PUBLIC RECORD

Dates: 06/11/2023 - 16/11/2023

Medical Practitioner's name:	Dr Narendra KOCHAR
GMC reference number:	5194360
Primary medical qualification:	MB BS 1991 Bhopal

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

Summary of outcome

Suspension, 6 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Ms Angela Georgiou
Lay Tribunal Member:	Mr Colin Sturgeon
Medical Tribunal Member:	Dr Pavan Rao

Tribunal Clerk:	Ms Ciara Fogarty

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Anthony Haycroft, Counsel, instructed by Clyde and Co
GMC Representative:	Ms Laura Barbour, 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 - 13/11/2023

Background

1. Dr Kochar qualified in 1991 and prior to the events which are the subject of the hearing, Dr Kochar moved to the United Kingdom in 1997 where he trained in gastroenterology. At the time of the events Dr Kochar was practising as a Consultant Gastroenterologist and Hepatologist for InHealth.

2. The allegation that has led to Dr Kochar's hearing can be summarised as on 30 July 2021, during the course of a full day session, Dr Kochar behaved in a sexually motivated way towards Ms A.

The Allegation and the Doctor's Response

3. The Allegation made against Dr Kochar is as follows:

1. On 30 July 2021, during the course of a full day session, you were assisted by Ms A. **Admitted and found proved.**

2. During procedures on patients, on one or more occasion, you whispered to Ms A:
    a. 'you are so beautiful, very very beautiful' or words to that effect; **To be determined**
    b. 'oh I like you' or words to that effect. **To be determined**

3. Whilst undertaking a colonoscopy during the morning session, you asked Ms A to XXX, and:
    a. manoeuvred your left hand under Ms A's right elbow touching her right breast; **To be determined**

b. touched Ms A's right breast again, after removing your hand from the patient's abdomen. To be determined

4. Whilst undertaking a colonoscopy during the afternoon session, you asked Ms A to XXX, and:
   a. manoeuvred your left hand under Ms A's right elbow despite Ms A positioning herself to allow you clear access to the patient, touching her right breast; To be determined
   b. touched Ms A's right breast again, after removing your hand from the patient's abdomen. To be determined

5. Your actions as set out in paragraphs 2 - 4 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.

The Admitted Facts

4. At the outset of these proceedings, through his counsel, Mr Andrew Haycroft, Dr Kochar made admissions to paragraph 1 of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced this paragraph of the Allegation as admitted and found proved.

The Facts to be Determined

5. In light of Dr Kochar's response to the Allegation, the Tribunal is required to determine whether he acted in the way alleged towards Ms A.

Witness Evidence

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

- Ms A, by video link,
- Ms B, XXX on Endoscopy Unit, by video link.

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

- Ms C, Deputy Sister at XXX Endoscopy Unit.
- Dr D, Consultant Colorectal and General Surgeon at East Suffolk and North Essex Foundation Trust

8. Dr Kochar provided his own witness statement dated 9 August 2023 and also gave oral evidence at the hearing.

Expert Witness Evidence

9. The Tribunal also received evidence from one expert witness called by Dr Kochar, namely Dr E. Dr E is an experienced Consultant Gastroenterologist and Hepatologist. He submitted an expert report on behalf of Dr Kochar dated 20 August 2023 and gave oral evidence, by video link before the Tribunal.

Documentary Evidence

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

- Patient logs from endoscopy sessions undertaken on 29 June 2021, 30 June 2021 and 30 July 2021
- Ms A's written complaint dated 17 October 2021
- Notes of Interview with Ms A as part of InHealth investigation dated 23 November 2021, 9 December 2021
- Notes of Interview with Ms B dated 23 November 2021
- Notes of Interview with Dr D dated 25 November 2021
- Notes of Interview with Dr Kochar dated 24 November 2021
- Note of discussion between Ms A, Ms C and Ms G dated 17 November 2021
- CV of Dr Kochar undated

The Tribunal's Approach

11. At this stage the Tribunal is required to determine whether the facts alleged, or any of them, have been proved.

12. The Tribunal must give separate consideration to the evidence in relation to each individual Allegation. Therefore, it does not follow from the fact that the Tribunal finds one

Allegation proved, or not proved, as the case may be, that the Tribunal will reach the same conclusion in relation to any of the other allegations.

13. In considering the Allegation the Tribunal must be satisfied that each of the elements of the Allegation have been made out before finding the particular allegation proved.

14. 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 Kochar does not need to prove, or disprove, anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

15. Where there are serious allegations or where there are serious consequences which would flow from a factual finding, the Tribunal is required to undertake a heightened examination of the evidence; *Casey v GMC* [2011] NIQB 95.

16. The Tribunal further accepted the relevance of the authority of *Lawrence v GMC [2015] EWHC 586 (Admin)* to this case, which stated that in serious offences, there is a need for cogent evidence. Whilst this does not alter the standard of proof required, a close and detailed analysis, as well as an examination of the inherent improbability of events is required in assessing the evidence.

17. The Tribunal were advised that it may draw reasonable inferences from the facts, using common sense and from experience. However, it would be wrong for it to enter into speculation about matters or for example to consider what evidence might or might not have been available in the case. The Tribunal must decide the case purely on the evidence that has been put before it. It was remined of the case of *Sony v GMC (2015) EWAC 0364 Admin* and counselled that it should only draw an inference if it can safely exclude other possibilities.

18. The Tribunal were reminded that it should have regard to the whole of the evidence [including any agreed/admitted evidence] and form its own judgement about the witnesses, and which evidence is reliable and which is not. Dr Kochar has chosen to give evidence and call witnesses. The Tribunal must judge his evidence by precisely the same fair standards it applies to any other evidence in the case.

19. The Tribunal were reminded of the case of *Okpara v GMC [2019] EWHC 2624 (Admin)* which sets out that the fact that a registrant has denied an allegation is not a factor to be held against them when assessing their evidence. It is up to the Tribunal to decide what weight it attached to the evidence before it.

20. The Tribunal also received legal advice on witness evidence, including witness credibility. Tribunals should consider all of the evidence before them before coming to a conclusion about a witness's credibility. This could include conflicts in evidence with another witness, denials of the allegations and reasons why they could not be true. It is open to Tribunals not to rule out the whole of a witness's evidence based on credibility; credibility can be divisible, as set out *in Khan v General Medical Council [2021] EWHC 374 (Admin).*

21. The Tribunal was advised that it should not assess a witness's credibility exclusively on their demeanor when giving evidence, but their veracity should be tested by reference to objective facts proved independently in their evidence, in particular by reference to any documents in the case. It is important to avoid the fallacy of the confident witness – a confident demeanor is not a reliable pointer to their honesty. The Tribunal should make a rounded assessment of a witness's reliability, rather than approaching their reliability in respect of each charge in isolation from the others. The Tribunal were reminded of the case of *R (on the application of Dutta) v GMC [2020] EWHC 1974 (Admin).*

22. The Tribunal were advised as regards sexual misconduct and assessment of witnesses. Whilst an authority from the criminal jurisdiction where different rules apply in relation to the burden of proof and the admissibility of evidence, the Tribunal was reminded of the case of *D [2008] EWCA Crim 2557.* In that case, the Court of Appeal accepted that a judge may give appropriate directions to counter the risk of stereotypes and assumptions about sexual behaviour and reactions to non-consensual sexual conduct. In short, these were that

(i) experience shows that people react differently to the trauma of a serious sexual assault, that there is no one classic response;

(ii) some may complain immediately whilst others feel shame and shock and not complain for some time; and

(iii) a late complaint does not necessarily mean it is a false complaint.

23. The Tribunal were advised that stereotypes of a 'complainant', an 'assailant' or views as to what is an appropriate or inappropriate reaction should be avoided. The Tribunal should approach their decision making without any pre-formed assumptions. The Tribunal were advised that they should bear in mind that there may be good reasons why a victim of sexual assault generally may not complain or may delay in complaining about a sexual offence.

24. The Tribunal were advised to be alert to the fact that the passage of time may have affected a witness's memory. The passage of time may affect that person's ability to take in and later recall the experience, whilst some people may go over an event afterwards in their minds many times and their memory may become clearer or can develop over time. The Tribunal was reminded that any clarity or development in memory may not necessarily be accurate, and in the case of Ms A may have been influenced by what she discovered about Dr Kochar after the events complained of. The Tribunal were reminded that an honest witness can be mistaken, and a mistaken witness is not necessarily wrong about every fact. Equally, the Tribunal were reminded to make due allowance for the fact that the passage of time may have created difficulties for the registrant to remember things that may have been important when responding to the Allegation.

25. Just because a person makes a consistent account about an event does not necessarily mean that account must be true, any more than an inconsistent account must be untrue. The complaint itself falls to be judged as part of the evidence of Ms A.

26. Evidence of Ms A's complaint is evidence about what she said on a previous occasion and so originates from Ms A herself. Consequently, it does not provide any independent support for her evidence. The Tribunal should consider, amongst other things:

- The context in which the complaint was made.
- The length of time that elapsed between the subject matter of the complaint and the making of the complaint.
- The explanation for any delay in making the complaint.
- The consistency/inconsistency of the complaint with Ms A's evidence.

The Tribunal are entitled to consider these when deciding whether or not the witness is accurate, reliable and truthful.

27. On sexual motivation, the Tribunal was reminded of the cases of *Basson v General Medical Council* [2018] EWHC 505 (Admin) and *Haris v General Medical Council* [2021] EWCA Civ 763. The Tribunal was advised that inappropriate conduct should not be equated with sexually motivated conduct: *Arunkalaivanan v General Medical Council* [2014] EWHC 873 (Admin) and consideration should be given as to whether there was any other explanation for inappropriate conduct. The Tribunal was further invited to have regard to the definition of '*sexual*' in section 78 of the Sexual Offences Act 2003.

28. The Tribunal considered Dr Kochar's positive good character evidence as important and relevant to its considerations in two respects. Although it is not a defence to the

allegations, Dr Kochar's good character counts in his favour when assessing the credibility of his evidence and whether it should be accepted. Secondly, his good character is relevant in his favour, as it may mean it is less likely that he has acted in the way alleged. The Tribunal was advised that the weight to be given to good character is a matter for the Tribunal, and it should not detract from '*the primary focus'* on the evidence before it: *Sawati v General Medical Council* [2022] *EWHC 283 (Admin), Donkin v The Law Society [2007] EWHC 414 (Admin) and Wisson v Health Professions Council [2013] EWHC 1036 (Admin).*

The Tribunal's Analysis of the Evidence and Findings

29. 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.

30. The Tribunal also received submissions from both parties and took them into account.

Paragraphs 2(a) and 2(b)

31. The Tribunal considered Ms A's evidence, witness statement and interview with InHealth. It considered Ms A to be a calm and measured witness, not prone to exaggeration. The Tribunal noted that Ms A was immediately uncomfortable with what had happened during the session on 30 July 2021, and either on the day or shortly thereafter, sought out Ms B to ask whether she had heard any of the comments that it was alleged Dr Kochar made. Within days of the session, Ms A spoke with Dr D about the events, and indicated in clear terms that she did not wish to work with him again. The Tribunal noted that Ms A did not make a formal complaint until 17 October 2021 when she saw the new rota and realised that she would have to work with Dr Kochar again. The Tribunal did not however consider this to be a late complaint, and accepted Ms A's reasons for not making a formal complaint earlier.

32. The Tribunal considered that Ms A was consistent in her accounts about what was said, and rather than immediately jumping to conclusions, had initially given Dr Kochar the benefit of the doubt. Her witness statement reads:

> *'At first I thought he was talking about the patient's bowel as he was performing the procedure but as he said the comments a couple of more times during the day I knew he was talking to me.'*

The Tribunal noted that prior to speaking with Dr D, Ms A 'googled' Dr Kochar and discovered that his registration was subject to conditions. Although the Tribunal have not heard

evidence about the reasons for those conditions being imposed, it was Mr Haycroft's submission that Ms A's perception of events on 30 July 2021 had been influenced by what she later discovered. In other words, Ms A attributed sinister motives to innocent events, based on what she had found out about Dr Kochar. The Tribunal was not persuaded by this submission.

33. The Tribunal noted that Dr Kochar did not advance a positive case in regard to paragraph 2(a) and 2(b) of the Allegation. He could not recall having said the words alleged, but indicated that if he had done so, the comments would not have been directed towards Ms A. Dr Kochar said that he may have been talking to himself, or commenting on the equipment he was using or the clarity of the images being obtained. The Tribunal also considered the evidence of Dr E that it is common for practitioners to make comments to themselves during procedures, and this was, to some extent, confirmed by Ms A.

34. The Tribunal considered the context in which paragraphs 2(a) and 2(b) of the Allegation allegedly took place. The Tribunal accepted Dr Kochar's evidence that the procedure room is often very loud due to the machinery, particularly the ventilation unit. The Tribunal also accepted that during this time period, practitioners were wearing masks so there was potential to misunderstand or mishear verbal comments made. However, it took account of Ms A's oral evidence that she had initially thought she was not hearing correctly and so moved closer to Dr Kochar so that she could hear more clearly, after which the comments continued. The Tribunal considered therefore that that there is room for doubt, but took account of Dr Kochar's evidence that he will whisper XXX on occasion if he wants to communicate information that he only wants XXX to hear.

35. The Tribunal was not greatly assisted on this issue by the evidence of Ms B, who was XXX in the room when Dr Kochar is said to made the comments to Ms A. It is perhaps not surprising that she did not hear any whipsering, being positioned at the 'head end' of the patient, some 1.5 – 2 metres away from Ms A. The Tribunal accepted Ms B's evidence that her focus would have been on the patient, and not Ms A or Dr Kochar. It also accepted that she would not have been able to hear whipsered comments, unless she was standing directly next to the colleague whispering.

36. On the balance of probabilities the Tribunal preferred the evidence of Ms A and accepted her evidence that the words, or words to that effect, were said, and that the comments were directed towards her. The Tribunal were not persuaded by the suggestion that the comments were made to an inanimate object, noting in particular the use of the words "you". The Tribunal accepted that the comments were repeated during the day. Further, the Tribunal noted that Dr Kochar did not suggest that he routinely muttered to

himself during procedures or commented on equipment or clarity of views. The Tribunal noted, in particular, that during his interview with Inhealth on 24 November 2021, Dr Kochar made no suggestion that the comments, if said, may have been mutterings to himself, or directed towards the equipment and/or images in the room.

37. In these circumstances, the Tribunal preferred the evidence of Ms A in relation to this allegation and considered it more likely than not to have occurred, and so found paragraphs 2(a) and 2(b) proved.

Paragraphs 3(a) and 3(b)

38. The Tribunal examined the various accounts of this alleged incident provided in the witness evidence. The Tribunal reminded itself of the evidence provided by Ms A,

'…. With his left hand he came under my right elbow touching my right breast and then moved his hand down to the patient's abdomen and XXX. When he removed his hand he again grazed my right breast as he pulled away.'

39. The Tribunal noted Ms A's evidence that most doctors XXX. She told us that she would be XXX. Although this was a much lower incidence than that suggested by Dr E, it did accord with the evidence of Ms B. The Tribunal noted that the events complained of occurred at a time when Ms A and Dr Kochar were working in close proximity to each other, and that they were competing for space with the patient trolley and the scope stack. The Tribunal accepted that there would be occasions when there would be accidental or inadvertent contact, but noted the evidence of Dr E that this would be limited to the shoulder, and there would be no reason for a doctor XXX, to come into contact with the XXX torso. This accorded with the evidence of Ms A and Ms B, XXX, to the effect that they have not experienced contact when XXX.

40. The Tribunal noted that Dr Kochar could not give a positive account regarding this incident. This is perhaps not surprising, since he was only interviewed by Inhealth on 24 November 2021, almost 4 months after the events complained of. Dr Kochar could not remember carrying out such an act, and considered the 30 July 2021 to have been a normal, unmemorable day for him with nothing unusual occuring during the patient list. Dr Kochar confirmed that there would be times when he would have to XXX. The Tribunal noted that this was not in keeping with Dr E's own practice. Dr E stated that he would physically take the XXX and place it on the location where he wanted XXX.

41. The Tribunal accepted Dr Kochar's evidence that an endoscopy is a dynamic procedure and that in circumstances where he has a tool in each hand (the controller in his left hand and the endoscope in his right hand) there is no set way or preffered hand to use when showing XXX to the patient's abdomen. Dr Kochar told us that he would not deliberately set out to come into contact with XXX, but in a patient-focused procedure such as this one, some contact may occur. Dr Kochar told us that if contact did occur on this occasion, it was inadvertant, and he was not aware of it.

42. The Tribunal was not greatly assisted in respect of Allegation 3(a) and (b) by the evidence of Ms B, who was XXX in the room when Dr Kochar is said to have grazed Ms A's breast during the morning session. Ms B confirmed that she did not observe anything unusual during the session on 30 July 2021, and saw nothing that caused her any concern. However, the Tribunal had regard to the fact that Ms B was inconsistent as to whether or not she had seen Dr Kochar show Ms A XXX, and what (if anything) she had seen of any such mechanism. The Tribunal also noted that Ms B was 1.5 – 2m away from Ms A at the 'head end' of the patient and was focused on the patient. The Tribunal considered it unlikely that Ms B would have been able to see a fleeting or grazing contact between the top of Dr Kochar's left hand and Ms A's right breast, given that Ms A's body would be blocking Ms B's line of sight.

43. Having considered the evidence in the round, and having formed the impression that Ms A was a credible witness, the Tribunal preferred the evidence of Ms A in relation to this allegation and found paragraphs 3(a) and 3(b) proved, on the balance of probabilities.

Paragraphs 4(a) and 4(b)

44. The Tribunal carefully examined the witness statement of Ms A in respect of these alleged incidents. In respect of this incident, Ms A's witness statement states as follows:-

' … On this occasion I positioned myself on an angle so that he could avoid my breast, but he used his left hand to go under my right elbow and touched my right breast as he moved down my arm to the patient's abdomen. He also touched my right breast when he moved his hand back to carry on the colonoscopy. I knew that touching on my breast for a second time was not an accident and both times has been [sic] on purpose.'

45. The Tribunal also considered Ms A's oral evidence. She told the Tribunal that she had never had an endoscopist interlocking arms with her in the manner that Dr Kochar had done, XXX. As she thought that the first time was a mistake, she altered her position XXX, to make sure that another mistake did not happen. Instead of being aligned with the bed, Ms A told

the Tribunal that she turned to her left, to be further away from Dr Kochar. She told us that she was trying to avoid contact.

46. The Tribunal noted that Ms A had not mentioned any contact between herself and Dr Kochar to Ms B when they spoke shortly after the events complained of. Indeed, she only mentioned the changing of position during the afternoon list in her witness statement. That evidence was not recounted to Dr D, or in her written complaint of 17 October 2021, or in the interview with Inhealth 23 November 2021. The Tribunal carefully considered whether Ms A's recollection on this issue may be honest but mistaken. In particular, the Tribunal considered whether Ms A may have incorrectly remembered changing positions when in fact she did not, having been influenced by matters she discovered about Dr Kochar after 30 July 2021. On balance, the Tribunal rejected the suggestion that Ms A was recounting an honest but false memory, and accepted that she had changed positions to avoid contact occurring. The Tribunal did not consider it unusual for the first formal mention of this to have been in the Ms A's witness statement, and noted that more details will often be elicited when information is being obtained for the purposes of a formal witness statement.

47. The Tribunal noted that Dr Kochar did not advance a positive case in respect of this incident, having no recollection of any contact having occurred. His evidence was to the effect that if contact occurred, it was accidental not deliberate. In any event, he was not aware of any contact having been made.

48. For the reasons outlined above, the Tribunal was not greatly assisted by the evidence of Ms B as regards Allegations 4 (a) and 4(b).

49. On balance, and having considered the evidence in the round and noting Ms A to be a credible and cogent witness, the Tribunal found paragraghs 4(a) and 4(b) proved, on the balance of probailities.

Paragraph 5

50. As the Tribunal found allegations 2(a) and 2(b), 3(a) and (b) and 4(a) and (b) proved, they went on to consider allegation 5 and whether or not the conduct found proved was sexually motivated.

51. The Tribunal adopted the definition of the phrase 'sexually motivated' from the High Court in the case of *Basson v GMC [2018] EWHC 505 (Admin)*. The guidance indicated that 'a sexual motive means that the conduct was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship'. To decide on the balance of probabilities whether

conduct was sexually motivated, the Tribunal was therefore required to consider Dr Kochar's state of mind at the time, which was something to be proved through inference or deduction from surrounding evidence, rather than through direct observation. The Tribunal acknowledged the need for proper scrutiny of all the evidence in order to determine whether a sexual motivation could be inferred, including weighing up the extent to which the evidence of the doctor's positive good character might be relevant to the issue of sexual motivation.

52. The Tribunal considered the case of *Haris v General Medical Council* [2021] EWCA Civ 763 where it was advised that sexual motivation can be inferred from a number of factors, including the fact that the touching was of the sexual organs, the absence of a sessional justification or the absence of any plausible reason for the touching.

53. The Tribunal had particular regard to the fact that Dr Kochar is of good character, making it inherently less probable that he behaved in the manner alleged. The Tribunal also noted that at the time of the events complained of, Dr Kochar's registration was subject to an interim order of conditions, XXX. Although the Tribunal noted that neither Ms A or Ms B appear to have been aware why Dr Kochar XXX, the Tribunal considered that that condition alone makes it inherently less probable that Dr Kochar would act in the manner alleged.

54. In respect of allegations 3 and 4, the Tribunal noted that Ms A initially considered that Dr Kochar's grazing of her right breast during the morning session may have been inadvertant. Her witness statement confirms *"…maybe it was a mistake and it could have happened by accident and that Dr Kochar had not noticed that he touched my breast."* This was confirmed during her oral evidence, when Ms A told the Tribunal that she thought it was a mistake the first time. In that regard, the Tribunal also noted and accepted Ms A's evidence that the contact was between the top (back) of Dr Kochar's left hand and her right breast, and that such contact was fleeting, with no 'cupping', fondling or lingering.

<u>Paragraph 5 in relation to 2(a) and 2(b)</u>

55. Although the Tribunal were satisfied, on the balance of probabilities that Dr Kochar whispered the words alleged, or words to that effect to Ms A, the Tribunal were not satisfied that same was sexually motivated. The Tribunal considered the words used, which did not change in character or tone during the day, to be inappropriate. However, the Tribunal were not satisfied, to the requisite standard, that Dr Kochar's conduct in relation to 2(a) and 2(b) of the Allegation was in the pursuit of sexual gratification or in pursuit of a future sexual relationship with Ms A.

56. Accordingly, the Tribunal did not find paragraph 5 proved in respect of paragraphs 2(a) and 2(b).

Paragraph 5 in relation to 3(a) and 3(b)

57. Having found paragraphs 3(a) and 3(b) of the Allegation proved the Tribunal went on to consider if Dr Kochar's conduct in relation to the paragraphs was sexually motivated.

58. The Tribunal revisited all of the reasons that they had found allegation 3(a) and 3(b) proved, as set out above. The Tribunal also considered the expert report of Dr E, which reads,

'XXX.

Furthermore, the colonoscopist and XXX can sometimes be in very close proximity for this as they have to compete for space with the stacks, the screen(s), the monitoring devices, a second assistant and the navigational sensor.'

59. The Tribunal considered that doctors and XXX, and that there is an inherent risk of accidental or inadvertent contact occurring during the procedure. The Tribunal noted the evidence from Ms A that in respect of the contact during the morning session, she initially considered that it may have been a mistake or an accident, or that Dr Kochar had not realised that he had done it.

60. Although the Tribunal accepted Ms A's evidence that the conduct complained of had occurred, the Tribunal noted Dr Kochar's previous good character, and the fact that the contact could have been accidental, inadvertent and not noticed by Dr Kochar. Accordingly, the Tribunal considered that there could be a plausible explanation for the conduct alleged during the morning session. On that basis, the Tribunal were not satisfied that the GMC had discharged the burden upon them of proving that the conduct found proved was sexually motivated.

61. As the Tribunal were not satisfied, on the balance of probabilities, that Dr Kochar's conduct in relation to 3(a) and 3(b) of the Allegation was done in the pursuit of sexual gratification or in pursuit of a sexual relationship, the Tribunal did not find paragraph 5 proved in respect of paragraphs 3(a) and 3(b).

Paragraph 5 in relation to 4(a) and 4(b)

62. The Tribunal accepted Ms A's evidence that when asked to XXX, she manoeuvred herself so that she was further away from Dr Kochar and so that his left hand, XXX, could avoid her breast. The Tribunal considered Ms A to be an honest and persuasive witness, not prone to jumping to conclusions. Whilst she initially gave Dr Kochar the benefit of the doubt in respect of the incident of touching during the morning list, the Tribunal accepted that Ms A was concerned, was on her guard, and therefore took steps to protect herself from any further accidental or inadvertent contact. The Tribunal had regard to Ms A's oral evidence that when her breast was touched for a third and fourth time in the afternoon, her immediate perception was that it could not have been an accident. She told the Tribunal that she felt terrible, and felt that her efforts to ensure that Dr Kochar would not be able to touch her breast again had not been enough to protect herself.

63. As above, the Tribunal noted Dr Kochar's previous good character; he qualified as a doctor in 1991 and has a hitherto unblemished record. The Tribunal also noted that on 30 July 2021, his registration was subject to conditions XXX. The Tribunal considered that those two factors would make deliberate conduct of a sexually motivated nature inherently less probable. However, the Tribunal noted that previous good character is not a defence to the allegation, and the Tribunal considered all of the evidence before it in the round.

64. The Tribunal considered the incidents at paragraphs 3 to differ to those of 4, in particular because Ms A was on her guard, and had taken steps to change her position to avoid any accidental or inadvertent touching, after what had occurred during the morning session. The Tribunal noted Dr Kochar's evidence to the effect that if he had noticed any accidental touching of the type alleged, he would apologise and take steps to ensure it did not happen again. His evidence however was that he was not at any stage aware of having made contact with Ms A's breast.

65. The Tribunal also noted the evidence from Ms A and Ms B to the effect that they had not experienced such contact previously, even accidentally, despite both being XXX. This tallied with the expert evidence of Dr E that whilst accidental contact may occur, it would be to the shoulder of XXX. Dr E considered there to be no reason why a doctor XXX would come into contact with the XXX torso. The Tribunal were cognisant of Ms A's evidence that such events had not happened in her career previously, but had occurred on four occasions that day.

66. The Tribunal noted that Dr Kochar did not put forward a positive case regarding paragraphs 4(a) and 4(b) and in the absence of any clear memory had to advance a speculative account. The evidence of Ms A spoke of a deliberate act in which Dr Kochar touched her breast on two occasions in the afternoon list, seemingly without a good reason

and in circumstances where Ms A had taken steps to ensure that touching did not occur. The Tribunal considered Ms A's account compelling and without embellishment. The Tribunal considered accidental contact between Dr Kochar's left hand and Ms A's right breast, without Dr Kochar's knowledge, on four separate occasions to be improbable, notwithstanding Dr Kochar's good character. On balance therefore, the Tribunal accepted Ms A's evidence that Dr Kochar's touching in the afternoon was intentional, and could not have been accidental.

67. The Tribunal considered that the conduct found proved amounted to sexual touching of Ms A's right breast. The Tribunal made this finding notwithstanding the fact that the contact was fleeting, in and out, XXX.

68. Further, the Tribunal considered that it was more probable than not there was sexual motivation by Dr Kochar, in that the conduct found proved was done for his own sexual gratification. Accordingly, the Tribunal found paragraph 5 of the Allegation proved in respect of allegation 4(a) and 4(b).

The Tribunal's Overall Determination on the Facts

69. The Tribunal has determined the facts as follows:

1. On 30 July 2021, during the course of a full day session, you were assisted by Ms A. ***Admitted and found proved***

2. During procedures on patients, on one or more occasion, you whispered to Ms A:
    a. 'you are so beautiful, very very beautiful' or words to that effect; ***Determined and found proved***
    b. 'oh I like you' or words to that effect. ***Determined and found proved***

3. Whilst undertaking a colonoscopy during the morning session, you asked Ms A to XXX, and:
    a. manoeuvred your left hand under Ms A's right elbow touching her right breast; ***Determined and found proved***
    b. touched Ms A's right breast again, after removing your hand from the patient's abdomen. ***Determined and found proved***

4. Whilst undertaking a colonoscopy during the afternoon session, you asked Ms A to XXX, and:

a. manoeuvred your left hand under Ms A's right elbow despite Ms A positioning herself to allow you clear access to the patient, touching her right breast; ***Determined and found proved***
b. touched Ms A's right breast again, after removing your hand from the patient's abdomen. ***Determined and found proved***

5. Your actions as set out in paragraphs 2 - 4 were sexually motivated ***Determined and found proved in relation to 4(A) and 4(B) but not proved in relation to 2(a),2(b), 3(a), 3(b).***

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 - 14/11/2023

70. 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 Kochar's fitness to practise is impaired.

The Evidence

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

72. The Tribunal also received, in support of Dr Kochar, ten testimonials from colleagues all of which it has read.

Submissions

Submissions on behalf of the GMC

73. On behalf of the GMC, Ms Laura Barbour, Counsel, submitted that Dr Kochar's fitness to practise is currently impaired by reason of serious professional misconduct. She referred the Tribunal to the relevant case law and to a number of paragraphs of Good Medical Practice (2013 edition) (GMP), namely 1, 36, 37 and 65 and submitted these paragraphs are engaged.

1 Patients need good doctors. Good doctors… establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.

36 You must treat colleagues fairly and with respect.

37 You must be aware of how your behaviour may influence others within and outside the team.

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

74. Ms Barbour invited the Tribunal to then consider Dame Janet Smith's test in *The Fifth Shipman Report, cited in CHRE v NMC and P Grant [2011] EWHC 927 (Admin)* in which sets out:

'Do our findings of fact in respect of the doctor's misconduct…show that his/her fitness to practise is impaired in the sense that s/he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

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; and/or…

d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

Ms Barbour submitted that each limb is engaged in this case.

75. Ms Barbour invited the Tribunal to consider the case of *General Medical Council v Meadow [2006] EWCA Civ 1390 (26 October 2006) which* sets out

'32 the purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a

person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past.'

Ms Barbour invited the Tribunal to assess Dr Kochar's current impairment but to take into account how Dr Kochar has behaved in the past.

76. Ms Barbour invited the Tribunal to have regard to the case of *Cheatle v General Medical Council [2009] EWHC 645 (Admin) (27 March 2009)* in which impairment is considered as:

' In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct.'

77. Ms Barbour reminded the Tribunal that the objective of proceedings is not to punish the practitioner but the Tribunal must focus on the need to protect the public and to declare and uphold proper standards of conduct and behaviour and to maintain public confidence in the profession. She submitted that the sexual touching of a colleague whilst a patient is mid procedure is so egregious that public confidence in the profession would surely be damaged if impairment was not found.

78. Ms Barbour invited the Tribunal to consider remediation. She submitted that sexual misconduct is not easily remediated and there is no evidence that Dr Kochar has, in fact, remediated. Furthermore, she submitted that there is no evidence that such conduct is unlikely to be repeated. Ms Barbour submitted that there is no evidence that Dr Kochar has genuinely reflected on his failures or his actions or that he has developed genuine insight, and as such his fitness to practice remains impaired.

79. Ms Barbour submitted that Dr Kochar, in a place of work, engaged in sexual touching of a hard-working colleague. She submitted that it is necessary to send a clear message to the public and members of the profession of what is, and is not, acceptable conduct and behaviour for a doctor.

80. Ms Barbour referred to the bundle of the testimonials submitted on behalf of Dr Kochar. She submitted that these testimonials were prepared in advance of the Tribunal's finding of fact at stage 1 and that accordingly none of the authors were aware of the findings of the Tribunal. She conceded that the testimonials spoke highly of Dr Kochar and of his ability as a clinician. None of the testimonials give any reason to worry that Dr Kochar is not a perfectly adequate practitioner. She submitted however that this is often the case in sexual misconduct matters, where the conduct is often secretive and hidden from colleagues. She invited the Tribunal to weigh the testimonials received against the facts found proved, and submitted that a finding of impairment should be made.

81. Ms Barbour submitted it was necessary for the Tribunal to make a finding of impairment in order to uphold public confidence in the profession. She also said that the Tribunal should consider if the need to uphold and maintain proper professional standards and the need to maintain public trust in the profession would be undermined if a finding of impairment was not made.

Submissions on behalf of Dr Kochar

82. On behalf of Dr Kochar, Mr Haycroft conceded that the facts found proved amounted to misconduct. Further, it was accepted that this misconduct amounts to impairment on public interest grounds namely under the second and third strands of the overarching objective, as any sexually motivated contact needs to be marked by a finding of impairment. He counselled the Tribunal against making findings of misconduct in relation to allegations 2 (a) and (b), on the basis that inappropriate comments should not be equated with misconduct.

83. Mr Haycroft reminded the Tribunal of the approach suggested by Silber J in *Cohen v General Medical Council [2008] EWHC 581 (Admin) (19 March 2008),* that in determining if a doctor's fitness to practice is impaired, it is relevant to consider:

(a) Are the failures easily remediable?
(b) Have the failures been remedied?
(c) *Are the failures highly unlikely to be repeated? '*

84. Mr Haycroft submitted that evidence overall suggests that these questions should be answered in the affirmative as regards *personal* impairment. Mr Haycroft suggested that too much had been made by the GMC, without any evidential foundation, of personal impairment. His submission was that there is no public protection issue under the first strand of the overarching objective for the following reasons:

(a) A fleeting contact, in and out, taking seconds only and amounting to a single isolated incident (Ms A regarded the incidents of contact as only 2 episodes).

(b) Also the nature of the contact means this is at the lower end of the spectrum: fleeting as stated, through clothes with the back of a gloved hand, grazing not cupping nor lingering.

(c) No prior or post incident.

(d) Dr Kochar's previous good character.

(e) In summary a "moment of madness".

85. Mr Haycroft reminded the Tribunal of the importance of insight and referred it to the relevant paragraphs of the Sanctions Guidance (November 2020), (the SG), namely paragraphs 45 and 46:

45 Expressing insight involves demonstrating reflection and remediation.

46 A doctor is likely to have insight if they:

1. *a accept they should have behaved differently (showing empathy and understanding)*
2. *b take timely steps to remediate*
   (see paragraphs 31–33) and apologise at an early stage before the hearing
3. *c demonstrate the timely development of insight during the investigation and hearing.*

86. Mr Haycroft reminded the Tribunal of Dr Kochar's previous and post event good character and the positive testimonials from colleagues. He submitted that the testimonials were highly relevant at this stage, evidencing no character flaw or propensity for such misconduct on the part of Dr Kochar. Mr Haycroft reminded the Tribunal that it would be wrong to equate the denial of an allegation with lack of insight. He also reminded the Tribunal that Dr Kochar had apologised to Ms A, both in his witness statement and in his oral evidence.

87. Mr Haycroft submitted that Dr Kochar is cognisant of the serious nature of his misconduct. Mr Haycroft reminded the Tribunal to look forward as it must do when considering current impairment. He invited the Tribunal to find that there was little risk of repetition, having regard to Dr Kochar's pre and post event character. He submitted that if the Tribunal was to make a finding of impairment, it should be restricted to a finding on the public interest basis.

The Relevant Legal Principles

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

89. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: firstly to consider whether the facts as found proved amounted to misconduct and secondly, to consider whether the misconduct was serious.

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

91. The Tribunal was also mindful of the need to protect the public, to maintain public confidence in the profession and to promote and maintain proper professional standards of conduct and behaviour of the medical profession. When considering the public interest in this case, the Tribunal took into account the submissions of both parties with regard to the case of *Roylance v. The General Medical Council (Medical Act 1983) [1999] UKPC 16 (24th March, 1999),* which states:

'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. 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. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will qualify. The professional misconduct must be serious.'

92. The Tribunal also had regard to paragraph 76 of the judgment in *CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin)*.

The Tribunal's Determination on Impairment

Misconduct

93. In determining whether Dr Kochar's fitness to practise is currently impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amounted to misconduct.

94. The Tribunal considered its previous determination, whereby it found that Dr Kochar's conduct in touching Ms A's breast with the back of his hand, albeit fleetingly and on an isolated occasion, was sexually motivated.

95. The Tribunal considered paragraphs 1, 36, 37 and 65 of GMP to be engaged in this case.

96. The Tribunal considered the key aspects of the Allegation individually to address whether Dr Kochar's conduct amounts to serious misconduct. It considered that the paragraphs of the Allegation found proved in regard to sexual motivation in this case did amount to serious misconduct.

Impairment

97. Having found that the facts found proved amounted to serious misconduct, the Tribunal went on to consider whether, as a result of that misconduct, Dr Kochar's fitness to practise is currently impaired.

98. In determining whether a finding of current impairment of fitness to practise is necessary, the Tribunal looked for evidence of remediation and insight, and the likelihood of repetition, balanced against the three elements of the overarching statutory objective.

99. The Tribunal had regard to paragraph 76 of the judgment in the case *of CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin*), in which Mrs Justice Cox set out the helpful and comprehensive approach of Dame Janet Smith in her 5th Shipman Report to determining issues of impairment. At paragraph 25.67 of the Shipman Report, she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise.

> *'Do our findings of fact in respect of the doctor's misconduct…show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

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; and/or…

d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

100. In the present case, the Tribunal considered that limbs (b) and (c) are engaged. In respect of limb (a), the Tribunal noted that the conduct had occurred whilst a patient was undergoing a clinical procedure, but found that there was no evidence of any harm having come to that patient as a result of Dr Kochar's conduct.

101. The Tribunal considered the approach taken in *Cohen*. It accepted that sexual misconduct is difficult to remediate. In relation to insight and remediation, the Tribunal considered that Dr Kochar has shown some limited evidence of remediation. The Tribunal noted Dr Kochar's witness statement which reads:

'I firmly deny that any of my interactions with Ms A were sexually motivated. I am nevertheless sorry if anything I said or did made her feel uncomfortable, or gave her the wrong impression. Since the events in question, I have reflected on how my own behaviour might have led to Ms A misinterpreting events, and I have made a point of being more careful to ensure that personal and physical boundaries are respected when I am at work. On 17 November 2022, I attended a "Maintaining Professionalism" course run by the Professional Boundaries Company, to further my learning and reflection on the issues raised by Ms A's complaint.'

102. The Tribunal noted they were not presented with the certificate of completion of the learning course, but accepted that Dr Kochar had completed it. The Tribunal noted Dr Kochar's public apology to Ms A during his oral evidence, for any behaviour which made her feel uncomfortable. The Tribunal accepted that Dr Kochar understood the gravity of his conduct.

103. The Tribunal read and considered the many testimonials it had received from friends and colleagues of Dr Kochar. They spoke in glowing terms of a highly respected, well-regarded and outstanding clinician and colleague. Many of the testimonials, including from those who have acted as nursing assistants to Dr Kochar during clinical procedures, spoke to their disbelief regarding the allegations Dr Kochar was facing. Accordingly the Tribunal

considered there to be a low risk of repetition in this case. It was not however satisfied that Dr Kochar's remediation is complete.

104. The Tribunal reminded itself that this is a case of sexual misconduct, whereby Dr Kochar acted inappropriately towards Ms A with his actions being sexually motivated. Nevertheless, the Tribunal considered that Dr Kochar's misconduct fell at the lower end of the spectrum of gravity in terms of sexual misconduct cases. It noted, in particular, that this was an isolated incident of fleeting, in and out contact, through clothes and with the back of a gloved hand.

105. Noting the facts found proved, Dr Kochar's previous good character and the positive testimonials provided by colleagues on his behalf, the Tribunal was satisfied that the misconduct which it had found was remediable. It found some limited evidence of remediation, but considered the likelihood of repetition was low.

106. Nonetheless, the Tribunal determined that the public expects doctors' conduct to justify its trust in them and expects doctors to maintain respectful relationships with colleagues and treat them fairly. Where doctors fail to do so in a significant way, the public's trust in the profession is undermined and a finding of impairment of fitness to practise is required. The Tribunal accepted that public confidence in the profession, and proper standards of professional conduct , would be damaged if a finding of impairment was not made in this case.

107. Therefore, the Tribunal determined that Dr Kochar's fitness to practise is currently impaired by reason of misconduct in respect of limbs 2 and 3 of the overarching objective, namely:

'…

b. to promote and maintain public confidence in the medical profession; and

c. to promote and maintain proper professional standards and conduct for members of that profession.'

Determination on Sanction - 15/11/2023

108. Having determined that Dr Kochar'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

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

Submissions

110. On behalf of the GMC, Ms Barbour submitted that the appropriate sanction in this case was one of erasure. She referred the Tribunal to the Sanctions Guidance (Nov 2020) ('the SG'), to the Tribunal's own determinations and the overarching objective throughout her submissions.

111. Ms Barbour submitted there were no exceptional circumstances that would justify no action being taken. Conditions would not be appropriate to deal with the serious nature of this misconduct, nor would they be workable or measurable. She submitted that the Tribunal could not be satisfied that Dr Kochar would comply with conditions. Ms Barbour reminded the Tribunal that the conduct found proved occurred at a time when Dr Kochar's registration was already subject to conditions. She submitted that this demonstrated a lack of respect for those conditions, and reminded the Tribunal that XXX. Ms Barbour invited the Tribunal to carefully consider the circumstances surrounding the conduct found proved. She reminded the Tribunal that the sexual misconduct took place during the course of a clinical procedure, in the presence of a patient who was in a vulnerable position. She submitted Dr Kochar had sought to disguise the sexually motivated touching of a colleague's breast under the cover of a legitimate clinical demonstration as part of his work. She submitted that this made Dr Kochar's conduct worse and engaged all three limbs of the overarching objective. Ms Barbour reminded the Tribunal of what had happened earlier in the day, as a result of which Ms A had taken steps to protect herself by moving to a different angle. Despite that, Dr Kochar chose to touch her again and she was left feeling like that there was nothing she could do to protect herself.

112. Ms Barbour submitted that an order of suspension would not be an appropriate way of addressing the Tribunal's finding of sexual misconduct, noting what she suggested was Dr Kochar's absence of reflection, his limited insight and remediation. Ms Barbour submitted that Dr Kochar had not demonstrated genuine insight. She observed that he had not made a full apology to Ms A, in that he had not apologised for his misconduct. She also submitted that although Dr Kochar had attended a course in November 2022, he had provided no detail in respect of that course, of what he had learned nor how he had put any learning into action.

113. Ms Barbour submitted that the Tribunal should erase Dr Kochar's name from the medical register to declare/uphold standards and to maintain public confidence in the medical profession. She submitted that Dr Kochar's sexual misconduct in the midst of a patient procedure is fundamentally incompatible with continued registration. Ms Barbour reminded the Tribunal that Dr Kochar would not have had access to Ms A's body in the way he did if he had not been working as a practitioner. She submitted that Dr Kochar put his own sexual interests before the interests of a patient. Dr Kochar chose to engage in sexual misconduct by touching Ms A's breast whilst Ms A was providing care to the patient. Ms Barbour submitted that a number of the factors outlined as aggravating factors in paragraph 55 of the SG were present in this case. She submitted that Dr Kochar had not yet acknowledged fault, which demonstrated insufficient insight and therefore a risk of repetition.

114. Ms Barbour submitted that erasure would be appropriate and proportionate, as it is necessary to satisfy, in particular, limbs two and three of the overarching objective set out in the Medical Act 1983.

115. On behalf of Dr Kochar, Mr Haycroft submitted that a short period of suspension, with or without a review, would be appropriate in this case. He reminded the Tribunal that any sanction should give effect to the overarching objective but should not be punitive. The Tribunal was required to act proportionately, taking the least restrictive sanction first. He submitted that the appropriate sanction depended on where on the spectrum of seriousness of misconduct the case was, and he suggested that the facts found proved in this case were not fundamentally incompatible with continued registration. He suggested that to find otherwise would lead to a situation where all sexual misconduct cases would lead to erasure.

116. Mr Haycroft submitted that taking no action was inappropriate in this case, nor was it a case in which the imposition of conditions on Dr Kochar's registration would be appropriate. Mr Haycroft submitted that these concessions, along with Dr Kochar's earlier concession that his fitness to practice was impaired, demonstrated insight on his part. It also demonstrated an understanding of the severity of his conduct. He reminded the Tribunal that although Dr Kochar had denied the allegation, his denial was of the sexually motivated element of the conduct, not of the underlying conduct itself, in respect of which he had not advanced a positive case. He reminded the Tribunal that a denial of an allegation was not to be taken as indicating a lack of insight.

117. Mr Haycroft submitted that the sanction of erasure would be wholly disproportionate in this case. He reminded the Tribunal of its determination and the low risk of repetition it had found. He characterised the conduct found proved as "spontaneous", committed under

the stress of working under the Covid conditions, and "an opportunistic touching, no more, no less."

118. Mr Haycroft reminded the Tribunal of the passage of time, noting that the events took place over 2 years ago. He submitted that Dr Kochar had no character flaw which predisposed him to misconduct of this or any other kind. There had been no further incidents of misconduct and Dr Kochar had engaged with the whole disciplinary process. He observed that Dr Kochar had now lost his good character. He referred the Tribunal to the testimonial evidence, which was positive and showed that Dr Kochar is a highly regarded and well-liked doctor, who is committed to the profession and is making a significant contribution to the care of patients in Blackpool and Wigan.

119. Mr Haycroft submitted that any sanction the Tribunal imposes should have no greater restriction on Dr Kochar's ability to practise his chosen profession than is necessary to achieve the regulatory objective. He submitted that Dr Kochar is an excellent clinician with a large number of patients who benefit from his care and professional expertise. He submitted that the Tribunal should therefore balance what action is necessary to uphold the overarching objective, with the need for the public to have the services of Dr Kochar. He submitted that there is no public protection issue in this case and that a short period of suspension, with or without a review, would meet the overarching objective.

The Relevant Legal Principles

120. The Tribunal reminded itself that the decision as to the appropriate sanction, if any, to impose was a matter for it exercising its own judgement. In reaching its decision on sanction, the Tribunal had regard to the SG. It bore in mind that the purpose of imposing a sanction was not to be punitive, but to protect patients and the wider public interest, although any sanction imposed may have a punitive effect.

121. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Kochar's interests with the public interest. It considered and had regard to the statutory overarching objective, which includes the protection of the public, the maintenance of public confidence in the profession, and the promoting and maintaining of proper professional standards and conduct for members of the profession. The Tribunal was mindful that it was required to ensure that any sanction it imposes is appropriate and proportionate but noted that the reputation of the profession as a whole is more important than the interests of any individual doctor.

122. The Tribunal also had regard to its findings of misconduct and impairment as well as the submissions received on behalf of the GMC and Dr Kochar.

The Tribunal's Determination on Sanction

123. The Tribunal first identified what it considered to be the aggravating and mitigating factors in this case.

Aggravating factors

124. The Tribunal considered the serious nature of sexual misconduct and had regard to paragraphs 149 and 150 of the SG which provide:

> ***149*** *This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child sex abuse materials) to sexual misconduct with patients, colleagues, patients' relatives or others…*
>
> ***150*** *Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases.'*

125. The Tribunal took into account that this case involved sexual misconduct, which is inherently serious. Although the Tribunal considered the conduct found proved to be at the lower end of the spectrum of sexual misconduct, it did not consider it to be at the bottom of the spectrum. The Tribunal had regard to the fact that sexual misconduct, even that at the lower end of the spectrum, seriously undermines public confidence in the profession.

126. The Tribunal considered the circumstances surrounding the conduct found proved. The Tribunal noted that the conduct took place in a clinical setting, whilst a patient was undergoing an invasive and embarrassing clinical procedure. The conduct involved the sexually motivated touching of a XXX colleague's breast, who was also mid-procedure and hence unable to take steps to protect herself. The Tribunal reminded itself of the events earlier in the day and noted that the touching occurred at a time when Ms A had taken steps to change her position to avoid any accidental contact. The Tribunal also noted that the conduct occurred at a time when Dr Kochar's registration was subject to conditions, and the conduct was motivated towards XXX.

127. The Tribunal considered paragraphs 51 and 52 of the SG.

> *51 It is important for tribunals to consider insight, or lack of, when determining sanctions…*
>
> *52 A doctor is likely to lack insight if they:*
> *(a) refuse to apologise or accept their mistakes*
> *(b) …*
> *(c) do not demonstrate the timely development of insight.*
> *(d)…*

128. The Tribunal noted that Dr Kochar had presented limited evidence of insight and remediation. Although it noted his concessions as to impairment and the appropriate sanction and accepted that he understood the gravity of the misconduct, the Tribunal was not satisfied that Dr Kochar had demonstrated full insight. In particular, the Tribunal found little evidence of reflection. It noted that Dr Kochar had not made a full apology to Ms A. The Tribunal were cognisant of the fact that a denial of an allegation was not to be taken as indicating a lack of insight. They considered the guidance given in *Sawati v General Medical Council [2022] EWHC 283 (Admin)* and noted that Dr Kochar had not denied the underlying conduct but had only denied sexual motivation of the conduct. The Tribunal accepted that Dr Kochar is sorry in a general sense for how he made Ms A feel. However, Dr Kochar has not taken responsibility for the specific misconduct found proved.

Mitigating factors

129. The Tribunal considered the findings made in relation to the facts founds proved. It reminded itself that this was an isolated episode of fleeting, in and out contact, through clothes and with the back of Dr Kochar's gloved hand. Whilst it noted the clinical context in which the touching had occurred, it found no evidence of any harm having come to the patient as a result of Dr Kochar's conduct. Accordingly, the Tribunal considered the risk to patient safety, whilst present, was low. Although the Tribunal did not accept that Dr Kochar's conduct was 'spontaneous', nor that the conduct was influenced by any external stressful factors such as the Covid situation, it accepted Mr Haycroft's submission that this was an isolated incident of brief, opportunistic touching.

130. The Tribunal acknowledged that Dr Kochar is an experienced doctor of previously positive good character and with an unblemished record. It noted that the many testimonials submitted to the Tribunal from friends and colleagues all speak highly of him, both as a

person and as a clinician. He is a highly valued member of the team, and the Tribunal accepts that his patients benefit from his skills.

131. The Tribunal also took into consideration Dr Kochar's full cooperation with the GMC throughout the investigation. It noted that there has been no repetition of his misconduct in the two years since the incident, nor have any other concerns been raised in that time. There have been and are no concerns about Dr Kochar's clinical abilities or practice.

132. The Tribunal accepted that Dr Kochar had shown some insight and some evidence of remediation, albeit limited. The Tribunal reminded itself that it considered the risk of repetition low in this case.

133. The Tribunal balanced the aggravating and mitigating factors throughout its deliberations and went on to consider each sanction in order of ascending severity, starting with the least restrictive.

No action

134. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

135. The Tribunal was satisfied that there were no exceptional circumstances in Dr Kochar's case which could justify it taking no action. Further the Tribunal considered that concluding the case by taking no action would be insufficient to protect the public interest and would not mark the seriousness of Dr Kochar's misconduct.

Conditions

136. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Kochar's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable. The Tribunal noted that conditions may be workable where a doctor has insight into their misconduct, is likely to comply with conditions, and where a doctor is likely to respond positively to remediation or retraining. The Tribunal considered that while Dr Kochar has limited insight into his misconduct, this was not a case in which conditions would sufficiently address the issues of the case.

137. The Tribunal further considered that no workable or measurable conditions could be formulated which would address the seriousness of Dr Kochar's misconduct. It reminded

itself that in any event, Dr Kochar's misconduct took place while he was working with conditions on his registration. It therefore concluded that conditions would be unworkable and would in any event be insufficient to maintain public confidence in the profession or to promote and maintain standards for members of the profession.

138. The Tribunal noted that neither counsel had suggested that conditions were appropriate in this case, and noted Mr Haycroft's concession that they would *not* be appropriate.

Suspension

139. The Tribunal then went on to consider whether a period of suspension would adequately maintain public confidence in the profession and uphold proper standards for its members. In considering whether to impose a period of suspension on Dr Kochar's registration, the Tribunal had regard to paragraphs 91 and 92 of the SG which provide:

> *'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. …*
>
> *92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e. for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).'*

140. The Tribunal determined that imposing a period of suspension on Dr Kochar's registration was the appropriate and proportionate sanction in this case. It considered that a period of suspension would mark the seriousness of the misconduct and satisfy the overarching objective by maintaining public confidence in the profession and maintaining proper professional standards for doctors. It was also satisfied that a period of suspension would send a clear message to the public and the medical profession that this type of behaviour is not acceptable.

141. Overall, the Tribunal concluded that this case was not one where Dr Kochar's misconduct is '*fundamentally incompatible with continued registration*' and therefore it considered that erasure would not be appropriate or proportionate, nor would it be in the public interest. Erasure would deny the public of an otherwise competent and well-regarded doctor, whose misconduct, whilst sexually motivated, was an isolated, opportunistic episode in an otherwise unblemished career.

Erasure

142. While the Tribunal determined a period of suspension would satisfy the overarching objective, it also considered the sanction of erasure. Having balanced the aggravating and mitigating factors, all the circumstances of this case and its findings that Dr Kochar's conduct was not fundamentally incompatible with continued registration, the Tribunal determined that a sanction of erasure would be disproportionate in this case. The Tribunal accepted that erasing Dr Kochar from the register would deprive the public of an otherwise excellent doctor and was not necessary to mark the seriousness of the misconduct found or to satisfy the public interest.

Duration of Suspension

143. Having decided that the appropriate sanction was one of suspension, the Tribunal went on to consider the length of suspension. It considered paragraphs 100 and 101 of the SG:

> ***100*** *The following factors will be relevant when determining the length of suspension:*
>
> *a. the risk to patient safety/public protection.*
>
> *b. the seriousness of the findings and any mitigating or aggravating factors (as set out in paragraphs 24–60).*
>
> *c. ensuring the doctor has adequate time to remediate.*
>
> ***101*** *The tribunal's primary consideration should be public protection and the seriousness of the findings. Following any remediation, the time all parties may need to prepare for a review hearing if one is needed will also be a factor.*

144. The Tribunal has set out its rationale for imposing a suspension in the wider public interest in order to maintain confidence in the profession and mark proper professional standards.

145. The Tribunal considered the aggravating factors in this case and acknowledged that this was a serious departure from the principles set out in GMP.

146. The Tribunal took account of the public interest in facilitating the safe return to practice of an otherwise competent doctor, where feasible.

147. Although the Tribunal determined that the sanction of suspension was appropriate, it did not agree with Mr Haycroft's submission that a 'short' period of suspension would be sufficient. The seriousness of the misconduct found proved, which occurred within a clinical context albeit without patient harm, required a period of suspension of sufficient length to enable Dr Kochar to reflect on his misconduct, the likely consequences for everyone concerned, as well as the damage to the reputation of the medical profession.

148. The Tribunal concluded that a six month period of suspension was necessary and appropriate in this case. It considered that a six month suspension was sufficient to mark the seriousness of Dr Kochar's misconduct, to uphold all three limbs of the overarching objective and would send a message to the profession and the wider public that such conduct was not acceptable. It would also provide Dr Kochar with time to reflect on why he acted as he did and how to avoid repetition. It would also allow Dr Kochar time to take steps to develop further insight into his misconduct, its impact and to take further steps to remediate it.

149. The Tribunal sought to be proportionate in its decision making, having at the forefront of it's mind the overarching objective and the need to protect the public and wider public interest. It considered that it was important to impose an appropriate sanction to mark the severity of his misconduct.

150. Having taken all these matters into account the Tribunal determined to impose a six-month period of suspension on Dr Kochar's registration.

Review

151. The Tribunal directed a review of Dr Kochar's case. A reviewing Tribunal will decide whether he may safely resume unrestricted practice after his period of suspension. It will consider the wider public interest as required by the overarching objective in the Medical Act 1983. A review hearing will convene shortly before the end of Dr Kochar's suspension unless an early review is sought by the doctor or the GMC. At the review hearing, the onus will be on Dr Kochar to advance such evidence as he considers appropriate, but it may assist the reviewing Tribunal if Dr Kochar was able to demonstate:

- evidence of reflection;
- evidence of the continued development of insight and/or remediation;

- evidence of continuing professional development and how he has kept his medical skills and knowledge up to date.

Dr Kochar may provide a reflective statement, testimonials, and any such other information he relies on.

Determination on Immediate Order - 16/11/2023

152. Having determined that Dr Kochar's registration should be suspended for a period of six 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

153. On behalf of the GMC, Ms Barbour, Counsel, submitted that an immediate order is necessary to reflect the seriousness of the findings of the Tribunal and its decision to suspend Dr Kochar for six months from the Medical Register. Ms Barbour submitted that an immediate order is necessary in order to protect the public interest, in particular to uphold standards and maintain public confidence in doctors. She submitted that it would be inappropriate to allow Dr Kochar to return to practice in circumstances where he has not carried out the steps that he ought to, as identified by the Tribunal in its Stage 3 determination.

154. On behalf of Dr Kochar, Mr Haycroft submitted that an immediate order was illogical in this case. He submitted that it was not necessary to impose an immediate order. Since the Tribunal had identified that the risk to the public was low, an immediate order was not required for public protection. He submitted that the seriouness of Dr Kochar's misconduct had already been marked by the impostion of a 6 month period of suspension, and that an immediate order would have the effect of making that a 7 month period of suspension. He submitted that Dr Kochar could safely return to practice, since he had in fact been practising safely since the events occurred. Moreover, Mr Haycroft suggested that an immediate order was disproportionate, and would amount to both a punishment and an inhibition on Dr Kochar to get on with the work he needed to do. He suggested that within the next 28 days, if an immediate order were made, some 200 patients would be deprived of his skills and this was not in the public interest.

The Tribunal's Determination

155. In reaching its decision, the Tribunal considered the relevant paragraphs of the SG and exercised its own independent judgement. In particular, it took account of paragraphs 172, 173 and 178, which state:

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

156. The Tribunal determined that, given the seriousness with which it viewed Dr Kochar's misconduct, its findings on impairment and the sanction it has imposed, it is in the public interest to suspend his registration with immediate effect in order to uphold standards for doctors and maintain public confidence in the medical profession.

157. This means that Dr Kochar's registration will be suspended 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.

158. XXX.

159. That concludes the case.