PUBLIC RECORD

Dates: 04/05/2023 - 17/05/2023

Medical Practitioner's name:	Dr Philippe BOISSIERE
GMC reference number:	1350579
Primary medical qualification:	MB ChB 1976 University of Dundee

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Not Impaired

Summary of outcome

No warning

Tribunal:

Legally Qualified Chair	Miss Samantha Gray
Lay Tribunal Member:	Ms Liz Daughters
Medical Tribunal Member:	Dr Nagarajah Theva

Tribunal Clerk:	Mr Josh Dayco

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Ms Alexandra Tampakopoulos, Counsel, instructed by Medical Protection Society
GMC Representative:	Ms Shirlie Duckworth, 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 - 15/05/2023

Background

1. Dr Boissiere qualified in 1976 from University of Dundee. Prior to the events which are the subject of the hearing Dr Boissiere undertook a number of medical posts across various locations including a specialist SHO post in obstetrics and gynaecology and was an SHO in an approved specialist training post for anaesthetics. Dr Boissiere became a GP Partner at St Paul's Medical Centre in Blackpool ('the Practice') in July 1997 until November 2013 when he retired from medical practice. At the time of the events Dr Boissiere was practising as a lead partner at the Practice for gynaecology cases.

2. The allegation that has led to Dr Boissiere's hearing involves sexual misconduct.

3. On 19 January 2011, Patient A had a consultation with Dr Boissiere ('the Consultation'). Dr Boissiere admitted that he had put Patient A at clinical risk when he failed to consider that administering 5mg of Diazepam intravenously carried a risk of a number of health/medical issues.

4. It is alleged that Dr Boissiere failed to communicate appropriately with Patient A when he: did not offer a chaperone; did not explain what IV sedation would involve; did not explain what fitting a coil involved; did not advise that he would carry out a vaginal examination ('the Examination') first; and did not provide an explanation as to why [Ms E] Patient A's relative could not be present during the Examination. It is also alleged that Dr Boissiere did not obtain informed consent for the following failures as set out above. However, Dr Boissiere admitted that he failed to communicate appropriately with Patient A when he did not advise of the risks of IV sedation. He also admitted that he did not obtain consent only in relation to his failure to advise of the risks of IV sedation including a number of health/medical issues. Dr Boissiere admitted that he failed to communicate and keep an adequate record of the Consultation in that he did not record the following failures as set out above. Dr Boissiere further admitted that he had placed Patient A at risk of adverse clinical outcome by fitting a coil using intravenous sedation without any clinical support present.

5. It is alleged that Dr Boissiere advised [Ms E] to 'stay downstairs' or words to that effect, whilst he carried out the Examination.

6. It is alleged that Dr Boissiere fitted Patient A with a Mirena Coil ('the Procedure') and he failed to carry out the Procedure correctly when Dr Boissiere administered sedation to Patient A when it was not clinically indicated and that he knew it would reduce Patient A's awareness of the procedures being undertaken. It is also alleged that Dr Boissiere did not offer Patient A a chaperone and/or allow Ms E to chaperone the Examination. It is further alleged that the above failures were sexually motivated.

The Allegation and the Doctor's Response

7. The Allegation made against Dr Boissiere is as follows:

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

1. On 19 January 2011 you consulted with Patient A ('the Consultation') and you:

a. put Patient A at clinical risk by failing to consider that administering 5mg of Diazepam intravenously carried a risk of:

i. respiratory depression;
Admitted and found proved

ii. over sedation;
Admitted and found proved

iii. delayed recovery;
Admitted and found proved

iv. anaphylactic reaction;
Admitted and found proved

b. failed to communicate appropriately with Patient A in that you:

i. did not offer a chaperone;
To be determined

ii. did not explain what IV sedation would involve;
To be determined

iii. did not advise of the risks of IV sedation including but not limited to:

1. respiratory depression;
Admitted and found proved

2. over sedation;
   Admitted and found proved

3. delayed recovery;
   Admitted and found proved

4. anaphylactic reaction;
   Admitted and found proved

iv. did not explain what fitting a coil involved;
To be determined

v. did not advise that you would carry out a vaginal examination ('the Examination') first;
To be determined

vi. did not provide an explanation as to why Patient A's relative could not be present during the Examination;
To be determined

c. placed Patient A at risk of adverse clinical outcome by fitting a coil using intravenous sedation without any clinical support present;
Admitted and found proved

d. advised Patient A's relative to 'stay downstairs' or words to that effect, whilst you carried out the Examination;
To be determined

e. in light of paragraphs 1.b.ii.-1.b.vi. you did not obtain informed consent;
Admitted and found proved only in relation to paragraph 1(b)(iii)
To be determined in relation to paragraphs 1(b)(ii), 1(b)(iv), 1(b)(v) and 1(b)(vi)

f. in the alternative failed to keep an adequate record of the Consultation in that you did not record as set out at paragraph:

i. 1.b.ii-1.b.vi. any discussion regarding consent;
Admitted and found proved

ii. 1.b.i any discussion regarding a chaperone;
Admitted and found proved

iii. 1.b.ii. what sedation was used;
Admitted and found proved

iv. 1.b.ii. the method by which sedation was administered;
Admitted and found proved

g. fitted Patient A with a Mirena Coil ('the Procedure') and you failed to carry out the Procedure correctly in that you:

i. administered sedation to Patient A when:

1. it was not clinically indicated;
To be determined

2. you knew it would reduce Patient A's awareness of the procedures being undertaken;
To be determined

ii. did not offer Patient A a chaperone and/or allow Patient A's relative to chaperone the Examination.
To be determined

2. Your actions in respect of paragraphs, 1.d., 1.e. and 1.g. 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

The Admitted Facts

8. At the outset of these proceedings and during the facts stage, through his Counsel, Ms Tampakopoulos, Dr Boissiere made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Witness Evidence

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

- Patient A, in person;
- Ms E, by video link.

10. Dr Boissiere provided his own witness statement dated 21 February 2022 and also gave oral evidence at the hearing. In addition, the Tribunal received evidence from the following witness on Dr Boissiere's behalf:

- Ms C, Lead Nurse at the Practice.

Expert Witness Evidence

11. The Tribunal received evidence from one expert witness. Dr D, GP, instructed on behalf of the GMC. He provided an Expert Report dated 23 December 2021 and two further supplemental Expert Reports dated 19 October 2022 and 14 March 2023.

Documentary Evidence

12. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:
    - Email from NHS England to the GMC;
    - Email from Patient A to the GMC;
    - Facebook post by Patient A;
    - Facebook message from Dr Boissiere to Patient A;
    - Dr Boissiere's Curriculum Vitae;
    - Testimonial from Ms C;
    - Medical Records of Patient A.

The Tribunal's Approach

13. 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 Boissiere 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.

14. The Tribunal considered the case of *Khan v The General Medical Council [2021] EWHC 374 (Admin)*. This case set out that Tribunals should not assess a witness's credibility exclusively on their demeanour when giving evidence. The Tribunal should consider all of the evidence before them before coming to a conclusion about a witness's credibility.

15. In assessing the evidence, the Tribunal considered the case of *Dutta, R (On the Application Of) v General Medical Council (GMC) [2020] EWHC 1974 (Admin) (22 July 2020)* where the judge addressed errors in the approach of the Tribunal. The Tribunal will be mindful of starting with the objective facts as shown by authentic contemporaneous documents, independent of witnesses, and using other evidence as a means of subjecting these to critical scrutiny.

16. The Tribunal noted that Dr Boissiere came before it as a person of good character. The Tribunal weighed this fact in his favour both when considering whether the evidence he had provided to the Tribunal was truthful, and in considering whether he was likely to have acted in the manner alleged.

The Tribunal's Analysis of the Evidence and Findings

17. The Tribunal first assessed the oral evidence of Patient A, Ms E and Dr Boissiere.

Patient A

18. The Tribunal considered that Patient A was an honest witness and was trying her best in providing the Tribunal her recollection of the events. There was no evidence that Patient A had any malicious intent or motive against Dr Boissiere and that there is no financial gain for her in making a complaint against Dr Boissiere. In fact, Patient A's evidence was that she held Dr Boissiere in a high regard as her family doctor for a number of years.

19. The Tribunal noted that at the time of the events, Patient A was given IV Diazepam and was sedated. Dr D gave the expert opinion that Diazepam may affect the patient's awareness and memory at the relevant time. In addition, Patient A said that her memory of the events was 'wishy washy' and that she was confused. Indeed, on 20 January 2011, the day after the Consultation, Patient A stated in a Facebook post that "*… don't remember too much*". Furthermore, the Tribunal acknowledged that due to the passage of time since the incident it was understandable that Patient A's memory recall of the incident was not entirely clear and that in trying to piece various recollections with hindsight certain aspects of the incident may have become confused.

20. Given that, the Tribunal was of the view that Patient A might be mistaken on various aspects of the events that took place on 19 January 2011. Therefore, the Tribunal found that whilst her evidence was truthful it was, at times, inconsistent.

Ms E

21. The Tribunal considered that whilst they had not reason to doubt Ms E's honesty in giving evidence, her evidence was unreliable. Her memory of the events, due to the passage of time, was, understandably, unclear. Indeed, when asked to recollect events that took place on 19 January 2011, she had no clear memory of the same and could not recall any different memories from those provided by Patient A. Ms E told the Tribunal that the first time any discussion of the 19 January occurred was after Patient A received the Facebook message from Dr Boissiere and she was of the opinion that he made contact as she had exchanged messages with him previously but not responded to his last correspondence. Ms E also stated that the first time she discussed Patient A's concerns was after Patient A had undergone another procedure in either 2019 or 2020. However, she later stated that such conversations may have occurred earlier but she could not specifically recall when. The Tribunal found that Ms E's inability to recall the chronology of events specifically was to be expected given the passage of time between the Consultation and the complaint being made and, indeed, the date of this hearing. Furthermore, Ms E stated that at the time of the Consultation nothing had occurred which gave her reason for this event to stand out in her memory.

Dr Boissiere

22. The Tribunal considered Dr Boissiere's evidence. It noted that Dr Boissiere could not recall what exactly happened on the Consultation with Patient A due to the passage of some 12 years since the date of the incident. However, Dr Boissiere relies on his usual practice. The Tribunal was content that there was no reason for Dr Boissiere to recall this specific consultation if nothing stood out for him. In addition, this consultation was one of many consultations for Dr Boissiere and that it was understandable for him to not have a specific recollection of the events and rely on his usual practice. Therefore, the Tribunal found Dr Boissiere to be an honest and reliable witness.

Chronology of the events

23. The Tribunal then considered the chronology of the events that took place. In Patient A's recollection, she said that after arriving at the surgery, she and Ms E went to the Consultation room with Dr Boissiere. A cannula was then inserted into Patient A's hand whilst in the consultation room. Patient A also said that Dr Boissiere administered the sedation downstairs in the consultation room. Thereafter, according to Patient A, Dr Boissiere took her upstairs to the treatment room and insisted that Ms E stay downstairs. Patient A said that she then got undressed and ready for the Procedure. Dr Boissiere carried out a vaginal sweep and then went downstairs to collect Ms E. Patient A said that Dr Boissiere came back to the room with Ms E and continued the Procedure.

24. In Dr Boissiere's chronology, he said that Patient A, Ms E and himself were all present in the consultation room. Dr Boissiere then said that he would have inserted the cannula and then assisted Patient A upstairs making sure that the cannula was not dislodged during the room change. Ms E would have been asked to stay downstairs given her mobility issues with his intention to return and escort her up the stairs once Patient A was taken to the treatment room. He said that he would not have been able to manage them both on the stairs which were difficult. Dr Boissiere then said that he would have asked Patient A to undress while he setup the treatment room and prepared the Diazepam syringe and instrument tray in preparation for the Procedure, given that he did not have a nurse to assist him on that day, due to staff absences. Dr Boissiere then said that he would have returned to the consultation room to collect Ms E and escort her up to the treatment room. Once everyone was settled, he would then flush the cannula and then prepare for the vaginal examination. During the vaginal examination, he would have applied lignocaine gel to the cervix. Thereafter, he would administer the Diazepam through the cannula and then undertake the Procedure.

25. The Tribunal considered and relied on the expert evidence of Dr D. He said that Diazepam's effect can kick in within minutes and it would usually last for approximately 15 minutes. The Tribunal also noted the evidence of Ms C who stated that the setting up of a consultation would take 15 minutes and the procedure would take 30 minutes. The Tribunal was of the view that it was more probable that sedation was given to Patient A upstairs in the treatment room rather than downstairs in the consultation room. It noted

that if the sedation was given to Patient A in the consultation room, its effect would have worn off before the Procedure even started given that Patient A had to go up the stairs, undress and Dr Boissiere prepared the treatment room. Further the Tribunal considered that it unlikely that, given the short time it took for the Diazepam to take effect, Dr Boissiere would administer it prior to a patient having to ascend stairs and undress.

26. The Tribunal considered Dr Boissiere's evidence where he stated that as a result of staff shortages he had to set up the room and equipment in order to carry out the procedure and this required ensuring that there were two of each piece of equipment, to ensure that he had access to sterile alternatives in the event one piece was dropped. The Tribunal acknowledged that this may have taken some time to compile and was a plausible explanation as to why Ms E recalled having to wait whilst Dr Boissiere came to collect her prior to the Procedure.

27. The Tribunal considered that the photograph provided by Patient A was helpful in considering the chronology. Patient A said the photograph was proof of her having been sedated in the consultation room, given the background of the room in the photograph. However, the Tribunal were mindful of the evidence of Dr D who stated that in order to insert a canula into a patient's hand a torniquet would need to be applied to a patient's arm to stimulate an appropriate vein. He also confirmed that a torniquet could not be applied over an outercoat and patients would usually be asked to remove outer garments in order for the torniquet to be applied appropriately. The Tribunal noted that in the photograph Patient A was wearing a coat and a scarf. Accordingly, it was of the view that it was unlikely that a cannula would have been inserted into Patient A whilst she was wearing her coat and scarf and it was more likely than not that the picture was taken after the Procedure had been carried out.

28. Therefore, the Tribunal prefers the chronology given by Dr Boissiere and, in particular, that only after when both Patient A and Ms E were present in the treatment room did Dr Boissiere administer the Diazepam and undertake the Procedure including the vaginal sweep.

29. The Tribunal then 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 noted that the stem of the Allegation relates to the Consultation between Dr Boissiere and Patient A, which took place on 19 January 2011.

<u>Paragraph 1(b)(i) of the Allegation</u>

31. The Tribunal considered whether Dr Boissiere failed to communicate appropriately with Patient A when he did not offer a chaperone.

32. The Tribunal noted that in the usual circumstances, a Nurse would have been present during the Procedure and that the Nurse would have acted as a chaperone. However,

given the circumstances surrounding the events that took place on 19 January 2011, Dr Boissiere was on his own during the Procedure. This was due to the absence of staff at that time.

33. The Tribunal considered that although Patient A was escorted by Dr Boissiere up the stairs first from the consultation room to the treatment room, Dr Boissiere did come back for Ms E and escorted her as well to the treatment room, before carrying out the Examination and the Procedure.

34. The Tribunal considered the expert evidence of Dr D. He said that:

> *…if Dr Boissiere's version of events is accepted Patient A's [relative] was present at relevant times and by the GMC guidelines was a suitable chaperone at the time. Therefore, in my opinion, if Dr Boissiere's version of events is accepted, a chaperone was present and Dr Boissiere's actions were not below the standard expected of a reasonably competent General Practitioner.*

35. The Tribunal found that given the expert opinion of Dr D and the evidence that Ms E was present in the treatment room during the Procedure, there was no requirement for Dr Boissiere to offer a chaperone to Patient A.

36. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 1(b)(i) of the Allegation not proved.

Paragraph 1(b)(ii) of the Allegation

37. The Tribunal considered whether Dr Boissiere failed to communicate appropriately with Patient A when he did not explain what IV sedation would involve.

38. The Tribunal considered the evidence of Patient A and Ms E. They opined that Dr Boissiere was a good doctor and takes his time to explain everything to the patient. Specifically, in cross examination Patient A said that she believes there was a discussion regarding sedation as she knew it was going to be administered intravenously and not orally. She also stated that she believed that at a previous appointment Dr Boissiere had asked her to bring someone along with her for the coil fitting appointment. Furthermore, in her oral evidence Patient A stated that she had expected to be sedated for the Procedure and that "i*t wasn't a surprise to her*".

39. The Tribunal was of the view that based on the evidence given by Patient A and her acceptance that a discussion must have taken place where Dr Boissiere explained to Patient A that she was going to have IV sedation because of her anxiety issues. She also stated that she was told that she would need to bring along someone to be with her. Accordingly, the Tribunal considered that it was more likely than not that a discussion was had regarding what IV sedation would involve.

40. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 1(b)(ii) of the Allegation not proved.

Paragraph 1(b)(iv) of the Allegation

41. The Tribunal considered whether Dr Boissiere failed to communicate appropriately with Patient A when he did not explain what fitting a coil involved.

42. The Tribunal was mindful of the evidence of Ms C who stated that Dr Boissiere often used props and equipment to explain to patients what would happen during a procedure. The Tribunal again considered the evidence of Patient A that Dr Boissiere was a good doctor and takes his time to explain everything to the patient. In particular, the Tribunal noted that In her oral evidence, Patient A said that she has a picture memory of the coil's size and shape. She also said that she knew where it was going to be inserted and how it was going to be inserted. Accordingly, she accepted that it was likely that because of the type of doctor, Dr Boissiere was and that because she had this specific memory it was fair to assume that he had explained what the coil fitting involved.

43. The Tribunal was of the view that for Patient A to describe the coil and know how it will be used, Dr Boissiere must have explained to Patient A what fitting a coil would involve.

44. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 1(b)(iv) of the Allegation not proved.

Paragraph 1(b)(v) of the Allegation

45. The Tribunal considered whether Dr Boissiere failed to communicate appropriately with Patient A when he did not advise that he would carry out a vaginal examination first.

46. The Tribunal considered the evidence of Patient A. She stated that she recalled that the purpose of the Examination was to put numbing gel on her cervix for the procedure and this was told to her verbally. The Tribunal also noted the expert evidence with regard to the Examination and, in particular, that the application of the anaesthetic gel to her cervix prior to coil insertion may account for the Patient A thinking her G spot was being rubbed and a warm wet sensation during the vaginal examination.

47. The Tribunal was of the view that Patient A's recollection of the vaginal examination was the most coherent element of her witness evidence in that this was the part of the procedure that she had specific memory of and what it involved. The Tribunal reminded itself that Dr Boissiere's evidence was that the sedation would have been administered after the Examination. It therefore followed that because Patient A was not sedated during the Examination, she would, of course, have a greater recollection of it. The Tribunal further considered that the expert evidence in relation to the likely sensations felt by Patient A during the course of the Examination was a plausible explanation for those sensations she experienced during the Examination. It noted that this being the

first time Patient A had undergone such procedure the sensation was likely to have been unexpected, but it was a result of the Examination being carried out correctly.

48. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 1(b)(v) of the Allegation not proved.

Paragraph 1(b)(vi) of the Allegation

49. The Tribunal considered whether Dr Boissiere failed to communicate appropriately with Patient A when he did not provide an explanation as to why [Ms E] could not be present during the Examination.

50. The Tribunal relies in its similar findings in relation to paragraph 1(b)(i) of the Allegation and the chronology in which the Tribunal prefers Dr Boissiere's version of the chronology of events. Accordingly, it was of the view that Ms E would have been present during the Examination.

51. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 1(b)(vi) of the Allegation not proved.

Paragraph 1(d) of the Allegation

52. The Tribunal considered whether Dr Boissiere advised [Ms E] to 'stay downstairs' or words to that effect, whilst he carried out the Examination.

53. The Tribunal relies in its similar findings in paragraphs 1(b)(i) and 1(b)(vi) of the Allegation. The Tribunal already found that Ms E was present during the Examination.

54. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 1(d) of the Allegation not proved.

Paragraph 1(e) in relation to Paragraphs 1(b)(ii), 1(b)(iv), 1(b)(v) and 1(b)(vi) of the Allegation

55. The Tribunal considered whether Dr Boissiere did not obtain consent in light of paragraphs 1(b)(ii), 1(b)(iv), 1(b)(v) and 1(b)(vi) of the Allegation.

56. The Tribunal considered its findings and it found paragraphs 1(b)(ii), 1(b)(iv), 1(b)(v) and 1(b)(vi) of the Allegation not proved. Therefore, paragraph 1(e) in relation to paragraphs 1(b)(ii), 1(b)(iv), 1(b)(v) and 1(b)(vi) of the Allegation must fall.

57. Therefore, the Tribunal determined and found paragraph 1(e) in relation to paragraphs 1(b)(ii), 1(b)(iv), 1(b)(v) and 1(b)(vi) of the Allegation not proved.

Paragraph 1(g)(i)(1) of the Allegation

58. The Tribunal considered whether Dr Boissiere failed to carry out the Procedure correctly when Dr Boissiere administered sedation to Patient A and it was not clinically indicated.

59. The Tribunal considered the expert evidence of Dr D. He stated:

> *…having read Dr Boissiere's rule 7 response I would say, if Dr Boissiere's response is accepted he had been trained to fit coils using iv sedation and had suitable anaesthetic qualifications; Dr Boissiere states that he would have made a clinical judgement as to whether or not sedation was required to allow coil fitment and as to whether or not it was clinically appropriate; Dr Boissiere notes that iv sedation in General Practice is unusual. I would now say that if Dr Boissiere's version of events is accepted the iv sedation was clinically indicated and Dr Boissiere was appropriately qualified to give it and this was not seriously below the standard expected of a reasonably competent General Practitioner.*

60. The Tribunal considered Dr Boissiere's qualifications and experience. It noted that he was trained and qualified to fit coils using IV sedation. Dr Boissiere said that sedation was clinically indicated because Patient A was anxious of the Procedure. The Tribunal also noted the evidence of Ms C who stated that sedation was sometimes offered to patients undergoing a coil insertion. Furthermore, the Tribunal noted Dr Boissiere's evidence that giving sedation to a patient undergoing a coil insertion was not common but was clinically indicated in patients such as Patient A where there was a history of anxiety and reoccurring panic attacks. The Tribunal therefore noted that taking into account the evidence of both Dr Boissiere and Ms C, it was more likely than not that whilst unusual, sedation may have been offered to other patients and this was not an isolated occurrence. Given that, the Tribunal adopts Dr D's opinion that administering sedation to Patient A was clinically indicated.

61. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 1(g)(i)(1) of the Allegation not proved.

<u>Paragraph 1(g)(i)(2) of the Allegation</u>

62. The Tribunal considered whether Dr Boissiere failed to carry out the Procedure correctly when Dr Boissiere administered sedation to Patient A and he knew it would reduce Patient A's awareness of the procedures being undertaken.

63. The Tribunal noted that administering sedation meant that a patient's awareness would be reduced in any circumstances. Given Dr Boissiere's experience, training and qualification as a doctor, he was aware that in his action to administer sedation to Patient A, it would reduce her awareness of the procedures being undertaken.

64. However, the Tribunal considered the stem of the allegation which alludes to Dr Boissiere's failure to carry out the Procedure correctly. The Tribunal noted that, in this

circumstances, Dr Boissiere did carry out the Procedure correctly and that administering the sedation was clinically indicated.

65. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 1(g)(i)(2) of the Allegation not proved.

Paragraph 1(g)(ii) of the Allegation

66. The Tribunal considered whether Dr Boissiere failed to carry out the Procedure correctly when Dr Boissiere did not offer Patient A a chaperone and/or allow [Ms E] to chaperone the Examination.

67. The Tribunal adopts its similar findings in paragraph 1(b)(i) of the Allegation and the chronology in which the Tribunal prefers Dr Boissiere's version. It was of the view that Ms E, would have been present during the Examination and had effectively acted as a chaperone.

68. Therefore, on the balance of probabilities, the Tribunal determined and found paragraph 1(g)(ii) of the Allegation not proved.

Paragraph 2 of the Allegation

69. The Tribunal considered whether paragraphs 1(d), 1(e) and 1(g) of the Allegation were sexually motivated.

70. The Tribunal considered its findings. It noted that it found paragraphs 1(d), 1(e) in relation to paragraphs 1(b)(ii), 1(b)(iv), 1(b)(v) and 1(b)(vi) and 1(g) not proved.

71. The only remaining paragraph to consider was paragraph 1(b)(iii) of the Allegation, which was admitted by Dr Boissiere. Given that, the Tribunal found that this did not lend itself in a sexually motivated situation.

72. Accordingly, the Tribunal determined and found paragraph 2 of the Allegation not proved.

The Tribunal's Overall Determination on the Facts

73. The Tribunal has determined the facts as follows:

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

1. On 19 January 2011 you consulted with Patient A ('the Consultation') and you:

   a. put Patient A at clinical risk by failing to consider that administering 5mg of Diazepam intravenously carried a risk of:

i. respiratory depression;
Admitted and found proved

ii. over sedation;
Admitted and found proved

iii. delayed recovery;
Admitted and found proved

iv. anaphylactic reaction;
Admitted and found proved

b. failed to communicate appropriately with Patient A in that you:

i. did not offer a chaperone;
Not proved

ii. did not explain what IV sedation would involve;
Not proved

iii. did not advise of the risks of IV sedation including but not limited to:

1. respiratory depression;
Admitted and found proved

2. over sedation;
Admitted and found proved

3. delayed recovery;
Admitted and found proved

4. anaphylactic reaction;
Admitted and found proved

iv. did not explain what fitting a coil involved;
Not proved

v. did not advise that you would carry out a vaginal examination ('the Examination') first;
Not proved

vi. did not provide an explanation as to why Patient A's relative could not be present during the Examination;
Not proved

c. placed Patient A at risk of adverse clinical outcome by fitting a coil using intravenous sedation without any clinical support present;
Admitted and found proved

d. advised Patient A's relative to 'stay downstairs' or words to that effect, whilst you carried out the Examination;
Not proved

e. in light of paragraphs 1.b.ii.-1.b.vi. you did not obtain informed consent;
Admitted and found proved only in relation to paragraph 1(b)(iii)
Not proved in relation to paragraphs 1(b)(ii), 1(b)(iv), 1(b)(v) and 1(b)(vi)

f. in the alternative failed to keep an adequate record of the Consultation in that you did not record as set out at paragraph:

i. 1.b.ii-1.b.vi. any discussion regarding consent;
Admitted and found proved

ii. 1.b.i any discussion regarding a chaperone;
Admitted and found proved

iii. 1.b.ii. what sedation was used;
Admitted and found proved

iv. 1.b.ii. the method by which sedation was administered;
Admitted and found proved

g. fitted Patient A with a Mirena Coil ('the Procedure') and you failed to carry out the Procedure correctly in that you:

i. administered sedation to Patient A when:

1. it was not clinically indicated;
Not proved

2. you knew it would reduce Patient A's awareness of the procedures being undertaken;
Not proved

ii. did not offer Patient A a chaperone and/or allow Patient A's relative to chaperone the Examination.
Not proved

2. Your actions in respect of paragraphs, 1.d., 1.e. and 1.g. were sexually motivated.
Not 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 - 17/05/2023

74. 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 Boissiere's fitness to practise is impaired by reason of misconduct.

The Evidence

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

Submissions

On behalf of the GMC

76. Ms Duckworth, Counsel, submitted that the GMC takes a neutral stance in relation to the question of whether Dr Boissiere's fitness to practise is impaired. Ms Duckworth referred the Tribunal to the relevant paragraphs of Good Medical Practice (2006 edition) (2006 GMP). Ms Duckworth also referred the Tribunal to the relevant case law.

77. Ms Duckworth referred the Tribunal to Dr D's expert reports and submitted that these reports were necessary for the Tribunal to assess whether the admitted clinical failings amounts to misconduct. She said that the Tribunal will be cautious of the assessments made by Dr D in relation to the standard of care given and the criticisms which were opined to have fallen seriously below the expected standards. In particular, the Tribunal should exercise caution where that assessment was intertwined with other criticisms which have not been found proved in this case.

78. Ms Duckworth said that this was an isolated incident. She submitted that the events surrounding the Allegation took place in 2011 and were not part of a pattern of any clinical failings. Ms Duckworth said that the Tribunal might consider that there has been no other similar complaints and given that Dr Boissiere retired from medical practice in 2013, it may be difficult to identify what future risk is presented by him. Given the length of time, Dr Boissiere's retirement from practice before the allegations were made and that Dr Boissiere had a long and unblemished career, Ms Duckworth submitted that the Tribunal may come to the conclusion that this is not a case where the public interest for making a finding of impairment is met.

On behalf of Dr Boissiere

79. Ms Tampakopoulos, Counsel, submitted that the facts admitted by Dr Boissiere and found proved by the Tribunal are not matters that amount to misconduct. She said that the facts were nowhere near deplorable nor the seriousness required for a finding of misconduct. Ms Tampakopoulos also referred the Tribunal to the expert report of Dr D. She adopts the approach similar to the GMC in that the Tribunal must draw apart the threads of the matters proved and those that were not proved and take into account the limit of the findings and filter Dr D's expert report accordingly.

80. Ms Tampakopoulos said that the facts found proved were the results of an imperfect situation. Dr Boissiere was trying to make the best of a situation where he was trying to help Patient A who had attended with [Ms E], but balance that against the fact that another healthcare professional was not present which would have been the normal practice. She asked the Tribunal to firmly place this appointment in a proper context, which was an isolated incident over decades of practice.

81. Ms Tampakopoulos said that if the Tribunal were to find these matters amount to misconduct, she submits that there are three reasons that Dr Boissiere's fitness to practise is not impaired either on a public protection or public interest grounds. Ms Tampakopoulos submitted that since the appointment approximately 12 years ago, there had been no repetition of similar behaviour nor other concerns raised against Dr Boissiere. This is against the background that Dr Boissiere had fitted more than 500 coils over the decades of his practice. She submitted that Dr Boissiere had an unblemished career and had retired from practice in October 2013. Ms Tampakopoulos submitted that the second reason is that Dr Boissiere had retired 10 years ago and has no intention of returning to practice. She said that there is simply no possibility of repetition in this case. Ms Tampakopoulos submitted that the third reason is that Dr Boissiere had clearly demonstrated insight into the matters raised and made full and appropriate admissions.

82. Given the circumstances, Ms Tampakopoulos submitted that it is hard to see how a member of the public fully appraised of all the facts and evidence, could possibly reach the conclusion that Dr Boissiere's fitness to practise is currently impaired.

The Relevant Legal Principles

83. 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.

84. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct and then whether the finding of that misconduct which was serious, could lead to a finding of impairment. The Tribunal had regard to the legal advice provided in relation to these stages together with the statutory overriding objectives.

85. The Tribunal must determine whether Dr Boissiere's fitness to practise is impaired today, taking into account Dr Boissiere'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.

The Tribunal's Determination on Impairment

86. In determining whether Dr Boissiere's fitness to practise is currently impaired by reason of misconduct, the Tribunal first considered whether the facts admitted and found proved amounted to serious misconduct.

Misconduct in relation to Paragraph 1(a) of the Allegation

87. The Tribunal first considered Dr Boissiere's failure in considering that administering 5mg of Diazepam intravenously carried a risk of: respiratory depression; over sedation; delayed recovery and anaphylactic reaction, which had put Patient A at a clinical risk.

88. The Tribunal considered that paragraph 2(a) of 2006 GMP is engaged. It stated:

> *2 Good clinical care must include:*
>
> *a adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient*

89. The Tribunal also considered Dr D's export report. He stated:

> *Whilst I would accept that there is less risk with using 5mg diazepam than a higher dose in my opinion it is not recognised that there is no risk.*
>
> *…he explained that because Patient A was very anxious he could offer sedation (which he was experienced in giving) and what this would involve…*

90. The Tribunal took account of Dr Boissiere's experience and qualifications as a doctor. It also considered that Dr Boissiere was familiar with Patient A, was appraised of her background and medical history and that he was administering intravenous sedation because Patient A was anxious. The Tribunal noted that Dr Boissiere considered that giving her intravenous sedation was the best option for Patient A at the time.

91. The Tribunal considered the evidence of Ms C. She said that administering intravenous sedation in this situation was unusual. However, it does happen.

92. Given the circumstances, the Tribunal was of the view that Dr Boissiere's actions in putting Patient A at a clinical risk was unacceptable. However, given Dr D and Ms C's evidence, along with Dr Boissiere's experience, qualifications and knowledge of Patient

A's background and medical history, the Tribunal found that Dr Boissiere's actions were below but not seriously below the standards expected of reasonably competent GP. Accordingly, the Tribunal determined that there was no misconduct.

Misconduct in relation to Paragraph 1(b)(iii) of the Allegation

93. The Tribunal then considered Dr Boissiere's failure to communicate appropriately with Patient A, which he did not advise of the risks of IV sedation including but not limited to: respiratory depression; over sedation; delayed recovery and anaphylactic reaction.

94. The Tribunal considered its findings of facts and noted that there was evidence that Dr Boissiere had communicated appropriately with Patient A but not relating to the risks as set out above.

95. The Tribunal considered the expert report of Dr D. He stated:

> *In my opinion, if Dr Boissiere's version of events is accepted his communication with Patient A and [Ms E] was not below or seriously below the standard to be accepted of a reasonably competent General Practitioner.*
>
> *…if Dr Boissiere's version of events is accepted, In my opinion Dr Boissiere's overall care of Patient A was below the standard accepted of a reasonably competent General Practitioner.*

96. The Tribunal considered that a communication took place between Dr Boissiere and Patient A. Given Dr Boissiere's experience as a doctor, he was aware of the risks of IV sedation. However, Dr Boissiere failed to inform Patient A of these risks. Given the circumstances and Dr D's opinion, the Tribunal was of the view that Dr Boissiere's actions were below but not seriously below the standards expected of reasonably competent GP. Accordingly, the Tribunal determined that there was no misconduct.

Misconduct in relation to Paragraph 1(e) of the Allegation

97. The Tribunal considered that Dr Boissiere did not obtain informed consent in relation to paragraph 1(b)(iii) of the Allegation as stated above.

98. The Tribunal considered and adopted its similar findings of misconduct in relation to paragraph 1(b)(iii) of the Allegation. It found that Dr Boissiere's actions in not obtaining informed consent were below but not seriously below the standards expected of reasonably competent GP. Accordingly, the Tribunal determined that there was no misconduct.

Misconduct in relation to Paragraph 1(f) of the Allegation

99. The Tribunal considered that Dr Boissiere failed to keep an adequate record of the Consultation in that he did not record: any discussion regarding consent; any discussion regarding a chaperone; what sedation was used and the method by which sedation was administered.

100. The Tribunal considered the expert report of Dr D. He stated:

> *…if Dr Boissiere's version of events is accepted, In my opinion Dr Boissiere's overall care of Patient A was below the standard accepted of a reasonably competent General Practitioner. I accept the remaining issues with iv sedation and record keeping but, in my opinion, they do not make the overall care seriously below.*

101. The Tribunal considered the medical record of Patient A. It noted that the Consultation which took place on 19 January 2011 was recorded by Dr Boissiere on 2 February 2011. The delay was 14 days. However, the Tribunal considered the surrounding factors on 19 January 2011. It noted that given that Dr Boissiere was on his own, he had to clear the treatment room and was conscious that he had offered a lift to Patient A and [Ms E]. It was understandable that the medical note was not done at that time.

102. The Tribunal also considered that it was unfortunate that the medical notes on the record was not made contemporaneously. However, the record indicates an adequate patient history and a description of what took place during the Consultation, although not complete and omitting crucial information.

103. Given the circumstances and in particular the expert opinion of Dr D in relation to the overall standard of care, Dr Boissiere demonstrated with regards to Patient A's treatment, the Tribunal was of the view that Dr Boissiere's actions were below but not seriously below the standards expected of reasonably competent GP. Accordingly, the Tribunal determined that there was no misconduct.

<u>Misconduct in relation to Paragraph 1(c) of the Allegation</u>

104. The Tribunal considered that Dr Boissiere had placed Patient A at risk of adverse clinical outcome by fitting a coil using intravenous sedation without any clinical support present.

105. The Tribunal considered the following relevant paragraphs from 2006 GMP.

> *3 In providing care you must:*
> …
> *j make good use of the resources available to you*

106. The Tribunal also considered the expert report by Dr D. He stated:

> *In my opinion Dr Boissiere's decision to undertake a coil fitting, using intravenous sedation and without any clinical support put [Patient A] at risk of an adverse clinical*

outcome. Not only are there the risks of problems with intravenous sedation which if they occurred Dr Boissiere would have required help with from an experienced health professional there are possible issues with patients having a coil fit such as the possibility of fainting or severe pain/distress where professional help may be needed. I would also say that in my opinion and experience when fitting a coil (or undertaking minor surgery) it is invaluable to have a trained person at hand to pass equipment or instruments to the doctor undertaking the procedure.

Overall, in my opinion and experience Dr Boissiere's fitting of a coil in an empty surgery, in the evening, using intravenous sedation and without a healthcare professional to help put [Patient A] at clinical risk and in my opinion was consequently seriously below the standard expected of a reasonably competent General Practitioner.

107. The Tribunal also considered that Dr Boissiere said that it would have been good practice and with hindsight he should not have carried out the procedure without any clinical support present. He also said that he would not do it again.

108. The Tribunal noted that although no adverse clinical outcome had occurred during the incident, Dr Boissiere had put Patient A at an adverse clinical risk by undertaking the Procedure without any clinical support present. It would have been unacceptable had Patient A had a reaction during the Procedure which would have benefited from clinical assistance. The absence of any adverse clinical outcome did not negate the best practice of having the assistance available. The Tribunal were mindful that Dr Boissiere did accept that he should have had assistance during the Procedure and would make different choices if faced with a similar situation again. Accordingly, taking into account the evidence and, in particular the expert opinion of Dr D, the Tribunal was of the view that Dr Boissiere's actions were seriously below the standards expected of reasonably competent GP.

109. Therefore, the Tribunal determined that Dr Boissiere's actions in relation to paragraph 1(c) of the Allegation amounted to serious misconduct.

Impairment

110. The Tribunal having found that paragraph 1(c) of the Allegation found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Dr Boissiere's fitness to practise is currently impaired.

111. 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.

112. The Tribunal noted that Dr Boissiere had admitted paragraph 1(c) of the Allegation and that he has fully engaged with the proceedings. It also noted that this was an isolated event contrasting against Dr Boissiere's long standing medical career, in which no issues of a similar nature had arisen. It also took into account the fact that both Patient A and Ms E spoke highly of the doctor in respect of his overall medical practise throughout their dealings with him both before and after the 2011 appointment The Tribunal were also mindful that the expert opined that the overall care provided by Dr Boissiere was not below the reasonable standard of care expected of a General Practitioner.

113. The Tribunal considered that in Dr Boissiere's evidence, he stated that, in hindsight, he had two choices to make on the evening of the procedure, either to put the best interests of Patient A first and undertake the Procedure or reschedule the procedure for another date when clinical support was available. He stated that on this occasion he put the interest of Patient A first in that he considered the risk of an unwanted pregnancy was the greater risk. He further acknowledged that, in hindsight, it may have been more prudent to have rescheduled. The Tribunal considered that such contemplation and acknowledgement by Dr Boissiere demonstrated insight and reflection in relation to assessing the risks associated to a particular situation.

114. The Tribunal also considered that Dr Boissiere had been retired from medical practice for almost 10 years with no intent to resume practise. Given the circumstances in this case, the Tribunal could not find any possible risk of repetition.

115. The Tribunal was of the view that, taking into account the insight demonstrated by Dr Boissiere, the fact that the misconduct was one isolated incident in a long unblemished career, the length of time since the incident and the retirement of Dr Boissiere in 2013, there is no risk to patients. The Tribunal was also of the opinion that, taking into account all of the matters set out above, this was not a case where measures needed to be adopted to protect the public or the wider public interest.

116. Accordingly, the Tribunal determined that Dr Boissiere's fitness to practise was not currently impaired by reason of his misconduct.

Determination on Warning - 17/05/2023

117. As the Tribunal determined that Dr Boissiere's fitness to practise was not impaired it considered whether in accordance with s35D(3) of the 1983 Act, a warning was required.

Submissions

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

118. Ms Duckworth, Counsel, submitted that this is not a case where the threshold for giving a warning is met. However, Ms Duckworth still referred the Tribunal to the consideration

it must give on whether to impose a warning or not. Ms Duckworth referred the Tribunal to the relevant paragraphs of the GMC Guidance on Warnings (March 2021) ('GoW').

119. Ms Duckworth also referred the Tribunal to its findings on impairment. She said that both Patient A and Ms E spoke highly of Dr Boissiere in respect of his overall medical practice throughout their dealings with him both before 2011 and afterwards. She also said that the opinion given by Dr D that Dr Boissiere's standard of care overall was not below the reasonable standards expected. Ms Duckworth stated that Dr Boissiere had been retired from medical practice for almost 10 years with no intention to resume practice, the misconduct was one isolated incident in a long unblemished career and that the Tribunal could not find any possible risk of repetition. Therefore, Ms Duckworth submitted that the statutory overarching objective does not require a warning to be given in this case.

On behalf of Dr Boissiere

120. Ms Tampakopoulos, Counsel, concurred with the submissions made by Ms Duckworth. She said that Dr Boissiere accepts the Tribunal's finding of misconduct in relation to paragraph 1(c) of the Allegation. However, she stated that this did not fall below the standard expected to a degree where it warrants a formal response by the Tribunal through a warning.

121. Ms Tampakopoulos submitted that, given the circumstances of this case, the decision to proceed with the coil fitting without the assistance of a healthcare professional was made by Dr Boissiere in the context of an extended hours at the end of a long day and was motivated entirely by a desire to assist Patient A. She said that, in doing so, Patient A did not need to wait and Dr Boissiere was trying to make the best of an imperfect situation.

122. Ms Tampakopoulos submitted that Dr Boissiere had shown genuine insight into this matter and that the Tribunal already found that there is no risk of repetition in this case. She said that Dr Boissiere has been retired for some 10 years already and that there is no need to formally record this misconduct. Ms Tampakopoulos submitted that this was a one-off isolated incident set against an unblemished long career and that issuing a warning would be disproportionate in this case.

The Tribunal's Approach

123. The Tribunal had regard to the following paragraphs of GoW:

> *11 Warnings allow the GMC and MPTS tribunals to indicate to a doctor that any given conduct, practice or behaviour represents a departure from the standards expected of members of the profession and should not be repeated. They are a formal response from the GMC and MPTS tribunals in the interests of maintaining good professional standards and public confidence in doctors. The recording of warnings*

allows the GMC to identify any repetition of the particular conduct, practice or behaviour and to take appropriate action in that event. Breach of a warning may be taken into account by a tribunal in relation to a future case against a doctor, or may itself comprise misconduct serious enough to lead to a finding of impaired fitness to practise.

13 Although warnings do not restrict a doctor's practice, they should nonetheless be viewed as a serious response, appropriate for those concerns that fall just below the threshold for a finding of impaired fitness to practise.

14 Warnings should be viewed as a deterrent. They are intended to remind the doctor that their conduct or behaviour fell significantly below the standard expected and that a repetition is likely to result in a finding of impaired fitness to practise. Warnings may also have the effect of highlighting to the wider profession that certain conduct or behaviour is unacceptable.

The test for issuing a warning

16 A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstance:

> *there has been a significant departure from Good medical practice*
> *[…]*

Factors to consider

20 The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.

> *a There has been a clear and specific breach of Good medical practice or our supplementary guidance.*
>
> *b The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor's fitness to practise has not been found to be impaired.*
>
> *c A warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely relating to a doctor's health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect*

patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.

d There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).

Proportionality

26 In deciding whether to issue a warning the decision maker should apply the principle of proportionality, weighing the interests of the public with those of the practitioner. It is important to bear in mind, of course, that warnings do not restrict the practitioner's practice and should only be considered once the decision maker is satisfied that the doctor's fitness to practise is not impaired.

Factors to consider when deciding if a warning is appropriate

32 If the decision makers are satisfied that the doctor's fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of factors to determine whether a warning is appropriate. These might include:

a the level of insight into the failings

b a genuine expression of regret/apology

c previous good history

d whether the incident was isolated or whether there has been any repetition

e any indicators as to the likelihood of the concerns being repeated

f any rehabilitative/corrective steps taken

g relevant and appropriate references and testimonials.

The Tribunal's Determination on Warning

124. Throughout its deliberations, the Tribunal had regard to the statutory overarching objective. In that regard it bore in mind that its power to issue a warning is an important feature of its role in protecting the public, which includes protecting the safety of

patients, maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

125. The Tribunal applied the principles of proportionality together with the fact that issuing a warning is a serious act and not one which is undertaken lightly. It has sought to balance the public interest against the interests of Dr Boissiere when approaching its determination on whether to issue a warning.

126. When approaching its decision on whether to issue Dr Boissiere with a warning, the Tribunal considered: his long-standing medical career; his retirement from medical practice for almost 10 years with no intent to resume practise; his insight; the misconduct found was one isolated incident in a long unblemished career; and the length of time since the incident. The Tribunal considered that, given the circumstances, it could not find any possible risk of repetition.

127. The Tribunal also considered Dr Boissiere's motivation in undertaking the coil fitting without the assistance of a healthcare professional. It was of the view that Dr Boissiere's actions were entirely motivated by putting Patient A's best interest first. This was acknowledged by Dr Boissiere that, in hindsight, it may have been more prudent to have rescheduled.

128. The Tribunal determined that sending out a message to the public that Dr Boissiere's misconduct is unacceptable has been met through these fitness to practise proceedings and the Tribunal's finding of misconduct.

129. The Tribunal considered that a reasonable and well-informed member of the public and medical profession would not require Dr Boissiere to be issued with a warning in light of all the circumstances of this case. As such, public confidence and proper professional standards would not be undermined by a decision not to issue a warning.

130. Therefore, the Tribunal determined that it was neither necessary nor proportionate to issue a warning in this case.

131. That concludes this case.