PUBLIC RECORD

Dates: 09/12/2020 – 18/12/2020 & 23/08/2021 – 27/08/2021

Medical Practitioner's name:	Dr Roger KURZ
GMC reference number:	7069887
Primary medical qualification:	MB ChB 2010 University of Aberdeen

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	Mr Colin Chapman
Lay Tribunal Member:	Mr Darren Shenton
Medical Tribunal Member:	Dr Barry Adams-Strump

Tribunal Clerk:	Mr Matt O'Reilly 08/12/2020 – 19/12/2020 Ms Evelyn Kramer 23/08/2021 – 27/08/2021

Attendance and Representation:

Medical Practitioner:	Present and not represented
Medical Practitioner's Representative:	N/A

GMC Representative:	Ms Sarah Barlow, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 17/12/2020

Background

1. Dr Kurz qualified in 2010 at the University of Aberdeen. Dr Kurz held a number of posts, prior to joining the GP Training Scheme in Falmouth in 2016. Dr Kurz was a GP Specialty Level 2 ("GPST2") trainee doctor, he was initially employed at the Royal Cornwall Hospital (RCH) in Truro, before commencing a placement in August 2016 at the West Cornwall Hospital (WCH) in Penzance - a satellite hospital of the Royal Cornwall Hospitals NHS Trust ('the Trust'). Further, Dr Kurz commenced a 12-month ST3 GP registrar post at Cape Cornwall Surgery ('Cape Cornwall') in Penzance on 2 August 2017.

2. The allegation against Dr Kurz is that between 29 November 2016 and 1 December 2016 he was involved in the care of Patient A at West Cornwall Hospital. On 30 November 2016 a lab sample was received and D Kurz was informed Patient A had a serum potassium (Hyperkalaemia) level of 7.6mmol/L, which is potentially 'life threatening.' A colleague raised concerns when Dr Kurz stated he was not going to treat Patient A in accordance with the Trust Hyperkalaemia Policy which was to arrange a prescription// of IV calcium gluconate, an infusion of insulin and dextrose, and a nebulised salbutamol.

3. Alternatively, it is alleged that, if Dr Kurz suspected that the high potassium was false, he failed to record his rationale for pseudohyperkalaemia and justify his own treatment plan.

4. It is further alleged that whilst employed as a trainee GP at the Cape Cornwall surgery, Dr Kurz engaged in an inappropriate personal relationship with Patient B, who was alleged to be vulnerable, and he acted dishonestly in attempting to conceal the relationship.

The Outcome of Applications Made during the Facts Stage

5. Ms Barlow made an application, on behalf of the GMC, to amend a typographical error on the first date on Schedule 1 - 22 September 2017. The amended date should read 25 September 2017. Ms Barlow requested the amendment to reflect the accuracy of the record due to the date being transcribed inaccurately from the notes of Dr E. Dr Kurz did not object to the application. The Tribunal determined it was reasonable and in the interest of justice to make the amendment and granted the application.

The Allegation and the Doctor's Response

6. The Allegation made against Dr Kurz is as follows:

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

Patient A

1. Between 29 November 2016 and 1 December 2016 you were involved in the care of Patient A and despite recording in Patient A's records that he had a serum potassium level of 7.6mmol/L on 30 November 2016, you failed to:

    a. arrange appropriate treatment for high potassium, in that you did not arrange:

        i. a prescription of IV calcium gluconate; **To be determined**

        ii. an infusion of insulin and dextrose; **To be determined**

        iii. nebulised salbutamol; **To be determined**

    b. follow the Royal Cornwall Hospitals NHS Trust policy on adult hyperkalaemia management ('the Policy'); **To be determined**

    c. in the alternative to paragraphs 1a-1b, record pseudo hyperkalemia as your rationale for not wanting to treat Patient A's high level of potassium. **Admitted and found proved**

Patient B – Consultations

2. You consulted with Patient B on a serial basis on the dates set out in Schedule 1, and your consultations on one or more of those dates:

    a. were:

        i. inappropriately long; **Admitted and found proved**

ii. known by you to be inappropriately long; **Admitted and found proved**

b. contained lengthy discussions of a social nature including discussions relating to your personal life and your plans for the future. **Admitted and found proved**

3. In the course of one or more of the consultations with Patient B set out in Schedule 1:

a. you once asked her if you could take her blood pressure, and when she said it was not necessary, you said "I was wondering what effect my presence had on it" or words to that effect; **Admitted and found proved**

b. she once spoke to you about allegations reported in the news and said her views about them related to a similar experience she had had in the past when she had been a victim of a sexual assault and you said "it's good that you have dealt with it though, don't worry, I am not going to write/mention that in your medical records" or words to that effect; **Admitted and found proved**

c. she once told you she hoped to go for a walk in Lelant and you looked up where it was on google maps, panned across to where you lived and said "oh look, that's my old jag". **Admitted and found proved**

4. On or around 30 October 2017, you met with your clinical and educational supervisor, Dr C, and he instructed you not to continue organising serial long consultations with vulnerable female patients, including Patient B, and you failed to follow that instruction. **To be determined**

5. On or around 4 December 2017, during a consultation with Patient B, she asked you what you were doing on Sunday and you:

a. told her you would be revising, or words to that effect; **Admitted and found proved**

b. said "if you happened to knock on my door and wanted a coffee it would be rude not to" or words to that effect. **Admitted and found proved**

<u>Patient B – Messages and meetings</u>

6. Between 10 December 2017 and 27 December 2017 Patient B visited your home on the dates set out in Schedule 2 and on one or more of those

occasions you arranged with her when you would next meet her. **Admitted and found proved**

7. On or around 10 December 2017 Patient B attended at your home and you:

   a. allowed her into the property for around one or two hours; **Admitted and found proved**

   b. threw your arms around her and hugged her as she was leaving; **Admitted and found proved**

   c. kissed her; **Admitted and found proved**

   d. said if she was over that way, by which you meant your home, she could pop round and see you, or words to that effect; **Admitted and found proved**

   e. said that she would "probably want to check [you] was in before driving all the way over" to your home and you mentioned communicating with her by way of Messenger, or words to that effect. **Admitted and found proved**

8. Between 10 December 2017 and 16 January 2018 you and Patient B exchanged messages on Messenger and:

   a. on one or more occasion you ended your message with kisses; **Admitted and found proved**

   b. you discussed personal matters including, but not limited to, those set out in Schedule 3. **Admitted and found proved**

9. On 11 December 2017, in response to comments Patient B made on Messenger about a cabin, you said "the cabin sounds like a lovely option, we'll have to take advantage of it sometime soon". **Admitted and found proved**

10. On 12 December 2017 you and Patient B exchanged messages on Messenger and you:

    a. agreed to watch a film with her; **Admitted and found proved**

    b. said "it's nice that you are enthusiastic" when she said she would love to see you. **Admitted and found proved**

11. On 14 December 2017 you:

a. made arrangements with Patient B on Messenger for her to visit your home; **Admitted and found proved**

b. were visited at your home by Patient B and you:

i. touched her back; **Admitted and found proved**

ii. kissed each other; **Admitted and found proved**

iii. cuddled each other; **Admitted and found proved**

c. blew kisses to Patient B as she left your home; **Admitted and found proved**

d. said to Patient B on Messenger "sweet dreams, you are wonderful company. X" after she had left your home. **Admitted and found proved**

12. On 16 December 2017 you made arrangements with Patient B on Messenger for her to visit your home on 17 December 2017. **Admitted and found proved**

13. On 17 December 2017 Patient B visited you at your home and you:

a. kissed each other; **Admitted and found proved**

b. cuddled each other. **Admitted and found proved**

14. On 18 December 2017:

a. you made arrangements with Patient B on Messenger for her to visit your home; **Admitted and found proved**

b. Patient B visited you at your home and you:

i. kissed each other; **Admitted and found proved**

ii. cuddled each other. **Admitted and found proved**

15. On 19 December 2017 you and Patient B exchanged messages on Messenger and you said:

a. "I like that you are including me xxx" when she told you about some renovation work she was doing; **Admitted and found proved**

b. "the name is certainly on your mind xxx [kissing emoji]" when she told you about three people called Roger; **Admitted and found proved**

c. "i'm sure that we will be able to formulate a successful strategy" and "I want to xxx" when she asked if you were going to sneak over in the new year; **Admitted and found proved**

d. "I haven't been to either, but both sound like a wonderful experience, i'll trust in your experience and intuition x" when she suggested going to a festival. **Admitted and found proved**

16. On 21 December 2017:

a. you and Patient B exchanged messages on Messenger and you:

i. said "i'm so sorry, wish I could be there to give you a hug and support" in response to her telling you she had had a terrible day; **Admitted and found proved**

ii. agreed to her bringing dinner to share with you; **Admitted and found proved**

b. Patient B visited you at your home and you:

i. kissed each other; **Admitted and found proved**

ii. cuddled each other. **Admitted and found proved**

17. On 25 December 2017 you sent Patient B, on Messenger, a picture of a stove fan you had accepted as a gift from her. **Admitted and found proved**

18. On 26 December 2017 you:

a. told Patient B on Messenger that you had been "summoned over to Dr C's for dinner tomorrow at six, but [could] still meet up in the afternoon xxx"; **Admitted and found proved**

b. made arrangements with Patient B on messenger for her to visit you at your home the following afternoon. **Admitted and found proved**

19. On 27 December 2017 Patient B visited you at your home and you:

a. cuddled each other; **Admitted and found proved**

b. both went for a walk and to a café. **Admitted and found proved**

20. On or around 1 January 2018 you had a telephone conversation with Patient B after she told you that she had told your work colleague, Dr D, that she had been meeting up with a doctor at your GP practice and you:

    a. ranted at her; **Admitted and found proved**

    b. said she had anxiety and you could not deal with it, or words to that effect; **Admitted and found proved**

    c. told her to go and register with a different GP practice the following morning, or words to that effect. **Admitted and found proved**

21. You:

    a. believed that you would be identified as the doctor who had been meeting up with Patient B, as described in paragraph 20; **Admitted and found proved**

    b. carried out the actions set out at paragraph 20c in an attempt to conceal your relationship with Patient B from your work colleagues, in that if she registered at a different GP practice she would no longer be a patient at the practice at which you worked. **To be determined**

22. Your actions at paragraph 20c were dishonest by reason of paragraph 21. **To be determined**

23. You failed to report one or more of the matters set out in paragraphs 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 to:

    a. Dr C at or before a meeting you had with him to discuss your competencies in December 2017; **Admitted and found proved**

    b. Dr C and/or another responsible person at work in a timely fashion, as you knew you should have done. **Admitted and found proved**

24. Your actions as described at paragraph 23 were designed to conceal the fact that you had:

    a. had further serial lengthy consultations with Patient B after being instructed by Dr C to desist from having such consultations with her; **To be determined**

    b. been seeing Patient B on a social basis and communicating with her by Messenger, which you knew was inappropriate. **Admitted and found proved**

25. Your actions as described at paragraph 23a and 23b were dishonest by reason of paragraph 24. To be determined

26. At all material times Patient B was vulnerable by reason of the matters set out in Schedule 4. To be determined

27. Your conduct as described at paragraphs 2a, 2b, 3a, 3b, 3c, 4, 5b, 6, 7a, 7b, 7c, 7d, 7e, 8a, 8b, 9, 10a, 10b, 11a, 11b, 11c, 11d, 12, 13a, 13b, 14a, 14b, 15a, 15b, 15c, 15d, 16a, 16b, 17, 18a, 18b, 19a and 19b was:

    a. sexually motivated; and/or To be determined

    b. for the purpose of pursuing an improper personal relationship with Patient B. Admitted and found proved

The Admitted Facts

7. At the outset of these proceedings, Dr Kurz made admissions to paragraphs/sub-paragraphs 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 these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Factual Witness Evidence

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

- Dr F, General Practitioner, and a statement dated 4 November 2019;
- Dr G, Consultant Geriatrician, and a statement dated 11 August 2020;
- Dr H, email correspondence dated between 6 January 2020 and 19 August 2020, and a supplemental report dated 7 October 2020;
- Dr C, General Practitioner (Clinical and Educational Supervisor), and a statement dated 3 September 2019.

The Tribunal also received oral evidence from Dr Kurz.

Documentary Evidence

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

- Dr E, General Practitioner, and a report dated 28 March 2018, and a supplemental statement dated 2 May 2019;

- Patient B, and statements dated 22 May 2019 and 24 August 2020;
- Messages between Dr Kurz and Patient B dated 10 December 2017 and 15 January 2018;
- 2016 Hyperkalaemia Policy;
- Email correspondence from Dr Kurz;
- Patient A, medical record;
- Patient B, medical record;
- Various written comments from Dr Kurz.

The Tribunal's Approach

10. 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 Kurz 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.

11. The Tribunal must consider each matter separately and reach a separate decision on each matter. In considering the allegation the panel must be satisfied that each of the elements of the alleged fact have been made out before finding the fact proved.

12. The Tribunal also considered how to approach the issues of whether Dr Kurz's actions were dishonest.

13. The question of what amounts to dishonesty is to be assessed by the test in the case to the case of *R v Barton & Booth* [2020] EWCA Crim 575, in which the Court of Appeal confirmed that the test for dishonesty is that set out in *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67 ('*Ivey*').

14. The Tribunal noted that in *Ivey* the Supreme Court provided the correct test of dishonesty which is that:

a. The Tribunal of fact must first ascertain (subjectively) the state of the individual's knowledge or belief as to the facts. The reasonableness of the belief is a matter of evidence going to whether or not he genuinely held the belief, but it is not a requirement that the belief must be reasonable, *and*

b. The Tribunal of fact must then consider whether that conduct was dishonest by the standards of ordinary decent people. There is no requirement that the individual must appreciate that what they have done was, by those standards, dishonest.

The Tribunal's Analysis of the Evidence and Findings

15. 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.

Patient A

16. The Tribunal noted that that this allegation relates to Dr Kurz's treatment of Patient A and whether he appropriately treated the patient for hyperkalaemia.

17. The Tribunal relied on the evidence of Dr H and the other medical evidence before it, including that of Dr G. Dr H gave evidence as an expert whose expertise and opinion the Tribunal considered it could accept. The Tribunal considered that he gave his evidence in a clear, objective and consistent manner.

18. Dr G gave evidence as a witness of fact but nonetheless demonstrated that he had relevant knowledge, experience and expertise in the field of geriatric medicine to assist the Tribunal in reaching its conclusions. The Tribunal was impressed with the manner in which he gave his evidence and was able to draw upon his evidence in dealing with the issues concerning Patient A. Dr G had no independent recollection of the events subject of the Allegations, but gave evidence based on Patient A's medical records.

19. The Tribunal were informed that hyperkalaemia is a condition in which there is an elevated level of potassium in the blood. Normal potassium levels range between 3.5 and 5.0 mmol/L. Levels which are higher than 5.0 mmol/L are defined as hyperkalaemia. Raised potassium is classified as mild when between 5.0 to 5.9, as moderate when between 6.0 to 6.4 and as severe when greater than 6.5.

20. High levels of hyperkalaemia can cause cardiac arrythmias and cardiac arrest leading to death. A level of 7.6 mmol/L, if a true reading, should be recognised as a medical emergency requiring immediate treatment. Patient A was treated in the Royal Cornwall Hospitals NHS Trust which had in 2016, an adult hyperkalaemia policy. This stated that if the level is greater than 5.2 mmol/L with ECG changes consistent with hyperkalaemia, or when greater than 6.4 without any ECG changes, the patient should be treated with calcium gluconate infusion, insulin dextrose infusion, nebulised salbutamol, and then treated with calcium resonium.

21. Typically, hyperkalaemia does not cause symptoms. It is detected by blood tests obtained from the patient. The Tribunal noted that two types of blood tests were referred to in Patient A's case.

22. Firstly, a blood sample taken from a patient which is then processed in a laboratory. For several reasons, including a delay in getting a sample to, and in processing it at the laboratory, such a sample can produce an artificially high, or elevated, level of potassium - "pseudohyperkalaemia". This occurs when the measured potassium level is falsely elevated. Pseudohyperkalaemia does not require treatment if correctly diagnosed.

23. Secondly, a blood sample taken from a patient which is processed in a "blood gas" machine. These machines are located within hospital departments to give a rapid analysis of

a sample. These machines can produce results within 10 – 15 minutes of the sample being taken, and because of the potential difficulties in the laboratory testing process are considered to produce more accurate and reliable results. In the evidence concerning Patient A, these tests are referred to as "venous blood gas" ("VBG"), and "point of care" ("POC"). The evidence was that these terms are interchangeable.

24. The Tribunal noted that paragraph 1 of the Allegation was that Dr Kurz failed to appropriately treat the high potassium level of 7.6 mmol/L in Patient A in accordance with Trust Policy. Dr Kurz' response to the Allegation was that Patient A did not suffer from hyperkalaemia because he had recognised that the potassium level was artificially high and therefore, he diagnosed pseudohyperkalaemia. Dr Kurz has admitted that he did not record pseudohyperkalaemia as his rationale for not wanting to treat Patient's A's high level of potassium.

25. In the context of the medical evidence, the Tribunal considered the facts relating to the treatment of Patient A. The Tribunal considered there to be no significant dispute about the treatment of Patient A up to the point on 30 November 2016 when paragraph 1 of the Allegation is said to have occurred. On the basis of Patient A's hospital records and the other medical evidence presented, the Tribunal therefore found the following facts.

26. Patient A was 83 years old. On 30 October 2016, he was taken to Derriford Hospital in Plymouth from the residential home where he lived because staff there were concerned that he had suffered a stroke. On 15 November 2016, he was transferred to the RCH in Treliske for rehabilitation.

27. The patient records from the RCH refer to concerns over Patient A's potassium levels at 18:50 on 16 November 2016 which were recorded as being 6.7 mmol/L. The notes show that consideration was given as to whether this was a true reading which would demonstrate hyperkalaemia, or an artificially high reading which would demonstrate pseudohyperkalaemia, but that, notwithstanding that consideration, treatment was given for hyperkalaemia in accordance with Trust Policy. At 02:50 on 17 November 2016, it was noted that the level was 6.1 mmol/L but that an ECG showed no changes so, again in accordance with policy, it was decided that further treatment for hyperkalaemia was not required. Further entries on the same date and the following day show that no further treatment was required.

28. On 28 November 2016, he was transferred again to the WCH for further rehabilitation and for discharge or placement in a community hospital for additional rehabilitation. It was at the WCH that the events subject of paragraph 1 of the Allegation concerning Patient A occurred.

29. Dr Kurz was working at WCH at the time as GPST2 in the ward to which Patient A was admitted. Also working there at the time was Dr F as a GPST1. Dr Kurz and Dr F worked as a part of the team caring for patients. There was no seniority or hierarchy in their respective roles. The Consultant Geriatrician was Dr G.

30. Dr F "clerked" Patient A on admission to the WCH on 28 November 2016 setting out his findings in a note timed at 19:15 on that day. In this note, Dr F noted only that there had been concerns about Patient A's potassium levels on admission to the RCH. He did not specifically refer to the entries made whilst Patient A was there made on 16 – 18 November 2016, nor that consideration had been given to the possibility of pseudohyperkalaemia.

31. Dr G saw Patient A on his ward round on 29 November 2016, and notes were made in the records timed at 09:05. These were written by Dr G. Dr Kurz saw Patient A later that same day and made notes timed at 14:45 and 16:20. These notes show that Dr Kurz was undertaking a review of Patient A's ongoing rehabilitation needs and for further placement in a community hospital, including relevant discussions he had with others about this. This was not intended to be a review of Patient A's medical care or treatment.

32. It is the events which occurred on the next day, 30 November 2016, which are the subject of paragraph 1 of the Allegation against Dr Kurz. The patient records show that Dr G saw Patient A at 09:30, that Patient A was discussed by the multi-disciplinary team at 11:40, and that he was seen by Dr F at 14:15. In his 1415 notes, Dr F recorded that Patient A was agitated, trying to leave, and punching out at nursing staff. The records from WCH up to this point do not show any concerns about Patient A's potassium levels since his arrival there.

33. Then, in the medical records timed at 15:40, there is an entry following a message from the laboratory indicating that the patient's potassium level was raised to 7.6mmol/L. This was accompanied by an electronic record stating that Patient A's blood contained an abnormally high platelet count. Dr Kurz was made aware of this message by the nursing staff shortly after it was received.

34. The next entry in Patient A's records is an entry by Dr Kurz timed at 16:20 that day in which he records:

- "K – 7.6
- Calcium Resonium Enema prescribed stat & regularly
- ECG requested
- Lorazepam 0.5mg PRN to enable treatment of hyperkalaemia if required"

35. The next entry is one made by Dr F timed at 16:20 in which he records:

- *"K+ ↑ d/w [Dr B] [increased potassium discussed with [Dr G]*
- *He agrees that should be treated as per RCH protocol*
- *Ptx [treat] as per protocol*
- *Restart calcium resonium"*

36. Following Dr F's discussion with Dr G, treatment of Patient A then commenced in line with Trust Policy. Dr Kurz cooperated in administering that treatment.

37. The next entry is timed at 16:35 that day. It is made by a speech and language therapist who saw Patient A. No reference is made to Patient's A's potassium level. Then, at 19:40 that day, Dr F entered the following note:

- *"VBG for ↑K+ [venous blood gas for raised potassium]*
- *K 4.1*
- *Glu 5.2 [glucose 5.2]*
- *P a/w calcium resonium [plan await calcium resonium]*
- *Note K 8.5 blood from 17:00"*

38. The next entry is in the early hours of the next day, 1 December 2016, timed at 00:20 and is made by another doctor. It states:

- *"Formal blood sent at 19:40 showed K+ 7.6*
- *(cf K+4.1 on VBG sample taken at same time)*
- *Also → ongoing AKI (eGFR 47 – baseline 67)*
- *IMP*
- *Ongoing hyperkalaemia, very slowly improving*
- *Plan*
- *further calcium gluconate + insulin/dextrose*
- *Add nebulised salbutamol 10mg stat*
- *repeat formal bloods + VBG*
- *IVI overnight"*

39. On 1 December 2016 at 07:35, the same doctor noted:

- *"Above treatment administered overnight.*
- *Attempted to take blood to recheck K+*
- *Patient refused. Agitated, wants to 'go home'.*
- *Not able to comprehend the importance of blood test*
- *Plan*
- *N/S [nursing staff] informed – they will try to talk patient down and convince him to agree*
- *Reattempt in 1h"*

40. Later that day at 11:15, another doctor obtained a VBG reading of 4.7 mmol/L. The notes show a discussion with Dr G who reassured the doctor that a VBG reading is good enough to measure the potassium level. The plan then was to continue the intravenous fluids and re-measure formal bloods after lunch. At 13:20, the same doctor discussed with Dr G the possibility that Patient A's blood test results may have shown a false reading, meaning that Patient A could have pseudo-hyperkalaemia. Dr G agreed that further POC blood tests be done, rather than relying on the laboratory tests because the delays in getting samples there increased the chance of a falsely high reading.

41. Dr Kurz had no further involvement in Patient A. Further checks of Patient A's potassium levels using POC tests were all in the normal range. Dr H's opinion, with which Dr G agreed was that, with the benefit of hindsight, Patient A's raised potassium levels had been artificially high and were the result of pseudo-hyperkalaemia, rather that hyperkalaemia, and that, with hindsight, it was possible to argue that Patient A had not in fact needed treatment for hyperkalaemia as per the RCH Trust policy.

42. In the context of the medical evidence and these findings of fact, the Tribunal had to determine whether, Dr Kurz had failed to arrange appropriate treatment at the time on 30 November 2016 when he became aware of the reading of 7.6 mmol/L, and whether he failed to follow Trust policy.

Paragraph 1 (a) (i)(ii)(iii), 1(b) of the Allegation

43. The Tribunal noted Dr Kurz made an admission to paragraph 1(c) and fully accepts that his record keeping was poor.

44. The Tribunal noted that paragraph 1(a) and (b) of the Allegation are that Dr Kurz failed to appropriately treat the high potassium level of 7.6 mmol/L in Patient A in accordance with Trust Policy. Dr Kurz's response to the Allegation was that Patient A was not suffering from hyperkalaemia because he had recognised that the potassium level was artificially high and therefore, he had diagnosed pseudohyperkalaemia. Dr Kurz has admitted that he did not record pseudohyperkalaemia as his rationale for not wanting to treat Patient's A's high level of potassium. It was for this reason, he admitted paragraph 1(c) of the Allegation.

45. The Tribunal noted that Dr Kurz, in his evidence, accepted that he was informed by a nurse of the high potassium level of 7.6 when the message was received by the laboratory. He stated that he then checked the electronic record from the laboratory which showed Patient A's platelet count to be high. He stated that this was a factor in causing him to suspect that the potassium level was artificially high and that this was a case of pseudohyperkalaemia. He stated that in reaching this conclusion, he also took into account:

- Patient A's history and in particular that pseudohyperkalaemia had also been previously suspect at the RCH;
- the delay in Patient A's blood sample being analysed because of the distance between WCH and the laboratory at RCH;
- the possibility of haemolysis (potassium seeping out of the cells into the serum);
- the high platelet count present in the laboratory analysis and previous high platelet counts;
- that there are risks in treating a patient for high potassium when the patient's potassium is not, in reality, high;

- that Patient A was a difficult patient who had shown aggression and agitation, from whom it might be difficult to obtain further samples, and who it might be difficult to cannulate in order to administer the required treatment.

46. Dr Kurz stated that due to these factors, he decided to treat Patient A accordingly. He therefore decided to administer calcium resonium, request an ECG, and prescribe lorazepam, and this decision is reflected in the note he made in Patient A's records at 16:15. In this same note, he recorded that the potassium level was 7.6, and that lorazepam was prescribed *"to enable treatment of hyperkalaemia if required"*.

47. Based on this evidence, the Tribunal decided that as a matter of fact, Dr Kurz was faced with a reading of 7.6 and that he did not arrange to treat Patient A for high potassium in line with Trust Policy by arranging for him to be given a prescription of IV calcium gluconate, an infusion of insulin and dextrose, and nebulised salbutamol. The Tribunal therefore decided that the factual elements of paragraphs 1(a) and (b) of the Allegation were proved.

48. The Tribunal then considered whether it was "appropriate" to treat Patient A in this way. In this respect, it had regard to the evidence of Dr G and Dr H.

49. Dr G told the Tribunal that most doctors, faced with a high potassium reading would err on the side of caution and treat accordingly because the risk was of cardiac arrest and death. He stated that, faced with a suspect false high reading, a POC blood test should be obtained to get an accurate reading, and that this should have been the first port of call. If a POC test showed a non-elevated reading then no treatment should be given. He accepted that there are risks in treating for high potassium if that is not the case. He stated that if the decision was made to not treat for high potassium, there would need to be clear evidence not to do so which would include a POC test result and an ECG. His view was that the note made by Dr Kurz suggested that he was preparing for treatment rather than arranging for treatment or actually administering treatment.

50. Dr H's evidence was consistent with that of Dr G. He stated that a reading of 7.6 was potentially fatal and needs immediate treatment. He stated that a doctor should assume the reading is real, start treatment, and obtain a POC to confirm whether the high reading was false or not. If false, the treatment already started could be stopped. He stated that he would only not treat a high potassium level if he had confidence that the level was false, and the correct way to treat was as per the policy. If there was doubt as to whether the level was accurate, then it should have been checked with a POC test. Dr H also stated that any deviation from Trust policy by a junior doctor should have been checked with, and authorised, by a consultant or senior doctor.

51. For these reasons, the Tribunal decided that on 30 November 2016 when Dr Kurz decided how to treat Patient A after being told of the 7.6 potassium level, he failed to arrange appropriate treatment in that he failed to arrange for Patient A to be given a

prescription of IV calcium gluconate, an infusion of insulin and dextrose, and nebulised salbutamol.

52. Accordingly, the Tribunal decided that paragraphs 1(a) and (b) of the Allegation were proved.

53. However, in reaching this conclusion, the Tribunal accepted Dr Kurz's evidence that he strongly suspected that the reading of 7.6 was falsely elevated, and that he had good reasons for doing so. The Tribunal accepted that he genuinely believed that he was faced with an artificially high reading, and that he acted in accordance with his genuine belief by not treating in accordance with the protocol. The Tribunal also noted that, in the event, Dr Kurz's suspicions were found to be justified in that further multiple blood tests confirmed that Patient A was not suffering from hyperkalaemia and that pseudohyperkalaemia was found to be the cause.

54. In accepting Dr Kurz's evidence about his findings at the time, the Tribunal decided that, overall, Dr Kurz was a consistent and credible witness, who had readily admitted his shortcomings with regard to both Patient A and B, notwithstanding the nature and gravity of the allegations he was facing. He gave evidence and represented himself in an open and straightforward manner.

55. It was suggested at the hearing that Dr Kurz did not genuinely suspect pseudohyperkalaemia because he did not mention this to Dr F when they had a discussion after a member of the nursing staff had raised concerns with Dr F's that Dr Kurz was not treating for hyperkalaemia in accordance with policy. In evidence, Dr F, who the Tribunal also considered to be a fair, consistent and credible witness, said that, although he recalled having the discussion, he could not recall what was specifically said. On the other hand, Dr Kurz gave evidence that he could recall the discussion and that he had told Dr F his reasons for not treating for hyperkalaemia.

56. It was also suggested that, if Dr Kurz had told Dr F about his suspicions, then this would have been relayed to Dr G, but Dr G could not assist on this point because he had not independent recollection of these events. Given that Dr F could not recall the details and there is no written record, on balance the Tribunal accepted Dr Kurz's evidence about what was said during the discussion. The Tribunal noted that Dr F did raise concerns with his supervisor in a statement later that day about Dr Kurz's failure to treat Patient A in accordance with policy, saying that Dr Kurz did not accept his concerns. The Tribunal decided that this was not inconsistent with Dr Kurz's evidence that he had told Dr F of his reasons for suspecting a falsely elevated reading. Further, the Tribunal noted from the same document that Dr F stated that Dr Kurz had assisted in the management of Patient A by taking bloods and inserting an IV cannula.

57. The Tribunal therefore accepted that Dr Kurz had good reasons for his approach to treating Patient A for pseudohyperkalaemia and not hyperkalaemia, and that the approach he took significantly mitigates the fact that he did not arrange appropriate treatment in

accordance with the policy. The Tribunal was mindful that the policy was administered after Dr F's consultation with Dr G and that Dr Kurz did not fail to follow the hospital policy after Dr G had been consulted. Indeed, the Tribunal decided that he fully cooperated in administering treatment very shortly thereafter.

58. In summary, regarding Patient A, the Tribunal found paragraphs 1(a) and (b) of the Allegation determined and proved, but that Dr Kurz had reasonable and sound reasons for the failure to follow hospital policy. On Dr Kurz's own admission, the Tribunal found paragraph 1(c) of the Allegation proved in that he did not record pseudohyperkalaemia as his rationale for not wanting to treat Patient A's high level of potassium. As Dr Kurz stated at the hearing, had he done so then his actions on the day may not have been misunderstood.

Patient B Background

59. The Tribunal's starting point in considering the facts concerning the Allegations against Patient B were the admissions made by Dr Kurz at the beginning of the hearing.

60. It was not disputed that at the time when these events occurred, Dr Kurz was engaged in the GP training programme which had started in 2016. As part of the programme, Dr Kurz started a period of training at the Cape Cornwall Surgery on 2 August 2017. Dr C was one of the partners at the practice. He had been Dr Kurz's Educational Adviser since 2016. When Dr Kurz started working at the practice, Dr C acted as both his Clinical Supervisor and his Educational Supervisor.

61. In his admissions, Dr Kurz accepted that he had 8 consultations with Patient B between 25 September 2017 and 4 December 2017. These consultations were all at the surgery with the exception of one, which was by telephone. They were: 25 September (recorded as being 72 minutes in duration; 9 October (43 minutes); 23 October (indeterminate); 30 October (56 minutes); 3 November (telephone consultation); 6 November (56 minutes); 20 November (36 minutes); and 4 December (45 minutes).

62. Dr Kurz accepted that these consultations were on a serial basis and that on one or more occasions they were inappropriately long and known by him to be inappropriately long. The conversations became more social and more of a personal nature as the consultations progressed. He accepted that comments were made about the effect his presence might have on Patient B's blood pressure, that he would not record something she had said about her past history in the medical records, and that he had pointed out to Patient B the location of his car as being near a place where she said she would be going for a walk. Dr Kurz accepted that in the last of the consultations, on 4 December, when Patient B asked what he was doing on the following Sunday (10 December), he told her he would be revising and words to the effect that if Patient B knocked on his door, it would be rude not to offer a coffee.

63. Dr Kurz accepted that he met Patient B at his home address on 10 December 2017. He accepted that on that occasion, he allowed her into the property for around 1 -2 hours,

had hugged and kissed her, suggested that she might visit again, and suggested that they could communicate by way of Messenger.

64. Dr Kurz accepted that Patient B visited his home on 5 further occasions. They were 14 December, 17 December; 18 December; 21 December; and 27 December. He accepted that they had kissed and cuddled on each occasion.

65. Dr Kurz also accepted that over the same period there had been a series of exchanges by way of Messenger between himself and Patient B. In these messages, Dr Kurz had made arrangements for the visits to his home to take place, agreed to Patient B bringing dinner to share, discussed personal matters (including when he had last drunk alcohol, XXX, and his mood), and had ended messages with kisses. Dr Kurz accepted that messages on 19 December included that he "wanted to" when Patient B suggested he "sneak over" in the new year, and it sounded like a wonderful experience when Patient B suggested they go to a festival together.

66. The Tribunal did not hear oral evidence from Patient B, but had two statements from her in which she described the consultations, meetings and messages. Patient A had made available the messages on Messenger which provided support for what she said in her statements about the meetings she had with Dr Kurz and the content of the communications between them. Dr Kurz had indicated at an early stage of these proceedings that he accepted what Patient B said in her statements, and did not therefore require to give oral evidence at the hearing.

67. In the context of these facts, the Tribunal considered the paragraphs of the Allegation concerning Patient B which had not been admitted.

68. The Tribunal considered the evidence and credibility of Dr Kurz, namely that overall he was a consistent and credible witness, who readily admitted his shortcomings with regard to both patients, notwithstanding the nature and gravity of the allegations he was facing. The Tribunal found that it could accept his evidence as reliable and credible.

Paragraph 4 of the Allegation

69. The Tribunal considered the allegation that, on or around 30 October 2017 Dr Kurz met with his clinical and educational supervisor, Dr C, and Dr C instructed him not to continue organising serial long consultations with vulnerable female patients, including Patient B, and he failed to follow that instruction.

70. The Tribunal had the benefit of hearing from Dr C in person at the hearing. It found his evidence, straightforward, credible and consistent, and evidence upon which it was able to rely. Dr C told the Tribunal that Patient B was considered vulnerable by both him and his partners at the practice, because they had built up knowledge and experience of treating her over the years. He accepted that there was no formal "marker" on her patient records to this

effect which would have highlighted her vulnerability to Dr Kurz when he was first consulted by her, or to anyone reading her notes.

71. Dr C told the Tribunal that, by 30 October 2017, his supervision of Dr Kurz had reached the stage where he was seeing him less frequently than before, but that he was still meeting him for a de-brief each day. At these meetings, Dr C was selecting patients at random for discussion, and this was how he came to discuss Patient B with Dr Kurz on that date. He accepted that this was also in the context of Dr Kurz having lengthy consultations with two other patients with mental health issues. Dr C accepted that the focus of the meeting was not about specific concerns regarding Dr Kurz's management of these patients, but that Dr Kurz needed to broaden his range of experience by seeing other patients who presented with different types of medical issues, and which would address his educational needs in preparation for his forthcoming examinations.

72. Although Dr C said he was firm that Dr Kurz should move on and not continue to see patients with mental health problems, he also accepted that what he said was generic and educational. The Tribunal also noted that Dr C added a note to Patient B's records in January 2018, after it became known that Dr Kurz had had a relationship with her. He recorded *"advised to consult less often"*.

73. Having considered this evidence carefully, and Dr Kurz's evidence that he was not "instructed" to desist seeing Patient B or any other patient, the Tribunal was not satisfied that Dr Kurz had been "instructed in the way set out at Allegation 4. The Tribunal decided that, on balance, what was said to Dr Kurz by Dr C on 30 October 2017 was more generic and advisory in educational context rather than a clear "instruction" as alleged in paragraph 4 of the Allegation.

74. The Tribunal decided therefore that this paragraph was not proved.

Paragraph 21(b) of the Allegation

75. Dr Kurz admitted paragraph 20(c) of the Allegation which was that in a telephone conversation with Patient B on or around 1 January 2018 he told her to register with a different GP practice. Paragraph 21(b) alleged that this was in an attempt to conceal the relationship with Patient B from his work colleagues, in that if she registered at a different GP practice, she would no longer be a patient at the practice at which he worked.

76. Dr Kurz's evidence was that Patient B had already provided sufficient information to Dr D (a partner at the practice) on 29 December 2017 for Dr D to identify him as the person having the improper relationship with the patient. Dr Kurz's evidence was that by the time he had the telephone call with patient B about this, the "the cat was already out of the bag", as the partners at Cape Cornwall surgery would be aware of the relationship. and he knew that he could no longer conceal the relationship. Dr Kurz accepted that he discussed with Patient B that she move to another surgery because her son was already registered elsewhere, but

not because he wanted to, or thought he could, conceal their relationship from his colleagues.

77. The Tribunal considered that Dr Kurz's evidence was supported by the messages passing between him and Patient B at the time.

78. The Tribunal accepted Dr Kurz's evidence. It was not satisfied that he had suggested the move to another GP practice in an attempt to conceal the relationship from his colleagues.

79. The Tribunal concluded that paragraph 21(b) is not proved.

Paragraph 22 of the Allegation

80. The Tribunal considered the allegation that the actions of Dr Kurz at paragraph 20c in telling Patient B to register with another surgery were dishonest by reason of paragraph 21.

81. The Tribunal decided it was not dishonest simply to believe that he would be identified as the doctor who was meeting Patient B (paragraph 21(a)), nor, given its finding that he did not try to conceal his relationship with Patient B, that he was acting dishonestly in doing so.

82. The Tribunal therefore found that paragraph 22 is not proved.

Paragraph 24(a) of the Allegation

83. The Tribunal considered the allegation Dr Kurz's actions as described at paragraph 23 in not reporting his relationship with Patient B were designed to conceal the fact that he had further serial lengthy consultations with Patient B after being instructed by Dr C to desist from having such consultations with her.

84. The Tribunal noted its findings regarding paragraph 4 that Dr Kurz was not instructed to desist from having such consultations with Patient B, and he was merely advised in a generic sense and in an educational context.

85. Since the Tribunal found that Dr Kurz had not been "instructed" to "desist" from further serial consultations with Patient B, it could not find that his actions were designed to conceal these consultations.

86. The Tribunal concluded that paragraph 24(a) is not proved.

Paragraph 25 of the Allegation

87. The Tribunal considered the allegation that his actions as described at paragraph 23a and 23b were dishonest by reason of paragraph 24.

88. The Tribunal noted that Dr Kurz admitted that he had failed to report that he was having a relationship with Patient B at a competency meeting with Dr C, his supervisor, in mid-December 2017 (paragraph 23(a)), nor in a timely fashion to Dr C when he knew he should have done (paragraph 23(b)), and that by failing to do so his actions were designed to conceal a relationship which he knew was inappropriate (paragraph 24(b)). The issue for the Tribunal was whether Dr Kurz was dishonest in failing to report these matters.

89. The Tribunal noted that the date of the competency meeting was unspecified in the evidence except that it occurred in "mid-December". The Tribunal considered it likely by this time that Dr Kurz had already met Patient B in a social context after the surgery consultations had stopped. The Tribunal noted Dr C's evidence that at the competency meeting it was noted that Dr Kurz had attended a Professional Boundaries Course, and that he had achieved the "Maintaining an Ethical Approach" competency, both of which were discussed at the meeting. The Tribunal considered that if ever there was an opportunity to disclose the improper relationship, this was it, but that Dr Kurz did not do so because, at that time, he was hoping that his developing relationship with Patient B would not be discovered.

90. The Tribunal found and Dr Kurz accepted that he was involved in an inappropriate relationship with Patient B and that he should have disclosed this to Dr C and the practice at which he was working. The Tribunal decided that in not disclosing the relationship, he was also seeking to conceal it, and that these actions would be considered untrustworthy and deceitful by ordinary decent members of the public, and that they would consider these actions dishonest. Dr Kurz accepted that he was dishonest, at the outset of the hearing, in relation to paragraph 24(b) of the Allegation.

91. The Tribunal therefore concluded that Dr Kurz was dishonest and found paragraph 25 proved in respect of paragraph 24(b) of the Allegation.

Paragraph 26 of the Allegation

92. The Tribunal considered the allegation that at all material times Patient B was vulnerable by reason of the matters set out in Schedule 4, namely her mental health and her personal circumstances at the time. The Tribunal noted that this was an allegation in which it had to consider whether or not Patient B was vulnerable at all material times, and not whether Dr Kurz knew or considered her to be vulnerable.

93. Dr Kurz told the Tribunal that there was nothing in Patient B's medical records to suggest that Patient B was vulnerable when he had the first consultation with her, and that he was unaware of the partners at the practice having considered her vulnerable. Dr C accepted there was no vulnerable flag or coding in the records. In considering Patient B's records, the Tribunal agreed with Dr Kurz that the last consultation for mental health matters had been in 2006, there was no current prescription for medication which might suggest mental health concerns, and Patient A had not sought medical advice for any reason for around one year before she first saw Dr Kurz.

94. In addition, Dr Kurz told the Tribunal that Patient B assured him at the first consultation that she did not have a mental health problem, and that the reference in her records was to a time when she was going through divorce proceedings. He said he had considered this at the time because she had spoken of anxiety, but he did not consider this to be significant or to any greater degree than many other people experience in their day to day lives. He noted that she was a busy but organised person who was involved in a business managing properties and project managing renovations. For these reasons, Dr Kurz did not consider Patient B to be vulnerable at that time, nor, he said, until sometime later and with a degree of hindsight.

95. In her submissions, Ms Barlow suggested that "vulnerable" in relation to Patient B meant that she is a person is more susceptible to harm than an ordinary member of the public because of her mental health and her personal circumstances at the time. The Tribunal also considered the ordinary meaning of the term "vulnerable" which it considered to be "at risk of physical, psychological, or emotional harm".

96. Although the Tribunal concluded that there may have been a time in the past when Patient B may have been vulnerable, it was not satisfied that, at all material times, particularly when first consulting Dr Kurz, she was vulnerable.

97. The Tribunal therefore concluded that paragraph 26 is not proved.

Paragraph 27 (a) of the Allegation

98. The Tribunal consider the allegation that your conduct as described at paragraphs 2a, 2b, 3a, 3b, 3c, 4, 5b, 6, 7a, 7b, 7c, 7d, 7e, 8a, 8b, 9, 10a, 10b, 11a, 11b, 11c, 11d, 12, 13a, 13b, 14a, 14b, 15a, 15b, 15c, 15d, 16a, 16b, 17, 18a, 18b, 19a and 19b was sexually motivated.

99. The Tribunal considered the nature, extent and quality of the relationship as it was described by Patient B in her written evidence, and as it was demonstrated through the many messages that passed between her and Dr Kurz. Patient B described kissing and cuddling but nothing more of a sexual nature, and she confirmed that intercourse did not occur. Her evidence is consistent with a new and developing, consensual, relationship which was more than platonic but primarily intended by both parties to be one of discovering more about each other and lead to possible longer-term romance. Such a relationship will often lead to sex, but it does not mean that the motivation for the relationship is sexual.

100. Dr Kurz's evidence to the Tribunal was consistent with this. He told the Tribunal he was a single person with no ties, and that he was open to the possibility of a longer-term, committed relationship. He did not accept that his motive was sexual.

101. Dr Kurz accepted that the relationship was inappropriate. The Tribunal agreed but decided that this, in itself, does not mean that it was sexually motivated. The Tribunal was

not satisfied that Dr Kurz's conduct as described in the several paragraphs contained in the Allegation was sexually motivated.

102. The Tribunal concluded that Paragraph 27(a) is not proved.

The Tribunal's Overall Determination on the Facts

103. The Tribunal has determined the facts as follows:

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

Patient A

1. Between 29 November 2016 and 1 December 2016, you were involved in the care of Patient A and despite recording in Patient A's records that he had a serum potassium level of 7.6mmol/L on 30 November 2016, you failed to:

    a. arrange appropriate treatment for high potassium, in that you did not arrange:

        i. a prescription of IV calcium gluconate; **Found proved**

        ii. an infusion of insulin and dextrose; **Found proved**

        iii. nebulised salbutamol; **Found proved**

    b. follow the Royal Cornwall Hospitals NHS Trust policy on adult hyperkalaemia management ('the Policy'); **Found proved**

    c. in the alternative to paragraphs 1a-1b, record pseudo hyperkalemia as your rationale for not wanting to treat Patient A's high level of potassium. **Admitted and found proved**

Patient B – Consultations

2. You consulted with Patient B on a serial basis on the dates set out in Schedule 1, and your consultations on one or more of those dates:

    a. were:

        i. inappropriately long; **Admitted and found proved**

        ii. known by you to be inappropriately long; **Admitted and found proved**

b. contained lengthy discussions of a social nature including discussions relating to your personal life and your plans for the future. **Admitted and found proved**

3. In the course of one or more of the consultations with Patient B set out in Schedule 1:

   a. you once asked her if you could take her blood pressure, and when she said it was not necessary, you said "I was wondering what effect my presence had on it" or words to that effect; **Admitted and found proved**

   b. she once spoke to you about allegations reported in the news and said her views about them related to a similar experience she had had in the past when she had been a victim of a sexual assault and you said "it's good that you have dealt with it though, don't worry, I am not going to write/mention that in your medical records" or words to that effect; **Admitted and found proved**

   c. she once told you she hoped to go for a walk in Lelant and you looked up where it was on google maps, panned across to where you lived and said "oh look, that's my old jag". **Admitted and found proved**

4. On or around 30 October 2017, you met with your clinical and educational supervisor, Dr C, and he instructed you not to continue organising serial long consultations with vulnerable female patients, including Patient B, and you failed to follow that instruction. **Not proved**

5. On or around 4 December 2017, during a consultation with Patient B, she asked you what you were doing on Sunday and you:

   a. told her you would be revising, or words to that effect; **Admitted and found proved**

   b. said "if you happened to knock on my door and wanted a coffee it would be rude not to" or words to that effect. **Admitted and found proved**

<u>Patient B – Messages and meetings</u>

6. Between 10 December 2017 and 27 December 2017 Patient B visited your home on the dates set out in Schedule 2 and on one or more of those occasions you arranged with her when you would next meet her. **Admitted and found proved**

7. On or around 10 December 2017 Patient B attended at your home and you:

   a. allowed her into the property for around one or two hours; Admitted and found proved

   b. threw your arms around her and hugged her as she was leaving; Admitted and found proved

   c. kissed her; Admitted and found proved

   d. said if she was over that way, by which you meant your home, she could pop round and see you, or words to that effect; Admitted and found proved

   e. said that she would "probably want to check [you] was in before driving all the way over" to your home and you mentioned communicating with her by way of Messenger, or words to that effect. Admitted and found proved

8. Between 10 December 2017 and 16 January 2018 you and Patient B exchanged messages on Messenger and:

   a. on one or more occasion you ended your message with kisses; Admitted and found proved

   b. you discussed personal matters including, but not limited to, those set out in Schedule 3. Admitted and found proved

9. On 11 December 2017, in response to comments Patient B made on Messenger about a cabin, you said "the cabin sounds like a lovely option, we'll have to take advantage of it sometime soon". Admitted and found proved

10. On 12 December 2017 you and Patient B exchanged messages on Messenger and you:

    a. agreed to watch a film with her; Admitted and found proved

    b. said "it's nice that you are enthusiastic" when she said she would love to see you. Admitted and found proved

11. On 14 December 2017 you:

a. made arrangements with Patient B on Messenger for her to visit your home; **Admitted and found proved**

b. were visited at your home by Patient B and you:

i. touched her back; **Admitted and found proved**

ii. kissed each other; **Admitted and found proved**

iii. cuddled each other; **Admitted and found proved**

c. blew kisses to Patient B as she left your home; **Admitted and found proved**

d. said to Patient B on Messenger "sweet dreams, you are wonderful company. X" after she had left your home. **Admitted and found proved**

12. On 16 December 2017 you made arrangements with Patient B on Messenger for her to visit your home on 17 December 2017. **Admitted and found proved**

13. On 17 December 2017 Patient B visited you at your home and you:

a. kissed each other; **Admitted and found proved**

b. cuddled each other. **Admitted and found proved**

14. On 18 December 2017:

a. you made arrangements with Patient B on Messenger for her to visit your home; **Admitted and found proved**

b. Patient B visited you at your home and you:

i. kissed each other; **Admitted and found proved**

ii. cuddled each other. **Admitted and found proved**

15. On 19 December 2017 you and Patient B exchanged messages on Messenger and you said:

a. "I like that you are including me xxx" when she told you about some renovation work she was doing; **Admitted and found proved**

b. "the name is certainly on your mind xxx [kissing emoji]" when she told you about three people called Roger; **Admitted and found proved**

c. "i'm sure that we will be able to formulate a successful strategy" and "I want to xxx" when she asked if you were going to sneak over in the new year; **Admitted and found proved**

d. "I haven't been to either, but both sound like a wonderful experience, i'll trust in your experience and intuition x" when she suggested going to a festival. **Admitted and found proved**

16. On 21 December 2017:

a. you and Patient B exchanged messages on Messenger and you:

i. said "i'm so sorry, wish I could be there to give you a hug and support" in response to her telling you she had had a terrible day; **Admitted and found proved**

ii. agreed to her bringing dinner to share with you; **Admitted and found proved**

b. Patient B visited you at your home and you:

i. kissed each other; **Admitted and found proved**

ii. cuddled each other. **Admitted and found proved**

17. On 25 December 2017 you sent Patient B, on Messenger, a picture of a stove fan you had accepted as a gift from her. **Admitted and found proved**

18. On 26 December 2017 you:

a. told Patient B on Messenger that you had been "summoned over to Dr C's for dinner tomorrow at six, but [could] still meet up in the afternoon xxx"; **Admitted and found proved**

b. made arrangements with Patient B on messenger for her to visit you at your home the following afternoon. **Admitted and found proved**

19. On 27 December 2017 Patient B visited you at your home and you:

a. cuddled each other; **Admitted and found proved**

b. both went for a walk and to a café. **Admitted and found proved**

20. On or around 1 January 2018 you had a telephone conversation with Patient B after she told you that she had told your work colleague, Dr D, that she had been meeting up with a doctor at your GP practice and you:

    a. ranted at her; **Admitted and found proved**

    b. said she had anxiety and you could not deal with it, or words to that effect; **Admitted and found proved**

    c. told her to go and register with a different GP practice the following morning, or words to that effect. **Admitted and found proved**

21. You:

    a. believed that you would be identified as the doctor who had been meeting up with Patient B, as described in paragraph 20; **Admitted and found proved**

    b. carried out the actions set out at paragraph 20c in an attempt to conceal your relationship with Patient B from your work colleagues, in that if she registered at a different GP practice she would no longer be a patient at the practice at which you worked. **Not proved**

22. Your actions at paragraph 20c were dishonest by reason of paragraph 21. **Not proved**

23. You failed to report one or more of the matters set out in paragraphs 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 to:

    a. Dr C at or before a meeting you had with him to discuss your competencies in December 2017; **Admitted and found proved**

    b. Dr C and/or another responsible person at work in a timely fashion, as you knew you should have done. **Admitted and found proved**

24. Your actions as described at paragraph 23 were designed to conceal the fact that you had:

a. had further serial lengthy consultations with Patient B after being instructed by Dr C to desist from having such consultations with her; **Not proved**

b. been seeing Patient B on a social basis and communicating with her by Messenger, which you knew was inappropriate. **Admitted and found proved**

25. Your actions as described at paragraph 23a and 23b were dishonest by reason of paragraph 24. **Found proved**

26. At all material times Patient B was vulnerable by reason of the matters set out in Schedule 4. **Not proved**

27. Your conduct as described at paragraphs 2a, 2b, 3a, 3b, 3c, 4, 5b, 6, 7a, 7b, 7c, 7d, 7e, 8a, 8b, 9, 10a, 10b, 11a, 11b, 11c, 11d, 12, 13a, 13b, 14a, 14b, 15a, 15b, 15c, 15d, 16a, 16b, 17, 18a, 18b, 19a and 19b was:

a. sexually motivated; and/or **Not proved**

b. for the purpose of pursuing an improper personal relationship with Patient B. **Admitted and found proved**

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

Determination on Impairment - 25/08/2021

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

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence on behalf of Dr Kurz, in the form of positive testimonials, all of which it has read.

3. Dr Kurz also gave oral evidence at the impairment stage. During his oral evidence, Dr Kurz reminded the Tribunal of its findings in relation to his treatment of Patient A. He acknowledged that if his record keeping had been better, the issues regarding Patient A might not have come before the Tribunal. He reminded the Tribunal of the difficulties experienced by all those trying to treat Patient A on 30 November 2016. He told the Tribunal about a quality improvement project he took part in on the Isle of Wight to improve record

keeping at the hospital. He explained that since taking part in that project, he has reflected on his own record keeping and that he can now see a distinct difference in the structure and thoroughness of the records he previously made and those he makes now.

4. Dr Kurz told the Tribunal about the significant impact his relationship with Patient B had on his professional and personal life. He told the Tribunal that he had not sought to minimise the seriousness of his actions and accepted that the matter in issue was very serious. He stated that he had answered honestly throughout and reminded the Tribunal of its finding that he was a credible and consistent witness.

5. Dr Kurz was cross-examined by Ms Barlow in respect of Patient B only. During cross-examination, he acknowledged that he had completed an Introduction to Professional Boundaries course prior to engaging in an emotional relationship with Patient B. He accepted that he understood Good Medical Practice (2013) ('GMP') and the *'Maintaining a professional boundary between you and your patient'* guidance (2013) ('the Guidance'), at the time he embarked upon the relationship with Patient B and that he should not have done so. Dr Kurz suggested that it was of note that he undertook no further consultations with Patient B after they began meeting socially and that he had encouraged her to register with another practice. Dr Kurz accepted that he had not sought advice about his relationship with Patient B, either prior to, or after they had begun to meet socially. He said he had tried to keep it a secret because he knew the vulnerable professional position he would be placed in if it were known he was in a relationship with a patient.

6. Dr Kurz accepted that trust is the foundation of the patient/doctor partnership and that his relationship with Patient B was originally, a professional one. He confirmed that once he ended the relationship, Patient B did not take it well. He did not accept that it would have been appropriate to discuss matters with someone at the Practice and that he believed she was being appropriately supported. In response to questions about whether he had sought to explain and apologise to Patient B through a third party, Dr Kurz explained that he had been advised by both the Deanery and the Practice not to contact Patient B so he had not done so. Dr Kurz accepted that his actions amounted to a serious departure from what is expected of a doctor. He accepted that his relationships with Patient B was entirely inappropriate and that he was dishonest in keeping the relationship from his colleagues. He said that he was aware it was wrong which was why he had sought to keep it a secret. Dr Kurz told the Tribunal that he had considered the Guidance, reflected on it and accepted that such guidance is there to protect all parties.

7. During Tribunal questions, Dr Kurz explained that he had not attended any further courses either on maintaining professional boundaries or on probity. He explained that he had not been able to work as a doctor for 18 months with little income which limited his ability to access relevant training courses. He accepted that there was scope for him to complete further training and development. When asked about whether he had undertaken any online training, Dr Kurz acknowledged that it had not occurred to him to do so and he was grateful for the suggestion. Dr Kurz said that he had reviewed relevant GMC and MPTS guidance. Dr Kurz accepted that in his email requesting testimonials, he had not referred to

his alleged dishonesty. He said this was not a deliberate omission and he had intended his email to be comprehensive. Dr Kurz explained that he had taken part in several discussions with his clinical and educational supervisors during which he has discussed the GMC's investigation and these proceedings.

Submissions

8. On behalf of the GMC, Ms Barlow submitted that Dr Kurz's actions amount to serious misconduct and that his fitness to practise is currently impaired. Throughout her submissions, Ms Barlow referred to relevant authorities and referred the Tribunal to the relevant paragraphs of GMP and the Guidance.

9. In respect of Patient A, Ms Barlow submitted that the matter of misconduct was more nuanced than in respect of Patient B. She reminded the Tribunal of the expert evidence it had received from Dr H, who was of the view that Dr Kurz's actions in respect of his recordkeeping and his decision not to follow the relevant policy on Hyperkalaemia, fell seriously below the standard expected of a reasonably competent GP Trainee. Ms Barlow invited the Tribunal to balance the expert evidence against the mitigation it had identified in relation to Dr Kurz's actions regarding Patient A. She submitted that the failures identified by Dr H did amount to serious misconduct. In relation to impairment, Ms Barlow submitted that Patient A's case amounted to a clinical failing, which she accepted was far easier to remediate. She further submitted that Dr Kurz's failings in relation to Patient A were far less significant than the matters related to Patient B.

10. Ms Barlow submitted that Dr Kurz's actions in respect of Patient B were the more serious matter for the Tribunal to consider. She stated that Dr Kurz accepted that his relationship with Patient B was deeply inappropriate. She submitted that Dr Kurz's emotional relationship with Patient B, was contrary to all relevant guidance including GMP and the Guidance. She reminded the Tribunal that interlinked with his inappropriate relationship with Patient B was Dr Kurz's dishonesty. She stated that he dishonestly concealed the relationship from colleagues, knowing the potential impact on his career. Ms Barlow submitted that that fellow practitioners would find Dr Kurz's conduct to be deplorable.

11. Ms Barlow submitted that, in respect of his relationship with Patient B, a finding of impairment was required 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. She submitted that a finding of impairment was required to mark how serious Dr Kurz's departure from expected standards was and without such a finding, public confidence would be undermined.

12. It was Ms Barlow's contention that Dr Kurz had knowingly entered the inappropriate relationship with Patient B and that he had, at times, sought to minimise the active role he had played in developing the relationship. She further submitted that Dr Kurz had sought to minimise his dishonesty, which also breached a fundamental tenet of the profession. Ms Barlow reminded the Tribunal of the significant impact the relationship ending had on Patient

B. She submitted that the impact on Patient B, who Dr Kurz accepted was in vulnerable position when the relationship ended, underlined the reason for the clear boundaries that are required between doctors and their patients.

13. Ms Barlow submitted that Dr Kurz's level of insight, remediation, low risk of repetition and the evidence presented in his testimonials that he is an excellent clinician carry limited weight in the circumstances of his behaviour. She submitted that Dr Kurz had continued to minimise his actions, had not reflected on why he had chosen to depart from GMP and the Guidance, had shown little, if any, insight to show that he appreciated the importance of the doctor/patient relationships remaining professional.

14. In his submissions, Dr Kurz took the Tribunal through the testimonials provided on his behalf in detail which he relied on to show that his fitness to practise is not currently impaired. He told the Tribunal that all of those who provided testimonials had volunteered to do so, and that he had not wished to interfere with what they wished to say so had not requested specific comments on his character or probity. He referred the Tribunal to the opinions, particularly of his colleagues, that he was approachable, supportive of his junior colleagues, treats patients as individuals and can communicate with patients and their families in an understanding and clear way. In particular, Dr Kurz drew the Tribunal's attention to the testimonials that commented on his probity, integrity and openness. Dr Kurz submitted that the testimonials should be considered alongside the conversations he has had on an ongoing basis with colleagues about these proceedings and the concerns raised about his practice.

15. Dr Kurz submitted that he had provided evidence to the Tribunal which demonstrate the lessons he has learned. He stated that in being permitted to continue to practise, he has demonstrated that his behaviour since these events has remained in line with GMP and the Guidance, and that this is wholly supported by the testimonials. He submitted that the evidence of his work as a doctor since the events in question, as shown by the testimonials, is strong evidence that his fitness to practise is not impaired.

The Relevant Legal Principles

16. 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.

17. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted. First, whether the facts as found proved amounted to misconduct which was serious. Second, whether the doctor's fitness to practise is thereby currently impaired.

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

19. Regarding impairment, the Tribunal applied the test as set out by Dame Janet Smith in the Fifth Report of the Shipman Inquiry as adopted by the High Court in *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) ('*Grant*'):

> *Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination 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*
>
> *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

The Tribunal's Determination on Impairment

20. Throughout its deliberations, the Tribunal bore in mind that Dr Kurz is of previous good character. It also had regard to the testimonials provided on behalf of Dr Kurz. It found them to be comprehensive in breadth and nature, particularly in attesting to Dr Kurz's competence and skill as a clinician, as well as his character.

21. The Tribunal considered Dr Kurz's actions in respect of Patient A and Patient B separately.

Patient A

Misconduct

22. The Tribunal had regard to its previous findings in relation to paragraph 1 of the Allegation. It also reminded itself of the expert evidence of Dr H and the corroborating evidence of Dr G, the Consultant on call on 30 November 2016.

23. From the outset, Dr Kurz admitted that his record keeping regarding his treatment of Patient A was poor, as he had not recorded pseudo-hyperkalaemia as his rationale for not wanting to treat Patient A's high level of potassium. The Tribunal determined and found proved that Dr Kurz did not arrange for appropriate treatment for high potassium and that he had not followed the Royal Cornwall Hospitals NHS Trust policy on adult hyperkalaemia management.

24. The Tribunal considered there to be significant mitigation in respect of Dr Kurz's treatment of Patient A. It accepted that as his approach was reasonable in the circumstances, and he had a sound rationale for not arranging the appropriate treatment in accordance with the Trust policy. Dr Kurz had then cooperated and administered the treatment for hyperkalaemia in line with the Trust policy as instructed by Dr G, despite his disagreement with the treatment plan. Further, it was later concluded that Dr Kurz's diagnosis of pseudo-hyperkalaemia was correct.

25. Nevertheless, the Tribunal received clear expert evidence, supported by the evidence of the Consultant on call, that Dr Kurz's actions in not following the Trust policy and not arranging for appropriate treatment in Patient A's case did fall seriously below the standards expected of a reasonably competent GP Trainee. Dr Kurz's poor record keeping, as to his rationale, was also considered to fall below, but not seriously below the same standard. It was Dr H's evidence that Dr Kurz's actions had potentially fatal consequences, and while Patient A did not come to any harm, there was a risk.

26. Taking the above into account, the Tribunal concluded that Dr Kurz's decision not to arrange appropriate treatment for Patient A in line with Trust policy was serious misconduct. It concluded that his actions fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct.

Impairment

27. The Tribunal, having found that the facts found proved amounted to serious misconduct in respect of Patient A, went on to consider whether, as a result, Dr Kurz's fitness to practise is currently impaired. The Tribunal considered the evidence before it.

28. The Tribunal accepted that Dr Kurz's actions amounted to a clinical failing which was remediable. It also accepted that Dr Kurz had given consistent and credible evidence that he had reflected on his actions, and had shown insight.

29. In reaching this conclusion, the Tribunal was reassured by Dr Kurz's evidence about how he has changed his record keeping practices following Patient A's case. He explained how he has improved his understanding of record keeping through the project he took part in when working at the hospital on the Isle of Wight.

30. The Tribunal was satisfied that there was clear, uncontested evidence about Dr Kurz's recent clinical practice as demonstrated by the testimonials of a number of Dr Kurz's recent colleagues and senior practitioners. The Tribunal accepted that Dr Kurz has continued to improve this aspect of his practice to ensure that his treatment plans are accurately and thoroughly documented to explain his treatment decisions. His testimonials also demonstrate Dr Kurz's skill in teaching other colleagues and set out that many clinicians seek him out for advice and guidance.

31. The Tribunal was of the view that Dr Kurz had taken clear steps to remediate his misconduct in Patient A's case and had developed good insight into his actions at the time. Accordingly, the Tribunal was satisfied that his misconduct, in respect of this clinical failing, was highly unlikely to be repeated.

32. The Tribunal considered that any reasonable and well-informed member of the public would also be reassured by the steps taken by Dr Kurz to fully remediate following Patient A's case, such that a finding of impairment is unnecessary to protect the public or to uphold public confidence and proper professional standards.

33. The Tribunal therefore concluded that Dr Kurz's fitness to practise is not impaired by reason of his misconduct in respect of Patient A.

Patient B

Misconduct

34. The Tribunal went on to consider Dr Kurz's actions in respect of his improper relationship with Patient B. It was accepted by both the GMC and Dr Kurz, that this was the much more serious element in this case.

35. Ms Barlow referred the Tribunal to a number of paragraphs of GMP and the Guidance:

GMP:

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

55 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

a put matters right (if that is possible)

b offer an apology

c explain fully and promptly what has happened and the likely short-term and long-term effects.

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

The Guidance:

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

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

5 If a patient pursues a sexual or improper emotional relationship with you, you should treat them politely and considerately and try to re-establish a professional boundary. If trust has broken down and you find it necessary to end the professional relationship, you must follow the guidance in Ending your professional relationship with a patient.

7 You must not end a professional relationship with a patient solely to pursue a personal relationship with them.'

36. The Tribunal considered that paragraphs 53 and 65 of GMP were particularly relevant and accepted that all paragraphs of the Guidance it had been referred to were engaged.

37. The Tribunal found, and Dr Kurz admitted, that he did, during the course of his professional relationship with Patient B, begin an improper emotional relationship with her with the intention of pursuing the relationship further if that was mutually agreed. The Tribunal found, and Dr Kurz admitted, that within a few days of his last consultation with Patient B, they had continued their developing relationship by meeting at his home and kissing and cuddling, and that they had then continued to meet in a similar way over the next two weeks whilst their relationship developed and continued.

38. The Tribunal found that Dr Kurz did not at any stage seek advice from colleagues about his wish to explore a personal relationship with Patient B, nor did he seek advice or guidance from colleagues about the difficulties such a relationship might cause for him or Patient B. Indeed, as he has admitted, he acted dishonestly by concealing his relationship with her from the Practice. He accepted that he concealed it because of his concerns that disclosure would potentially impact adversely on his career.

39. The Tribunal concluded that Dr Kurz had breached fundamental tenets of the profession in engaging in an improper relationship with Patient B, and by being dishonest in concealing the relationship from his colleagues. The Tribunal decided that these actions amounted to significant departures from GMP and the Guidance.

40. Therefore, the Tribunal concluded that Dr Kurz's improper relationship with Patient B, and his dishonesty regarding that relationship, fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct.

Impairment

41. The Tribunal having found that the facts found proved amounted to serious misconduct went on to consider whether, as a result, Dr Kurz's fitness to practise is currently impaired.

42. The Tribunal considered the four limbs of the test set out in *Grant*.

43. Regarding the first limb, although at the facts stage the Tribunal had concluded that Patient B was not vulnerable when she and Dr Kurz began their relationship, Dr Kurz accepted that the manner in which the relationship ended had resulted in her becoming psychologically vulnerable. The Tribunal agreed and considered that there had been a risk that her mental health could deteriorate. The Tribunal considered that the nature of the relationship and its coming to an end had placed Patient B at the unwarranted risk of harm and therefore that Dr Kurz had acted in the past so as to put a patient at risk of harm.

44. Regarding the second, third, and fourth limbs, the Tribunal concluded that Dr Kurz had also by his misconduct in the past brought the profession into disrepute and breached fundamental tenets of the profession by pursuing an improper relationship with Patient B and by being dishonest in concealing the relationship, and that he had acted dishonestly. The Tribunal therefore concluded that, regarding his past behaviour, all four limbs of the test in *Grant* are satisfied.

45. The Tribunal then considered whether Dr Kurz was likely to act in a similar way in the future. In doing so, the Tribunal considered his level of insight and remediation.

46. In his oral evidence, Dr Kurz accepted several times that his relationship with Patient B, had breached GMP and the Guidance. The Tribunal considered that it was to his credit that he had made several admissions at the outset of the hearing and that he has clearly demonstrated that he accepts that his relationship with Patient B was wrong.

47. However, the Tribunal was concerned that Dr Kurz's insight appeared to go little further than that acceptance. He has not provided evidence that he has fully reflected on his behaviour beyond its significant impact on himself. Dr Kurz has not satisfactorily reflected on the impact of the relationship on Patient B or his colleagues with whom he had been dishonest. The Tribunal was of the view that Dr Kurz has also not appropriately reflected on the impact of his behaviour on the wider profession and public who trust doctors not to embark on personal relationships with patients they are treating professionally. The Tribunal concluded that Dr Kurz currently has only limited insight into the impact of his actions.

48. Turning to remediation, Dr Kurz conceded in response to questions from the Tribunal, that he has not sought out any training either on maintaining professional boundaries or honesty and probity. This was of considerable concern to the Tribunal because Dr Kurz completed an Introduction to Professional Boundaries course before embarking on a relationship with Patient B and knew then that there was a more comprehensive three-day course available specifically addressing the issues in this case.

49. Although the Tribunal accepted Dr Kurz's evidence that he was out of work or with very limited income for a period of 18 months and could not afford to undertake such a course, he has now been in paid work as a doctor for some time yet has still not considered undertaking the course. Nor, until it was suggested to him at the hearing that there may be some online learning available, had he considered this to be an option to develop his understanding.

50. The Tribunal was satisfied that Dr Kurz's testimonials did demonstrate that he is a very competent and well-liked clinician, but it was not satisfied that he had been completely forthcoming when e-mailing his colleagues asking for testimonials. Whilst he had explained most of the allegations against him, he had not referred to the allegation of dishonesty. Although the Tribunal was satisfied that this was not a deliberate attempt to conceal the allegation, it considered it to demonstrate that his insight into the seriousness of the allegation remains limited.

51. The Tribunal was also concerned that Dr Kurz had not taken more steps towards remediation for his misconduct in respect of Patient B in the eight months since the conclusion of the facts stage of the hearing. He had not sought to re-engage with those who had previously provided testimonials and told them about the Tribunal's findings. Dr Kurz was clear in his evidence that he has been open about these proceedings with his educational and clinical supervisors but there was no evidence to confirm this.

52. The Tribunal considered that Dr Kurz has clearly understood the impact of his misconduct on himself. However, in the absence of sufficient evidence of insight or remediation, the Tribunal was unable to conclude that Dr Kurz has thought about or developed strategies to cope if he should ever find himself in a similar position again.

53. At the hearing, Dr Kurz placed great emphasis on his qualities and abilities as a doctor as demonstrated by his own evidence and that of the testimonials he has provided. In evidence and submissions, he relied on his recent clinical practice as being significant evidence which shows that his current fitness to practise is not impaired. However, in considering impairment, the Tribunal must take into a wider range of factors such as insight and remediation, patient protection and the wider public interest as required by the over-arching objective.

54. Having done so the Tribunal concluded that all three limbs of the over-arching objective are engaged.

55. Regarding the first limb, the Tribunal acknowledged that the relationship with Patient B was over four years ago, for a limited period of time, and that there has been no repetition. Nevertheless, as already observed, there has been little evidence of full insight or remediation. In these circumstances, the Tribunal is unable to conclude that there is no risk of repetition. Accordingly, the Tribunal concluded that a finding of impairment is necessary on the grounds of public protection.

56. Further the Tribunal considered that Dr Kurz's misconduct engaged the second and third limbs of the over-arching objective. The Tribunal considered that a fully informed member of the public would be very concerned about a doctor who embarked on a relationship with a patient and who was dishonest in trying to conceal it to ensure it did not impact on his career.

57. The Tribunal concluded that confidence in the medical profession would be undermined and that there would be a failure to uphold professional standards if a finding of impairment was not made.

58. The Tribunal therefore determined that Dr Kurz's fitness to practise is impaired by reason of serious misconduct in respect of Patient B.

Determination on Sanction - 27/08/2021

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

The Evidence

2. The Tribunal has considered the evidence received during the earlier stages of the hearing, where relevant, in reaching a decision on sanction. In addition, the Tribunal received further evidence on behalf of Dr Kurz including correspondence and documentation in relation to his current employment as well as documentation from his previous clinical and educational supervisor.

Submissions

3. On behalf of the GMC, Ms Barlow submitted that the only appropriate sanction in Dr Kurz's case was one of erasure. She reminded the Tribunal and Dr Kurz of the relevant paragraphs of the Sanctions Guidance (2020) ('the SG'), GMP and the Tribunal's own findings at the previous stages of the hearing. She stated that Dr Kurz's behaviour was a serious departure from GMP, and serious action is needed to maintain public confidence in the profession. Ms Barlow submitted that there has been no remediation, that Dr Kurz has shown limited insight into his behaviour, and that he has not shown an understanding of how serious his misconduct has been and that it cannot simply be remediated by good clinical practice.

4. Ms Barlow submitted that taking no action would not be appropriate as there are no exceptional circumstances. She submitted that this was not an appropriate case for imposing conditions on Dr Kurz's registration because of the lack of insight and because it would not mark the seriousness of the misconduct.

5. Ms Barlow submitted that suspension would be the very least sanction that the Tribunal should impose but submitted that erasure is the appropriate sanction and the only means of protecting the public. She pointed to several factors referred to in the SG which pointed towards erasure: the serious departure from GMP; a blatant disregard for safeguards and guidance designed to protect members of the public and maintain high standards within the profession; an abuse of a position of trust; dishonesty; and lack of insight leading to a risk of repetition. Ms Barlow submitted that Dr Kurz's conduct was fundamentally incompatible with continued registration and that his name should be erased from the medical register.

6. Dr Kurz submitted that he accepted the Tribunals findings and that he recognised the need to reassure the public that the profession was safe and could be trusted. He acknowledged that taking no action would not be appropriate as he accepted that he had not fully reflected on the impact his behaviour had on Patient B and his colleagues. He acknowledged that he had become aware of Patient B's vulnerability during their relationship, but still did not report it, and sought to keep it a secret which he accepted was a shortcoming.

7. Dr Kurz submitted that the appropriate sanction was to impose conditions on his registration. He submitted that the public should be able to continue to benefit from the skills and qualities he has shown as a doctor, whilst he undertakes the development courses that he has now identified would be beneficial for his insight and remediation. He referred the Tribunal to the testimonials which support his good character and good clinical practice and stated he could still be of great value to the public as a doctor. He stated that his current circumstances are such that either an order of suspension or erasure would prevent him from being able to remediate fully and would jeopardise his ability to return to practise in the future.

The Tribunal's Determination on Sanction

8. The decision as to the appropriate sanction, if any, is a matter for the Tribunal exercising its own judgement.

9. The Tribunal reminded itself that the purpose of a sanction is not to be punitive, but to protect the public, even though they may have a punitive effect.

10. Throughout its deliberations, the Tribunal has taken into account the overarching objective and the SG, and has applied the principle of proportionality, balancing Dr Kurz's interests with the public interest.

11. The Tribunal has already set out its decision on the facts and impairment which it also took into account during its deliberations on sanction.

Aggravating and Mitigating Factors

12. The Tribunal first considered the aggravating and mitigating factors in the case.

13. The Tribunal identified the following aggravating factors:

- Dr Kurz abused his professional position in pursuit of an emotional relationship with Patient B;
- In attempt to conceal his relationship with Patient B from his colleagues, Dr Kurz acted dishonestly;
- Dr Kurz has demonstrated limited insight into his misconduct.

14. The Tribunal identified the following mitigating factors:

- Dr Kurz has no previous findings against him and is of good character;
- Dr Kurz's relationship with Patient B and dishonesty in concealing the relationship was short-lived, and took place almost four years ago;
- Dr Kurz's relationship with Patient B did not cause her actual harm;
- Dr Kurz has not repeated his misconduct, and has been practising without incident since;
- Dr Kurz is highly unlikely to repeat his misconduct;
- Dr Kurz recognised the seriousness of his misconduct at an early stage, made admissions and has fully engaged with both the GMC investigation and these proceedings;
- Dr Kurz has expressed genuine remorse, regret and apology from an early stage in these proceedings;
- Dr Kurz has provided positive testimonials which attest to his competency and skill as a clinician.

15. The Tribunal then considered each sanction in ascending order of severity, starting with the least restrictive.

No action

16. 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. Neither the GMC nor Dr Kurz had suggested that it would be appropriate to conclude this case by taking no action. The Tribunal determined that there are no exceptional circumstances in this case and that, given the seriousness of its findings, it would not be sufficient, proportionate, or in the public interest to conclude the case by taking no action.

Conditions

17. The Tribunal next considered whether to impose conditions on Dr Kurz's registration. Dr Kurz had invited the Tribunal to place conditions on his registration as conditional registration would allow him to fund relevant courses, appropriately remediate, and remain

in practice under supervision which would reassure the public that he was safe to practise. It was the GMC's contention that conditions would not mark the seriousness of his misconduct and would undermine public confidence.

18. The Tribunal acknowledged that conditions must be appropriate, proportionate, workable and measurable. It had regard to the relevant paragraphs of the SG, in particular, paragraph 81 and 82:

> '*81 Conditions might be most appropriate in cases:*
>
> > *a involving the doctor's health*
> >
> > *b involving issues around the doctor's performance*
> >
> > *c where there is evidence of shortcomings in a specific area or areas of the doctor's practice*
> >
> > *d where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision.*
>
> *82 Conditions are likely to be workable where:*
>
> > *a the doctor has insight*
> >
> > *b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings*
> >
> > *c the tribunal is satisfied the doctor will comply with them*
> >
> > *d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.'*

19. With regard to these paragraphs, the Tribunal noted that Dr Kurz's case was not one in which the SG suggested that conditions might be appropriate. The Tribunal accepted Dr Kurz's assurance that he would comply with and respond positively to any conditions imposed but considered that Dr Kurz had not yet shown the degree of insight to make conditions appropriate. The Tribunal also considered that, regarding its finding of dishonesty, it would be very difficult to identify conditions which would be appropriate, proportionate, workable, and measurable.

20. In considering whether conditions were the proportionate sanction, the Tribunal decided it had to attach significant weight to the seriousness of Dr Kurz's misconduct and the need to uphold the over-arching objective following a finding of serious misconduct and impairment. The Tribunal concluded that to impose conditions would not sufficiently mark the seriousness of the misconduct. The Tribunal therefore determined that it would not be

appropriate or proportionate to conclude the case by imposing conditions on Dr Kurz's registration.

Suspension

21. The Tribunal then went on to consider whether imposing a period of suspension on Dr Kurz's registration would be appropriate and proportionate.

22. The Tribunal acknowledged that suspension has a deterrent effect and can be used as a signal to Dr Kurz, the profession, and the public about what is regarded as behaviour unbefitting a registered doctor.

23. The Tribunal took account of paragraphs of the SG which indicates circumstances in which it may be appropriate to impose the sanction of suspension:

> *'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> *92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*
>
> *93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49).'*

24. The Tribunal also took account of paragraph 97 which provides a non-exhaustive list of factors which indicate suspension might be appropriate. The Tribunal considered a, e, f and g to be engaged in this case.

> *97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> > *a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any*

sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.

…

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

f *No evidence of repetition of similar behaviour since incident.*

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

25. The Tribunal was of the view that Dr Kurz has fully accepted the seriousness of his misconduct and has been responsive to the concerns expressed by the GMC and the Tribunal during the hearing. However, it remained of the view that he has yet to demonstrate that he understands the wider context and impact of his actions, both in terms of his improper relationship with Patient B and in his decision to dishonestly conceal the relationship from his colleagues. The Tribunal was very concerned that Dr Kurz had not utilised the eight-month period since the facts stage to develop his insight but accepted his readiness to do so now that his shortcomings have been pointed out to him.

26. The Tribunal considered the testimonials provided by Dr Kurz. In the main, these testimonials spoke positively with regards to Dr Kurz's clinical competence but there was limited evidence within the testimonials with regards to Dr Kurz's honesty, integrity and the maintenance of boundaries in the context of this case and the wider public interest. The Tribunal therefore was unable to place significant weight on the testimonials provided in this respect.

27. The Tribunal had regard to the nature of the relationship with Patient B. It was a very short-lived relationship, was not sexually motivated, did not involve a patient who was vulnerable at that time, and did not result in harm to Patient B. The Tribunal had regard to Patient B's correspondence with the GMC in which she stated that she did not consider herself vulnerable and that she had not been harmed by her relationship with Dr Kurz. The Tribunal did not consider Dr Kurz's pursuit of the relationship to be predatory and noted that Patient B played an active role in pursuing the relationship.

28. The Tribunal also had regard to the nature of Dr Kurz's dishonesty. His actions amounted to a failure to be open with his colleagues about his relationship with Patient B, which he knew was inappropriate. Again, the dishonesty was short-lived, and once challenged about the relationship, Dr Kurz admitted it immediately without any further attempt to conceal what he had done. He has continued to be open and honest about his failings in this regard throughout the GMC investigation and this hearing. Dr Kurz's dishonesty was not persistent, and beyond his initial attempt to conceal his relationship with Patient B,

his dishonesty itself was not covered up and was quickly admitted. The Tribunal considered the dishonesty was at the lower end of the spectrum of dishonest acts.

29. Taking the above into account, the Tribunal was satisfied that Dr Kurz's improper relationship with Patient B and his connected dishonesty amounted to a short-lived and therefore isolated episode of serious misconduct. It was satisfied that the misconduct has not been repeated since and that any repetition is unlikely.

30. The Tribunal was of the view that, when considering the serious breaches of the standards of behaviour expected of a doctor alongside the mitigating factors in the case, as well as Dr Kurz's clear willingness to remediate, this was a case in which Dr Kurz's misconduct was serious but not so serious as to be fundamentally incompatible with continued registration.

31. The Tribunal therefore determined that a period of suspension would uphold all three limbs of the overarching objective, mark the seriousness of Dr Kurz's misconduct, and would allow Dr Kurz the opportunity to develop his insight and remediate his conduct.

32. Further, the Tribunal was also of the view that a period of suspension would not be contrary to the public interest because it would allow Dr Kurz, once he has successfully demonstrated sufficient insight and remediation, to return to work as a competent doctor.

33. The Tribunal carefully considered Ms Barlow's submission that erasure was the only appropriate sanction in this case. Having balanced all the factors in this case, including the aggravating and mitigating factors, Dr Kurz's limited but developing insight, his willingness to remediate, and the low risk of repetition, the Tribunal considered that erasure would be disproportionate in the circumstances.

34. The Tribunal the considered the length of the period of suspension. The Tribunal determined to suspend Dr Kurz's registration from the medical register for a period of six months. It was satisfied that such a period would send a message to the medical profession and to the wider public that such misconduct is not acceptable, and it would reflect the seriousness of the misconduct. It would also provide Dr Kurz with an opportunity to develop further insight into his misconduct and remediate appropriately.

35. The Tribunal determined to direct a review of Dr Kurz's case. A review hearing will convene shortly before the end of the period of suspension unless an early review is sought. Dr Kurz should understand that at the review hearing, it will be Dr Kurz's responsibility to demonstrate how he has remediated and developed insight into his misconduct and thereby addressed this Tribunal's concerns.

36. It may assist the reviewing Tribunal if Dr Kurz attends the review hearing and before doing so provides:

- Evidence of having completed a Maintaining Professional Boundaries course and having reflected in writing on the learning from the course;
- Evidence of having completed a course dealing with professional ethics, probity and honesty and having reflected in writing on the learning from the course;
- If not dealt with by the above written reflections, a written statement of personal reflections on his misconduct, including the impact of his behaviour on patients, colleagues, the profession and the wider public;
- Evidence of any other relevant Continuing Professional Development (CPD);
- Further testimonials, not limited to Dr Kurz's professional colleagues;
- Evidence that Dr Kurz has maintained his knowledge and clinical skills;
- Any other information Dr Kurz considers will be of assistance to the reviewing Tribunal.

Determination on Immediate Order - 27/08/2021

1. Having determined to suspend Dr Kurz, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Ms Barlow referred the Tribunal to the relevant paragraphs of the SG and submitted that an immediate order was necessary and appropriate in this case.

3. Dr Kurz accepted that it would be appropriate for his suspension to commence immediately in order to send out the correct message to the profession and the wider public.

The Tribunal's Determination

4. The Tribunal has taken account of the relevant paragraphs of the SG, in particular paragraph 172 which states:

> 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…*

5. The Tribunal acknowledged that both parties had accepted the need for an immediate order of suspension to be made.

6. The Tribunal determined that, given the seriousness with which it viewed Dr Kurz's misconduct, its findings on impairment and the sanction it has imposed, it was necessary to protect the public and in the public interest to suspend his registration with immediate

effect.

7. The substantive period of suspension to be imposed on Dr Kurz's registration will take effect 28 days from when notice is deemed to have been served upon him, unless he lodges an appeal in the interim. If Dr Kurz lodges an appeal, the immediate order for suspension will remain in place until such time as the outcome of any appeal is determined.

8. The interim order currently imposed on Dr Kurz's registration will be revoked when the immediate order takes effect.

9. That concludes the case.

Confirmed
Date 27 August 2021 Mr Colin Chapman, Chair

SCHEDULE 1 – Consultations

~~22~~25 September 2017 – recorded 72 minutes **(Amended following GMC application)**
9 October 2017 – recorded 43 minutes
23 October 2017 – (indeterminate duration recorded)
30 October 2017 – recorded 56 minutes
3 November 2017 (telephone consultation)
6 November 2017 – recorded 56 minutes
20 November 2017 – recorded 36 minutes
4 December 2017 - recorded 45 minutes

SCHEDULE 2 – Meetings

10 December 2017
14 December 2017
17 December 2017
18 December 2017
21 December 2017
27 December 2017

SCHEDULE 3

when you had last drunk alcohol
XXX
your mood

SCHEDULE 4

Mental health
Personal circumstances at the time