PUBLIC RECORD

Dates: 11/08/2025 - 22/08/2025

Doctor:	Dr Manish TRIPATHI
GMC reference number:	7089669
Primary medical qualification:	MB BS 1998 Chhatrapati Shahu Ji Maharaj University

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

Summary of outcome

Suspension 10 months
Review Directed
Immediate Order Imposed

Tribunal:

Legally Qualified Chair	Mr Robin Ince
Lay Tribunal Member:	Mr Thomas Scapens
Registrant Tribunal Member:	Dr Carl Egdell

Tribunal Clerk:	Ms Fiona Johnston

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Ranald Davidson, Counsel instructed by Weightmans.
GMC Representative:	Ms Megan Tollitt, Counsel

Attendance of Press / Public

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

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 - 18/08/2025

Background

1. Dr Tripathi qualified as a doctor in 2000 and obtained his MBBS at GSVM Medical College, CSJM University, Kanpur India. Between March 2000 and November 2004 he worked in India as a private medical practitioner whilst preparing for his post-graduate and civil service examinations.

2. In January 2005 Dr Tripathi came to the UK. His first role was a non-clinical role working as a Senior Lecturer at the Health and Social Care faculty of Sheffield Hallam University. Dr Tripathi stayed teaching at the University for six years before moving into clinical medicine.

3. Dr Tripathi obtained GMC registration in July 2011. Initially he worked as a middle grade SHO in surgery in Surgery at the Rotherham General Hospital and as a locum in General surgery and AE in local hospitals.

4. In 2012 Dr Tripathi obtained a place on the VTS Training Programme and completed his training in 2016 and obtained MRCGP in 2017. Dr Tripathi joined the GMC GP register on 27 April 2017 and has worked as a locum GP since.

5. The allegation that has led to Dr Tripathi's hearing can be summarised as follows: on 24 August 2023, during a consultation with Patient A, Dr Tripathi conducted an

examination that was not clinically indicated and which constituted sexual harassment. It is alleged that Dr Tripathi's actions were sexually motivated.

6. The initial concerns were raised with the GMC by Patient A on 7 September 2023.

Events that led to the allegation

7. Patient A had an appointment with Dr Tripathi at Barkantine Practice, London ("The Practice") on 24 August 2023 XXX ("the appointment"). This was the first and only appointment she had with Dr Tripathi and is the only time she met him. The appointment with Dr Tripathi was in relation to her thyroid. Patient A attended the appointment with her XXX son XXX who was also present in the room. Once the examinations were complete, Dr Tripathi informed Patient A that a referral would be made for an ultrasound of her neck and thyroid. Patient A left the consultant room, she immediately went to reception and asked to see the practice manager. She was informed that they were unavailable so she asked for the doctors name and how she could make a complaint.

8. On the 7 September 2023, Patient A made a written complaint about her consultation with Dr Tripathi by e-mail to the Practice and she also referred her compliant to GMC on the same date. She alleged that:

    - Dr Tripathi had displayed 'aggressive' body language when she entered the consultation room that made her uncomfortable;
    - The light was turned off in the consultation room and the examination couch did not have a hygiene cover;
    - Dr Tripathi failed to ask for consent before the examination and locked the door to the room;
    - During a chest examination, Dr Tripathi started to lift her top, and shortly after pulled down her bra exposing her right breast and nipple, without explaining why this was necessary or without taking her consent;
    - When checking her abdominal region, Dr Tripathi 'almost touched' Patient A's pubic bone;
    - Dr Tripathi did not use gloves for the examination despite there being a full box available in the room;

- Instead of checking in the kidney area, where Patient A said she experienced pain, he 'starting pushing the top of my glutes' and 'once again tried to lift my trousers up' without consent or providing an explanation;
- Dr Tripathi "also checked my lymph nodes under my arms on both sides also without my top but at this point I did not let him to touch me anymore".

9. Patient A also reported the incident to the Metropolitan Police and, as part of the police investigation, a witness statement was obtained from her on the 6 November 2023. The police advised Patient A that it had closed its investigations with no further action in March 2024.

10. The Practice carried out an internal investigation. Dr Tripathi, who denied the allegations, was spoken to by another doctor at the Practice and he provided a written reflection and response. The doctor denied the allegations made by Patient A but accepted that during the consultation he had examined Patient A's thyroid and abdomen.

The Outcome of Applications Made during the Facts Stage

11. Ms Megan Tollitt, Counsel on behalf of the GMC, made an application pursuant to Rule 35(4) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that Patient A be granted anonymity throughout the proceedings. Mr Ranald Davidson, Counsel on behalf of Dr Tripathi, did not oppose the application.

12. The Tribunal considered the reasons for the anonymity request. It concluded that, given the nature of the allegations, it was appropriate, in the circumstances, to grant the application.

The Allegation and the Doctor's Response

13. The Allegation made against Dr Tripathi is as follows:

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

1. On 24 August 2023, during a consultation with Patient A:

    a. you touched, with your stethoscope, her:

i. left breast; To be determined
ii. left nipple; To be determined

b. you pulled Patient A's bra up towards you, exposing her right breast; To be determined
c. you touched her right breast with your stethoscope; To be determined
d. whilst purporting to carry out an examination of her kidneys you:

i. touched Patient A's gluteal region with your hand; To be determined
ii. tried to lift the waistband of her trousers; To be determined
iii. conducted the examination with Patient A in the prone position. To be determined

2. Your actions as set out at paragraph 1:

a. were not clinically indicated; To be determined
b. constituted sexual harassment as defined in Section 26(2) of the Equality Act 2010, in that you engaged in unwanted conduct of a sexual nature which had the purpose or effect of violating the dignity of Patient A, or creating an intimidating, hostile, degrading, humiliating or offensive environment for Patient A; To be determined
c. were sexually motivated. To be determined

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

Witness Evidence

14. The Tribunal received evidence on behalf of the GMC from Patient A (via video link) together with her letter of complaint to The Practice and her referral to the GMC, both dated 7 September 2023, her witness statement to the Police dated 4 November 2023, and her witness statements to the GMC dated 27 March 2024 and 17 January 2025.

15. Dr Tripathi gave oral evidence. The Tribunal also received Dr Tripathi's statement in response to the complaint dated 8 September 2023, and witness statements dated 25 June 2025 and 3 July 2025.

Expert Witness Evidence

16. The Tribunal also received oral evidence from Dr B, expert witness for the GMC. It also received his expert report dated 5 June 2024.

Documentary and Other Evidence

17. The Tribunal had regard to the documentary and other evidence provided by the parties. This evidence included but was not limited to witness statements, Patient A's written complaint to the Practice and initial concerns form, but also included Patient A's medical records.

18. In the course of the hearing, Dr Tripathi provided a testimonial bundle attesting to Dr Tripathi's clinical practice and good character.

The Tribunal's Approach

19. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Tripathi does not need to prove 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.

Sexual Motivation

20. Under s.78 of the Sexual Offences Act 2003, touching is "*sexual*" if a reasonable person would consider it so, based on nature or context. The Tribunal noted an on-line definition of "*sexual*" as "*of, relating to, or characterized by sex or sexuality*". Motivation is key—it need not lead to gratification but must show intent or purpose (***Basson v GMC [2018]***, ***Harris v GMC [2021]***). Delay in reporting does not prove or disprove an allegation. Generally, the Tribunal should consider Patient A's reasons, acknowledging varied responses such as fear, shame, or confusion, and assess how these affect reliability.

Good character

21. The Tribunal has heard that Dr Tripathi is of good character, in that he has had no previous involvement with professional disciplinary proceedings. Further, there has been evidence placed before the Tribunal of Dr Tripathi's good character in the form of testimonials. Good character is not a defence to the charges before the Tribunal, but it is relevant to the consideration of the case in two ways. First, his good character is a positive feature which the Tribunal should take into account when considering whether to accept his account. Second, the fact that Dr Tripathi has not been the subject of professional criticism in the past, may make it less likely that he acted as is now alleged.

22. The Tribunal is reminded about the consideration of the probability of an event occurring as alleged and this is a matter to weigh into that balancing exercise. It noted the case of *Byrne v GMC [2021] EWHC 2237* which stated:

> *"First, the seriousness of an allegation does not of itself require more cogent evidence: as indicated in paragraph 22 above. Rather it depends on the inherent probability of the relevant conduct. In the present case, the relative improbability of the Appellant behaving as alleged was to be balanced against the relative improbability of Patient A fabricating the allegations and putting herself through the ordeal involved in doing so."*

23. However, the Tribunal is not expected to make a judgement about Dr Tripathi's previous good character in isolation from the evidence it has heard in this hearing. The decisions whether Dr Tripathi 's previous good character assists, and, if so, what weight should be given to it, are for the Tribunal alone to make.

24. In addition, the Tribunal bore in mind that it would also be entitled to take account of the fact that, having heard nothing detrimental regarding Patient A's character, there was no reason for it not to treat her as being of good character either (*Gopakumar v GMC [2008] EWCA Civ 309)*.

The Tribunal's Analysis of the Evidence and Findings

25. In considering the evidence, the Tribunal had regard to the evidence presented to it from Patient A, Dr B and from Dr Tripathi.

26. The Tribunal took account of the submissions of the parties who agreed that the outcome of the case rested upon whose evidence (Patient A's or Dr Tripathi's) the

Tribunal preferred. It further noted and accepted the LQC's advice (which was not challenged by either party) that, in assessing the reliability of any evidence it was entitled to pay heed to: whether a witness' account had been consistent; whether there had been exaggeration or embellishment; whether there was any ulterior motive for the witness saying what s/he said; whether there had been any adverse admissions by a witness about his/er actions, which may indicate candour generally and whether any evidence had been corroborated, particularly by any documentation, such as a statement, letter, e-mail, text message or note of any meeting, which was produced contemporaneously or in the weeks or months after the relevant incident. Where there was more than one statement or utterance given by a witness, the Tribunal would be entitled to take more account of an earlier statement as it was more contemporaneous to the event in question.

27. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts. However, where there were subparagraphs based on one incident, the Tribunal found it necessary to consider the whole incident in context.

Consideration of the evidence

28. Dr Tripathi worked as a Locum GP and had not met Patient A before. It is Dr Tripathi's case that the actions alleged simply did not occur. This is not a case in which it is suggested that Patient A misunderstood or misinterpreted the reasons for Dr Tripathi touching her breasts and/or gluteal region, or for examining her while she was in a prone position. Dr Tripathi had a limited recollection of the consultation. In his own words he did not believe it was a '*remarkable consultation*'. However, he stated that he does have a clear recollection of the beginning and end of the consultation, although he could not remember any specific "*verbalisations*".

29. Having said that, Dr Tripathi did make a written response to the allegations (which he received shortly after 8 September 2023) on or around 20/23 September 2023. It noted that Patient A made a near – contemporaneous, account of the events that took place on 24 August 2023 in her complaints to both the Practice and to the GMC on 8 September 2023, some two weeks later.

30. The Tribunal began by making a general evaluation of the evidence of Patient A, particularly since the burden of proof was upon the GMC. Moreover, it considered it

appropriate first of all to analyse specific arguments put forward by Mr Davidson regarding various inconsistencies and implausibilities identified by him, before considering each of the respective allegations.

31. The Tribunal noted that Patient A's initial written complaint to the Practice/GMC and her subsequent police statement were broadly consistent with each other, and her oral testimony before the Tribunal was generally so in keeping with both. However, Mr Davidson has argued that there are concerns about the delay in producing her complaint, it's authorship (Patient A confirmed that her husband, when he had time, had assisted by typing her complaint at her dictation) and the fact that she had spoken to an unidentified doctor (known personally to her) about her examination in the interim.

32. The Tribunal noted that there was a period of approximately two weeks between the consultation on 24 August 2023 and Patient A's formal complaint on 7 September 2023. The Tribunal did not regard this delay as unusual. She confirmed that she was shocked by the incident and needed time to come to terms with it. Furthermore, Patient A explained that she wished to speak to another doctor about the incident and to reflect on the matter before deciding how to proceed. She had, in fact, raised her concerns immediately after the consultation with The Practice reception staff (which was not disputed by the Doctor) by asking to speak to the Practice Manager and, when told that they were unavailable, asked for details about lodging a complaint against the Doctor, which she was given. The Tribunal accepted her explanation that her complaint was drafted by her husband, XXX. The Tribunal considered that these factors also accounted for minor differences in wording across her various written and oral statements.

33. The Tribunal therefore considered that, especially given that there was an immediate indication by Patient A that she wished to make a complaint, the subsequent delay in formulating this complaint was not unusual, in the above circumstances.

34. Mr Davidson further suggested that there was an inconsistency in Patient A's evidence as to whether the auscultation to her left side was above or below her bra (in other words, whether the stethoscope was in contact with her skin) and whether her left breast was exposed. This inconsistency arose from Patient A's GMC statement dated 27 March 2024 where she said that at no point was her left breast or nipple exposed. When challenged on this during her oral evidence, Patient A accepted that

this was incorrect and reverted to her previous description set out in her complaint and in her police statement.

35. The Tribunal took into account Ms Tollitt's argument that the process of taking a GMC statement was different in that it was taken over a telephone and was not face to face. Moreover, it is clear from her witness statement that Patient A was asked a number of clarification questions about matters not commented upon before by Patient A, and therefore the Tribunal considered that it was likely that this process might easily have produced some variation in her previous accounts. However, the Tribunal noted that, in her oral evidence, after some reflection, Patient A indicated that her GMC statement was not correct and that her earlier (and more contemporaneous) accounts were correct. The Tribunal therefore considered this was likely to be the result of an understandable lapse in recollection rather than deliberate fabrication, particularly since her earlier accounts were more contemporaneous.

36. Mr Davidson also noted a discrepancy in Patient A's account of the examination of her Axillai. In her complaint she stated that both sides were examined but in her oral evidence she said that it was only the left side. The Tribunal first of all noted that this part of the examination did not give rise to any complaint by Patient A and consequently, it was perhaps understandable that her recollection of what was a peripheral feature of the examination was not consistent. In any event, the Tribunal considered it appropriate to rely upon her contemporaneous account rather than her oral evidence given some two years after the event.

37. Mr Davidson went on to argue that Patient A had been inconsistent about when she was asked about her kidney pain. In her complaint and in her police statement, Patient A had said that, when she had got up from couch following her abdominal examination, she was asked by the Doctor whether she had pain anywhere else and volunteered that she had pain in her kidneys. However, in her oral evidence, Patient A had agreed to a question from Mr Davidson which suggested that she told the Doctor about her abdominal and kidney pain at the same time. Once again, the Tribunal considered that it was appropriate to rely upon Patient A's more contemporaneous account rather than her oral evidence. It noted, in particular, that Patient A has been consistent about the sequence of events in that her abdominal examination concluded, she then got up from the couch and then got back onto the couch, lying in

the prone position at her own volition. The Tribunal therefore does not place much weight upon this apparent inconsistency.

38. Mr Davidson also commented on what he described as the supplementations of Patient A's evidence, namely her adding extra detail to her account during her oral evidence. For instance, he pointed out the description of how Patient A said the Doctor moved his stethoscope on her chest. In her GMC witness statement, Patient A had described Dr Tripathi moving the stethoscope in a gentle circular motion, but in her oral evidence she stated that, in fact, he had moved the stethoscope in a circular direction but raised the stethoscope by a millimetre or so before moving it and then placing it down again. Consequently, there was no continuous contact with her skin with the stethoscope.

39. The Tribunal noted that this detail was not in her initial complaint nor in her police statement. However, it took the view that it may well have been likely that this description arose because she was asked to supply further details by the GMC. Furthermore, although she modified her description of how the stethoscope was moved, her overall account remained the same, namely that Dr Tripathi was examining her with his stethoscope in an inappropriate way because of where he was placing the stethoscope. The Tribunal therefore attached little weight to this apparent discrepancy.

40. Mr Davidson further pointed out that in her oral evidence Patient A had made reference to an examination of her lymph nodes which she had not mentioned before. Once again, the Tribunal notes that no complaint was made by Patient A about the manner in which Dr Tripathi examined her lymph nodes so it is plausible that she may well have forgotten what was, at the time, a relatively inconsequential detail.

41. Accordingly, in the Tribunal's view, the core elements of Patient A's account remained reasonably consistent across her initial complaint, her police statement, and her oral testimony. While there were some small inconsistencies, particularly arising from her account to the GMC, the Tribunal considers that there are reasonable explanations for these apparent inconsistencies and that they, neither individually or collectively, damage the overall impression of consistency regarding the core of her account.

42. Finally, Mr Davidson referred to the improbability of Dr Tripathi's supposed behaviour. He pointed out that the Doctor had never met Patient A and therefore would not have known how she might have responded to sexual touching. However, the Tribunal considers that Patient A's descriptions of Dr Tripathi's actions are commensurate with opportunistic behaviour and therefore places little weight upon this argument. Further, Mr Davidson argued but it was improbable that the Doctor would attempt sexual touching when Patient A's XXX son was present. However, the Tribunal notes that the doctor was examining Patient A behind a curtain and therefore her son could not see what was going on. Furthermore, the Tribunal is aware that the presence of third parties is not necessarily a bar to sexual touching.

43. In addition, Mr Davidson suggested it was improbable that Dr Tripathi touched Patient A only with the head of his stethoscope and not with his hands. However, the Tribunal considers that, given the areas where the Doctor is alleged to have touched, for instance the left nipple, it is possible that he was hoping to arouse Patient A sexually. Mr Davidson also maintained that Patient A "*invited*" further clinical examination following the abdominal examination by "*volunteering*" further symptoms. The Tribunal would not categorise what occurred as Patient A volunteered to submit a further examination. Her evidence is that Dr Tripathi asked her further questions to which she responded. Patient A stated that she permitted the consultation to continue because she was initially unsure how to react and may have been in shock. She also mentioned that the practice usually stated that when seeing a GP, they would only consider one issue. This meant that she had to wait for an appointment with another doctor. Dr Tripathi was asking her if she had pain and was willing to check her condition, '*so I went with it*'.

44. The Tribunal considers this to be a plausible explanation. It also notes that, eventually, when the Doctor started asking about her breasts, Patient A decided to terminate the consultation as quickly as possible and left. The Tribunal notes her description of being in a danger zone and in survival mode.

45. Finally, Mr Davidson argued that the touching of Patient A's gluteal region could not have been contrived by Dr Tripathi because Patient A had chosen to lie prone on the examination couch. The Tribunal would make two observations upon this argument. First, it repeats the point made earlier that sexual touching does not have to be contrived but it can be opportunistic. Second, it ignores the fact that the Doctor was in charge of the examination and he could have told Patient A to alter her position so

that he could properly examine the kidneys from the front (as Dr B indicated was appropriate).

46. In addition, Mr Davidson submitted that the record of the consultation in Patient A's medical records completely supported Dr Tripathi's version of events and did not mention many of the examinations alleged by Patient A. Whilst the Tribunal notes the logic of this argument, it also considers that it is a "*two-edged sword*" in that it could also be argued that, as Dr Tripathi was the sole author of those medical notes, he would not include anything that was detrimental to him or would incriminate him. The Tribunal therefore does not place any significant weight upon this argument.

47. The Tribunal took into account the good character of both Dr Tripathi and Patient A. It noted, however, that Patient A had no plausible motive to make a false allegation, particularly given that she had relatively swiftly reported the matter to multiple agencies (the Practice, the GMC and to the Police). The Tribunal also considered it improbable that she would have fabricated the complaint knowing that this was her only consultation with Dr Tripathi and that she might never see him again.

48. Finally, The Tribunal noted Patient A's demeanour when giving evidence. She came across as thoughtful and measured and, on occasion, took time to consider her answers. In particular, the Tribunal noted that she was concerned about giving as accurate an account as possible. For instance, when asked how many times the stethoscope contacted her breast she indicated that she did not think that she had mentioned how many times this occurred before but that she wanted to be "*as accurate as possible*". Furthermore, she stated that she had no reason to exaggerate or lie or "*cause pain to someone*", which indicated to the Tribunal that she was particularly concerned about not exaggerating what she could recall.

49. Taking all these factors into account, the Tribunal generally considered Patient A's evidence to be credible and reliable, and that it was to be preferred to the evidence of Dr Tripathi.

<u>Paragraphs 1 (a)(b)(c)</u>

1. On 24 August 2023, during a consultation with Patient A:

    a. you touched, with your stethoscope, her:

i. left breast;
ii. left nipple;

b. you pulled Patient A's bra up towards you, exposing her right breast;
c. you touched her right breast with your stethoscope;

50. The Tribunal considered paragraphs 1(a) i & ii, (b) and (C) together.

51. Prior to her appointment with Dr Tripathi on 24 August 2023, Patient A had the following contacts with the surgery:

52. On 16.08.23, Patient A submitted an online request as follows:

''Me and my husband we would like to have a second child but before going ahead would like to have a full check-up of my health. I have a thyroid and always feel tired, fatigue and body ache "

53. On 18 August 2023, Patient A had a telephone consultation with a GP, Dr C. Patient A presented symptoms of tiredness and bloods were requested. She also complained of fullness in her neck. The record of this consultation is as follows:

''History: Feeling TA TT [tired all the time] generalised aches/ exhausted whether she sleeps or not TTC [trying to conceive] wants to be optimised known goitre feel possibly more protrusion ? lump on side

Comment: Bloods inc [including] TFTs [thyroid function tests] book F2F [face to face appointment] to examine neck

Test request: full blood count bone profile/ ferntin/ serum fo!ate/ vitamin B12 renal profile/ LFTs [liver function tests] TFTs/ HbAlc [glycated haemoglobin]'

54. An appointment was made for Patient A to see Dr Tripathi on 24 August 2023 to review her neck, examine the thyroid and perform a general examination. The record of this consultation made by Dr Tripathi is as follows:

''Problem: lump in neck
History: Ongoing ? known goitre/ recent consult noted. TA TT - bloods awaited, attends for F2F review

Examination: Alert well perfused hydrated. Thyroid - mid line fullness nil lump nodules. Eye - NAD [no abnormality detected] Lymphadenopathy absent – head, neck, axillae. Abdomen examined - NAD/ Chest clear 0/E [on examination] heart sounds normal. 0/E pulse rhythm regular

Comment: USS [ultrasound scan] neck inc [including] thyroid and review with bloods
Test request: USS thyroid and parathyroid'

55. On 24 August 2023 Patient A alleged that Dr Tripathi carried out the following: examination of the thyroid gland, heart and the lungs. The Tribunal had regard to Patient A's evidence as set out in her written complaint statement dated 7 September 2023, and which she maintained during her oral evidence to the Tribunal.

'While Dr Manish Tripathi was examining me, he closed the curtain even more and asked "I need to listen to your chest". I was wearing a V neck top so I have tried to move my top slightly so Dr Manish Tripathi could listen to my chest, as I normally had before with any other male of female doctors who wanted to listen my chest. Dr Manish Tripathi did not look satisfied and wanted to lift my top from the bottom and I had to stop him as I did not like him undressing me. So, I lifted my top up and he started to listen my chest on my left side and then he slowly started to move down to my breast and nipples. and then he moved to my right side of breast and he pulled my bra and expose my right breast and nipples. Even child knows that heart is on the left and not on the right. I felt very insecure and exposed. All of this was done without my consent or giving full explanation why he was touching my private areas'.

56. The Tribunal took account of Dr Tripathi's statement in Response of the allegations, and his oral evidence in which he denied touching Patient A:

'I have done chest examinations throughout my career and never had to expose the breasts or lift the top. I have regularly educated Junior doctors, ANPs - HCAs the technique and steps of chest auscultation throughout my clinical career. The Ideal chest examination consists of inspection, palpation, percussion, and auscultation….. However, not every chest exam needs percussion or palpation.

This examination was a routine chest examination that I did on the top of clothes – auscultation with a stethoscope- listening to the heart areas on the left side – left lung field and then auscultation of the right anterior lung field. This involved no exposure of breasts or nipples at any point, nor did it involve any percussion or palpation by hands.'

57. The Tribunal has had regard to Dr Tripathi's oral evidence on the incident. Dr Tripathi provides a different factual account of the consultation and records his shock and distress at the allegations. Dr Tripathi states that he greeted Patient A politely, he does not accept that he locked the door or displayed aggressive body language, and states that he explained and took consent for the examination. Dr Tripathi stated

"I sat the patient down and reassured her, explained the findings and laid out the management plan that was understood and agreed with the my patient. And there was no sign of any [distress] that I noticed. And I remember that very clearly".

58. In his oral evidence, Dr Tripathi maintained that he did not touch Patient A's breast with his stethoscope:

'*I did not touch the breast at all on the right side at all because I was just auscultating the top of the chest. Which is much [above] the level of breast tissue, because I had just listened to a couple of areas on the chess'.*

59. The Tribunal noted the submission by Dr Tripathi's representative that the alleged incident did not occur, and that Dr Tripathi examined only the appropriate parts of the chest area without touching Patient A's breasts.

60. Having considered all the evidence, the Tribunal found Patient A's account to be more credible than that of Dr Tripathi. The Tribunal has already addressed the submission that Patient A's evidence changed as to whether the stethoscope was placed directly on the skin of her left breast, on her bra, or whether the breast was felt through the bra.

61. In the Tribunal's view, this variation is not material. Whether the stethoscope was placed on the bra or directly on the skin, the Tribunal finds that it still made contact with Patient A's left breast and nipple and therefore "*touched*" it.

62. The Tribunal noted that the allegation rests solely on Patient A's account. Dr Tripathi has consistently denied the allegations throughout the proceedings. The Tribunal accepted that his denials have been consistent.

63. However, taking all of the evidence in the round and taking into account the issues relating to the evidence that the Tribunal has identified above, the Tribunal concluded that the GMC has discharged its burden to prove these paragraphs of the Allegation on balance of probabilities.

64. Accordingly, the Tribunal determined, on the balance of probabilities, that paragraphs 1a i & ii, 1b and 1c of the Allegation were found proved.

Paragraphs 1(d)i-iii

d. whilst purporting to carry out an examination of her kidneys you:
    i. touched Patient A's gluteal region with your hand;
    ii. tried to lift the waistband of her trousers;
    iii. conducted the examination with Patient A in the prone position.

65. In his written statement, Dr Tripathi stated:

> *'The abdominal examination was a very focused examination in this consultation, to assess for any organomegaly including the Liver and spleen. It did not extend below the bladder area and did not involve percussion or auscultation. I performed the examination without gloves as a routine procedure although the patient thought that I should have used the gloves. If she had mentioned it, then – I would have taken all the time to explain the rationale of bare-hand examination….*
>
> *The patient mentions that I had tried to lower the trousers and tried to touch the glutes- implying that she was lying prone or in a lateral position. Renal examination DOES NOT need a patient to be in the left/ right lateral position on the couch……- there was neither an indication nor need and hence my examination did not go below the pelvic brim. There is NO indication of kidney or renal area examination in this presentation unless and until the patient specifically mentions the flank pain.*

I do not recollect her mentioning the kidney pain and cannot recollect an examination of the kidney areas. At this point of the examination, I had no feeling that the patient was uncomfortable or was not sure about my examination. I did realise at this point that whilst I had checked the head and neck for the lymph nodes, I forgot to examine the axillae and therefore I apologised and asked her permission to examine the axillae to look for any lumps – which she agreed. The examination was unremarkable.'

66. The Tribunal had regard to the evidence of Patient A:

"I can confirm that Dr Tripathi did not explain why he was conducting an abdominal examination. He asked if I had abdominal pain but did not explain what abdominal pain had to do with my thyroid. I also confirm that Dr Tripathi did not explain why he was examining me without gloves….

The waist band of my trousers were below my belly button, resting on my hip bone. As the trousers that I was wearing that day have a rubber band around the waist, when they were pulled down and resting on my hip bone, they were not tight to my tummy and there was a gap in between my skin and trousers. Dr Tripathi was pushing down on my abdominal area, going deeper than where I believe he should've done. Dr Tripathi's fingers were pushing down on my skin almost as low as my pubic bone. Dr Tripathi then went under the waistband of my trousers, pulling them up slightly, like lifting back a curtain peering to see what was behind. It's easier to demonstrate than to describe but I feel as though he was trying to see my lady parts……

Dr Tripathi was pushing in the middle of my glutes using his right hand. I would describe the amount of pressure he was using as firm. Dr Tripathi pushed my glutes for a few seconds until I told him that he was pushing the wrong area, that my kidneys were higher up than that and showed him where they were. He then tried to "lift" up my trousers in the same way I described in paragraph 20 of this statement before examining the area where my kidneys are…..

I let Dr Tripathi examine my lymph nodes. While they were tender and slightly swollen, there was no issue with that check, all was fine.

When I said "I did not let him touch me anymore" I was referring to when Dr Tripathi was asking me questions around my breasts. He offered to examine them, to which I said "no my breast is fine, they've been checked". I felt as though Dr Tripathi just wanted to invade and touch every part of my torso."

67. The Tribunal prefers Patient A's account to that of Dr Tripathi. The allegation relating to the examination of the kidney area arises without any apparent prompting or obvious motive. Patient A described completing the initial examination lying on her back, after which she got up. Dr Tripathi then asked if she felt pain anywhere else. She then got back on the couch onto her front for a further examination.

68. The Tribunal considered this sequence of events to be a curious and specific detail to fabricate if it had not occurred in the manner she described.

69. The Tribunal noted the expert evidence that such an examination would ordinarily be conducted from the front. Dr Tripathi stated that the sequence of events described by Patient A was implausible and not the way in which he would have conducted an examination. The Tribunal considered that, as this sequence was inconsistent with standard practice, and taken together with the other evidence, it supported the conclusion that Patient A was describing what actually took place.

70. Therefore, the Tribunal finds paragraph 1(d)i-iii proved in its entirety.

<u>Paragraph 2a</u>

a. were not clinically indicated;

71. The Tribunal considered the expert opinion of Dr B.

'If this account is accepted, then my opinion is that Dr Tripathi's actions were seriously below the standard expected. This is because exposing Patient A's right breast by pulling her bra up towards him, and placing his stethoscope on Patient A's right breast using circular movements was unnecessary and inappropriate. It is not possible to auscultate the lungs through breast tissue in this way, especially not when moving the stethoscope around in circles. My opinion is that these actions had no clinical purpose. My opinion is that Dr Tripathi's actions placed Patient A at risk of embarrassment and distress and

reluctance to undergo similar examination in the future. Therefore my opinion is that his actions were seriously below the standard expected.'

72. The Tribunal noted that Dr B' evidence was not disputed by the Doctor and accepted it. Having also accepted Patient A's evidence, the Tribunal concluded that the actions described in Allegation 1 would not have served any clinical purpose. On the basis of Patient A's credible account, these actions were unnecessary for the examination. The Tribunal finds this allegation proved.

Paragraph 2b in relation to 1 a, b and c

b. constituted sexual harassment as defined in Section 26(2) of the Equality Act 2010, in that you engaged in unwanted conduct of a sexual nature which had the purpose or effect of violating the dignity of Patient A, or creating an intimidating, hostile, degrading, humiliating or offensive environment for Patient A;

73. The Tribunal noted the provisions of Section 26 of the Equality Act 2010 and the advice of the LQC, which was as follows:

"*We should first decide whether the facts found proved constitute "unwanted conduct of a sexual nature". See my advice below on sexual motivation for a definition of "sexual".*

If we find that it Dr Tripathis's actions were "unwanted conduct of a sexual nature", we will then move on to consider whether it "has the purpose or effect of" either "violating Patient A's dignity" or "creating an intimidating, hostile, degrading, humiliating or offensive environment for Patient A".

In deciding whether the conduct has the effect (but not the purpose) referred to in subsection (1)(b) were are to take account of

(a) the perception of Patient A;
(b) the other circumstances of the case; and
(c) whether it is reasonable for the conduct to have that effect."

74. The first question for the Tribunal was whether the conduct was unwanted

The Tribunal finds that it was. In Patient's A evidence she stated:

> *'disgusted and shaking while I am describing my frightening experience in the room with Dr Manish Tripathi. I have trusted Dr Manish Tripathi and his professionalism but I was violated, used, abused, sexually assaulted and sexually harassed by this man.'*

75. On that basis, the Tribunal concludes that the conduct was unwanted. The Tribunal next considered whether the conduct was of a sexual nature. Taking account of the on-line definition provided above ("*of, relating to, or characterized by sex or sexuality*") it finds that it was. The conduct involved the touching of intimate parts of Patient A's body, such as her left breast and left nipple, inappropriate exposure of her breast, touching of her buttocks over clothing, and attempting to lift the waistband of her trousers.

76. The Tribunal is satisfied that these actions were inherently sexual in nature, particularly as they were not clinically justified.

77. The Tribunal pauses there to remind itself of the advice of the LQC, namely that:

"*The Doctor's good character is not only relevant when we are considering factual matters; it is also relevant should we have to consider Charges 2 b and/or 2 c (whether the Doctor "engaged in unwanted conduct of a sexual nature" or whether his actions "were sexually motivated") (Arunkalaivanan v GMC [2014] EWHC 873 (Admin)).*"

78. The Tribunal has taken account of Dr Tripathi's good character in assessing this aspect of Charge 2 b. However, although his good character makes it less likely than otherwise might have been the case that he "*engaged in unwanted conduct of a sexual nature"*, it is not determinative. Further, the Tribunal has found that his actions were not clinically indicated and the Doctor's unequivocal denials have left no room for the possibility that his actions were misinterpreted and/or were innocent, where his previous good character would have played more of a part. Accordingly, the Tribunal maintains its findings on this matter.

79. The Tribunal then moved on to consider whether the doctor's actions had

"..the purpose or effect of" either "violating Patient A's dignity" or "creating an intimidating, hostile, degrading, humiliating or offensive environment for Patient A".

80. The Tribunal consider that there was insufficient evidence before it for it safely to conclude that Dr Tripathi's actions had the purpose of either violating Patient A's dignity or creating a particular environment for her. The Tribunal accepts that Dr Tripathi may not have consciously reflected on his purpose at the time, but the evidence before it suggests that these were opportunistic actions.

81. In considering whether the Doctor's actions had the effect specified in section 26 1(b), the Tribunal took into account *(a) the perception of Patient A; (b) the other circumstances of the case; and (c) whether it is reasonable for the conduct to have that effect*.

82. The Tribunal is satisfied that the actions had the effect of violating Patient A's dignity, having regard to her evidence of the effect upon her of the doctor's actions, as outlined above, the fact that those actions were not clinically indicated and the fact that it would be reasonable for such unwanted sexual conduct to have that effect.

83. As to whether the Doctor's actions had the effect of "*creating an intimidating, hostile, degrading, humiliating or offensive environment*" for Patient A, for the same reasons, the Tribunal finds that those actions created an intimidating, degrading, humiliating or offensive environment for Patient A. It has also taken account of the fact that Dr Tripathi was in a position of authority and power, and that Patient A was therefore subjected to the power imbalance inherent in the doctor–patient relationship.

84. However, The Tribunal considers that there is insufficient evidence to demonstrate that a "*hostile*" environment was created since Patient A did not report any aggression displayed by Dr Tripathi when examining her. However, such a specific finding is not necessary since the remaining pleaded environments are established, which is sufficient for finding the charge proved overall.

85. Accordingly, the Tribunal finds 2b proved, in that: Dr Tripathi engaged in unwanted conduct of a sexual nature which had the effect of violating the dignity of Patient A and creating an intimidating, degrading, humiliating and offensive environment for her.

Paragraph 2c

c. were sexually motivated.

86. The Tribunal noted that, when considering sexual motivation, there are two considerations:

(1) Was the act overtly sexual or reasonably able to be perceived as such? and

(2) Was the act carried out for the Doctor's own sexual gratification or with the intention of pursuing a sexual encounter or relationship?

87. The GMC's case is that only the first alternative applies, namely that it was carried out for the Doctor's own sexual gratification.

88. The Tribunal noted the response from Dr Tripathi in his written statement

'I deny allegation 2(b) for all the reasons above. There was absolutely no motivation behind my actions towards Patient A on 24 August 2023 other than to carry out an examination and consultation to advance her medical care.'

89. The Tribunal found that none of the actions carried out by Dr Tripathi were clinically motivated or justified. He has denied performing any of these actions, and therefore there is no suggestion before the Tribunal that he accidentally touched Patient A's breast or ventured too far down her abdomen. No innocent explanation has been put forward.

90. The Tribunal therefore considered whether the actions were sexual, or could reasonably be perceived as such. It finds that they were. All matters 1a–1d, in the absence of any innocent explanation or clinical justification, were either sexual in nature or could reasonably be perceived to be so. In reaching this conclusion, the Tribunal has applied the principle set out in *Haris*, namely that "*if there is no innocent explanation or clinical justification, the Tribunal is entitled to conclude that the only possible explanation for the actions is that they were sexual*."

91. The Tribunal next considered whether the actions were carried out for Dr Tripathi's sexual gratification. In the absence of any alternative explanation, the Tribunal is

entitled to and does conclude that they were. The Tribunal, however, does not find that these actions were planned; rather, they were opportunistic in nature.

92. As before, the Tribunal has taken account of Dr Tripathi's good character in assessing this aspect Charge 2c. However, it repeats its earlier findings in respect of Charge 2b. Although his good character makes it less likely than otherwise might have been the case that his actions "were *sexually motivated"*, it is not determinative. Further, the Tribunal has found that his actions were not clinically indicated and the Doctor's unequivocal denials have left no room for the possibility that his actions were misinterpreted and/or were innocent, where his previous good character would have played more of a part. Accordingly, the Tribunal maintains its findings on this matter.

93. Therefore, it finds paragraph 2c proved.

The Tribunal's Overall Determination on the Facts

94. The Tribunal has determined the facts as follows:

.

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

1. On 24 August 2023, during a consultation with Patient A:
    a. you touched, with your stethoscope, her:
        i. left breast; **Determined and found proved**
        ii. left nipple; **Determined and found proved**

    b. you pulled Patient A's bra up towards you, exposing her right breast; **Determined and found proved**
    c. you touched her right breast with your stethoscope; **Determined and found proved**
    d. whilst purporting to carry out an examination of her kidneys you:

        i. touched Patient A's gluteal region with your hand; **Determined and found proved**
        ii. tried to lift the waistband of her trousers; **Determined and found proved**
        iii. conducted the examination with Patient A in the prone position. **Determined and found proved**

2. Your actions as set out at paragraph 1:

    a. were not clinically indicated; **Determined and found proved**
    b. constituted sexual harassment as defined in Section 26(2) of the Equality Act 2010, in that you engaged in unwanted conduct of a sexual nature which had the purpose or effect of violating the dignity of Patient A, or creating an intimidating, hostile, degrading, humiliating or offensive environment for Patient A; **Determined and found proved**
    c. were sexually motivated. **Determined and found proved**

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 - 20/08/2025

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

The Evidence

3. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received a statement from Dr Tripathi's Responsible Officer, dated 8 March 2025, and a Maintaining Professional Boundaries Course Certificate dated 7 November 2024.

Submissions

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

4. On behalf of the GMC, Ms Tollitt outlined the staged approach to misconduct and impairment and reminded the Tribunal of the overarching objective of the GMC as set out in section 1(1A) and 1(1B) of the Medical Act 1983 (as amended).

5. Ms Tollitt referred the Tribunal to the relevant caselaw and submitted that paragraphs 1, 47, 53 and 65 of the Good Medical Practice (2013), as set out below, had been breached by Dr Tripathi as a result of the allegations found proved.

> *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, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*
>
> *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*.

6. She also referred the Tribunal to the GMC guidance entitled "*Maintaining a professional boundary between you and your patient*" 2013, in particular paragraph 3:

> *3 Trust is the foundation of the doctor-patient partnership. Patients should be able to trust that their doctor will behave professionally towards them during consultations and not see them as a potential sexual partner.*

7. Ms Tollitt reminded the Tribunal that Dr Tripathi's actions involved unwanted sexual behaviour towards a female patient during a consultation, which occurred in the presence, though out of the sight, of her XXX son. As noted by the Tribunal in its determination, the conduct involved: touching, not just one, but multiple parts of Patient A's body, which included her left breast, left nipple and right breast; inappropriate exposure of her breast; touching of her buttocks over her clothing; and attempting to lift the waistband of her trousers. She submitted that the behaviour was opportunistic, taking place while the Doctor was carrying out the examination.

8. She submitted that the Tribunal, in its decision on facts, also took into account the fact that Dr Tripathi was in a position of authority and Patient A was therefore subject to a power imbalance. She submitted that the Doctor's conduct has been found to be sexually motivated and to constitute sexual harassment, and that the Tribunal had concluded that the Doctor's actions had the effect of violating the dignity of Patient A and creating an intimidating, degrading, humiliating and offensive environment for her.

9. She submitted that Patient A describes how, since the appointment, she does not trust doctors anymore. In her evidence, Patient A stated that she now takes her husband with her to appointments, especially with male doctors. For these reasons, she submitted that Dr Tripathi's conduct amounted to very serious misconduct.

10. In considering impairment, Ms Tollitt referred the Tribunal to Dame Janet Smith's test in the Fifth Shipman Report, as adopted by the High Court in *CHRE v NMC & Grant (2011) EWHC 927*. She submitted that Dr Tripathi:

> *"…b. Has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
> *c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession…"*

11. With regard to the issues of insight and remorse, she submitted that Dr Tripathi, at the Facts stage, denied that any of the actions set out in Allegation 1 had occurred. She submitted that, especially since the Doctor has not given evidence following the Tribunal's findings on the facts, there is an absence of evidence on which the Tribunal could conclude that he now shows remorse or full insight into his misconduct.

12. She submitted that, within his written reflection documents, Dr Tripathi has apologised to Patient A on certain aspects of the consultation. However, Ms Tollitt submitted that the apologies do not specifically address the acts which are set out in Allegation 1, nor the sexual nature or motivation of that conduct.

13. She submitted that some of the other reflections which have been made by Dr Tripathi within those documents further reveal the limits of his current insight. She said that the Doctor makes the following reflection on the importance of professional boundaries:

'I was always aware of the professional boundaries all through my career. Been extremely important to give the best to me to give the best clinical care to my patients, respect their dignity and to make them feel comfortable in any setting in which I've interacted with them over my entire career'.

14. Ms Tollitt submitted that the following observation is made about the issue of sexual attraction:

    'I had no such feelings for the patient during the consultation and I affirm that I conducted the consultation with impeccable integrity and professional'.

15. She submitted that both of those reflections are clearly at odds with the factual findings made and that they demonstrate a lack of insight on the Doctor's part into the conduct which has been found proved.

16. Ms Tollitt therefore submitted that the Doctor has not fully remediated for his misconduct. However, there is evidence of some effort to remediate. Dr Tripathi completed a Professional Boundaries course in early November of last year. However, the reflections which have followed from it are limited by the fact that it was completed before the fitness to practise proceedings at a time when Dr Tripathi was denying all of the facts now proven.

17. In considering the question of impairment she submitted that, acting in the way that he did during the consultation on the 24 August 2023, Dr Tripathi undermined the well-being of Patient A. She submitted that his actions fell far short of the proper professional standards and conduct for members of the medical profession. She submitted that it was also the opinion of the GMC expert this his actions in Allegation 1 were seriously below the standard of the competent General Practitioner.

18. Ms Tollitt submitted that the Doctors' actions undermine fundamental tenets of the medical profession and have plainly brought the profession in disrepute.

19. Finally, she submitted that a finding of impairment is necessary to reaffirm clear standards of professional conduct in order to maintain public confidence in the profession and to uphold all three limbs of the Overarching Objective in this case.

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

20. Mr Davidson submitted that the Tribunal had already heard details of the Doctor's attendance and reflections on the Boundaries course, together with his testimonials, which cover not only character but indicate his good standard of clinical practice as well.

21. Turning to the issue of misconduct, he submitted that there is no statutory definition for misconduct provided within the Medical Act or any secondary legislation. The Tribunal had found that Dr Tripathi has acted inappropriately in the examination of Patient A and that his actions were sexually motivated. He submitted that his actions in conducting that examination are contrary to one or more of the core tenets of GMP. He submitted that Dr Tripathi accepts that the Tribunal are likely to make a finding of misconduct.

21. When considering the issue of impairment, he submitted that the Tribunal are entitled to have regard to the doctor's previous character, to the testimonials that have been provided, and indeed to the fact this was a one-off instance.

22. However, he submitted that, recognising the gravity of the allegations, Dr Tripathi did not seek to convince the Tribunal that his practice is currently not impaired.

Relevant Legal Principles

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

24. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts found proved amount to misconduct and then whether Dr Tripathi's fitness to practise is currently impaired by reason of that misconduct.

25. The Tribunal was reminded by the LQC that '*Misconduct*' has been defined by the Privy Council in the case of *Roylance v GMC* as: '*a word of general effect involving some act or omission which falls short of what would be proper in the circumstances*'. In that case the Privy Council went on to say, '*The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances*.' Accordingly, the Tribunal would be entitled to have regard to the GMC's *Good Medical Practice* which was in force at the time.

26. The Tribunal is also to have regard to the Overarching Objective, which is to:

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

27. The Tribunal was reminded that the misconduct must involve the Doctor falling not just short, but far short, by omission or commission, of the standards of conduct expected of a Registered GP. Such falling short as is established must be serious; (*Roylance v GMC* and *Cheatle v GMC*); seriousness must be given its proper weight and has been referred to in other contexts as '*conduct which would be regarded as deplorable by fellow practitioners*' (Nandi v GMC); and that this concept was echoed and adopted in the case of *R v. Nursing and Midwifery Council (ex parte Johnson and Maggs) (No 2) [2013] EWHC 2140 (Admin)* which observed that '*It was common ground, and the Committee accepted, that simple negligence was not sufficient for this purpose and that "gross professional negligence" or conduct that would be seen as "deplorable" by fellow practitioners was required'.*

28. The Tribunal must consider whether Dr Tripathi's fitness to practise is, as of today, impaired. In addition to the test set out in the case of *CHRE v NMC and Grant [2011] EWHC 927 (Admin)*, the Tribunal should also apply the *Cohen* test. The Tribunal should also consider whether Dr Tripathi has exhibited remorse and/or has demonstrated insight into his actions and whether he would, if faced with the same situations again in the future, act differently.

29. The Tribunal was reminded that insight requires Dr Tripathi to (i) understand what went wrong; (ii) appreciate that he should have acted differently; and (iii) understand how he can act in the future to ensure that what he did does not happen again.

30. The Tribunal should also consider paragraph 94 of the case of *GMC v Sawati [2022] EWHC 283 (Admin);*

> *"94. The High Court recently reviewed the principles to be derived from the 'rejected defence' authorities on the question of 'denial of allegations, insight and sanctions' in*

Sayer v General Osteopathic Council [2021] EWHC 370 (Admin) at paragraph 25 as follows:

(1) Insight is concerned with future risk of repetition. To this extent, it is to be distinguished from remorse for the past conduct.

(2) Denial of misconduct is not a reason to increase sanction.

(3) It is wrong to equate maintenance of innocence with lack of insight. Denial of misconduct is not an absolute bar to a finding of insight. Admitting misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it.

(4) However, attitude to the underlying allegation is properly to be taken into account when weighing up insight. Where the registrant continues to deny impropriety, that makes it more difficult for him to demonstrate insight.

(5) The assessment of the extent of insight is a matter for the tribunal, weighing all the evidence and having heard the registrant. The Court should be slow to interfere."

31. The LQC indicated that, even if the Tribunal concluded that Dr Tripathi is not currently impaired on a personal/public protection basis solely by reference to the *Grant* or *Cohen* tests outlined above, there may be wider issues of public interest and public confidence in the profession which come into play. The LQC reminded the Tribunal of the case of *Grant* which states at paragraph 101:

'*The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case*'.

32. In considering the issue of impairment on public interest grounds, the Tribunal should assess where, in the overall spectrum of seriousness, to place Dr Tripathi's misconduct. If the Tribunal consider it to be low on the spectrum, the public interest argument might not apply – if it is higher up, then it may. It was a matter for the Tribunal's judgement. However, *Grant* also says that the more serious the misconduct found, the more difficult it should be to justify a finding of '*no impairment*'.

The Tribunal's Determination on Impairment

Misconduct

33. In determining whether Dr Tripathi's fitness to practise is impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amount to misconduct. In relation to each of the paragraphs it had found proved, it considered the context within which the conduct had taken place and the extent of any departure from the professional standards expected.

Paragraph 1a, b, c and d

34. In reaching its decision in respect of paragraph 1a, b, c and d the Tribunal reminded itself of its findings at the fact-finding stage of proceedings. The Tribunal has found that Dr Tripathi inappropriately touched Patient A during a consultation. It noted that he had not sought Patient A's consent to the interaction, and from her perspective, it had been unexpected and unwanted. It is apparent to the Tribunal that Dr Tripathi clearly failed to maintain an appropriate professional boundary.

35. The Tribunal also took into account the opinion of the GMC expert, Dr B. His report detailed various questions which he was asked to consider, including:

> *'7. Where aspects of the care were seriously below the standard expected of a reasonably competent General Practitioner:*
>
> *a. state the specific aspects which were seriously below the standard;*
> *b. explain why they were seriously below.*
>
> *If Patient A's account is accepted then on 24.08.23 Dr Tripathi placed his stethoscope over Patient A's left breast and nipple and made gentle circular motions. My opinion is that these actions did not have any clinical purpose. My opinion is that they placed Patient A at risk of embarrassment and distress and reluctance to undergo similar examination in the future. Therefore my opinion is that his actions were seriously below the standard expected.*
>
> *If Patient A's account is accepted then on 24.08.23 Dr Tripathi exposed Patient A's right breast by pulling her bra up towards him and placed his stethoscope on Patient A's right breast using circular movements. My opinion is that these actions had no clinical purpose. My opinion is that Dr Tripathi's actions placed Patient A at risk of embarrassment and distress and reluctance to undergo similar examination in the*

future. Therefore my opinion is that his actions were seriously below the standard expected.

If Patient A's account is accepted then on 24.08.23 Dr Tripathi performed a kidney examination while she was in the prone position, pressed down on her gluteal areas and lifted the waistband of Patient A's trousers. My opinion is that this was seriously below the standard expected because these actions served [sic] placed Patient A at risk of embarrassment and distress and served no clinical purpose.'

36. The Tribunal has, in its factual determination, found that this conduct was inappropriate, and that Dr Tripathi acted with sexual motivation. The Tribunal also concluded that its finding that Dr Tripathi's actions constituted sexual harassment was significantly serious so as to amount to misconduct, and that it occurred within the context of a power imbalance as Dr Tripathi held as a doctor.

37. The Tribunal considered whether Dr Tripathi's conduct amounted to a departure from the professional standards set out in Good Medical Practice (2013) ('GMP') as set out above. It agreed with Ms Tollitt that paragraphs 1, 47, 53 and 65 of GMP were engaged. It also agreed that paragraph 3 of the GMC Guidance on Professional Boundaries was engaged, but in addition, also considered that paragraph 4 was also relevant, which states:

'*You must not pursue a sexual or improper emotional relationship with a current patient*.'

38. In addition, the Tribunal took account of the fact that the Sanctions Guidance indicates that "*sexual misconduct*" is listed amongst those cases "*that indicate more serious action is likely to be required*".

39. Generally, the Tribunal considered that patients have a right to be treated with respect. Dr Tripathi had subjected Patent A to unwanted behaviour that made her feel that her dignity was violated, she felt degraded, and it created an offensive and intimidating environment. The conduct had also taken place in a consultation room in the presence of her XXX son.

40. The Tribunal accepted that Dr Tripathi's conduct was a one-off event that had not happened previously, nor has it been repeated since. However, the Tribunal considered

that its findings of inappropriate touching and exposure of intimate parts of a patient's body with sexual motivation; which also amounted to sexual harassment, against the background of an abuse of his position as a doctor, were serious departures from the standards expected of a registered general practitioner and would be considered "*deplorable*" by fellow practitioners.

41. The Tribunal also determined that Dr Tripathi's actions constituted a serious departure from Good Medical Practice. His actions fell far short of the standards of conduct reasonably expected of a doctor.

42. Therefore, the Tribunal found that the matters found proved amounted to misconduct.

Impairment

43. The Tribunal, having found misconduct, went on to consider whether Dr Tripathi's fitness to practise is currently impaired by reason of that misconduct.

44. The Tribunal agreed with Ms Tollitt that paragraphs (b) and (c) of the Grant test were applicable and that the Doctor has in the past brought the medical profession into disrepute by his actions; and/or has in the past breached one of the fundamental tenets (as set out in GMP) of the medical profession.

45. In determining whether a finding of current impairment of fitness to practise is necessary, the Tribunal looked for evidence of insight, remediation and the likelihood of repetition, bearing in mind the three elements of the overarching statutory objective. It considered that insight and remediation are important in order for a doctor to recognise areas of their practice and behaviour that require improvement, and to take appropriate and relevant steps to address them, thus reducing the likelihood of repetition.

46. The Tribunal considered whether Dr Tripathi's misconduct is capable of being remedied, whether it has been remedied, and whether it is highly unlikely to be repeated (the *Cohen* test). In so doing, it considered whether there was evidence of Dr Tripathi's insight into his misconduct and any steps taken by him to remediate it.

47. The Tribunal therefore first considered whether the misconduct, and in particular the sexual misconduct, was capable of being remedied. It concluded that, whilst it was

theoretically possible, it was difficult to demonstrate remediation, especially since it was attitudinal.

48. The Tribunal then considered whether Dr Tripathi's misconduct had been remedied, which included whether he has demonstrated insight into his failings.

49. It noted that Dr Tripathi had undertaken a course relating to maintaining professional boundaries. Following the course, Dr Tripathi produced a detailed reflective piece containing his personal learning, which included:

> *'The course has deepened my understanding of essential concepts such as the importance of maintaining and respecting clinical boundaries. I have also gained a greater appreciation for the role of self-awareness and situational awareness in ensuring that I respond appropriately to different scenarios. Learning how to read and interpret both my body language and that of patients and colleagues has become a key focus, helping me to communicate more effectively and to better understand the unspoken messages that accompany interactions.*
>
> *I also now have a clearer grasp of the significance of setting appropriate limits on self-disclosure and understanding the delicate balance between clinical and non-clinical touch in patient care. This course helped me explore the power dynamics present in clinical consultations, particularly when dealing with dual relationships with colleagues, and how these dynamics can influence the course of a consultation. Additionally, I gained a deeper understanding of cognitive distortions and how they can impact decision-making, which has allowed me to develop more balanced and objective thinking.*
>
> *Another crucial lesson from the course for me was the pivotal role of consent and communication in the clinical setting. It highlighted to me in greater gravity - how open, clear, and respectful communication is essential in maintaining a professional and safe environment for both patients and healthcare providers.'*

50. The Tribunal also noted the positive testimonials. The testimonials make reference to his competent good character and clinical performance:

> *Dr Tripathi is a competent and conscientious medical practitioner who has consistently demonstrated integrity and responsibility in his role as a GP. While working at our*

practice, he was a well-liked and highly respected clinician who developed strong working relationships with both primary care colleagues and secondary care professionals.

The allegations made against Dr Tripathi are wholly inconsistent with the character and professionalism I have observed over the years. He has always conducted himself with honesty and demonstrated a clear commitment to patient care.
…….

Throughout our professional association, I have consistently found Dr. Tripathi to be a diligent, meticulous, and highly professional General Practitioner. He approaches his duties with the utmost integrity and dedication. Importantly, I am not aware of any complaints lodged against him by either patients or fellow staff members during his time at our practice.

To the best of my knowledge, Dr Tripathi has maintained amicable and effective working relationships with the practice staff and his GP colleagues. He is held in high regard as an integral member of the practice team, contributing positively to the overall quality of patient care and service.'

51. The Tribunal reminded itself that insight required the Doctor to demonstrate that he (i) understood what went wrong; (ii) appreciated that he should have acted differently; and (iii) understood how he can act in the future to ensure that what he did does not happen again.

52. Although Dr Tripathi has undertaken a relevant course and provided reflections, the Tribunal considered that these were largely expressed in theoretical terms and did not demonstrate a full acknowledgement of the impact upon Patient A. Moreover, although it can be said that he perhaps appreciates that he should have acted differently, he has not explained his own actions fully, nor demonstrated that he understands why he acted in this way. The Tribunal concluded that this amounts to limited insight. In doing so, it notes that this is in line with the case of Sawati, wherein it was stated:

"*Where the registrant continues to deny impropriety, that makes it more difficult for him to demonstrate insight*"

53. The Tribunal next considered whether Dr Tripathi's misconduct is "*highly unlikely*" to be repeated. It took into account the likely impact that this Fitness to Practise process has had on Dr Tripathi. It accepted that the experience of being subject to these proceedings will likely have been stressful and distressing to him and, in itself, is likely to have had a salutary effect on his future behaviour to the extent that it may well act as a deterrent to Dr Tripathi from engaging in similar misconduct. However, while this factor likely reduces the risk of repetition, the Tribunal considered that this alone cannot offset the need for Dr Tripathi to demonstrate that he clearly understands how he can act in the future to ensure that what he did does not happen again. Once again, the Tribunal is drawn to the conclusion that, as his insight at present is not fully developed, in that he has failed to demonstrate sufficient understanding of why he acted in the way that he did, there is currently a real risk of repetition. Accordingly, the Tribunal considers that the likelihood of repetition is currently not sufficiently low so as to be described as "*highly unlikely*".

54. The Tribunal therefore finds that Dr Tripathi is currently impaired.

55. The Tribunal next considered whether, notwithstanding that it had found that Dr Tripathi was currently impaired, it was appropriate also to make a finding of impairment on public interest grounds in any event. In doing so, it considered the overall seriousness of the misconduct and all three limbs of the overarching objective.

56. The Tribunal first considered the seriousness of the misconduct found proved. The Tribunal considered that, although Dr Tripathi's actions were not at the higher end of the scale in terms of sexual misconduct, it must not be forgotten that the incident nonetheless had traumatised Patient A. The Tribunal took account of Ms Tollitt's submissions on the point and also noted that, in her oral evidence, Patient A had confirmed that she had not followed up on various clinical issues identified by Dr Tripathi during his examination because "*after such a stress, I did not want to see any doctor at all*". The Tribunal considered that this was a clear demonstration of his actions not only threatening the safety and well-being of the public (paragraph a of the Overarching Objective) but also paragraph b (public confidence in the medical profession) which made his conduct entirely unacceptable by the standards expected in society. The Tribunal also considered that the requirement to promote and maintain proper professional standards and conduct for the members of the profession (paragraph c of the Overarching Objective) would be emphasised by the profession being reminded that such conduct was unacceptable. The Tribunal therefore determined that a finding of impairment on public interest grounds was also required.

57. The Tribunal has therefore determined that Dr Tripathi's fitness to practise is impaired on both grounds, by reason of his misconduct.

Determination on Sanction - 22/08/2025

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

The Evidence

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

Submissions

On behalf of the GMC

3. On behalf of the GMC, Ms Tollitt provided written submissions which she also presented verbally to the Tribunal.

4. She submitted that in all the circumstances of the case, the only appropriate sanction was one of erasure from the medical register.

5. She drew the Tribunal's attention to the GMC/MPTS Sanctions Guidance ('the SG') and reminded the Tribunal of the approach it should take at this stage of the hearing.

6. Ms Tollitt submitted that prior to these proceedings, Dr Tripathi's fitness to practise had not previously been found to be impaired by a Tribunal. He has continued to work under the conditions of his interim order.

7. She submitted that Dr Tripathi has, in this case, made some efforts to remediate; he has attended a professional boundaries course in November of last year and provided subsequent reflections from it; and also more recently attended a webinar in relation to chaperones. She submitted that both courses were completed before the Tribunals finding of fact at a time when Dr Tripathi was denying all of the now proven misconduct.

8. Ms Tollitt submitted that, in this case, the serious nature of the misconduct from Dr Tripathi is difficult to remediate. She referred the Tribunal back to paragraph 47 of its previous determination where it concluded that, whilst remediation of the sexual misconduct in this case was theoretically possible, it was difficult to demonstrate remediation especially as it was attitudinal.

9. She submitted that the Tribunal concluded that Dr Tripathi had shown limited insight. Whilst the doctor had undertaken relevant courses and provided reflections, the Tribunal considered that his reflections were largely expressed in theoretical terms and did not demonstrate a full acknowledgement of the impact of his actions upon Patient A.

10. She submitted that the Tribunal noted that Dr Tripathi has not explained his own actions fully, nor demonstrated that he understood why he acted in this way.

11. Ms Tollitt submitted that the Doctor continues to deny impropriety which makes it more difficult for him to demonstrate insight. She reminded the Tribunal of the reflections made by Dr Tripathi within his written reflection documents, which, she maintained, further demonstrate the limits of his current insight into misconduct.

12. She accepted that Dr Tripathi has apologised to Patient A for aspects of the consultation. However, there has been a lack of apology specifically addressing the acts as set out in Allegation 1, the sexual nature or motivation of that conduct, or specifically the impact of those acts on Patient A.

13. She stated that the Tribunal has been provided with a number of testimonials from professionals who have worked alongside Dr Tripathi. The Tribunal should consider what weight, if any, to give to those documents and may therefore question how far the views expressed within the testimonials are now relevant to the specific findings which have been made about Dr Tripathi.

14. In addition to mitigating factors, Ms Tollitt suggested that the Tribunal will also consider aggravating factors.

15. She submitted that the allegations against Dr Tripathi now proven arise from his conduct on a single date towards a single patient. However, his behaviour did not involve a single

incidence of touching, but involved the Doctor touching and exposing, or attempting to expose, multiple parts of Patient A's body.

16. She submitted that other aggravating features could include the touching occurred whilst Dr Tripathi was purporting to carry out physical examinations of Patient A; and the presence of her son in the room, although out of sight whilst the examinations took place.

17. Ms Tollitt turned to the sanctions available to the Tribunal. She submitted that it was clear that taking no action, imposing conditions or a suspension, would not reflect the seriousness of the conduct or satisfy the public interest in this case. She submitted that erasure is the only means of protecting the public and is an appropriate and proportionate response in order to promote and maintain public confidence in the profession, and professional standards and conduct.

On behalf of Dr Tripathi

18. On behalf of Dr Tripathi, Mr Davidson submitted that this is a case which can properly and proportionately be concluded with an order of suspension. Ultimately, the decision is entirely for the Tribunal, which is assisted by the SG rather than bound by the SG.

19. Mr Davidson emphasised the issue of proportionality to the Tribunal. He submitted Dr Tripathi is XXX; the entirety of his family is financially dependent upon him. He has no other means or sources of income, and nor does the family have significant savings upon which they can rely. He submitted that if he is unable to work as a medical practitioner he will suffer as he is not trained or skilled in any other profession. This will inevitably be a significant loss of income which he will not be able to redress by working elsewhere.

20. He submitted that the Doctor will have to live in future in the knowledge that he has been found guilty of sexual misconduct. The stigma associated with that will obviously pervade his professional career, but beyond that, his social and family life as well will be adversely affected, and that effect will continue to blight his reputation for the remainder of his life.

21. With regards to the mitigating factors, he submitted that the doctor was a man of good character, having been clear of any complaints or any disciplinary matters throughout the totality of his career, both in the United Kingdom and, prior to that, in India.

22. Mr Davidson referred the Tribunal to the testimonials and submitted that they reflect not only upon the Doctor's character, but his clinical abilities and his generally compassionate response towards patients.

23. He submitted that the lapse of time since the consultation with Patient A is almost exactly two years, within which time there has been no further concern or complaint raised about Dr Tripathi.

24. With regards to insight and remediation Mr Davidson referred the Tribunal to Dr Tripathi's initial response to the complaint. He submitted that there is some insight on the part of the doctor. He recognises the upset on the part of his patient. He acknowledges and he expresses his sympathy and indeed, conditional remorse to those concerns and this reflects back on his compassionate nature. He submitted that this is not a man who turns a blind eye to the expressions of emotion by his patients. He submitted that he may not have agreed with her concerns or complaints in this case, but he is not without some sympathy for the upset, which was shown by his patient, and some readiness to demonstrate remorse on his part.

25. In terms of remediation, he submitted that Dr Tripathi has now reviewed his practice and undertaken steps of remediation. He recognises his own capacity as a clinician and wants to improve his skills and to identify areas of weakness. Dr Tripathi has done that through his participation in two courses, providing detailed reflections in relation to the professional boundaries course and he supplements those educational activities with practical changes.

26. Mr Davidson submitted that since these events the doctor has been the subject of an interim order of conditions which has not precluded him from working and he has continued to work almost continuously.

27. He submitted that Dr Tripathi works at urgent treatment centres, whereby he works on a hospital premises essentially in a separate unit to which primary care complaints are redirected either by the A&E service or sent directly to that service by NHS 111. He has been exposed to a variety of patients, male, female, young and old over the past two years. He submitted that there has been no concern or complaint, and he has complied with his interim order of conditions to have a chaperone present for any consultation with a female patient.

28. Mr Davidson submitted that Dr Tripathi has adopted additional safeguards to his practice, utilising the documents/images of a patient's torso that the Tribunal was provided with, as a means of educating his patients before the examination takes place, which detail where the examination will occur and what parts of the anatomy will be examined. He submitted that the concerns which have been brought to the Tribunal's attention and have been found proved will not be repeated in the future.

29. Moving to the seriousness of the misconduct, he submitted that the misconduct occurred on one occasion in the course of one consultation lasting approximately 10 minutes. It involved the inappropriate touching a patient as breasts via the stethoscope rather than skin to skin.

30. He submitted that this is a case which is not at the upper end of the spectrum of sexual misconduct and addressing all of these features it can properly be dealt with an order of suspension with a review.

Relevant Legal Principles

31. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal exercising its own judgment by reference to the SG. It must consider the least restrictive sanction first and then, if necessary, consider the other sanctions in ascending order of severity. The Tribunal must consider its determination on impairment and take those matters into account during its deliberations on sanction.

32. The Tribunal recognised the purpose of a sanction is not to be punitive but to protect patients and the wider public interest, although it may have a punitive effect. It reminded itself that in deciding what sanction, if any, to impose, it should consider the sanctions available, starting with the least restrictive. If the Tribunal departs from the SG, it must give reasons for departing from relevant parts of the SG.

33. The Tribunal should have regard to the overarching objective, which includes the protection of the public, the maintenance of public confidence in the profession, and the promotion and maintenance of proper professional standards and conduct for members of the profession. The Tribunal will apply the principle of proportionality, balancing the wider public interest with that of Dr Tripathi. The Tribunal bore in mind the reputation of the profession as a whole is more important than the interests of an individual member.

The Tribunal's Determination on Sanction

34. The Tribunal first considered the facts of the case and identified any aggravating and mitigating factors present. It had regard to the submissions made by both parties in this regard.

Aggravating factors

35. The misconduct involved an abuse of professional position (paragraph 55 (d) of the SG) - Dr Tripathi took advantage of a power imbalance between himself and Patient A.

36. The conduct involved sexual misconduct, as indicated in paragraph 55 (e) of the SG.

37. Further, whilst the allegations arose from an incident on one day involving a single patient, it nonetheless involved two instances of touching different intimate parts of Patient A's body.

38. Finally, the misconduct also took place with Patient A's XXX son present in the room, albeit she was out of his sight.

Mitigating factors

39. The Tribunal reminded itself that it previously acknowledged that Dr Tripathi had developed some insight, albeit not full insight. However, regarding the latter, it acknowledged Mr Davidson's submission as follows:

"*The Tribunal is reminded of the decision of Sawati*[1] *and referred to the comment of Kerr J in Shah*[2] *that, in circumstances where a registrant had exercised his "unqualified right of self-defence...(t)he tribunal was right not to expect a Damascene overnight revelation of full insight the day after the findings of fact" (para 123)."*

40. Accordingly, the Tribunal took into account that Dr Tripathi likely had not had sufficient time to properly reflect upon the Tribunal's findings, which in turn impacted upon, and partially explained, the level of his insight.

41. Dr Tripathi has also apologised to Patient A for the conduct of parts of his examination. As Mr Davidson said in his oral submissions, in his reflections Dr Tripathi recognised that Patient A had been upset and this, Mr Davidson submitted, reflected a compassionate nature. Dr Tripathi did not "*turn a blind eye*" and he therefore was not without some sympathy towards Patient A.

42. The Tribunal accepted that this was an isolated event in that Dr Tripathi has no previous adverse findings against him and there has been no evidence of repetition of similar behaviour.

43. The Tribunal acknowledged that there have been no concerns about his clinical competence.

44. The Tribunal noted the testimonials that attest to Dr Tripathi's previous good character.

45. The Tribunal accepted that Dr Tripathi has made some efforts to remediate through his attendance on relevant courses. It noted that, since the incident with Patient A, Dr Tripathi has also reviewed the way he practises and has added additional safeguards to his examinations of patients, such as telling them (with the aid of diagrams) which parts of their bodies he will touch, and why. The Tribunal considers that this is a further demonstration of his developing insight.

Sanction

46. The Tribunal had regard to the submissions made by both parties that the seriousness of this case was such that taking no action or imposing conditions was neither appropriate nor proportionate.

47. The Tribunal accepted these submissions and found that neither of these options would be sufficient to satisfy the Overarching Objective given the seriousness of the misconduct found which involved sexually motivated actions which included inappropriately touching a patient.

48. The Tribunal therefore confined its considerations regarding sanction to the options of suspension and erasure. Furthermore, the Tribunal noted that Mr Davidson conceded

that the Doctor's misconduct was so serious that the appropriate outcome could be no lower than a period of suspension.

Suspension

49. The Tribunal first considered the sanction of suspension, and the advice provided in the SG. It had regard to paragraph 93 which states:

'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..'

50. The Tribunal considered that the following sub-paragraphs of paragraph 97 were applicable to Dr Tripathi's case:

'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

[…]

e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f No evidence of repetition of similar behaviour since incident.

g The Tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'

51. In relation to paragraph 97 a of the SG, the Tribunal acknowledged that it had found an abuse of professional position and sexual misconduct. It noted its assessment in its Impairment determination that Dr Tripathi's actions were not at the highest end of the spectrum of seriousness. The Tribunal further noted Mr Davidson's additional submissions on the seriousness of the misconduct:

"*…13. Nevertheless, the Sanctions Guidance does acknowledge that sexual misconduct will "encompass 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 other".*

14. Implicit in the guidance is also a recognition that there will be a spectrum of severity in sexual misconduct cases with particularly serious misconduct occurring "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"[3]. The existence of this spectrum of severity encapsulating misconduct warranting a sanction less than erasure is also recognised in various appeal cases…

…15. In assessing the gravity of the sexual misconduct in the present case the Tribunal is asked to consider the following points,

a. the misconduct involved a single patient (Patient A);

b. Patient A was not particularly vulnerable insomuch as she did not have any of the characteristics described in para 145 of the Sanctions Guidance;

c. the misconduct occurred on a single (10 minute) consultation;

d. the inappropriate touching of Patient A's breasts did not involve direct skin to skin contact but rather contact via the stethoscope;

e. inappropriate touching of P. A's gluteal region took place through clothing and was at the level of "the top of my glutes"[4] rather than closer to the anus or vagina;

f. the misconduct did not involve any of the predatory behaviour described in para 147 of the Sanctions Guidance

16. It is therefore respectfully submitted that the charges found proved against Dr. T do not lie at the upper end of the spectrum of sexual misconduct."

52. The Tribunal agreed that sub-paragraphs 15 a, b, c and f of Mr Davidson's submissions were applicable to Dr Tripathi's case. The incident was, to all intents and purposes, an isolated incident involving one patient (among the "*thousands*" of patients who have been seen by the Doctor in his career, without complaint), although the Tribunal does acknowledge Ms Tollitt's argument that during the examination, more than one intimate area was targeted.

53. Further, Patient A does not fall into any of the categories of vulnerability listed in paragraph 145 of the SG, nor were the Doctor's actions predatory (they were opportunistic). The misconduct was also of short duration, although it must not be forgotten that, notwithstanding, Patient A was deeply affected by the incident (as outlined before).

54. The Tribunal attaches less weight to sub-paragraphs 15 d and e. It has already commented upon the suggestion that "*skin-on-skin*" contact is necessarily different from touching with a stethoscope, which can nonetheless be a means of sexual arousal. The same argument could apply to touching through clothing. Having said that, however, the Tribunal does find some merit in the submission that the touching did not venture closer to the "*erogenous areas*" of Patient A's anus and vagina. Further, the Tribunal also notes that the sexual touching carried out by Dr Tripathi was not as serious, for instance, as going so far as penetration of, or contact with, those areas.

55. Accordingly, the Tribunal maintains its initial view that Dr Tripathi's actions were not at the highest end of the spectrum of seriousness.

56. In relation to paragraph 97 e of the SG, the Tribunal notes that Dr Tripathi abided by the conditions of his interim order and, indeed, appears to have used the opportunity to amend his practice to ensure that patients better understand the process and point of clinical examinations. Moreover, he has made some attempts at remediation by attending relevant courses and reflecting extensively upon what he had learned. Further, he has

engaged fully with this process. Accordingly, the Tribunal concludes that his attempts at further remediation will, at the very least, be genuine and wholehearted.

57. In relation to paragraph 97 f, the Tribunal has nothing to add to what has already been said – the point speaks for itself.

58. Finally, in relation to paragraph 97 g, the Tribunal repeats the reference to the quote from the case of *Shah* above ("*not to expect a Damascene overnight revelation of full insight the day after the findings of fact*") and takes account of the fact that, if it decides to make a suspension order with a review, then Dr Tripathi would have the opportunity of reflecting on the Tribunal's decision with a view to developing further insight into the matter. Accordingly, the fact that his insight is currently regarded as limited, is perhaps understandable – however, he does have some insight.

59. In relation to the question in the latter part of paragraph 97 g, namely whether Dr Tripathi "*does not pose a significant risk of repeating behaviour*" the Tribunal noted Mr Davidson's written submissions that maintained that there were strong grounds for believing that the Doctor would not repeat his misconduct. The Tribunal reminds itself of its conclusions at the Impairment stage on this point, namely that the likelihood of repetition was currently not sufficiently low so as to be described as "*highly unlikely*" (that phrase mirroring the Cohen test). Having heard the further submissions, the Tribunal repeats its suggestion that the experience of this regulatory process is likely to act as a deterrent to him repeating this behaviour, to which can now be added the knowledge that, as his family is entirely financially dependent upon him, there would be an additional incentive upon him not to threaten his family's well-being any further by acting as he has done in the past. Accordingly, whilst it cannot be said that there is no risk of him repeating his behaviour, the Tribunal does consider that it can now be said, bearing all the factors argued by Mr Davidson in mind, that Dr Tripathi does not pose a "*significant*" risk of repetition.

60. In light of the above, the Tribunal determined that as Dr Tripathi satisfied a number of the requirements set out in the SG justifying a period of suspension, a suspension order was a potential and justifiable sanction in this case

<u>Erasure</u>

61. However, the Tribunal went on to consider the submissions made together with the SG in relation to the sanction of erasure from the medical register. It noted the following paragraphs of the SG:

"*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.

109 Any of the following factors being present may indicate erasure is appropriate

a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.

b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.

[…]

d Abuse of position/trust.

e Violation of a patient's rights/exploiting vulnerable people

f Offences of a sexual nature, including involvement in child sex abuse materials

62. In relation to paragraph 109 a of the SG, the Tribunal agrees that Dr Tripathi's misconduct was a serious departure from the GMP. However, it has found that, in the spectrum of seriousness, his misconduct was not at the higher end of that spectrum. The Tribunal is also aware that sexual misconduct is included in the section of the SG, most specifically in paragraphs 149 to 150, as a case where more serious action is likely to be required. Further, paragraph 150 states:

"*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*."

63. However, it is also apparent to the Tribunal that not every case of sexual misconduct results in erasure (as exemplified by the cases cited by Mr Davidson). For that reason, together with its finding that his misconduct was not at the higher end of the spectrum of seriousness, the Tribunal does not consider that it can be said that Dr Tripathi behaviour automatically "*is fundamentally incompatible with being a doctor*."

64. In relation to paragraph 109 b of the SG, the Tribunal accepts that there was a deliberate disregard by Dr Tripathi for the principles of GMP and for patient safety, but this was nonetheless an isolated incident of relatively short duration which, again, was not at the higher end of the spectrum of seriousness.

65. In relation to paragraph 109 d of the SG, the Tribunal accepts that his misconduct was an abuse of his position and trust, but it was not predatory and was an isolated incident.

66. In relation to paragraph 109 e of the SG, the Tribunal accepts that the misconduct amounted to a violation of Patient A's rights, but notes that she does not fall into the categories of vulnerability indicated in paragraph 145 of the SG (as indicated above).

67. In relation to paragraph 109 f of the SG, the Tribunal repeats its comments regarding paragraph 109 a above. It would also mention that this is not a child abuse case.

68. In conclusion, the Tribunal accepts that, as some of the sub-paragraphs of paragraph 109 are applicable to Dr Tripathi's case, there are arguments that could justify a sanction of erasure. However, the Tribunal considers that the arguments in favour of a sanction of suspension outweigh those in favour of erasure at this stage. In particular, the Tribunal returns to the point regarding his current limited insight and him needing further time to reflect properly on the Tribunal's findings. It considers that it would not be fair to Dr Tripathi not to be given the opportunity to develop his insight by further reflection, which a suspension order, with a review, would enable him to do. Of course, if he fails to take that opportunity, or fails to demonstrate that he has developed further insight into his failings, then the reviewing Tribunal would still have the power to erase him, for instance

on the basis of a persistent failure to demonstrate sufficient insight (see paragraph 109 j). For that reason, a suspension order should not be regarded by him as a reprieve, especially as the case of *Sawati* indicated that "*Where the registrant continues to deny impropriety, that makes it more difficult for him to demonstrate insight.*" In addition, the public would still be safeguarded as he would be suspended from practice.

69. Accordingly, the Tribunal, having considered the factors above, concluded that erasure would be disproportionate and was not appropriate as his misconduct was not fundamentally incompatible with continued registration.

70. Accordingly, the Tribunal, having considered the factors above, concluded that erasure would be disproportionate and was not appropriate as his misconduct was not fundamentally incompatible with continued registration.

Length of Suspension

71. The Tribunal took into account paragraph 102 of the SG and the factors set out in the table attached regarding the length of suspension. It considered that most of the criteria indicated in the section regarding seriousness applied to the Doctor's case, but that none of those in the subsequent two sections did. The Tribunal recognised that whilst matters of sexually motivated misconduct are always serious, it considered in this case that the actions of Dr Tripathi were not at the higher end of this spectrum.

72. The Tribunal also acknowledged that there was a public interest in allowing an otherwise competent doctor to return eventually to practice, whilst still upholding the statutory overarching objective and marking the seriousness of the misconduct.

73. The Tribunal considered that a period of 10 months suspension would provide Dr Tripathi with the opportunity to reflect on his misconduct and to demonstrate, to a future reviewing Tribunal, that he has undertaken meaningful reflection on the facts found proved against him.

74. In the Tribunal's view, a ten-month suspension was sufficient to satisfy the need to promote and maintain public confidence and to send out a clear message to the profession that this type of conduct is unacceptable, in order to maintain proper professional standards. The Tribunal was satisfied that a reasonable and well-informed member of the public or the profession would be satisfied that this was a proportionate

response to Dr Tripathi's misconduct. A suspension for any longer period would be purely punitive in nature and therefore disproportionate.

Review hearing directed

75. In determining whether to impose a review, the Tribunal had regard to Paragraphs 163 and 164 of the SG dealing with review hearings which state:

163 It is important that no doctor is allowed to resume unrestricted practice following a period of conditional registration or suspension unless the Tribunal considers that they are safe to do so.

164……, in most cases where a period of suspension is imposed, and in all cases where conditions have been imposed, the Tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions or further conditions. A review hearing is therefore likely to be necessary, so that the Tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):

a they fully appreciate the gravity of the offence

b they have not reoffended

c they have maintained their skills and knowledge

d patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.

76. In view of the guidance set about above and the Tribunal's findings, it determined that a review hearing would be necessary in Dr Tripathi's case. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Tripathi to demonstrate that he has gained full insight and remediated sufficiently so as to be safe to return to unrestricted practice. It therefore may assist the reviewing Tribunal if Dr Tripathi can provide:

- Evidence of personal and professional development plans showing the pathway to insight and remediation;

- Focused and targeted written reflections on the Tribunal's findings to demonstrate further development of insight;

Dr Tripathi will also be able to provide any other information that he considers will assist the reviewing Tribunal.

Determination on Immediate Order - 22/08/2025

1. Having determined to suspend Dr Tripathi's registration for a period of 10 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Ms Tollitt submitted that an immediate order is necessary to protect the public, and was in the public interest. She submitted that the misconduct involved a serious breach of professional standards and boundaries involving unwanted sexual contact towards a patient in Dr Tripathi's care.

3. She submitted that the public confidence in the medical profession will be undermined if an immediate order were not imposed, and Dr Tripathi were allowed to return to practice before the order of suspension took effect following the findings that the Tribunal has made.

4. On behalf of Dr Tripathi, Mr Davidson referred the Tribunal to paragraph 172 of the sanction's guidance. He submitted that it is a test of necessity and draws in the issue of proportionality. He submitted that the Doctor has been the subject of an interim order of conditions since October 2023. That interim order obviously encompasses the requirements of the Doctor to contact the GMC and various other standard requests.

5. He submitted that the key requirement on him which he has complied with is the requirement for a chaperone to be present for every face to face female consultation. He has done so diligently and kept a log.

6. He submitted that in the absence of any concerns or complaints in the last two years these conditions represent or fulfil the requirement of necessity and indeed proportionality in this case.

7. He submitted that an order of conditions rather than suspension would be appropriate and fulfils the test of necessity and proportionality.

8. He referred the Tribunal to the testimonials; he submitted that those who work with Dr Tripathi at the urgent treatment centre are fully aware of these concerns and he has already spoken to them about the outcome of stages one and stages two. He submitted that they are fully cognisant of what has been determined by the Tribunal and will therefore understand the context in which he may return to practise in that 28 day period should they agree to do so. He submitted that this is an extra safeguard that would be in place if it assists.

The Tribunal's Determination

9. In reaching its decision, the Tribunal considered the relevant paragraphs of the Sanctions Guidance and exercised its own independent judgment. In particular, it took account of paragraphs 172 and 173.

'*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. …*

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.

10. The Tribunal was of the view that, an interim order was necessary on the grounds of public protection and public interest. The Tribunal considered that having determined that suspension is the only sanction appropriate to address the seriousness of Dr Tripathi's misconduct, it follows that it would be inappropriate to allow him to practise during any appeal period.

11. This means that Dr Tripathi's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, 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.

12. The interim order is hereby revoked.

13. That concludes this case.