient in her witness statement of 05.04.19 is accepted, then Dr Cox should have recorded the history of frequent chest infections, as this was the reason for carrying out a respiratory examination. My opinion is that the history recorded by Dr Cox was below the standard expected because he failed to record the outstanding actions needed to complete the assessment of hypertension and failed to record the history of recurrent chest infections."*

Indeed, it did not appear that Dr Cox disputed that such an obligation on his part would exist, had such information had been imparted to him.

77. The Tribunal considered that Patient A's recollection and evidence on this matter was clear and in context to the issues being considered at the consultation. It noted that Dr Cox accepts that his records relating to the consultation are deficient and his evidence was not that this statement was not made, but that he had no recollection of it.

78. Taking the available evidence into account, the Tribunal accepted Patient A's evidence that she did raise the issue of a history of recurrent chest infections. As such, it considered that Dr Cox was under a duty to record that information and that he failed to do so. The Tribunal therefore found this paragraph of the Allegation proved.

Paragraphs 1(h) of the Allegation

"1. On 24 May 2017 you consulted with Patient A (the 'Consultation') and you failed to:

h. seek Patient A's consent to make a referral to Cardiology."

79. The Tribunal noted that in his report Dr F stated that:

> *"On 24.05.17, my opinion is that Dr Cox did not seek consent from Patient to make a referral to cardiology, either explicitly or implicitly (by discussing the reason for referral). My opinion is that this falls below the standard expected because a reasonably competent GP should use a process of shared decision making in the consultation to achieve a mutually acceptable plan of action. However, I do not feel that this failing was seriously below the standard expected because if Patient had questions about the referral she could have sought advice from the surgery and could also have cancelled the appointment if that was her choice."*

80. In his oral evidence, Dr F stated again that Dr Cox was duty bound to seek consent to make a referral; and that referrals can have implications in a number of ways, for example in relation to insurance issues when entries are made in a patient's notes and records.

81. The Tribunal accepted Dr F's expert evidence that consent is required to make a referral to cardiology and that Dr Cox was under a duty to obtain such consent.

82. In his witness statement, Dr Cox stated that he advised Patient A that he would be making a referral and he stated that Patient A did not indicate a difficulty with that. Dr Cox stated that it was not his practice to ask a patient for consent to make a referral, but that it was a matter for the patient as to whether they chose to attend the appointment. In his oral evidence, Dr Cox stated that he will normally say *"I will refer you"* to a patient as a way to obtain consent.

83. In reaching a decision in respect of this paragraph of the Allegation, the Tribunal was mindful of its findings in respect of paragraph 1(f)(iv) as outlined at paragraphs 60 – 67. It noted Dr Cox's own evidence that he does not routinely seek consent to make a referral and its earlier conclusion that, on the balance of probabilities, Dr Cox failed to advise Patient A of the need for a referral to cardiology.

84. In such circumstances, and taking into account its analysis of the evidence in respect of paragraph 1(f)(iv) of the Allegation, the Tribunal considered that it must follow that, on the balance of probabilities, Dr Cox failed to seek Patient A's consent to make such a referral.

85. The Tribunal therefore found this paragraph proved.

Paragraph 2(a)i of the Allegation

"2. During the Consultation you inappropriately examined Patient A in that you:

a. failed to:

i. offer a chaperone;"

86. The Tribunal had regard to the following excerpts from Dr F's expert witness report:

"If the front of the chest is examined, then my opinion is that it is usual in general practice to confine the examination to the upper half of the chest which is exposed by asking the patient to unfasten, or pull down, the top of their clothing at the front. My opinion is that it is not usual for a GP to include the lower part of the front of the chest (the breast area) as part of a respiratory examination. This is because it is difficult to expose and because in female patients' examination of the underlying structures is hampered by the presence of the breasts. It is also more difficult to hear breath sounds due to the position of the heart at the front of the chest and the presence of heart sounds. If there is a specific need to examine the lower part of the front of the chest in a female patient, then my opinion is that a reasonably competent GP should take the following steps: explain the nature and purpose of the examination, seek consent to perform the examination, offer a chaperone (GMC, 2013b) and allow the patient to undress behind a curtain. Examination of the lower part of the front of the chest in a female patient may require lifting each of the breasts in turn in order to be able to examine the underlying chest wall. This process should be explained in advance and consent obtained."

"It is not clear from Patient description the extent to which Dr Cox's examination extended over Patient breasts. My opinion is that if the examination was limited to the upper part of the front of the chest at the level where the amount of breast tissue is small then the examination was appropriate. However, if Dr Cox's examination extended down to the level at which the amount of breast tissue becomes significant, including the nipple area, then my opinion is that this would not have been

appropriate. My opinion is that any examination which involves direct contact with the substantive part of a patient's breasts should be regarded as an intimate examination, and professional guidance (GMC, 2013b) should be followed, including the offer of a chaperone. In addition, there is only limited value in auscultating the lungs over a patient's breasts as it is extremely difficult to hear the breath sounds."

87. The Tribunal accepted that a doctor is not under a duty to offer a chaperone for all chest examinations but is under such a duty if it is intended that the examination will involve contact with the lower area of a female patient's chest and/or contact with the breast area.

88. In his witness statement, Dr Cox said the following in respect of this paragraph of the Allegation:

"Denied. I did not offer a chaperone for the chest examination but I do not accept this was a failing. I did not conduct a breast examination. I am aware of the GMC guidance on chaperones and I did not in this case consider the chest examination to be in intimate examination. I did not believe the patient would consider this to be an intimate examination.

It was my practice to offer a chaperone for intimate, including breast, examinations."

"It is my recollection that I was particularly keen to examine Patient A's cardiovascular system because of the blood test results and the BP and ECG findings. This was because hypertension can cause hypertrophy (the thickening and growth of the muscle) of the heart which can be detected on examination and can itself damage the heart's electrical system and make it difficult for the coronary vessels to adequately supply the muscle."

89. In his oral evidence, Dr Cox accepted that, at the time he decided to conduct a chest examination, he had intended to examine all four areas of Patient A's chest, to include conducting an 'Apex' examination which would involve contact with the breast area and would have required the offer of a chaperone. Dr Cox stated that he decided during the examination that he did not need to proceed with the apex examination in light of his findings from the first three areas of examination and also on the basis that *"there was a lot of tissue in that area and this would have required a chaperone"*.

90. In light of Dr Cox's own evidence, and although he did not in the event proceed to conduct an apex examination, the Tribunal considered that, at the time that he sought consent to conduct the chest examination, Dr Cox was under a duty to offer a chaperone to Patient A. On his own evidence, he did at that time intend to conduct an apex examination. Dr Cox therefore should have offered a chaperone at the outset.

91. The Tribunal therefore found this paragraph of the Allegation proved.

Paragraph 2(a)ii of the Allegation

"2. During the Consultation you inappropriately examined Patient A in that you:

a. failed to:

ii. use an appropriate method of holding a stethoscope."

92. The noted that, in her witness statement, Patient A stated that:

> *"Whilst I was still seated in my chair Dr Cox began to use a stethoscope to listen to the front of my chest by going down the front of the vest top I was wearing. He held the stethoscope in the palm of his hand and sort of cupped the rest of his hand over this so his fingertips and heel of the palm came into contact with my skin along with the stethoscope. I was not wearing a bra so it was skin on skin contact. He moved the stethoscope over each breast around 3 to 4 times on each one for a few seconds each time. He didn't say anything when he was doing this."*

93. In her oral evidence, Patient A stated that Dr Cox was *"squeezing"* her breasts and "*cupping his hand, squeezing down all over my breasts*".

94. Dr Cox stated that he did not hold the stethoscope in the manner alleged and that he performed the examination using an appropriate method. He stated that he did not understand how it would be possible to hold a stethoscope in the manner Patient A described.

95. In reaching a conclusion in relation to this paragraph of the allegation, the Tribunal was reminded that Patient A did not in her account to either the Practice nurse or her statement to police appear to allege that Dr Cox had held his stethoscope in the manner now described. It noted that, although the issue did not feature in her statement to police, the assertion that Dr Cox *'cupped'* her breasts was a feature of Patient A's oral evidence to the Crown Court. However Patient A did not in the Crown Court hearing appear to state that Dr Cox *'squeezed'* her breasts as she did during this hearing.

96. The Tribunal noted that Patient A did not appear to have considered at the time of the examination that it was being improperly conducted and it noted that she permitted Dr Cox to proceed with an examination of her back. It was only after the event, and after making her allegation to the nurse and to police, that Patient A appeared to attach significance to the manner in which the chest examination had been carried out.

97. The Tribunal did not consider that Patient A was being untruthful in her evidence or intentionally seeking to embellish or exaggerate the facts. Whilst it noted that Patient A said that her first account did not contain the full details of what occurred, it considered that the inconsistencies between the various accounts, perhaps caused by the lapse in time or, in Patient A's words *'piecing everything together'* after the event, were such that it did not

believe that it could rely on this particular aspect of her evidence. Accordingly, the Tribunal found paragraph 2(a)ii of the Allegation not proved.

Paragraph 2(b) of the Allegation

"2. During the Consultation you inappropriately examined Patient A in that you:

b. made excessive contact with patient A's breasts on one or more occasions as a result of your inappropriate stethoscope technique; "

98. In coming to a conclusion in respect of this paragraph of the Allegation, the Tribunal was mindful of its decision in respect of paragraph 2(a)(ii). On the basis that it did not find proved the allegation that Dr Cox used an inappropriate stethoscope technique, and in light of the specific wording of paragraph 2(b), the Tribunal considered that this paragraph must also be found not proved.

Paragraph 2(c) of the Allegation

"2. During the Consultation you inappropriately examined Patient A in that you:

c. masturbated behind the back of Patient A while carrying out the examination."

99. The Tribunal noted that in her witness statement Patient A stated:

"Dr Cox then asked me to stand up so he could do a more thorough examination of my back, so I stood up and he was stood behind me. He initially tried to listen to my back but he found this difficult as I was wearing a waistcoat so I took this off and threw it over the chair I had been sitting on.

Dr Cox then began to examine my back with the stethoscope. He had both hands on my back under my top and went from the bottom up to the top and back down, listening. I am very talkative so I was waffling through most of this time about my condition and symptoms etc. I then recall that Dr Cox removed one of his hands from my back whilst one remained on my back. Due to the passage of time I cannot be certain which hand he removed from my back. I then felt a kind of jerking movement behind me and I heard laboured breathing of Dr Cox. Although I didn't want to believe it at the time I am certain that Dr Cox was masturbating behind my back. The noise he was making was just unmistakeable; it was the sound of a male pleasuring himself.

I couldn't feel anything on my back as such but Dr Cox was kind of trembling behind me. I was thinking to myself 'you know what he's doing' but I didn't want to know, I trusted him as a doctor. I was trying to think of any other explanation, but there isn't one. I always thought I would react differently in any situation of this kind, that I would say something or do something but when I was in that situation I couldn't. I just stood there.

It is very hard to explain my thought process at that time as I believe I did know what he was doing but I just didn't want to believe it. I didn't want to turn around to see although now I wish I had as there would be no doubt about what he was doing. I just can't get away from the sound of his breathing and the movements behind me. I know that he could not have been doing anything else.

When Dr Cox finished he said something like 'Oh sorry, I'll just wipe you off' and he wiped the top of my shorts with some paper towel. I believe there would have been no other reason for him to do this other than to remove semen he had got onto my clothing.

I then stepped away from Dr Cox in order to sit back down and I noticed some drops of liquid on the floor which I believe to be semen. I had not noticed these prior to him undertaking the examination on my back. Dr Cox noticed I had seen this and he said sorry and immediately grabbed some paper towel off the examination bed before wiping the liquid off the floor.

I also noticed a spot of liquid around the size of a £2 coin on Dr Cox's trousers, around his fly area. I put my waistcoat back on following the examination before sitting back down.

The appointment finished quite quickly following this incident. I do not recall any conversation about a referral but I am aware Dr Cox says he ordered a scan for me. I went out of the appointment thinking everything was okay with me health wise but I accept I may have just not taken in what Dr Cox was saying to me if he mentioned it following this incident. …"

100. In her oral evidence, Patient A said that while Dr Cox was behind her back, she was thinking *"what on earth is he doing?"*, *"oh gosh no"*, *"oh my goodness, this beggars belief"* and *"this is the weirdest thing I have ever seen"*. She said she was stunned and on being asked what she was doing, she said "*I don't know, I couldn't speak"*. Patient A said that while driving home, she had a *"dreadful feeling, something was wrong"*.

101. In response to questioning by Mr Haycroft, Patient A freely accepted that she did not see Dr Cox's penis at any stage and she did not hear a zipper. She said that she was not listening for a zipper. When asked why she did not turn around when she became suspicious that Dr Cox was masturbating behind her back, Patient A said that she *"just froze"*. When asked why she did not immediately agree to the nurse reporting what she believed had happened, and why she agreed that the fluid on the floor could have been hand gel, Patient A explained that she *"needed time to get my head around it and decide what to do".* She accepted that she was advised by friends to *"follow her gut instinct and report it"*. Patient A told the Tribunal that the experience was "*the most surreal thing";* and that *"It made everything change and I froze. Everything stopped. A most peculiar feeling".* Patient A

accepted that she did not see drops of fluid fall on the floor, as the practice nurse had stated in her police statement.

102. The Tribunal noted that Dr Cox denied having masturbated behind Patient A's back; and, as outlined in his second handwritten statement given to police and his written statement to the Tribunal, stated that he had masturbated in his consultation room in advance of Patient A's appointment and while he was alone in the room which was locked. In his witness statement, Dr Cox said that on the day in question he had been experiencing stress as a result of transitioning into a new workplace, being in negotiations to become a salaried partner and being late to his afternoon shift as a result of being delayed at home. He said that he was worried that he had upset the administrative staff and his patients by being late and that he had a full list of nine or ten patients to see. Dr Cox said that Patient A was the fourth patient to see that afternoon and that his previous consultation had been difficult, with the patient having challenged his advice. He said that this had left him *'rattled'*. Dr Cox stated that:

> *"…Patient A's appointment had been booked in to my list at some point during my other patient attendances in what had been a timetabled free slot. Despite that I was running behind, I felt I needed a "time out". I didn't want to go out to the coffee room as I feared the staff might think I should not be having a break, having started so late. I sought to relieve my stress and tension privately behind a locked door (the consultation room) by masturbating. I accept that this was very ill-advised. I also accept that I should have used this time to catch up with my patient list, but on that day I really felt I needed a break and did not want to be seen taking a liberty in the staff area (which would mean passing by patients) when I was running behind.*
>
> *17 I locked the door to my consultation room and I sat in my swivel chair whilst I masturbated, facing the couch and patient chair. This was an impulsive action and I assumed that I would have some tissue in my pocket. It was only when coming to climax that I realised my assumption was incorrect. I therefore stood up to reach the couch tissue to catch my ejaculate. However, because I had not appreciated I would need to reach for the couch roll, and while I thought I had caught all my ejaculate in the torn off couch tissue, there may have been some spillage of which I was unaware in my rush to tear off some tissue. Nothing was immediately apparent to me, but regrettably I did not check with any diligence. I used the same tear off from the couch to clean myself and my hands. The tissue roll is situated at the head of the bed. There is perforation on the roll, and it is from this roll that I ripped some off to wipe myself.*
>
> *18 I did my zipper up, put the tissue in the bin, and moved to the sink in the room to wash my hands and then dried them using a towel from the rack above the sink. This towel was placed in the same bin. I then used the alcohol hand gel from a hand pump to sterilise my hands which was usually stationed on the edge of the desk next to the patient chair (but could be elsewhere depending on the clinician using the room). When I pumped the hand gel, it did not come out straight, but it instead squirted out in the direction of the patient chair/ couch. I really was not concerned by this, as I was*

just sterilising my hands. Some drops of the hand gel escaped my hands and landed on my trouser front. At that stage, I was not aware of any ejaculate or hand gel on the patient chair or the floor."

"24 May – Patient A consultation with Me

...

29 I have also seen the photographs from Patient A showing her to be wearing a waistcoat/gilet. I have no memory of Patient A wearing a waistcoat, nor of her having to remove it for the chest or back examination. I would not have attempted to listen to Patient A's heart and lung sounds through a waistcoat, nor palpate her back, and cannot see how I could have accessed the patient's back to complete such examinations while she was wearing a thick outer layer. I therefore do not believe that Patient A had a waistcoat on while seated in the patient chair.

...

35 Patient A was approximately 50 years of age at the time of the consultation and as such, she was relatively young for these symptoms to be present. It was important to detect any abnormality and refer her on to the cardiology specialists as soon as possible. That is why I examined her in this way. It was then, during this examination, that Patient A drew my attention to her achy neck and back. I believe she advised me that she was a hairdresser and that they had been troubling her for some time. I do not believe that I asked her about her neck without prompting as Patient A has suggested in her witness statement to the GMC. I note that in her statement to the police it is recorded that it was Patient A that mentioned that she had a stiff neck. Patient A informing me of her back pain and that her neck hurt was unexpected and not her presenting complaint but I nevertheless dealt with the additional issue as she was expressing how troublesome it was.

36 As a result of her complaint, I decided I needed to palpate Patient A's spine from the thoracic spine down, through to the lumbar spine. I believe I said to Patient A something like; "Shall we have a look at your back then?" and she agreed. At this point, she stood up and walked two steps forward to allow me space behind her and lifted her shirt slightly. Again, I have no memory of Patient A wearing a waistcoat and having to remove it for the examination. I would not have attempted to palpate through a waistcoat.

37 For the examination, I was standing facing the window, behind Patient A who was also facing the window. I had moved so that I was between Patient A and the patient chair. My desk was ahead of me, to my left.

38 My standard practice is to palpate the spine by using both hands, pressing on each vertebra in turn (on the left and then the right and then the left and then the right), having asked the patient to advise me if this causes any pain. Patient A was standing and facing away from me. To facilitate the examination Patient A slightly lifted her top at the back to allow me to palpate her spine. I cannot recall now if I asked her to adjust her clothes, but it was evident to both of us that this would need to happen for

the examination (to allow me to visualise her back). At some point during the palpation I asked Patient A where the pain was and I asked her to point this out me.

39 It was as I was pressing down Patient A's back when I saw some staining on Patient A's waistband (roughly around the centre of the lumbar spine). This sent my mind into a panic and I was concerned there may have been some drops of fluid on the chair. I feared that the spots of fluid were my ejaculate because I had been acting in such a hurry prior to the consultation with Patient A. I also worried that the stain could be the cleaning gel. Either substance could have been transferred onto Patient A's clothes from the couch or the chair. I did not know how I could make it better without worrying Patient A. It was for this reason that I tried to wipe the chair/couch with tissue from the white couch roll without saying anything to alarm Patient A. I did this whilst her back was turned. With one hand (the other remaining on Patient A's back so as not to alert her) I tugged a section of the white couch roll, which was within touching distance behind me, and wiped it over the chair/ couch first assuming the stain had come from where Patient A had sat, as well as the adjacent couch in case there was a trace of fluid or gel there. I did this without needing to detach a section of the couch roll.

40 In that moment, I decided to attempt to also clean the stain from Patient A's waistband. I realised that I would need to actually detach the piece of tissue from the roll if I were to be able to reach Patient A's waistband, as I could not easily extend the roll to reach the affected area. I had tugged the roll but the tissue attached to the roll would not reach as far as her back.

41 The roll of tissue on the examination couch is wide and quite difficult to tear off with one hand. The paper roll is at the far end of the couch and the towel then has to pass across the pillow and down across the bed, with there being friction created by the surfaces it passes across. It therefore takes an effort to pull the roll down. I made swift movements in tugging/pulling at the roll, hoping it would tear at the point of perforation. This may have been the jerking feeling that Patient A described. However, it is likely that the rubbing of the chair/couch may have caused her initial concern. In doing so I would have used my left hand, as I am left handed, and my right hand would have remained on her back. In the event, I needed to remove my right hand from Patient A's back and turn slightly to face the couch in order to use both my hands to seize and tear free a piece of tissue.

42 When I pressed the tissue onto her waistband I suppose Patient A assumed the examination was over and turned around whilst tucking in her top. I believe I may have made a comment to Patient A at this time, I cannot be sure. It was however at this point I noticed the drops on the floor and crouched down with the wad of tissues to wipe them up. I cannot recall how many sheets of perforated tissue I detached; it could be one or two. I remember I was flustered, anxious and feeling guilt-ridden about my actions before she entered the consultation room.

43 Patient A did not say anything as I was wiping the floor, but I noticed her looking at me. She saw me putting the tissue onto the two to three drops on the floor. I recall that I said something to Patient A to attempt to reassure her about what was going on, but I cannot recall the exact words I used. I was flustered, and I was too embarrassed to suggest to Patient A a reason for 'cleaning up'. I placed the tissues in the bin before taking a seat back at my desk.

44 I note that Patient A has said that I was breathing deeply. I was not aware that I was doing this. I was however flustered and so my breathing may have increased, including when I was tugging to tear the couch roll. I was desperate to try and clear up so that Patient A would not suspect that I had masturbated in my consulting room, never did I appreciate that she might misinterpret my actions to believe that I would perform such an act on her. I am very sorry that Patient A was left with this impression.

45 I placed the used tissue in the waste bin in the consulting room, which the police later seized, and took a seat at my desk. I then summarised the consultation with Patient A when we were both seated. I was mainly concerned to reassure her and return to the conversation about her blood pressure control, new treatment and referral for further tests. I advised her that I had heard a heart murmur and I spoke to her about being seen by doctors in hospital to look at her heart.

...

47 I still do not know whether the fluid I saw on Patient A's waistband was part of my ejaculate or the hand gel. I did not masturbate and neither did I ejaculate whilst Patient A was in the consulting room. My actions before Patient A entered the room were wholly inappropriate.

48 When the police came to the practice later that evening and seized the contents of my bin, I had assumed that whatever allegation had been made, it was most likely to have been made by Patient A. This was because of my act that preceded her consultation and the horror of seeing the stain on Patient A's waistband and the fluid on the floor, and me being flustered and worried that she had identified the fluid as ejaculate and the mess I made of clearing up. When I had wiped the fluid on the floor my eyes met with Patient A's and I did not provide her with any proper explanation for what I was doing. I was feeling guilty about my earlier act and that there was possible seminal fluid on her and/or the floor. In my mind I convinced myself that she had guessed what I had done, by which I mean that I had inappropriately masturbated in my consultation room and not cleaned up. I thought that she may have seen or smelt something. I did not appreciate at that stage it was being alleged that I performed such an act while the patient was present (that was not made clear to me until I was interviewed by the police). Because the police had taken the contents of the bin, I was more convinced that it was Patient A that had complained to the police. I could not think of any other reason why the police would be interested in the contents of the bin, all other consultations that day were unremarkable.

...

50 I remain acutely embarrassed and ashamed of my actions. I accept it was entirely inappropriate to masturbate in such an environment. I have never done so before or since. I am also very sorry that Patient A had cause to come into contact with any sexual fluids and indeed that she came to misunderstand what had happened and feel that she had been violated."

103. In his oral evidence, Dr Cox denied that he has a penchant for sexual activity in the workplace and stated that he has a great interest in helping people. Dr Cox stated that it was not a common practice for him to masturbate at work and that he could recall having done so on only one other occasion which, he said, was during a period of stress caused by family bereavement.

104. Dr Cox said that he was stressed on the day in question and that this was definitely related to his difficult consultation with the patient he saw immediately prior to Patient A. He said that he did not feel that he could leave the room to, for example, get a coffee to de-stress, because staff and patients would have seen that and would have *'found that inexplicable'* given he was running behind. Dr Cox stated that, had a toilet been adjacent to the consultation room, he would have gone there to masturbate instead of using the consultation room.

105. When asked whether he had checked the floor for semen or hand gel prior to his consultation with Patient A, Dr Cox stated that he didn't expect to see it there and that he thought it had been contained. He stated that he did not check the patient chair.

106. Dr Cox stated that he was aware that Patient A was not wearing a bra during his consultation with him, but that he was not aroused by that and this was '*not on* [his] *mind'*. He stated that he does not get aroused by things like that as this was a serious setting. Dr Cox denied being sexually excited during the consultation and stated that he '*had no interest in this woman sexually at all*'. He said that the back examination lasted about 45 seconds to one minute; but accepted in re-examination by Mr Haycroft that he had previously said that it had lasted a maximum of 2 minutes. Dr Cox denied that he had any intention to gratify himself during the examination of Patient A's back and he denied having masturbated at that time, stating that '*it would have been absolute madness to have done that*'.

107. Dr Cox stated that he was panicked that his ejaculate might have been on Patient A's clothes and he accepted that he may have said '*I'll just wipe you off'* to Patient A and that he may have said '*sorry*' to her as he said he is *'generally pretty apologetic'*. Dr Cox said that he didn't think that he was breathing heavily and that he thought that he was breathing normally. He accepted that his ejaculate was on Patient A's shorts but stated that he did not know how it got there.

108. When asked whether the consultation as he had described would be likely to cause a patient to suspect that a doctor had been masturbating, Dr Cox replied *'no, definitely not'* but he said that Patient A had seen some drops of fluid on the floor.

109. The evidence quoted and referred to is a summary of that received by the Tribunal. The Tribunal, as indicated previously, has taken into account all of the evidence presented in addition to the parties' submissions.

110. The Tribunal noted that Patient A and Dr Cox recounted two materially different versions of events, both of which could be considered to be very unlikely to occur.

111. The Tribunal considered that, whereas there is some evidence of inconsistency in Patient A's various accounts (some of which has been referred to in relation to other paragraphs of the Allegation), her evidence relating to the examination of her back and her belief that Dr Cox masturbated behind her back as given in her account to the Practice Nurse, police statement, evidence to the Crown Court and to the Tribunal, has been largely clear and consistent throughout. The Tribunal considered Patient A to be a truthful witness and it did not consider that she was attempting to embellish or exaggerate her evidence. Indeed, it was specifically stated by Mr Haycroft that he was not suggesting that Patient A was being untruthful.

112. The Tribunal reminded itself that Patient A's impression and belief that Dr Cox masturbated behind her back was just that – her impression and belief. It reminded itself of the need to identify cogent evidence before finding the allegation proved, and of the need for a heightened examination of the evidence in light of the jury verdict.

113. The Tribunal noted that Dr Cox had also been largely consistent in his account from the time he gave his second written statement to police. Whereas there was evidence of some inconsistency between the accounts given, for example in relation to his recollection of Patient A's waistcoat, or the length of time of the examination of Patient A's back, the Tribunal did not consider that such inconsistencies were of great assistance in considering this paragraph of the Allegation, when the effect of lapse of time etc on memories is taken into account.

114. In reaching a conclusion in respect of this paragraph of the Allegation, particularly when Patient A was clear that she did not actually see Dr Cox masturbate behind her back, the Tribunal was assisted by the contents of the Practice nurse's statement to police. The Tribunal reminded itself that the nurse had not been subject to examination / cross-examination / tribunal questions etc, however it also reminded itself that the statement was admitted by agreement of the parties following enquiry by the Tribunal itself and, again in response to Tribunal enquiry, there was no dispute or caveat highlighted by either Mr Haycroft or Mr Breen in relation to its contents.

115. The Tribunal noted that the Practice Nurse's statement confirmed that, upon leaving the consultation room and being spoken to by the Practice Nurse, Patient A immediately asserted that she thought that Dr Cox had just masturbated behind her back. The allegation was made without an opportunity to ruminate on the consultation or discuss the matter with friends or family. It was Patient A's clear impression at the time of the consultation that Dr Cox had masturbated behind her back and this impression was not tainted by post-event

influence or thought process. The Tribunal noted that Patient A made the assertion to the Practice nurse prior to forensic analysis of her shorts and therefore without knowing whether semen was present. She formed this impression/belief prior to smelling her clothing and believing them to smell of semen. Although it was clear that Patient A has considered and re-considered the events in question (as is inevitable given that she has now given several accounts in several different forums and contexts) the Tribunal did not consider that *'confirmation bias'* or *'hindsight'* could be said to have distorted her perception or evidence in relation to this paragraph of the Allegation, as submitted by Mr Haycroft. Patient A's respective accounts on this matter have been largely consistent from the time she left the consultation room. A verbal police statement was made the same day, which was then reduced to writing by police, and signed by Patient A on 21 June 2017.

116. The Tribunal considered that Patient A was clear in her evidence that she felt a *"jerking movement"* behind her and heard Dr Cox's *'laboured breathing'*. In her oral evidence she stated that this continued for *'a few minutes'*. At a later stage, Patient A said the back examination lasted *'possibly eight – ten minutes'*, before accepting that it may have lasted less than that, *'maybe 5 – 10'*. Dr Cox indicated that the examination may have lasted up to two minutes, however when this was put to Patient A, she stated that it was *'longer than that'*. Although Patient A's evidence on the duration of the back examination was not entirely consistent (as was the case with Dr Cox's account, to a lesser extent), the Tribunal did not consider that Patient A was seeking to embellish or exaggerate the length of time taken; but that she was having difficulty estimating with any accuracy.

117. The Tribunal accepted Patient A's evidence that it was Dr Cox's breathing and the jerking motions which initially caused her to suspect that Dr Cox was masturbating. While being careful not to reverse the burden of proof onto Dr Cox to prove or disprove any matter, the Tribunal considered that it is extremely unlikely that the motion of tearing paper roll – which could last only a matter of seconds – would, of itself, reasonably give rise to a suspicion in any patient's mind that a doctor was masturbating during a consultation.

118. The Tribunal noted that Patient A initially stated to police that Dr Cox removed his right hand from her back while leaving his left hand in place. It noted that Patient A subsequently stated in her written statement that she cannot now be sure which hand he removed, but then stated in her oral evidence again that it was his right hand. The Tribunal noted that Dr Cox stated that his dominant hand is his left hand and that would be the hand he would use to masturbate. Further, Dr Cox stated that it was, in fact, his left hand which he removed from Patient A's back. The Tribunal considered that Patient A may or may not have been wrong initially about which hand was removed from her back but that it was not possible to determine one way or the other. Further, the Tribunal did not consider that the issue was of material importance either way. Both Patient A and Dr Cox agree that one hand was removed from Patient A's back. On Dr Cox's version of events, it was his dominant hand which he ordinarily uses to masturbate. Patient A's evidence was not clear on the point, but even if it was Dr Cox's right hand, the Tribunal does not have evidence to conclude that that hand would or could not be used to masturbate. Further, the Tribunal did not consider that

Patient A's evidence, having changed in this respect between her written statement and the hearing, was such that it undermined her account or credibility generally.

119. The Tribunal noted and considered it relevant that the existence of fluid on the floor was noticed by Patient A after her suspicion had been aroused that Dr Cox was masturbating behind her back. The same is true in respect of Dr Cox having wiped Patient A's shorts – she already had formed a suspicion by reason of the jerking motion and breathing. Patient A had already formed the suspicion prior to seeing the stain (whether hand gel or semen) on Dr Cox's trousers; and prior to smelling her shorts after leaving the surgery. The Tribunal considered the fact that Patient A's evidence in her police statement on the number of drops ('seven or eight') slightly differed when compared with what she told the Crown Court ('a couple of drops') was not of particular significance. The fact is, both Patient A and Dr Cox state that drops of fluid (whether seminal fluid or hand gel) were on the floor. To the extent that there was any inconsistency, the Tribunal did not consider that Patient A's evidence or credibility overall were undermined. The Tribunal formed the same view in relation to the practice nurse's account that Patient A had said that drops of fluid fell on the floor. It reminded itself that it had not heard directly from the practice nurse on this point and in particular the specific or precise words used by Patient A.

120. The Tribunal noted that both Patient A and Dr Cox stated that Dr Cox became flustered during the examination of Patient A's back. It considered that such demeanour could potentially be consistent with either version of events under consideration.

121. The Tribunal noted that, following forensic analysis, seminal fluid was, in fact, detected on Patient A's shorts and that it was accepted that this was Dr Cox's seminal fluid. It noted that Dr Cox's semen could have transferred to Patient A's clothing as a result of either version of events and that the following was said to be agreed for the purposes of the Crown Court trial:

> *Coming back to the admissions then, admission number nine, the forensic scientist has concluded as follows, the seminal fluid on the complainant's shorts, JAC06, could have originated from either the shorts being in direct contact with another object or surface with wet seminal fluid on it, or to if the defendant masturbated in the presence of the complainant and part of his ejaculate landed directly on the shorts during masturbation. … (c) The findings could be explained by the defendant either ejaculating prior to his consultation with the complainant and his seminal fluid transferring to her during it, or him ejaculating during the consultation. (d) Scientifically the forensic evidence is neutral on to which of those two possibilities, effectively the possibilities in (c) may apply.*

122. The Tribunal took account of the fact that Patient A had not on leaving the consultation room intended to speak to the Practice nurse; she was reluctant to make a formal complaint; and she did question in her own mind whether she had been right. However, it did not consider that these matters undermined her evidence of her impression of what occurred during the consultation with Dr Cox. The Tribunal considered that this could

be said to be consistent with the feelings of shock and confusion that she had articulated. It considered that Patient A reasonably questioned her own judgement of the highly unusual event she had just experienced.

123. The Tribunal did not consider that it could attach any weight to the fact that Dr Cox had not disposed of the tissues from the bin in determining this paragraph of the Allegation. It did not accept that *'this alone disproves the GMC case'* as submitted by Mr Haycroft. The Tribunal considered that there could have been any number of reasons why the tissues may not have been disposed of.

124. The Tribunal did not consider that it could make an assessment of why Dr Cox would *'pick'* Patient A, nor indeed when the alleged action was decided upon.

125. Taking all of the available evidence into account, being acutely conscious that the burden of proof rests with the GMC, and while acknowledging the Crown Court jury acquitted Dr Cox when applying the higher standard of proof, the Tribunal considered that on the balance of probabilities, it is more likely than not that Dr Cox masturbated behind Patient A's back while carrying out the examination. It considered that the available evidence supported the version of events alleged by the GMC. It therefore did not accept Dr Cox's evidence in relation to this paragraph of the Allegation.

126. The Tribunal therefore found this paragraph proved.

Paragraph 3 of the Allegation

"3. In the alternative to paragraph 2.c you masturbated in your GP surgery before the Consultation."

127. In light of its findings in relation to the alternative paragraph 2(c) of the Allegation, the Tribunal did not find this paragraph proved.

Paragraph 4 of the Allegation

"4. Your actions as described at paragraph 2 and/or 3 were sexually motivated."

Paragraph 2(a)(i) of the Allegation

128. In considering whether Dr Cox's failure to offer a chaperone was sexually motivated, the Tribunal reminded itself of its findings in respect of paragraphs 2(a)(i), (ii), and (b). It noted that it had determined that Dr Cox was under a duty to offer a chaperone in light of his intention to carry out all four areas of heart examination, to include an apex examination.

129. The Tribunal noted, however, that Dr Cox had not actually proceeded to perform an apex examination, which would have involved contact with Patient A's breast, and it was reminded that it did not find that Dr Cox used an inappropriate method of holding a

stethoscope or make excessive contact with Patient A's breasts as a result of such inappropriate technique. Taking the available evidence into account, the Tribunal did not consider that it had been proved that Dr Cox's failure to offer a chaperone was sexually motivated.

Paragraph 2(c) of the Allegation

130. The Tribunal considered that the act of masturbation is by its very nature sexually motivated. Accordingly, the Tribunal considered that it was bound to find this paragraph, as it relates to paragraph 2(c), proved.

The Tribunal's Overall Determination on the Facts

131. The Tribunal has determined the facts as follows:

1. On 24 May 2017 you consulted with Patient A (the 'Consultation') and you failed to:

    a. obtain an adequate medical history from patient A in that you did not:

        i. review the actions already taken to assess Patient A's hypertension to identify any outstanding issues;
        Admitted and found proved

        ii. consider the blood results, including elevated lipid levels;
        Determined and found proved

    b. obtain Patient A's verbal consent prior to examining her chest;
    Determined and found not proved

    c. carry out and/or arrange for:

        i. a cardiovascular risk assessment using a validated screening tool;
        Admitted and found proved

        ii. a urine analysis for protein and blood;
        Admitted and found proved

        iii. blood tests covering:

            1. fasting lipid profile; **Admitted and found proved**

            2. fasting blood glucose; **Admitted and found proved**

            3. liver function test; **Admitted and found proved**

4. thyroid function test; **Admitted and found proved**

d. action within one to two weeks of the consultation:

   i. a referral to Cardiology; **Admitted and found proved**

   ii. repeat blood tests to check renal function; **Admitted and found proved**

e. review Patient A's understanding of the diagnosis of hypertension and the implications in terms of lifelong treatment and monitoring; **Determined and found not proved**

f. advise Patient A on the:

   i. nature and purpose of the additional drug treatment you prescribed; **Determined and found not proved**

   ii. requirement for blood testing to check kidney function after initiation; **Determined and found proved**

   iii. need to follow 'sick day rules' to avoid acute kidney injury; **Admitted and found proved**

   iv. need for a cardiology referral for further assessment of patient A's raised BNP level; **Determined and found proved**

   v. modifiable cardiovascular risk factors. **Determined and found not proved**

g. record:

   i. the outstanding actions needed to complete the assessment of hypertension; **Admitted and found proved**

   ii. a history of recurrent chest infections; **Determined and found proved**

   iii. the reasons for carrying out a chest examination; **Admitted and found proved**

   iv. your findings from the examination of Patient A's chest; **Admitted and found proved**

v. elevated lipid levels in Patient A's blood test results;
Admitted and found proved

vi. having carried out the actions set out in paragraph 1.a – c, 1.e, 1.f.
Admitted and found proved

h. seek Patient A's consent to make a referral to Cardiology.
Determined and found proved

2. During the Consultation you inappropriately examined Patient A in that you:

a. failed to:

i. offer a chaperone; **Determined and found proved**

ii. use an appropriate method of holding a stethoscope.
Determined and found not proved

b. made excessive contact with patient A's breasts on one or more occasions as a result of your inappropriate stethoscope technique;
Determined and found not proved

c. masturbated behind the back of Patient A while carrying out the examination.
Determined and found proved

3. In the alternative to paragraph 2.c you masturbated in your GP surgery before the Consultation. **Determined and found not proved**

4. Your actions as described at paragraph 2 and/or 3 were sexually motivated.
Determined and found proved in relation to paragraph 2(c)

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

Determination on Impairment - 11/06/2021

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

133. Having delivered its decision on the facts in this case ('the Substantive Case'), the Tribunal was made aware that it was being requested to conduct a review of an entirely separate case ('the Review Case') in which Dr Cox's fitness to practise had been found to be

impaired as a result of misconduct and in respect of which Dr Cox has been subject to an order of suspension. The request was made by agreement of both parties.

134. The Tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act):

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

Background to the Review Case

135. Dr Cox was referred to a fitness to practise Tribunal ('the 2020 Tribunal') which heard allegations of misconduct relating to consultations between Dr Cox and five individual patients. The case began in February 2020 and concluded in November 2020. The 2020 Tribunal outlined the background to the allegations in that case as follows:

> *"2. The allegations which have led to Dr Cox's hearing relate to concerns raised in relation to consultations with four patients whilst he was working for Integrated Care 24 Ltd ('IC24') as a sessional self-employed out-of-hours GP. IC24 is an organisation which provides primary care services from a number of Primary Care Centres in South East England. The initial concerns were raised with the GMC on 30 August 2017 via a referral from NHS England. In the referral, NHS England confirmed that they were carrying out an investigation in relation to historic concerns raised by IC24. The concerns related to consultations consisting of two home visits made whilst Dr Cox was working as an out-of-hours GP (Patient A, who was seen in January 2013, and Patient C, who was seen in October 2016), one telephone consultation made whilst working as an out-of-hours GP (Patient D, who was seen in January 2017) and one daytime home visit made whilst working as a 'roving GP' (a service provided whereby an IC24 GP carries out a day-time home visit on behalf of another GP) (Patient B, who was seen in December 2015).*
>
> *3. A subsequent complaint was made by Patient E following a surgery consultation which took place on 19 May 2017 whilst Dr Cox was working at a daytime GP surgery; The Quintin Medical Centre in Hailsham."*

136. In respect of Patient A, Dr Cox admitted that he:

- failed to obtain details of Patient A's existing medication and past medical history;
- failed to measure Patient A's respiratory rate and oxygen saturation;
- prescribed inappropriate medication;
- failed to record a diagnosis of possible Atrial Fibrillation and any advice given to Patient A or Patient A's son.

137. In respect of Patient B, Dr Cox admitted that he:

- failed to take an adequate medical history in a number of respects;
- prescribed inappropriate medication, failed to consider associated risks, and failed to advise Patient B on the manner in which medication was to be taken; and
- failed to make appropriate records, to include that he had referred Patient B to the Rapid Response Nursing Team.

138. In addition, the 2020 Tribunal determined that Dr Cox failed to record other relevant matters.

139. In respect of Patient C, Dr Cox admitted that he:

- failed to obtain an adequate medical history in a number of respects;
- failed to consider a possible diagnosis of intestinal obstruction, examine Patient C's abdomen or arrange for an urgent visit by another doctor;
- inappropriately administered injections and an enema; and
- failed to ensure that an accurate record was made.

140. In respect of Patient D, Dr Cox admitted a number of failings during a telephone consultation which included failing to ask to speak directly to Patient D or establish whether Patient D consented to him speaking to Patient D's wife; and failing to take an adequate history in several respects.

141. In respect of Patient E, Dr Cox admitted that he:

- failed to take an adequate medical history in a number of respects;
- failed to adequately examine Patient E or put in place an appropriate management plan;
- failed to explain why a referral to rheumatology was not being made; and
- inappropriately suggested Patient E's symptoms could be caused by ME or Fibromyalgia.

142. The 2020 Tribunal considered that Dr Cox's actions in relation to Patients A and C amounted to serious misconduct, as his care of those patients fell seriously below the standard expected of a reasonably competent medical practitioner. It then went onto consider whether Dr Cox's fitness to practise was impaired as a result of the misconduct in relation to Patient A and Patient C. The 2020 Tribunal was satisfied that Dr Cox's conduct was such that it was capable of remediation. It noted that Dr Cox had some insight into his misconduct, as evidenced by his reflective statement and his oral evidence. However, the 2020 Tribunal determined that Dr Cox's remediation was not yet complete. It noted that Dr Cox had not at that time worked in a clinical setting for over three years and, given this, he has been unable to apply his reflections and learning in a clinical setting. As such, the 2020

Tribunal determined that that there remained a risk of repetition and found that Dr Cox's fitness to practise was impaired.

143. The 2020 Tribunal determined that a period of suspension was the appropriate and proportionate sanction to protect public confidence in the profession and promote and maintain proper standards of conduct and behaviour. In arriving at its decision, the 2020 Tribunal noted that although Dr Cox had identified improvements he needs to make, such remediation had not been evidenced as embedded into his practice. The Tribunal determined that six months would be sufficient to reflect the gravity of Dr Cox's misconduct.

144. The 2020 Tribunal directed a review of the case and informed Dr Cox that a reviewing Tribunal would be assisted by the following:

- *"Evidence of what he has been doing during his six-month suspension;*
- *How he has kept his clinical knowledge and skills up to date;*
- *Further reflections and plans on how these would become embedded into his practice;*
- *Dr Cox will also be able to provide any other information that he considers will assist."*

The Evidence – Substantive Case

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

The Evidence – Review Case

146. In addition to the evidence considered in the substantive case, the Tribunal received the following for the purposes of reviewing Dr Cox's previous case:

- Determinations from the hearing; and
- Evidence considered by the 2020 Tribunal.

Submissions – Substantive Case

Submissions on behalf of the GMC

147. In brief submissions on behalf of the GMC, Mr Breen stated that it is clear and apparent that there has been misconduct on behalf of Dr Cox. He submitted that it is clear that Dr Cox's fitness to practise is impaired by reason of the severity of the paragraphs of the Allegation that have been found proved, in relation to clinical matters and other matters.

Submissions on behalf of Dr Cox

148. On behalf of Dr Cox, Mr Haycroft submitted that the Tribunal might consider that the clinical failings, in combination, do amount to misconduct as they fall below the standards

expected of a competent clinician. However, he submitted that if these were the only matters the Tribunal was considering, it may well not find impairment on the clinical matters alone. With regard to the fact found proved that Dr Cox masturbated behind Patient A's back during a consultation, Mr Haycroft submitted that, although this appeared from the Tribunal's determination to have been considered to be a spontaneous and unplanned act, the Tribunal may consider that it leads to a finding of impaired fitness to practise.

Submissions – Review Case

Submissions on behalf of the GMC

149. In brief submissions on behalf of the GMC, Mr Breen stated that there has been no change in Dr Cox's circumstances, he has not worked in a clinical capacity since 2017 and his actions remain un-remediated. Mr Breen submitted that Dr Cox's fitness to practise is impaired by reason of both his current and previous misconduct.

Submissions on behalf of Dr Cox

150. In brief submissions on behalf of Dr Cox, Mr Haycroft agreed that that there has been no change in Dr Cox's circumstances, he has not remediated, and the Tribunal is likely to find current impairment.

The Relevant Principles – Substantive Case

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

152. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct which was serious; and, if so, whether such misconduct leads to a finding of impairment.

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

The Relevant Principles – Review Case

154. The Tribunal again reminded itself that at this stage of proceedings, the decision on impairment is a matter for the Tribunal's judgment alone.

155. The Tribunal must determine whether Dr Cox's fitness to practise is impaired today, taking into account his conduct at the time of the events and any relevant factors since then

such as whether the matters are remediable, have been remedied, likelihood of repetition and insight shown.

156. The Tribunal reminded itself that in a review case there is a persuasive burden on a doctor to demonstrate that he or she is fit to resume unrestricted practice.

The Tribunal's Determination on Impairment – Substantive Case

Misconduct

157. The Tribunal first noted that the paragraphs of the Allegation found proved could be divided into those relating to either clinical or sexual misconduct matters.

158. In considering whether the clinical matters amounted to misconduct which was serious, the Tribunal reminded itself of the duties of a doctor registered with the GMC as outlined in Good Medical Practice (2013) ('GMP') and it considered that the following paragraphs of GMP were engaged and had been breached by Dr Cox:

> *'1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date …*
>
> *7. You must be competent in all aspects of your work, including management, research and teaching.*
>
> *15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> > ***a** adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> >
> > ***b** promptly provide or arrange suitable advice, investigations or treatment where necessary*
>
> *…*
>
> *16. In providing clinical care you must:*
>
> > ***a** prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs …*
>
> *17. You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment…'*

19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

21. Clinical records should include:

a *relevant clinical findings*
b *the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
c *the information given to patients*
d *any drugs prescribed or other investigation or treatment*
e *who is making the record and when*

32. You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.

47. You must treat patients as individuals and respect their dignity and privacy'.

159. The Tribunal noted Dr F's expert opinion that the following (individually) fell below, but not seriously below, the standard expected of a reasonably competent doctor:

- The history recorded by Dr Cox;
- Failing to mention Patient A's elevated lipid levels;
- Failing to arrange for blood tests or a cardiovascular risk assessment;
- Failing to refer to cardiology within 1 – 2 weeks or arrange for repeat blood tests to check renal function;
- Failing to record a history of recurrent chest infections
- Failing to obtain consent for a referral to cardiology;
- Failing to appropriately respond to Patient A's raised BNP level;
- Failing to record the reason for carrying out a chest examination;
- Failing to make an adequate record of his consultation with Patient A.

160. The Tribunal noted Dr F's expert opinion that the following (individually) fell seriously below the standard expected of a reasonably competent doctor:

- Failing to communicate with Patient A regarding the drug treatment, need for blood testing, need to follow 'sick day rules', and the need for a referral to cardiology;
- Failure to carry out a urine analysis;
- Failing to arrange for a cardiovascular risk assessment.

161. The Tribunal noted that, although Dr F considered some matters to be below the standard required, and others to be seriously below, he opined that:

'My opinion is that the overall standard of care provided by Dr Cox to Patient [A] *was seriously below the standard expected of a reasonably competent general practitioner. This is because Dr Cox failed to ensure that important elements of the assessment process for newly detected hypertension were carried out and failed to communicate adequately with Patient* [A] *in terms of the implications of her diagnoses and the arrangements needed for monitoring and follow up. Hypertension is an important risk factor for cardiovascular disease and requires careful assessment, management and follow up and my opinion is that by failing to follow clinical guidance (NICE, 2011) and by failing to communicate adequately Dr Cox placed Patient* [A] *at risk of harm.'*

162. The Tribunal noted that it had found a relatively large number of failings on the part of Dr Cox and that these failings had the potential for serious consequences for Patient A. It also noted that the failure to offer a chaperone, even in circumstances in which the Tribunal had not found sexual motivation, had the potential to undermine trust in the profession and was of itself a serious failing on the part of Dr Cox. The Tribunal agreed with the views of Dr F and it considered that, collectively, Dr Cox's actions fell seriously below that which is expected of a reasonably competent doctor and it amounted to misconduct which was serious.

163. In considering whether its findings in respect of paragraph 2c of the allegation – masturbating during the consultation behind Patient A's back - amounted to misconduct which was serious, the Tribunal considered that the following paragraphs of GMP were engaged and had been breached by Dr Cox:

'47. You must treat patients as individuals and respect their dignity and privacy.

53. You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.

65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession'.

164. The Tribunal noted and agreed with Dr F's expert opinion that:

'On 24.05.17, if the account given by Patient [A] *in her witness statement is accepted, and if Dr Cox masturbated behind Patient* [A] *whilst continuing an examination of the back of her chest, then my opinion is that this was utterly inappropriate and seriously below the standard expected. This is because masturbation in this context is a serious distraction from clinical care; raises issues of hygiene and infection control; and would place Patient* [A] *at significant risk of psychological distress and trauma.'*

165. The Tribunal considered that Dr Cox's conduct as found proved was clearly misconduct which was serious. The act of masturbating behind the back of a patient during a consultation is utterly reprehensible and a serious breach of the trust a patient places in a

doctor. It brings the profession into disrepute, undermines public confidence, and falls far short of the standards required.

Impairment

166. Having found that the facts found proved do amount to misconduct which was serious, the Tribunal went on to consider whether, as a result, Dr Cox's fitness to practise is currently impaired.

167. The Tribunal considered that Dr Cox's clinical misconduct was potentially remediable, but it has not been remediated. It considered that Dr Cox has shown some limited insight and remorse into his clinical misconduct in respect of those matters which he had admitted. However, Dr Cox has not demonstrated any insight or remorse in respect of those matters which were disputed but found proved. As such, and taking into account those facts found proved in the previous case now being reviewed which were of a similar nature, the Tribunal considered that there was currently no evidence which suggested that such misconduct was unlikely to be repeated.

168. The Tribunal considered that Dr Cox's sexual misconduct breached a fundamental tenet of the profession. This conduct has brought the profession into disrepute. While noting that Dr Cox had displayed remorse in relation to the facts as he had outlined them to be, the Tribunal considered that Dr Cox had shown no insight or remorse in relation to this aspect of his misconduct, as found proved by the Tribunal. The Tribunal was of the view that there is currently a risk of repetition of such misconduct.

169. Taking into account the overall circumstances of this case, in respect of both the clinical and sexual misconduct, the Tribunal considered that a finding of current impaired fitness to practise is necessary and appropriate. It considered that such a finding is required 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 the profession.

The Tribunal's Determination on Impairment – Review Case

170. The Tribunal noted that the matters considered by the 2020 Tribunal were considered to be remediable and that the 2020 Tribunal had given an indication of those matters which would assist a reviewing Tribunal.

171. The Tribunal noted that Mr Haycroft accepted on Dr Cox's behalf that Dr Cox has not provided evidence of what he has been doing during his 6 month period of suspension; or of how he has kept his clinical knowledge and skills up to date. It noted that Dr Cox has not provided further reflections on his past misconduct or how he plans to embed such reflections into his practice.

172. The Tribunal noted that Mr Haycroft accepted that, in the absence of such evidence or further evidence to assist the Tribunal, it is likely that this Tribunal will consider Dr Cox's fitness to practise remains impaired by reason of his past misconduct. Mr Haycroft outlined that Dr Cox has not been in clinical practise and has not had an opportunity to address the concerns of the 2020 Tribunal or demonstrate remediation.

173. The Tribunal considered that it has no evidence addressing those matters outlined by the 2020 Tribunal or of further insight or remediation following the 2020 hearing. It has no evidence of any steps taken by Dr Cox to address the issues previously identified with his clinical practise.

174. The Tribunal considered that, in such circumstances, Dr Cox has not satisfied the persuasive burden on him at a review hearing. It determined that Dr Cox's fitness to practise therefore remains impaired by reason of his previous misconduct.

175. In conclusion, the Tribunal determined that Dr Cox's fitness to practise is currently impaired; both as a result of those matters relating to the substantive case and those relating to the review case.

Determination on Sanction - 18/06/2021

176. Having determined that Dr Cox's fitness to practise is impaired by reason of his misconduct, the Tribunal now has to decide in accordance with rules 17(2)(n) and 22(1)(h) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

177. The Tribunal has taken into account the background to the case and the evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions

<u>On behalf of the GMC</u>

178. Mr Breen submitted that the appropriate sanction in Dr Cox's case, due to the Tribunal's findings at both the Facts and Impairment stages, is that of erasure.

179. Mr Breen stated that the principal basis upon which he makes his submission is the findings of the Tribunal, particularly in relation to sexual misconduct and the risk of repetition. He drew the Tribunal's attention to paragraphs 10 and 14 of the Sanctions Guidance (16 November 2020) ('the SG') which outline the fundamental aspects of a doctor's role and the overarching objective. Mr Breen stated that Dr Cox's sexual misconduct was a fundamental breach of all three limbs of the overarching objective. He reminded the

Tribunal of the principle of proportionality and that any sanction imposed must be proportionate based on the findings already made. Mr Breen submitted that it was entirely proportionate in the circumstances, bearing in mind the sexual misconduct and clinical misconduct elements in this case; and it was appropriate for the Tribunal to impose a sanction of erasure.

180. Mr Breen referred to paragraph 31 of the SG and stated that Dr Cox's clinical misconduct is potentially remediable, but the sexual misconduct in this case is so serious that it cannot be remediated. He reminded the Tribunal of paragraph 45 of the SG and stated that Dr Cox had denied the allegation of sexual misconduct and that this demonstrated that he has no insight.

181. In terms of mitigating and aggravating factors, Mr Breen stated that the Tribunal is entitled to consider these when making a finding on sanction but he could identify no mitigating circumstances when considering the sexual misconduct in this case. He stated that the explanation proffered by Dr Cox that he had masturbated before Patient A had entered the consultation room was 'fanciful'. Mr Breen submitted that an aggravating factor was Dr Cox's denial of the allegation as found proved by the Tribunal, his lack of insight and that his misconduct was an abuse of his professional position.

182. Mr Breen stated that this was not a case where no action should be taken or a case where conditions should be imposed. Mr Breen moved directly to consideration of a suspension.

183. Mr Breen stated that the sexual misconduct in this case was so serious that it was incompatible with continued registration and that, in these circumstances, a period of suspension would not be proportionate when considering the overarching objective and GMP.

184. Mr Breen referred the Tribunal to paragraphs 107 and 108 of the SG and stated that erasure may be the appropriate sanction even where a doctor does not pose a risk to patient safety (which he said did was not the position in this case) but where the action is necessary to maintain public confidence in the profession. He stated that this was a particularly serious departure from GMP and an abuse of Dr Cox's position of trust. Mr Breen referred the Tribunal to paragraph 149 of the SG and stated that this gives a good indication of the type of conduct where a more serious sanction is likely to be required. Mr Breen highlighted paragraph 150 of the SG and stated that sexual misconduct seriously undermines public trust in the profession and is an abuse of the special position of trust a doctor occupies.

185. Mr Breen submitted that it was clear that, in the circumstances of this case, Dr Cox's misconduct was fundamentally incompatible with continued registration and invited the Tribunal to impose an order of erasure.

<u>On behalf of Dr Cox</u>

186. Mr Haycroft submitted that Dr Cox notes and respects the decision of the Tribunal in this case but that he maintains his denial of facts found proved in relation to the sexual element of the allegation. He submitted that any suggestion that this equates to a lack of insight is fundamentally flawed and he referred the Tribunal to the case of *KARWAL v GMC 2011 EWHC 826* in this regard. Mr Haycroft stated that in essence Dr Cox fully understands the gravity of the misconduct and a lack of acceptance of the facts found proved does not equate to an aggravating factor.

187. Mr Haycroft submitted that Dr Cox acknowledged his impairment in both the substantive and the review cases and he referred to the Tribunal's determination on impairment at paragraphs 17 and 19 and that this shows that Dr Cox does have insight.

188. Mr Haycroft reminded the Tribunal that Dr Cox has not worked as a medical practitioner since the end of 2017 and he stated that Dr Cox has since been pursuing a career in an unrelated field. Mr Haycroft stated that Dr Cox has no intention of returning to clinical practice in the future.

189. Mr Haycroft stated that, given those matters, he has no substantive further submissions to make with regard to sanction.

The Tribunal's Determination on Sanction

190. The decision as to the appropriate sanction, if any, to impose, is a matter for the Tribunal exercising its own judgment. In reaching its decision, the Tribunal has taken into account the SG and the statutory overarching objective.

191. The Tribunal bore in mind that the main reason for imposing sanctions is to protect the public and that sanctions are not imposed to punish a doctor, albeit that a sanction may have a punitive effect. The Tribunal has applied the principle of proportionality and has sought to balance Dr Cox's interests with the public interest.

192. The Tribunal took its earlier determination on facts and impairment into account in coming to a decision on sanction. It first considered the aggravating and mitigating factors in this case and then moved on to consider the available sanctions ascending order of severity.

Aggravating & Mitigating Factors

Aggravating Factors - Clinical Matters

193. The Tribunal noted that the 2020 Tribunal was considering a relatively significant number of clinical failings which related to a number of patients and that, although the Tribunal hearing in respect of those matters had not yet taken place in advance of the matters under consideration in the substantive case, Dr Cox had repeated a further relatively significant number of clinical failings in respect of Patient A. Several of the clinical failings in

the substantive case fell seriously below the standard required of a reasonably competent practitioner.

194. The Tribunal considered that, although Dr Cox has not practised since 2017, he has some insight into his clinical failings. However, Dr Cox has not sought to remediate them or develop his insight. He has not provided evidence of having taken any steps to remediate his actions and he did not follow the advice of the previous Tribunal with regard to providing evidence for this Tribunal to consider. Dr Cox has not provided any reflective statement, evidence of having sought out or completed targeted CPD, or evidence of having kept his skills up to date.

Mitigating Factors – Clinical Matters

195. The Tribunal noted that Dr Cox acknowledged in his admissions, statement and oral evidence a significant amount of his clinical misconduct in both the review case and the substantive case; accepting that he made significant clinical errors and omissions. Broadly, Dr Cox did display some remorse for this element of his misconduct.

Aggravating Factors – Sexual Misconduct

196. The Tribunal considered that Dr Cox's conduct was a very serious breach of trust of his position as a doctor and of the doctor-patient relationship, which had brought the profession into disrepute.

197. The Tribunal noted that the incident occurred during a professional consultation whilst Dr Cox was undertaking his professional duties.

198. While conscious that Dr Cox is not required to accept culpability as a condition precedent for demonstrating insight, the Tribunal considered that it had received no evidence sufficient to demonstrate the Dr Cox has insight into the misconduct which the Tribunal found proved.

199. The Tribunal noted that Dr Cox's fitness to practise has previously been found to be impaired as a result of sexual misconduct in a workplace setting, albeit that the Tribunal noted again that the factual circumstances in that case were different to those under current consideration.

Mitigating Factors – Sexual Misconduct

200. Dr Cox's misconduct as found proved in this case appeared to be a one-off incident and not part of a pattern of behaviour.

201.Dr Cox apologised for the misconduct as he had asserted it to be (as opposed to that which the Tribunal found proved) and he has shown some insight into the potential impact on a patient and to the profession of a patient being exposed to seminal fluid.

202.In balancing the aggravating and mitigating factors and the seriousness of the clinical and sexual misconduct in this case, the Tribunal considered that the identified aggravating factors far outweigh the identified mitigating factors. Dr Cox's clinical misconduct has been a serious departure from the standards required of a reasonably competent medical practitioner. Further, and in particular, Dr Cox's sexual misconduct was a very serious departure from the standards of behaviour as set out in GMP and breached a fundamental tenet of the medical profession.

203.Overall, the Tribunal considered that the mitigating factors were very limited in effect. It reminded itself of paragraph 24 of the SG, which reads as follows:

> *'24… The Tribunal is less able to take mitigating factors into account when the concern is about patient safety, or is of a more serious nature, than if the concern is about public confidence in the profession.'*

204. In terms of whether Dr Cox's conduct as found proved is remediable, the Tribunal considered that the misconduct which related to his clinical practice was potentially remediable, but had not been remediated. However, the Tribunal considered that Dr Cox's sexual misconduct, which breached a fundamental tenet of the profession and had the potential to significantly damage trust in the medical profession is not remediable. The Tribunal considered that patients should be able to trust members of the profession to act appropriately during a medical consultation.

No action

205.In reaching its decision as to the appropriate sanction, if any, to impose in Dr Cox's case, the Tribunal first considered whether to conclude the case by taking no action.

206. The Tribunal determined that there were no exceptional circumstances present in this case which would justify taking no action. The Tribunal determined that it would be neither sufficient, proportionate nor in the public interest to conclude this case by taking no action.

Conditions

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

208. In its deliberations the Tribunal was mindful of paragraph 82 of the SG, which states:

> *82 Conditions are likely to be workable where:*

a the doctor has insight
b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings
c the tribunal is satisfied the doctor will comply with them
d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.

209. The Tribunal determined that it could not formulate any conditions to address the sexual misconduct and clinical matters in this case. The Tribunal was not satisfied that Dr Cox would comply with any conditions imposed on his registration given that he has failed to follow the direction of the 2020 Tribunal in relation to remediation. It considered that conditions are generally not suitable for misconduct of a sexual nature and it noted again that Dr Cox has not taken steps toward remediating his clinical misconduct.

210.The Tribunal therefore considered that a period of conditional registration would not be sufficient to address the risks or to adequately safeguard the public interest and maintain public confidence in the medical profession.

Suspension

211. The Tribunal then went on to consider whether imposing a period of suspension on Dr Cox's registration would be appropriate and proportionate and reflect the seriousness of Dr Cox's impairment. In doing so it had regard to the following paragraphs of the SG:

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

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

94 Suspension is also likely to be appropriate in a case of deficient performance or lack of knowledge of English in which the doctor currently poses a risk of harm to patients but where there is evidence that they have gained insight into the deficiencies and have the potential to remediate if prepared to undergo a rehabilitation or retraining programme.

97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

> *a. A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors…*

212. The Tribunal noted that Dr Cox has not practised medicine since 2017 and there is no evidence that he has developed appropriate insight into the new clinical matters before the Tribunal in the substantive case or in relation to those matters considered by the 2020 Tribunal. Dr Cox has not remediated this element of his misconduct in respect of either case. As previously stated, the Tribunal considered, however, that Dr Cox's clinical misconduct is potentially remediable and, were it to be taken alone, a further period of suspension may have been an appropriate sanction to impose, at least at this stage.

38. However, taking into account the sexual misconduct element of this case, and for the reasons outlined below, the Tribunal considered that an order of suspension would not be an appropriate or proportionate sanction. In the circumstance of the case, and taking all matters into account, the Tribunal considered that Dr Cox's sexual misconduct was such that it was a very serious departure from GMP and brought the profession into disrepute. Dr Cox's actions in covertly masturbating behind the back of a patient during a consultation with the result that that patient was exposed to seminal fluid seriously breached all three limbs of the over-arching objective. The Tribunal considered that such conduct is fundamentally incompatible with continued registration as a doctor and that members of the public would be appalled were the Tribunal to find otherwise.

Erasure

213.Having considered each of the previous sanction options in turn, and having determined that taking no action, imposing conditions or imposing a period of suspension would not be sufficient to reflect the seriousness of the findings against Dr Cox, the Tribunal went on to consider whether erasure was the appropriate and proportionate sanction to apply in the circumstances of this case.

214.In considering the sanction of erasure, the Tribunal was mindful of the following paragraphs of the SG:

> *Erase the doctor's name from the medical register*

107 The tribunal may erase a doctor from the medical register in any case – except one that relates solely to the doctor's health and/or knowledge of English – where this is the only means of protecting the public.

108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.

Sexual misconduct

149 This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child sex abuse materials) to sexual misconduct with patients, colleagues, patients' relatives or others. …

150 Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases.

215. As outlined above, the Tribunal determined that Dr Cox's actions and behaviours were a very serious departure from the principles of Good Medical Practice, breached fundamental tenets of the profession and are fundamentally incompatible with continued registration. Again, as outlined above, the Tribunal considered that Dr Cox's sexual misconduct is not remediable. In addition, the clinical aspects of his misconduct undermined public confidence in the profession.

216.The Tribunal therefore determined that, in light of the all the circumstances of the case, the appropriate sanction is that of erasure from the medical register. It considered that such an order is necessary to protect and promote 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 the profession.

Determination on Immediate Order - 18/06/2021

217. Having determined to erase Dr Cox's name from the Medical Register, the Tribunal has considered, in accordance with rule 17(2)(o) of the Rules, whether Dr Cox's registration should be subject to an immediate order.

Submissions

218. On behalf of the GMC, Mr Breen submitted that, whilst it is understood that Dr

Cox is not currently practising medicine and has no intention of returning to do so, an immediate order is necessary to protect members of the public, is in the public interest and to protect public confidence in the medical profession.

219. Mr Haycroft submitted that, in light of the Tribunal's findings and decisions, the test for the imposition of an immediate order is met in this case and he could not argue against the submissions of the GMC.

The Tribunal's Determination

220. In making its decision the Tribunal exercised its own judgement. It had regard to the SG and found the following paragraphs to be relevant:

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

221.The Tribunal was of the view that the seriousness of Dr Cox's misconduct meant that it was necessary to impose an immediate order on his registration. It concluded that this was appropriate in order to protect members of the public, maintain public confidence in the medical profession and to uphold proper professional standards and conduct for the profession. It considered that an immediate order will cover any gap between now and the substantive order taking effect.

222. In all the circumstances, the Tribunal determined to impose an immediate order of suspension on Dr Cox's registration.

223. This means that Dr Cox's registration will be suspended from when notification is deemed to have been served. The substantive direction, as already announced, will take effect 28 days from when written notice of this determination has been served upon Dr Cox, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

224.The order currently imposed on Dr Cox's registration will be revoked when the immediate order takes effect.

225.That concludes this case.

Confirmed
Date 18 June 2021 Mr Stephen Killen, Chair