PUBLIC RECORD

Dr Chatterjee has lodged an appeal against decisions of this Tribunal. His registration remains suspended while the appeal is considered.

Dates: 21/10/2024 - 18/11/2024

Medical Practitioner's name:	Dr Sanjay CHATTERJEE
GMC reference number:	4599111
Primary medical qualification:	MB BS 1990 Calcutta

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

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr Graham White
Lay Tribunal Member:	Ms Liz Daughters
Medical Tribunal Member:	Dr Ann Wolton

Tribunal Clerk:	Mr Andrew Ormsby (Ms Jemine Pemu, 24/10/2024 – 25/10/2024)

Attendance and Representation:

Medical Practitioner:	Not present, represented
Medical Practitioner's Representative:	Mr Martin Forde, KC, instructed by the DDPU (representatives withdrew from the hearing at facts stage)

GMC Representative:	Ms Jade Bucklow, 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 - 12/11/2024

1. This determination will be handed down in private under the provisions of Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). However, as this case concerns Dr Chatterjee's alleged misconduct and conviction a redacted version will be published at the close of the hearing.

Background

2. It is alleged that on 5 May 2021, during a consultation with a female patient at Aylesford Medical Centre (the Surgery) for ulcerative colitis and rectal bleeding, Dr Chatterjee undertook a rectal examination having failed to obtain informed consent and undertook an inappropriate vaginal examination without consent when it was not clinically indicated and without explanation, and without giving the patient the opportunity to ask questions or provide consent. It is further alleged that Dr Chatterjee's actions were sexually motivated.

3. It is also alleged that on 11 April 2017, at Central Kent Magistrates Court, Dr Chatterjee was convicted of four offences of failing to comply with his notification requirements as a sex offender. He was sentenced to 84 days imprisonment, suspended for 12 months with an unpaid work requirement of 200 hours and ordered to pay £200 in costs.

The Outcome of Applications Made before the Facts Stage

4. At the outset of the hearing, Mr Forde KC, on behalf of Dr Chatterjee, made an application to adjourn the hearing under Rule 29(2) of the Rules. Mr Forde sought an adjournment on the basis that XXX The Tribunal refused this application. Having decided not to adjourn the proceedings, the Tribunal went on to consider whether it would be appropriate to proceed with the hearing in Dr Chatterjee's absence pursuant to Rule 31. The Tribunal determined that the case should proceed in Dr Chatterjee's absence. The Tribunal's full decision on the application is included at Annex A.

5. The Tribunal went on to consider an application made by Mr Forde to allow Dr Chatterjee to be voluntarily erased from the Register. XXX. He argued that XXX and that it would be appropriate and would satisfy the public interest to grant Voluntary Erasure. The Tribunal determined that, given the seriousness of the Allegation, the lack of exceptional circumstances, and doubts around the ability of the GMC to revive the Allegation effectively in the future, it was in the public interest to continue with the hearing. The application was refused. The Tribunal's full decision on the application is included at Annex B.

6. Mr Forde then withdrew from the case.

The Allegation and the Doctor's Response

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

1. On 5 May 2021 during a consultation for rectal bleeding with Patient A you:

    a. undertook a rectal examination and failed to obtain informed consent in that you did not:

        i. explain to Patient A why a rectal examination was necessary and/or give her an opportunity to ask questions; To be determined

        ii. explain to Patient A what the rectal examination would involve, in a way she could understand, so that she had a clear idea of what to expect, including any pain or discomfort; To be determined

        iii. obtain Patient A's permission before the rectal examination and record that she had given it; To be determined

    b. undertook an inappropriate vaginal examination in that:

        i. you failed to obtain informed consent for the vaginal examination in that you did not:

1. explain to Patient A why a vaginal examination was necessary and/or give her an opportunity to ask questions; To be determined

2. explain to Patient A what the vaginal examination would involve, in a way she could understand, so that she had a clear idea of what to expect, including any pain or discomfort; To be determined

3. obtain Patient A's permission before the vaginal examination and record that she had given it; To be determined

ii. a vaginal examination was not clinically indicated. To be determined

2. Your actions as set out at paragraph 1b were sexually motivated. To be determined

3. On 11 April 2017 at Central Kent Magistrates' Court you were convicted of:

   a. on 1 August 2016, being a relevant offender within the terms of Section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that you failed to register travel to Portugal, contrary to Section 91(1)(a) and (2) of the Sexual Offences Act 2003; To be determined

   b. on 3 January 2016, being a relevant offender within the terms of Section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that you failed to register travel to Calcutta, contrary to Section 91(1)(a) and (2) of the Sexual Offences Act 2003; To be determined

   c. on 7 September 2016, being a relevant offender within the terms of Section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that you failed register a new passport, contrary to Section 91(1)(a) and (2) of the Sexual Offences Act 2003; To be determined

   d. on 28 July 2016, being a relevant offender within the terms of Section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that you failed to register travel to Calcutta, contrary to Section 91(1)(a) and (2) of the Sexual Offences Act 2003. To be determined

4. On 11 April 2017 at Central Kent Magistrates' Court you were sentenced to:

   a. 84 days' imprisonment, suspended for 12 months; To be determined

   b. an Unpaid Work Requirement of 200 hours to be completed within 12 months. To be determined

And that by reason of the matters set out above your fitness to practise is impaired because of your:

a. misconduct in relation to paragraphs 1-2; To be determined

b. conviction in relation to paragraphs 3-4.' To be determined

Witness Evidence

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

- Patient A, who also provided a witness statement, dated 11 May 2023;
- Person B, Patient A's daughter, who also provided a witness statement, dated 16 March 2024;
- Person C, Patient A's friend, who also provided a witness statement, dated 14 February 2024;
- Dr D, locum GP, previous GP Partner at the Surgery until 31 December 2021, who also provided a witness statement, dated 1 March 2024; and
- Ms E, student nurse who acted as a chaperone during the index incident, and who also provided a witness statement dated 14 March 2024.

8. Dr Chatterjee provided a brief undated handwritten prepared statement he provided at the police investigation stage. He did not attend the hearing.

Expert witness evidence

9. The Tribunal received expert witness evidence from Dr F, GP, Certified Expert Witness, who provided an expert report, dated 28 May 2023, and a supplemental report dated 11 July 2024.

10. Dr F also gave oral evidence at the hearing.

Documentary Evidence

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

- Prepared statement of Dr Sanjay Chatterjee;
- Patient A's handwritten letter to the Surgery, undated;
- Patient A's record of police interview, dated 9 May 2021;
- WhatsApp messages between Patient A and Person C, on various dates between 4 and 11 May 2021;
- Kent Online article, published 28 September 2011;
- 'Events of 5 May 2021' recorded by Dr D on 8 May 2021;
- Police reports and statements dated January/February 2017;
- Certificate of Conviction, dated 11 April 2017

Advice from the Legally Qualified Chair and the Tribunal's Approach

12. 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 Chatterjee 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. The Tribunal was advised that where there are serious allegations or where there are serious consequences which would flow from a factual finding, the Tribunal was required to undertake a heightened examination of the evidence, although this did not of itself alter the standard of proof to be applied.

13. The Tribunal was advised that, if any of the facts alleged in paragraph 1(b) of the Allegation were found proved, it would then be necessary to consider whether they were sexually motivated. In *Basson v GMC* [2018] EWHC 505 (Admin), the High Court defined acting with sexual motivation as conduct done either in pursuit of sexual gratification or in pursuit of a future sexual relationship.

14. The Tribunal also took into account that, when considering sexual motivation, it should reach its conclusions from all the facts and circumstances of the case, looking at the material in the round. It understood that the best evidence of sexual motivation may be the behaviour itself. Where there was no plausible, alternative explanation as to why the doctor engaged in conduct or actions of an overtly sexual nature, then a tribunal would be entitled to conclude that the motivation was sexual.

15. The Tribunal had particular regard to the case of *Haris v General Medical Council* [2021] EWCA Civ 763 in which it was said that sexual motivation could be inferred from:

- The fact that the touching was of the sexual organs;
- The absence of a clinical justification; and
- The absence of any other plausible reason for the touching.

16. The Tribunal also had regard to the case of *Chief Constable of Thames Valley Police v A Police Misconduct Panel and Jaweed* [2023] EWHC 2693 where Mr Justice Jay stated that some actions were inherently, or by their very nature, sexual, whereas others may be sexual, depending on the circumstances, including any inferences to be drawn from any explanation, or lack of it, given by the individual in question.

17. The case of *McClennan v General Medical Council* [2020] CSIH 12 confirmed that evidence of bad character is not generally relevant to proof of a propensity to act in a particular way. The Tribunal noted that the GMC does not rely on Dr Chatterjee's 2011 conviction for sexual assault against a colleague in this regard.

Events of 5 May 2021

18. Paragraph 1 and 2 of the Allegation arise from a consultation between Dr Chatterjee and Patient A on 5 May 2021.

19. The Tribunal heard evidence from Patient A about a telephone call she made to the Surgery after she had been advised by the A&E Department of her local hospital to contact her GP so that her rectal bleeding could be investigated.

20. Dr D referred to a conversation she had with Dr Chatterjee in the Surgery on 5 May 2021 regarding a telephone call with Patient A. She considered that Patient A's rectal bleeding may have been caused by more than just haemorrhoids and it was agreed that Dr Chatterjee would ask Patient A to come in so that he could check her haemorrhoids and make a colorectal referral for her.

21. Patient A said that Dr Chatterjee telephoned her and told her to come to the Surgery at 5pm and that he would carry out an examination.

22. Evidence as to what happened after Patient A arrived at the Surgery later that day came from Patient A herself and Ms E, a student nurse at the Surgery. Ms E had not been

trained for a chaperone role, but was asked by the Surgery receptionist that day to undertake that role during Patient A's examination as no one else was available.

23. Patient A said that Dr Chatterjee was in the consultation room when she went in with Ms E and that he asked her to get on the examination couch. She stated that Dr Chatterjee never explained anything to her, and she subsequently saw him pick up a speculum from a table by the sink. Patient A said that Dr Chatterjee used lubrication gel and she felt the doctor apply the speculum to her anus. She stated that he opened it up a bit and said that he could not see any haemorrhoids "*no inside haemorrhoids so that's all good*".

24. Patient A stated that Dr Chatterjee then took the speculum out and, without saying anything, put it straight into her vagina for a few seconds.

25. Ms E explained that Dr Chatterjee initially put on a surgical glove and proceeded to put lubrication onto the plastic speculum which he handed to her whilst he put on his blue glove. She said that he nudged her to hand the speculum back without saying anything and she did so. Dr Chatterjee put some lubricant on it and inserted it into Patient A's vagina. She said that most of the speculum went in and it was there for at least two and a half minutes. Ms E stated that while this was happening, Dr Chatterjee did his 'per rectum' examination with one of his fingers in Patient A's rectum. She stated that he then took off the blue glove, washed his hands and asked Patient A to get dressed.

26. Ms E said that there was no 'pre-warning' from Dr Chatterjee relating to the examination apart from him stating *"let's take a look".* She said that Dr Chatterjee never explained anything to Patient A.

The Tribunal's Analysis of the Evidence and Findings

27. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Paragraph 1(a) of the Allegation

28. The Tribunal noted that, although Dr Chatterjee was not present at the hearing, neither he nor his representatives had ever disputed that Dr Chatterjee had undertaken a rectal examination on Patient A during a consultation on 5 May 2021.

29. Further, the Tribunal bore in mind Dr Chatterjee's handwritten undated prepared statement to the police, in which he accepted that he *'carried out'* a rectal examination of Patient A. It was satisfied that such an examination had taken place.

30. When considering whether there had been a duty to obtain informed consent the Tribunal noted the GMC guidance *'Intimate examinations and chaperones'* (2013), in particular:

> *'5 Before conducting an intimate examination, you should:*
>
> *a explain to the patient why an examination is necessary and give the patient an opportunity to ask questions*
>
> *b explain what the examination will involve, in a way the patient can understand, so that the patient has a clear idea of what to expect, including any pain or discomfort*
>
> *c get the patient's permission before the examination and record that the patient has given it'*
>
> […]
>
> *'6 During the examination, you must follow the guidance in Consent: patients and doctors making decisions together. In particular you should:*
>
> *a explain what you are going to do before you do it and, if this differs from what you have told the patient before, explain why and seek the patient's permission'*

31. The Tribunal also took account of *'Decision making and consent'* (2020), including the following paragraphs:

> *'7. For some quick, minimally or non-invasive interventions – particularly examinations – it would be reasonable to rely on a patient's non-verbal consent. Examinations are a necessary part of diagnosis, and it's reasonable to believe that a patient presenting for a consultation wants to be diagnosed.*

However, even for such routine procedures you should:

a. explain what you're going to do and why

b. make clear the patient can say no, and stop immediately if they do

c. be alert for any sign that they may be confused or unhappy about what you are doing.'

'10. You must give patients the information they want or need to make a decision. […]'

32. The Tribunal also considered *Good Medical Practice* (2013) (GMP), in particular:

'17. You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.'

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

'21. Clinical records should include:

a relevant clinical findings

b the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c the information given to patients

d any drugs prescribed or other investigation or treatment

e who is making the record and when.'

'32. You must give patients the information they want or need to know in

a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.'

33. The Tribunal also acknowledged Dr F's expert report, dated 28 May 2023, specifically in relation to establishing informed consent:

'[…] *it is expected that a reasonably competent GP would explain the process of the examination (including which areas would be examined), and explain why the examination is needed, to the patient before commencing. This would include advising the patient that consent can be withdrawn at any time, including during the examination itself, for any reason. It is also expected that prior to commencing an intimate examination, the patient would indicate that they are happy to proceed with the examination following such a discussion.'*

34. The Tribunal took into account all the above guidance and also the expert evidence which it accepted. It determined that, in relation to Dr Chatterjee's undertaking of a rectal examination upon Patient A on 5 May 2021, there had been an explicit duty to obtain Patient A's informed consent.

35. The Tribunal considered that Patient A's informed consent could indeed have been obtained by:

- explaining to Patient A why a rectal examination was necessary and/or giving her an opportunity to ask questions;
- explaining to Patient A what the rectal examination would involve, in a way she could understand, so that she had a clear idea of what to expect, including any pain or discomfort; and
- obtaining Patient A's permission before the rectal examination and recording that she had given it.

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

36. The Tribunal considered whether, on 5 May 2021 during a consultation for rectal bleeding with Patient A, Dr Chatterjee undertook a rectal examination and failed to obtain informed consent in that he did not explain to Patient A why a rectal examination was necessary and/or give her an opportunity to ask questions.

37. The Tribunal noted Patient A's oral evidence in which she stated that Dr Chatterjee had introduced himself to her at the Surgery and then told her to get on the examination couch. She said that Dr Chatterjee did not explain anything to her at that point. She had assumed that she was there for an internal examination as she had discussed the matter with him during a telephone conversation earlier that day, although during the call he had been *'dithery'* and *'was not making any sense'*.

38. Patient A, in her oral evidence, went on to state, when asked whether Dr Chatterjee had told her what an examination would involve:

> *'No, he never went into detail about any of what he was going to do… he never spoke of it. He never mentioned it to me.*
> *He just kind of got on with it really. So, I mean, I know what was going to be done, but he didn't explain it to me.'*

39. The Tribunal accepted the evidence of Ms E. In her witness statement dated 14 March 2024, she said:

> *'I was asked if I recall any conversation at the start of Patient A's appointment. I don't recall what was said specifically by Patient A or Dr Chatterjee, but I remember Dr Chatterjee's communication was really poor. Dr Chatterjee didn't have an introduction with Patient A at the start of the appointment (for example, he didn't say hello, ask how she was, invite her to take a seat or explain what was going to happen in the appointment). I remember Patient A came into the room and Dr Chatterjee said along the lines of 'ok, get undressed.''*

40. Given Patient A's evidence that Dr Chatterjee did not explain to her why a rectal examination was necessary and in the light of Ms E's recollection that Dr Chatterjee's communication was *'really poor'* , the Tribunal considered that it was more likely than not that Dr Chatterjee had failed to obtain informed consent to the examination. It was satisfied that he did not explain to Patient A why a rectal examination was necessary and/or give her an opportunity to ask questions.

41. Accordingly, the Tribunal determined that paragraph 1(a)(i) of the Allegation was found proved.

<u>Paragraph 1(a)(ii) of the Allegation</u>

42. The Tribunal considered whether, on 5 May 2021 during a consultation for rectal bleeding with Patient A, Dr Chatterjee undertook a rectal examination and failed to obtain informed consent in that he did not explain to Patient A what the rectal examination would involve, in a way she could understand, so that she had a clear idea of what to expect, including any pain or discomfort.

43. The Tribunal accepted Patient A's assertion that Dr Chatterjee did not give her any prior explanation regarding the rectal examination.

44. It also further took into account Ms E's evidence about Dr Chatterjee's poor communication. Ms E stated that she was unaware of what Patient A was being examined for.

45. The Tribunal was satisfied that Dr Chatterjee had failed to explain to Patient A what the rectal examination would involve, in a way she could understand, so that she had a clear idea of what to expect, including any pain or discomfort.

46. In the circumstances, the Tribunal concluded that, it was more likely than not, that Dr Chatterjee had failed to obtain informed consent in that he did not explain to Patient A what the rectal examination would involve, in a way she could understand, so that she had a clear idea of what to expect, including any pain or discomfort.

47. Accordingly, the Tribunal determined that paragraph 1(a)(ii) of the Allegation was found proved.

Paragraph 1(a)(iii) of the Allegation

48. The Tribunal considered whether, on 5 May 2021 during a consultation for rectal bleeding with Patient A, Dr Chatterjee undertook a rectal examination and failed to obtain informed consent in that he did not obtain Patient A's permission before the rectal examination and record that she had given it.

49. The Tribunal noted that Patient A had repeated throughout her oral evidence that Dr Chatterjee did not discuss the forthcoming rectal examination with her, either during her earlier telephone consultation or at the Surgery. She said that he *'never spoke of it'* and *'didn't explain it to me'*.

50. Further, Ms E, stated that Dr Chatterjee's communication was *'really poor'* and that '*he didn't say hello, ask how she was, invite her to take a seat or explain what was going to happen in the appointment'.*

51. The Tribunal also bore in mind that it had received no evidence that Dr Chatterjee had recorded that Patient A had given informed consent.

52. In the circumstances, the Tribunal concluded that it was more likely than not that, on 5 May 2021 during a consultation for rectal bleeding with Patient A, Dr Chatterjee undertook a rectal examination and failed to obtain informed consent in that he did not obtain Patient A's permission before the rectal examination and record that she had given it.

53. Accordingly, the Tribunal determined that paragraph 1(a)(iii) of the Allegation was found proved.

Paragraph 1(b) - 'vaginal examination'

54. The Tribunal considered whether a vaginal examination had taken place.

55. Ms Bucklow, on behalf of the GMC, had asserted that Dr Chatterjee's actions in inserting a speculum into Patient A's vagina was a vaginal examination '*as this is an alleged insertion of a medical instrument usually used for examination purposes, and was done so within a clinical setting'.*

56. The Tribunal took account of Patient A's police statement, dated 9 May 2021, in which she described the following:

> *'I said yeah okay, probably went a little bit tense, it was a little bit sore. Erm put loads of lubricant on it so it wouldn't hurt and erm sort of put it in once so it was a little way and then he put it in again a bit further, had a look around and said I can't see anything in there, maybe they're further up - that's all he said […] was still talking to me so I thought 'Oh that's it now' and the next, in the next second or so he just put it straight into my vagina with no warning, no explanation, erm nothing and I was just so shocked I really didn't know how to react to it at all.'*

57. In her oral evidence to the Tribunal Patient A described Dr Chatterjee inserting the speculum into her anus. She thought that was the end of it but then he took it out and put it straight into her vagina *'quite deeply'* which shocked her.

58. The Tribunal also noted Ms E's statement dated, 14 March 2024:

> *'As per my statement in Exhibit BC1, I saw Dr Chatterjee insert the speculum into Patient A's vagina without informing Patient A before doing so. The speculum was not put into Patient A's rectum during the examination. I was asked by the GMC how long the examination took. The speculum was inside Patient A's vagina for at least two, up to three minutes. I say this because I was talking with Patient A for at least two minutes during.'*

59. Ms E told the Tribunal that she saw Dr Chatterjee insert the speculum into the vagina and that it was in there for at least two and a half minutes. During this time Dr Chatterjee did his per rectum examination, putting one of his index fingers into Patient A's rectum.

60. The Tribunal also took account of Dr Chatterjee's handwritten undated prepared statement in which he stated that a chaperone was present and if there was any contact with [Patient A's] vagina it was unintentional.

61. Although the accounts of Patient A and Ms E were not identical in every aspect, both clearly described the insertion of the speculum into the vagina. The Tribunal found that on balance of probabilities on 5 May 2021, during a consultation for rectal bleeding with Patient A, Dr Chatterjee did carry out a vaginal examination.

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

62. The Tribunal considered whether, on 5 May 2021 during a consultation for rectal bleeding with Patient A Dr Chatterjee undertook an inappropriate vaginal examination in that he failed to obtain informed consent for the vaginal examination and did not explain to Patient A why a vaginal examination was necessary and/or give her an opportunity to ask questions.

63. The Tribunal noted that it had already found that Dr Chatterjee had failed to obtain consent for a rectal examination in that he failed to explain to Patient A why such an examination was necessary and/or give her the opportunity to ask questions.

64. It bore in mind that Patient A had stated, when asked whether Dr Chatterjee had told her what an examination would involve, that Dr Chatterjee never went into any detail about what he was going to do:

> *'No, he never went into detail about any of what he was going to do… he never spoke of it. He never mentioned it to me.*
> *He just kind of got on with it really. So, I mean, I know what was going to be done, but he didn't explain it to me.'*

65. The Tribunal further bore in mind Ms E's evidence that Dr Chatterjee did not *'explain what was going to happen in the appointment'* and that his communication was *'really poor'.*

66. Further, the Tribunal considered that it was highly unlikely that Dr Chatterjee had given Patient A the opportunity to ask questions regarding the vaginal examination beforehand. Patient A was not expecting a vaginal examination in relation to a consultation for rectal bleeding.

67. In the circumstances, the Tribunal concluded that on 5 May 2021, during a consultation for rectal bleeding with Patient A, Dr Chatterjee undertook an inappropriate vaginal examination in that he failed to obtain informed consent for the vaginal examination, he did not explain to Patient A why a vaginal examination was necessary and he did not give her an opportunity to ask questions.

68. Accordingly, the Tribunal determined that paragraph 1(b)(i)(1) of the Allegation was found proved.

Paragraph 1(b)(i)(2) of the Allegation

69. The Tribunal considered whether on 5 May 2021 during a consultation for rectal bleeding with Patient A Dr Chatterjee undertook an inappropriate vaginal examination in that he failed to obtain informed consent for the vaginal examination in that he did not explain to Patient A what the vaginal examination would involve, in a way she could understand, so that she had a clear idea of what to expect, including any pain or discomfort.

70. The Tribunal has already decided that Dr Chatterjee did not give any prior explanation regarding her examination and has taken into account both Patient A's and Ms E's evidence about his lack of communication. .

71. Further, the Tribunal considered that it was unlikely that Dr Chatterjee had explained to Patient A what the vaginal examination would involve, in a way she could understand, so that she had a clear idea of what to expect, including any pain or discomfort, as a vaginal examination during a consultation for rectal bleeding had not been expected.

72. In the circumstances, the Tribunal concluded that on 5 May 2021, during a consultation for rectal bleeding with Patient A, Dr Chatterjee undertook an inappropriate vaginal examination in that he failed to obtain informed consent for the vaginal examination and he did not explain to Patient A what the vaginal examination would involve in a way she could understand, so that she had a clear idea of what to expect, including any pain or discomfort.

73. Accordingly, the Tribunal determined that paragraph 1(b)(i)(2) of the Allegation was found proved.

Paragraph 1(b)(i)(3) of the Allegation

74. The Tribunal considered whether on 5 May 2021 during a consultation for rectal bleeding with Patient A Dr Chatterjee undertook an inappropriate vaginal examination in that he failed to obtain informed consent for the vaginal examination and did not obtain Patient A's permission before the vaginal examination and record that she had given it.

75. The Tribunal adopted its findings in respect of particulars 1(a) and 1(b)(i) 1 and 2 above.

76. The Tribunal also bore in mind that Dr Chatterjee had not recorded in the medical notes any information regarding a vaginal examination and, in particular, had not recorded that Patient A had given informed consent for a vaginal examination or use of a vaginal speculum. In his oral evidence Dr F confirmed that specific consent for the use of a speculum was an essential part of the consent process.

77. Furthermore, the Tribunal noted that Patient A had attended a consultation for rectal bleeding, and she had not been expecting a vaginal examination.

78. In the circumstances, the Tribunal concluded that on 5 May 2021, during a consultation for rectal bleeding with Patient A, Dr Chatterjee undertook an inappropriate vaginal examination in that he failed to obtain informed consent for the vaginal examination and did not obtain Patient A's permission before the vaginal examination and record that she had given it.

79. Accordingly, the Tribunal determined that paragraph 1(b)(i)(3) of the Allegation was found proved.

Paragraph 1(b)(ii) of the Allegation

80. The Tribunal considered whether, on 5 May 2021 during a consultation for rectal bleeding with Patient A, Dr Chatterjee undertook an inappropriate vaginal examination in that a vaginal examination was not clinically indicated.

81. The Tribunal noted that, on 5 May 2021, Patient A had attended a consultation for rectal bleeding, after having telephoned the Surgery earlier that day to discuss her ulcerative colitis.

82. The Tribunal bore in mind that Dr D had been unable to identify anything in Patient A's records which might indicate why a vaginal examination might be necessary in relation to Patient A's consultation for rectal bleeding.

83. Further, the Tribunal noted Dr F's expert report, dated 28 May 2023, in particular his following opinion:

> *'I can see no reason why a vaginal examination was clinically indicated or appropriate, given the presenting symptoms were bowel related and seemed to have nothing to do with her vagina.'*

84. In the circumstances, the Tribunal concluded that, it was more likely than not, that on 5 May 2021 during a consultation for rectal bleeding with Patient A, Dr Chatterjee undertook an inappropriate vaginal examination in that a vaginal examination was not clinically indicated.

85. Accordingly, the Tribunal determined that paragraph 1(b)(ii) of the Allegation was found proved.

Paragraph 2 of the Allegation

86. The Tribunal considered whether Dr Chatterjee's actions as set out paragraph 1(b), in relation to his undertaking of an inappropriate vaginal examination, were sexually motivated.

87. The Tribunal noted Dr Chatterjee's handwritten undated prepared statement in which he stated:

> *'I accept that I carried out the rectal examination of the patient. A chaperone was present. If there was* […] *any contact with the patient's vagina then this was unintentional.'*

88. The Tribunal took into account Ms Bucklow's submissions that Dr Chatterjee's actions in undertaking the inappropriate vaginal examination were sexually motivated

89. Ms Bucklow referred to Dr F's evidence that nothing within the clinical records or the documented patient history suggested a vaginal examination was indicated. He had stated specifically that a vaginal speculum should not be used in a rectal examination. It would be a highly unusual thing to do. Ms Bucklow submitted that it had not been explicitly advanced by Dr Chatterjee that he used a speculum to examine Patient A's rectum.

90. Ms Bucklow had argued that the presence of a chaperone was not an indication that there had been no malicious intent by Dr Chatterjee when he inserted the speculum into Patient A's vagina, particularly when the chaperone is inexperienced as in this case.

91. Further, Ms Bucklow had asserted that the suggestion that Dr Chatterjee could accidentally insert the full length of a speculum into the vagina of Patient A was incredulous, and that had he done so he would have known, and immediate steps should have been taken to address that. She stated that there is no plausible explanation for the insertion of a speculum into Patient's A's vagina and that it was in all but name a sexual assault by penetration. Ms Bucklow invited the Tribunal to find that this act was sexually motivated.

92. The Tribunal reminded itself that when Dr D had spoken to Dr Chatterjee regarding Patient A on 5 May 2021 she had indicated to Dr Chatterjee that a rectal examination on Patient A was necessary, and that the cause of bleeding may be other than piles.

93. The Tribunal also took into account the fact Dr Chatterjee had arranged for a chaperone to be present during the examination of Patient A.

94. Patient A had described Dr Chatterjee as being *'dithery'* and said that in their earlier telephone call he *'was not making any sense'*.

95. The Tribunal has found that Dr Chatterjee inserted a speculum into Patient A's vagina during the course of the examination and that this had been inappropriate.

96. The Tribunal acknowledged the shock and concern felt by Patient A as a result of such an unexpected and inappropriate act and that she felt violated by it. It considered that it was feasible that Dr Chatterjee's actions in inserting a speculum into Patient A's vagina during the consultation for rectal bleeding may have been sexually motivated. However, it considered that it was equally feasible that the doctor inserted the speculum into Patient A's vagina during the course of an examination through incompetence and lack of understanding of what was required in the circumstances, taking into account Dr D's oral evidence that she had told Dr Chatterjee to *'look beyond piles'* when he sought her advice before he saw Patient A.

97. The Tribunal concluded that the evidence was insufficient to establish that it was more likely than not that Dr Chatterjee inserted the speculum into Patient A's vagina, during an examination, in pursuit of sexual gratification. It was highly improbable that it would have been in done in pursuit of a future sexual relationship.

98. The Tribunal concluded that the GMC had failed to discharge its burden of proof and accordingly, determined that paragraph 2 of the Allegation was not proved.

<u>Paragraphs 3(a), 3(b), 3(c) and 3(d) of the Allegation</u>

99. The Tribunal had regard to a Certificate of Conviction, dated 11 April 2017, and Rule 34 of the Rules.

100. The Certificate of Conviction was *headed 'MEMORANDUM of an ENTRY entered in the REGISTER of the Central Kent Magistrates' Court'*.

101. The Tribunal considered the content of the Certificate of Conviction. The Certificate identified a *'DR SANJAY CHATTERJEE'* with a date of birth of *'XXX* as having been convicted of the following offences:

- 01/08/2016 at AYLESFORD in the County of KENT, being a relevant offender within the terms of section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that failed to register travel to Portugal. Contrary to section 91(1)(a) and (2) of the Sexual Offences Act 2003;
- On 03/01/2016 at AYLESFORD in the County of KENT, being a relevant offender within the terms of section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that failed to register travel to Calcutta. Contrary to section 91(1)(a) and (2) of the Sexual Offences Act 2003;
- On 07/09/2016 at AYLESFORD in the County of KENT, being a relevant offender within the terms of section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that failed to register a new passport. Contrary to section 91(1)(a) and (2) of the Sexual Offences Act 2003; and
- On 28/07/2016 at AYLESFORD in the County of KENT, being a relevant offender within the terms of section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that failed to register travel to Calcutta. Contrary to section 91(1)(a) and (2) of the Sexual Offences Act 2003.

102. The Tribunal was satisfied that the Certificate of Conviction related to Dr Chatterjee and that he had been convicted of the offences set out in paragraph 3 of the amended Allegation.

103. Accordingly, paragraph 3 of the Allegation was found proved in its entirety.

Paragraph 4(a) and 4(b) of the Allegation

104. The Tribunal had regard to the Certificate of Conviction, dated 11 April 2017, and Rule 34 of the Rules.

105. The Certificate of Conviction was headed *'MEMORANDUM of an ENTRY entered in the REGISTER of the Central Kent Magistrates' Court'*.

106. The Tribunal considered the content of the Certificate of Conviction. The Certificate identified a *'DR SANJAY CHATTERJEE'* with a date of birth of *'XXX* as having been:

- Committed to prison for 84 days concurrent suspended for 12 months. Reason: Offence so serious. Reason for custody: SEVERAL DELIBERATE BREACHES OF ORDER. The defendant must comply with the following requirements within the supervision period of 12 months: Unpaid Work Requirement: Carry out unpaid work for 200 hours within the next twelve months. This work will be supervised by the responsible officer. In the event of activation of sentence: 0 bail remand days to count. Overall length of sentence 84 DAYS.

107. The Tribunal was satisfied that the Certificate of Conviction related to Dr Chatterjee and that he had been sentenced as set out in paragraph 4 of the Allegation.

108. Accordingly, paragraph 4 of the Allegation was found proved in its entirety.

The Tribunal's Overall Determination on the Facts

109. The Tribunal has determined the facts as follows:

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

1. On 5 May 2021 during a consultation for rectal bleeding with Patient A you:

    a. undertook a rectal examination and failed to obtain informed consent in that you did not:

        i. explain to Patient A why a rectal examination was necessary and/or give her an opportunity to ask questions; **Determined and found proved**

        ii. explain to Patient A what the rectal examination would involve, in a way she could understand, so that she had a clear idea of what to expect, including any pain or discomfort; **Determined and found proved**

        iii. obtain Patient A's permission before the rectal examination and record that she had given it; **Determined and found proved**

    b. undertook an inappropriate vaginal examination in that:

i. you failed to obtain informed consent for the vaginal examination in that you did not:

1. explain to Patient A why a vaginal examination was necessary and/or give her an opportunity to ask questions; **Determined and found proved**

2. explain to Patient A what the vaginal examination would involve, in a way she could understand, so that she had a clear idea of what to expect, including any pain or discomfort; **Determined and found proved**

3. obtain Patient A's permission before the vaginal examination and record that she had given it; **Determined and found proved**

ii. a vaginal examination was not clinically indicated. **Determined and found proved**

2. Your actions as set out at paragraph 1b were sexually motivated. **Not proved**

3. On 11 April 2017 at Central Kent Magistrates' Court you were convicted of:

a. on 1 August 2016, being a relevant offender within the terms of Section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that you failed to register travel to Portugal, contrary to Section 91(1)(a) and (2) of the Sexual Offences Act 2003; **Determined and found proved**

b. on 3 January 2016, being a relevant offender within the terms of Section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that you failed to register travel to Calcutta, contrary to Section 91(1)(a) and (2) of the Sexual Offences Act 2003; **Determined and found proved**

c. on 7 September 2016, being a relevant offender within the terms of Section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that you failed register a new passport, contrary to Section 91(1)(a) and (2) of the Sexual Offences Act 2003; **Determined and found proved**

d. on 28 July 2016, being a relevant offender within the terms of Section 80 of the Sexual Offences Act 2003, failed without reasonable excuse to comply with the notification requirements as provided by Part 2 of that Act in that you failed to register travel to Calcutta, contrary to Section 91(1)(a) and (2) of the Sexual Offences Act 2003. **Determined and found proved**

4. On 11 April 2017 at Central Kent Magistrates' Court you were sentenced to:

a. 84 days' imprisonment, suspended for 12 months; Determined and found proved

b. an Unpaid Work Requirement of 200 hours to be completed within 12 months. Determined and found proved

And that by reason of the matters set out above your fitness to practise is impaired because of your:

a. misconduct in relation to paragraphs 1-2; To be determined

b. conviction in relation to paragraphs 3-4'. To be determined

Determination on Impairment - 15/11/2024

1. This determination will be handed down in private under the provisions of Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). However, as this case concerns Dr Chatterjee's alleged misconduct and conviction a redacted version will be published at the close of the hearing.

2. 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 Chatterjee's fitness to practise is impaired by reason of misconduct and/or a conviction.

The Evidence

3. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. The Tribunal received no further evidence.

Submissions

Submissions on behalf of the GMC

4. Ms Bucklow provided written submissions and supplemented these orally. She submitted that Dr Chatterjee's fitness to practise was impaired by reason of both his misconduct and his conviction.

5. Ms Bucklow submitted that Dr Chatterjee's failure to obtain Patient A's consent was a significant departure from Paragraph 17 of Good Medical Practice. She stated that the guidance on 'Decision Making and Consent' explained that consent was a fundamental legal and ethical principle and that all patients have the right to be involved in decisions about their treatment and care and to make informed decisions if they can.

6. Ms Bucklow referred to Dr F's expert opinion that if a rectal and/or vaginal examination was carried out on a patient without the patient's informed consent then this would fall seriously below the standard expected of a reasonably competent GP.

7. Ms Bucklow referred also to Dr F's expert opinion that carrying out an intimate examination without obtaining informed consent can leave a patient feeling vulnerable and/or violated and potentially lead to a patient having long-term emotional difficulties, and reduce a patient's trust in the medical profession.

8. In addition, Ms Bucklow submitted that Dr Chatterjee's failure to obtain informed consent was aggravated by the fact that a vaginal examination was not clinically indicated and as such was likely to have added to the distress experienced by Patient A in that the exam was neither consented to nor necessary.

9. Ms Bucklow submitted that Dr Chatterjee's failure to obtain Patient A's informed consent was further aggravated by the highly unusual and inappropriate use of a vaginal speculum and placing that speculum into Patient A's vagina after it had been in her anus. She reminded the Tribunal of Dr F's opinion that this would have been unhygienic and highly unpleasant psychologically for the patient.

10. Ms Bucklow emphasised that not only had the patient not properly consented to either a rectal or vaginal examination, the rectal examination itself was carried out in an abnormal and highly unusual way and was likely to have led to embarrassment and distress on the part of the patient.

11. Ms Bucklow stated that Patient A had attended the surgery with the very specific complaint of piles and rectal bleeding and had no reason to expect a vaginal examination. She said that Dr Chatterjee did not record the vaginal examination in any way and, according to the chaperone, did not take a swab and there would have been little clinical gain.

12. Ms Bucklow noted that the Tribunal did not find that Dr Chatterjee's actions in undertaking an inappropriate vaginal examination were sexually motivated. However, she stated that Patient A was left confused and feeling violated, contacted friends and family in a distressed state and subsequently had to give evidence to the police so that they could consider whether she had been sexually assaulted. Ms Bucklow emphasised that *'all of this arose from Dr Chatterjee's failure to obtain informed consent for intimate examinations and the carrying out of a vaginal examination that was inappropriate and not clinically indicated.'*

13. In relation to misconduct, Ms Bucklow submitted that, due to the seriousness of the proven facts, the lack of insight on the doctor's part and the risk of repetition, public confidence would be undermined were a finding of impairment not made. Further, she stated that Dr Chatterjee's misconduct engaged all three limbs of the overarching objective, including patient safety.

14. In relation to Dr Chatterjee's conviction, Ms Bucklow submitted that, although not relied upon in the present case or subject to these proceedings, his previous conviction for sexual assault provides important context. It would have significantly undermined public confidence and he was *'fortuitous'* to remain on the register.

15. Ms Bucklow suggested that the minimum expectation following a conviction of that nature would have been for Dr Chatterjee to have complied with the requirements of his sentence. She stated that it was clear from his police interviews that he had known what was required of him. He had shown a blatant disregard for the notification requirements as an offender under the Sexual Offences Act.

16. Ms Bucklow submitted that a finding of impairment in relation to Dr Chatterjee's conviction was necessary to maintain confidence in the regulatory process and to signal that convictions of this nature are not compatible with the standards expected of a doctor.

17. Ms Bucklow concluded by submitting that, in respect of Dr Chatterjee's conviction, a finding of impairment was necessary to uphold public confidence in the profession and maintain proper professional standards.

Submissions on behalf of Dr Chatterjee

18. The Tribunal's decision on facts had been sent to Dr Chatterjee's representatives. Mr Forde did not attend the hearing at the impairment stage but submitted limited written submissions to the Tribunal as follows:

> *'The doctor's representatives have been invited to make submissions on the issue of whether the doctor's fitness to practice is impaired.*
>
> *Dr Chatterjee is [XXX] but very limited submissions can be made based on basic principles. These submissions are therefore made to protect the position of the doctor.*
>
> *The doctor has been found to have failed to comply with the notification requirements pursuant to the Sexual Offences Act.*
>
> *The events in question occurred relating to overseas travel in January, July and September of 2016, in the final year of a five year notification period, which commenced in November 2011.*
>
> *Dr Chatterjee was convicted in April 2017. He diligently notified the GMC of this on the same day [refence made to defence bundle]. The delay in dealing with the case was not the fault of the doctor.*
>
> *The doctor resumed his career with no complaints (see* [Dr D's] *email submitted with VE application and* [Dr G's] *reference* […]*) other than the single patient in this case. There was no repetition of any sexually motivated behaviour in the period 2011 to the present day, 2024 a period of 13 years.*
>
> *He made successful applications to travel abroad from 2011 to 2015 as was regarded as low risk (see disclosure Defence bundle* […]*).*
>
> *Had he made an application for travel or renewal of passport in 2016, as he should have done it is likely to have been granted.*
>
> *The proven charges relating to lack of informed consent, relate to one patient and one consultation. Clearly, the Panel have found communication could have been better, but such a failure is not sufficiently serious to be the foundation for a finding of impairment. It is easily remediable (see Calhaem v GMC).*

The Panel might be assisted by looking at the criteria for a Warnings Guidance […] *in assessing whether, in the light of the overarching interests Dr Chatterjee's conduct passes the impairment threshold.*

There is no risk of repetition as Dr Chatterjee has no desire to resume his career. The conviction is of great antiquity, a sentence has been imposed and served and the lack of informed consent issues are not sufficiently serious, are easily remediable or, alternatively, will not be repeated.'

The Relevant Legal Principles

19. 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.

20. The Tribunal has found that the statutory ground of a criminal conviction has been established. It must now determine Dr Chatterjee's fitness to practise is currently impaired by reason of that conviction.

21. The Tribunal was mindful of the two-stage process to be adopted in respect of misconduct: first whether the facts as found proved amounted to misconduct, and if so to go on to decide then whether as a consequence Dr Chatterjee's fitness to practise is currently impaired.

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

23. The Tribunal noted that there is no statutory definition of misconduct. It was defined in the leading case of *Roylance v GMC (No.2)* [2000] 1 AC 311, as a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily to be followed by the practitioner in the particular circumstances. It is not any professional misconduct which would qualify. The professional misconduct must be serious.

24. In the case of *Nandi v GMC* [2004] EWHC 2317, Mr Justice Collins adopted the approach of Lord Clyde in the case of *Rylands v GMC* [1999] Lloyds Rep Med 139 that professional conduct is *'a falling short by omission or commission of the standards of conduct expected among medical practitioners and such falling short must be serious'.* The adjective "serious" must be given its proper weight and conduct which would be considered deplorable by fellow practitioners, whilst not a legal threshold, may be a helpful benchmark. Lord Clyde went on to say that "*It is of course possible for negligent conduct to amount to serious misconduct but the negligence must be to a high degree".*

25. There is no statutory definition of impairment and there is no burden or standard of proof. Impairment may be based on historical factors or a continuing state of affairs but it is to be judged as at the present time. The Tribunal should look forward taking into account any changes in practice behaviour or attitude since the matters found proved occurred.

26. The Tribunal should have at the forefront of its mind the overarching objective set out in S1(A) & (B) of the Medical Act 1983. This is (a) to promote and maintain the health safety and well-being of the public (b) to maintain public confidence in the profession and (c) to promote and maintain proper professional standards and conduct for members of the profession.

27. As stated by Mr Justice Silber in *Cohen v GMC* [2008] EWHC 581 (Admin), a significant consideration at the impairment stage is (i) whether the misconduct is easily remediable (ii) whether it has been remedied and (iii) whether there is a risk of such behaviour being repeated in the future.

28. The Tribunal had regard to the case of *CHRE v NMC and Grant* [2011] EWHC 927 where Dame Janet Smith's observations in the Fifth Report of the Shipman Inquiry were endorsed by Mrs Justice Cox. Questions for determining whether a practitioner's fitness to practise is impaired can be summarised as follows:

> *'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; and/or

c. ….'

The Tribunal's Determination on Impairment

Misconduct

29. In reaching its determination on whether Dr Chatterjee's actions amounted to misconduct, the Tribunal first reminded itself of the findings of fact that it had made.

30. When considering Dr Chatterjee's failure to obtain informed consent in relation to his undertaking of a rectal examination on Patient A and his failure to obtain informed consent for a vaginal examination, which was inappropriate and not clinically indicated, the Tribunal had regard to the following paragraphs of GMP:

'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.'

'2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability'

'12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work'

'17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.'

'23 To help keep patients safe you must:

a contribute to confidential inquiries

b contribute to adverse event recognition

c report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at risk […]*'*

'31 You must listen to patients, take account of their views, and respond honestly to their questions.'

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

'35 You must work collaboratively with colleagues, respecting their skills and contributions.'

'36 You must treat colleagues fairly and with respect.'

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

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

31. The Tribunal also took account of the guidance in *'Decision making and consent'* (2020), including the following principles from *'the seven principles of decision making and consent'*:

'One
All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able.

Two

Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.

Three
All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.'

32. When considering Dr Chatterjee's duty to obtain informed consent the Tribunal also noted the GMC guidance *'Intimate examinations and chaperones'* (2013), in particular:

'1 In Good medical practice we say:

- *15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
  a ...where necessary, examine the patient.
- *47 You must treat patients as individuals and respect their dignity and privacy.'*

'3 Intimate examinations can be embarrassing or distressing for patients and whenever you examine a patient you should be sensitive to what they may think of as intimate. This is likely to include examinations of breasts, genitalia and rectum, but could also include any examination where it is necessary to touch or even be close to the patient.'

'5 Before conducting an intimate examination, you should:

a explain to the patient why an examination is necessary and give the patient an opportunity to ask questions

b explain what the examination will involve, in a way the patient can understand, so that the patient has a clear idea of what to expect, including any pain or discomfort

c get the patient's permission before the examination and record that the patient has given it

[...]'

'6 During the examination, you must follow the guidance in Consent: patients and doctors making decisions together. In particular you should:

a explain what you are going to do before you do it and, if this differs from what you have told the patient before, explain why and seek the patient's permission'

'9 A chaperone should usually be a health professional and you must be satisfied that the chaperone will:

[…]

c be familiar with the procedures involved in a routine intimate examination'

33. Further, the Tribunal also noted Dr F's conclusions in his expert report, dated 28 May 2023:

'To summarise the above, it is expected that a reasonably competent GP would explain the process of the examination (including which areas would be examined), and explain why the examination is needed, to the patient before commencing. This would include advising the patient that consent can be withdrawn at any time, including during the examination itself, for any reason. It is also expected that prior to commencing an intimate examination, the patient would indicate that they are happy to proceed with the examination following such a discussion.

If it is accepted as fact by a Case Examiner and/or Tribunal that such a discussion did not take place prior to the intimate examination on 5 May 2021 with [Patient A], then in my opinion this would fall seriously below the standard expected of a reasonably competent GP, due the distinct likelihood that [Patient A] would feel vulnerable and/or violated due to an examination being carried out without consent and prior explanation.'

34. The Tribunal noted Dr F's expert opinion in relation to Dr Chatterjee's non-clinically indicated vaginal examination of Patient A and his use of a speculum:

'I can see no reason why a vaginal examination was clinically indicated or appropriate, given the presenting symptoms were bowel related and seemed to have nothing to do with her vagina.

Therefore, I aver that were [Patient A's] account be accepted as fact by a Case Examiner and/or Tribunal, conducting a vaginal examination would fall seriously below the standard expected of a reasonably competent GP as it is clinically unnecessary, and would be likely to make [Patient A] feel violated and/or vulnerable.

I would like to add that it would be extremely unhygienic to insert a speculum that had been in a patient's anus into the patient's vagina. Such an act would fall seriously below the standard expected of a reasonably competent GP as it increases the likelihood of infection being introduced into the genito-urinary tract.'

35. The Tribunal further noted Dr F's conclusions in relation to Dr Chatterjee's overall standard in relation to his examination of Patient A:

'..assuming that it is accepted as fact that Dr Chatterjee failed to obtain consent for an intimate examination of [Patient A's] *anus, then I am of the view that Dr Chatterjee's care of* [Patient A] *on 5 May 2021 fell seriously below the standard expected of a reasonably competent GP. This is because in spite of any other aspect of Dr Chatterjee's care of* [Patient A], *failure to obtain consent for an intimate examination would be likely to cause [Patient A] to feel vulnerable and/or violated, and potentially lead to long term emotional difficulties, along with reducing* [Patient A's] *trust in the medical profession.*

Were [Patient A's] *account accepted as fact by a Case Examiner/Tribunal, then Dr Chatterjee's care of* [Patient A] *fell seriously below the standard expected of a reasonably competent GP in my opinion. This is because Dr Chatterjee conducted a clinically unnecessary examination (of* [Patient A's] *vagina) using an unhygienic instrument, and failed to gain* [Patient A's] *consent for any form of intimate examination. This would be likely to cause* [Patient A] *to feel vulnerable and/or violated, and potentially lead to long term emotional difficulties, along with reducing* [Patient A's] *trust in the medical profession.'*

36. Further, the Tribunal accepted the evidence of Ms E when she said that, although she knew she was to act as a chaperone, she had not been informed at any time by Dr Chatterjee as to the nature of the examination.

37. The Tribunal accepted that Dr Chatterjee had a professional duty to obtain Patient A's informed consent to every aspect of the examination and found that he had clearly failed to do so.

38. The Tribunal accepted Dr F's expert opinion that the failure to obtain Patient A's informed consent fell seriously below the standard expected of a reasonably competent GP.

39. It further accepted Dr F's view that Dr Chatterjee's failure to obtain Patient A's informed consent would cause her to feel vulnerable and potentially lead to long term emotional difficulties along with a reduced trust in the medical profession. Patient A's evidence was that during the examination she was in shock and that subsequently she had felt anger, distress and that she had been violated. Both Patient A's daughter and friend described her as being distressed and in tears when she discussed what had happened to her.

40. The Tribunal noted Dr Chatterjee's inappropriate lack of record keeping in relation to Patient A's intimate examination.

41. The Tribunal also noted the distress caused to Ms E, a young nurse who had been asked to act as a chaperone, and who had not been informed by Dr Chatterjee what examination was to take place, and who, after the intimate examination, had been left feeling uncomfortable.

42. Further, the Tribunal took account of the emotional impact that Dr Chatterjee's failure to obtain informed consent had on Patient A and considered that any patient in those circumstances would have been likely to have felt the same way.

43. In the circumstances, the Tribunal concluded that Dr Chatterjee's failure to obtain Patient A's informed consent for a rectal examination, his failure to obtain informed consent for an inappropriate non-clinically indicated vaginal examination, and his failure to explain the nature of the examinations to the chaperone fell so far short of the standards of conduct reasonably expected of a doctor as to clearly amount to serious misconduct.

44. It considered that Dr Chatterjee's misconduct amounted to a gross dereliction of duty, put the public's trust in the profession at risk and would be regarded as deplorable by fellow practitioners.

Impairment

45. The Tribunal, having found that the facts found proved in relation to Dr Chatterjee's failure to obtain Patient A's informed consent for a rectal examination and his undertaking an inappropriate and non-clinically indicated vaginal examination, also without consent, amounted to serious misconduct, went on to consider whether, as a result of that serious misconduct, Dr Chatterjee's fitness to practise was currently impaired.

46. The Tribunal considered that Dr Chatterjee's serious misconduct had brought the medical profession into disrepute. It was conduct that was liable to undermine the public's trust in the profession and it had caused emotional harm to Patient A.

47. The Tribunal considered the approach taken in *Cohen*. The Tribunal looked for evidence of remediation and insight, and the likelihood of repetition, in the context of the three elements of the overarching statutory objective.

48. The Tribunal noted that Dr Chatterjee had provided no evidence of reflection or remediation such as the undertaking of professional training.

49. There was no evidence of insight or remediation on the part of Dr Chatterjee. There had been no reflection or recognition of fault in this case and no apology to Patient A or Ms E, nor any evidence that Dr Chatterjee understands the gravity of his misconduct. On that basis, the Tribunal considered that a risk of repetition of serious misconduct was high.

50. The Tribunal determined that the public expects doctors' conduct to justify its trust in them and expects doctors to obtain informed consent from patients when performing intimate examinations. Where doctors fail to do so in a significant way, the public's trust in the profession is undermined. The Tribunal considered that public confidence in the profession would be seriously damaged if a finding of impairment were not made in this case.

51. Therefore, the Tribunal considered that a finding of impairment was necessary to protect, promote and maintain the health, safety and well-being of the public; to promote

and maintain public confidence in the medical profession and to promote and maintain proper professional standards and conduct for members of the profession.

52. Accordingly, the Tribunal the Tribunal determined that Dr Chatterjee's fitness to practise is impaired by reason of his misconduct.

Conviction

53. The Tribunal also considered Dr Chatterjee's convictions under Section 91(1)(a) and (2) of the Sexual Offences Act 2002, and the sentence of 84 days' imprisonment, suspended for 12 months and an Unpaid Work Requirement of 200 hours to be completed within 12 months to be serious.

54. It noted that the court considered that Dr Chatterjee's behaviour in failing to inform the police of his plans to travel abroad, and to fully disclose the nature of the trips, on four occasions, constituted four serious breaches of the law.

55. The Tribunal bore in mind that the court considered Dr Chatterjee's breaches of the Sexual Offences Act 2003 to have been deliberate. It had imposed a custodial sentence, albeit suspended, with an additional punishment element of an unpaid work requirement. The Tribunal was mindful that the purpose of the Sex Offenders Register is to protect the public and that the notification requirements that Dr Chatterjee breached were in place for this purpose.

56. Furthermore, the Tribunal considered that Dr Chatterjee's explanations given, during police interviews, for his failure to fully disclose the details and extent of his trips abroad lacked integrity and showed a clear disregard for the requirement to do so.

57. The Tribunal concluded that Dr Chatterjee's convictions were so serious that the need to uphold public confidence in the profession to promote and maintain proper standards of conduct and behaviour for the members of the profession, would be undermined if no finding of impairment were made.

58. Accordingly, the Tribunal determined that Dr Chatterjee's fitness to practise is impaired by reason of his conviction.

59. The Tribunal therefore determined that both the misconduct and the conviction brought the medical profession into disrepute and breached a fundamental tenet of the medical profession.

Determination on Sanction - 18/11/2024

1. This determination will be handed down in private under the provisions of Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). However, as this case concerns Dr Chatterjee's alleged misconduct and conviction a redacted version will be published at the close of the hearing.

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

Submissions

Submissions on behalf of the GMC

3. Ms Bucklow provided written submissions and supplemented these orally. She submitted that the appropriate sanction in this case was erasure.

4. Ms Bucklow reminded the Tribunal that Dr Chatterjee had expressed, through his representatives, that he did not want to work as a doctor again and had made applications for voluntary erasure, which were refused. She stated that the Tribunal was not being invited to erase Dr Chatterjee's name from the register because he stated that he no longer wished to work as a doctor, but rather that Dr Chatterjee's intentions for his career were relevant when considering if he was willing to engage in remediation going forward.

5. Ms Bucklow submitted that the nature and seriousness of the findings against Dr Chatterjee are an important consideration, the more serious the findings the more likely that a sanction is required, and the sanction needs to be sufficient to meet the overriding objective.

6. Ms Bucklow reminded the Tribunal that Dr Chatterjee had been made subject to sex offender notification requirements, following his conviction for sexually assaulting a female colleague in 2011, and submitted that his 2017 conviction under the Sexual Offences Act

2003, relating to four offences of breaching his notification requirements under Part 2 of the same Act showed a blatant disregard for his notification requirements.

7. Ms Bucklow submitted that Dr Chatterjee knew what was required of him in respect of notifying the police of his foreign travel and stated that the doctor accepted this in his police interviews on 8 September 2016 and 11 November 2016. She stated that Dr Chatterjee's 2017 conviction represented deliberate and repeated criminal conduct.

8. Further, Ms Bucklow argued that the nature of Dr Chatterjee's convictions represented an attitudinal and behavioural problem, a lack of regard for the law and orders of the court. She stated that from a public confidence perspective, it was likely to cause great concern and there was likely to be a degree of discomfort that Dr Chatterjee was able to practise as a GP at all, following a conviction of sexual assault of a colleague and his placement on the sex offender's register.

9. Ms Bucklow submitted that, for the public to learn that Dr Chatterjee had repeatedly breached his sex offender notification requirements will significantly undermine public confidence as to Dr Chatterjee's character and willingness to act within regulations and abide by the law. She asserted that a further conviction under the Sexual Offences Act 2003, was something that the public will struggle to align with being able to practise as a doctor.

10. Ms Bucklow submitted that Dr Chatterjee's misconduct in respect of Patient A was serious and stated that obtaining informed consent for any medical treatment or examination is a fundamental legal and ethical requirement.

11. Ms Bucklow referred to the expert opinion of Dr F that a failure to obtain informed consent for an intimate examination fell seriously below the standard expected of a reasonably competent GP. She stated that Patient A was not expecting a vaginal examination as she had gone very specifically with the complaint of piles and rectal bleeding and that Patient A's vaginal examination was not clinically indicated or anticipated by the patient.

12. Ms Bucklow submitted that there appeared to have been very little clinical assessment or gain from Patient A's vaginal examination. There was no indication from Dr Chatterjee as to his intentions or findings from the vaginal examination, because he omitted it from the medical record. Dr Chatterjee said any contact with the vagina was unintentional. Further, Ms Bucklow asserted that the vaginal examination, if Patient A's account is accepted, was carried out in a highly unusual manner, and unhygienically.

13. Ms Bucklow submitted that Patient A has come to psychological harm, having been left confused, angry and feeling violated. She stated that Patient A contacted her friends and family, she was trying to make sense of what had happened. She stated that Patient A felt cause to complain to her GP and had to give evidence to the police so that they could consider whether she had been sexually assaulted, all because Dr Chatterjee had failed to obtain informed consent for an intimate examination and carried out a vaginal examination that was inappropriate and not clinically indicated.

14. Ms Bucklow also referred to the impact on Ms E a young nurse on a placement as part of her training, who was not trained to chaperone and was not given any information from Dr Chatterjee about what examinations she was being asked to chaperone.

15. Ms Bucklow emphasised the importance of obtaining informed consent and referred to GMC guidance on *'Decision making and Consent'*. She further stated that Dr Chatterjee should have been well aware of this as he had previously been subject to stringent conditions because of his 2011 conviction, which included restrictions relating to intimate examinations. She stated that Dr Chatterjee's failures in relation to his examination of Patient A raised questions about his ability to remediate and learn from his fitness to practise history and ensure compliance with GMC guidance.

16. Ms Bucklow argued that conditions were inappropriate and stated imposing a suspension on Dr Chatterjee's registration with a review would undermine public confidence in circumstances where Dr Chatterjee has had sufficient time already. Further, he is unlikely to engage with a review, having indicated an intention never to practise again and he failed to engage with these proceedings despite a finding he was fit to do so.

17. Ms Bucklow concluded by emphasising that Dr Chatterjee had shown a persistent lack of insight into both his conviction and conduct in respect of Patient A and submitted that his focus appeared to remain on the impact his conduct has had on himself and his career. He had shown no insight into the harm he has caused Patient A and the impact on public confidence in the profession. She stated, therefore, that a sanction of erasure was the only proportionate sanction that could meet the overarching objective.

<u>Submissions on behalf of the Dr Chatterjee</u>

18. The Tribunal's decision on impairment had been sent to Dr Chatterjee's representatives. Mr Forde informed the Tribunal by email correspondence that he was unable to make submissions on sanction in the absence of instruction.

The Tribunal's Determination on Sanction

19. The decision as to the appropriate sanction to impose, if any, is a matter for this Tribunal exercising its own judgement. There is no burden or standard of proof at this stage. The Tribunal recognises that every case will necessarily turn on its own facts.

20. In reaching its decision, the Tribunal has given careful consideration to the *Sanctions Guidance* (2024) generally and to all the paragraphs outlined in submissions. It has borne in mind that the purpose of a sanction is not to be punitive although it may have a punitive effect.

21. The Tribunal has borne in mind that in deciding what sanction, if any, to impose, it should consider all the sanctions available, in ascending order of severity, starting with the least restrictive.

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

23. The Tribunal has taken into account its earlier determinations on the facts and on impairment, the SG and GMP.

Aggravating and Mitigating Factors

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

Aggravating Factors

25. The Tribunal considered that Dr Chatterjee has shown no evidence of insight. He has shown no understanding of his misconduct, or the effect of that misconduct on Patient A or the wider profession and the public.

26. Dr Chatterjee's failure to obtain Patient A's informed consent caused her emotional harm, leaving her in shock and distress and feeling as if she had been violated. Both Patient A's daughter and friend described her as being distressed and in tears when she discussed what had happened to her.

27. Dr Chatterjee failed to establish that Ms E, who was a student nurse on a training placement and had never carried out this role before, was suitably qualified to act as a chaperone. He explained nothing to her. The Tribunal noted that Ms E was left feeling uncomfortable following Patient A's examination.

28. Dr Chatterjee's convictions for failing to inform the police of his plans to travel abroad whilst on the Sexual Offenders Register, and to fully disclose the nature of the trips on three occasions, and to register his new passport, constituted four serious breaches of the law. These later convictions took place whilst Dr Chatterjee was still under restrictions from his first conviction.

29. The Tribunal considered that the fact that Dr Chatterjee's registration had previously been suspended following a finding of impairment in relation to a 2011 conviction for sexual assault against a colleague was a significant aggravating factor.

Mitigating Factors

30. The Tribunal noted the lapse in time following Dr Chatterjee's misconduct but also noted Dr Chatterjee's efforts to delay the fitness to practise proceedings.

31. The Tribunal took account of Dr G's positive testimonial, dated 12 April 2023, in relation to Dr Chatterjee's time working as a salaried GP between April 2020 and September 2021 at the Vine Medical Centre. However, the Tribunal consider that this testimonial to be of limited value in the light of the wide ranging aggravating factors.

32. Having considered the aggravating and mitigating factors in this case the Tribunal then weighed them against each other in relation to the misconduct and conviction.

33. It considered that there was no evidence of any insight or remediation for the Tribunal to consider. There was no evidence that Dr Chatterjee understood the nature or gravity of his misconduct and convictions. There was no evidence of any attempts by him to address or remediate his misconduct and convictions. There were no expressions of regret or

apology. There was no evidence that Dr Chatterjee accepts that he should have behaved differently showing understanding as to the nature of his misconduct and convictions.

34. The Tribunal went on to consider each sanction in ascending order of severity, starting with the least restrictive.

No Action

35. 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.

36. The Tribunal determined that there were no exceptional circumstances in this case which would justify taking no action.

Conditions

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

38. The Tribunal took account of the following paragraphs of the SG which indicate circumstances in which it may be appropriate to impose a sanction of conditions:

'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.'

'84 Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:

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

b identifiable areas of their practice are in need of assessment or retraining

c willing to respond positively to retraining, with evidence that they are committed to keeping their knowledge and skills up to date throughout their working life, improving the quality of their work and promoting patient safety (Good medical practice, paragraphs 1-5
(Being Competent) and 11-13 (Maintaining, developing and improving your performance)

d willing to be open and honest with patients if things go wrong (Good medical practice, paragraphs 45-46)

e has insight into any health problems, complies with the guidance on health (Good medical practice, paragraphs 77–80) and will abide by conditions relating to their medical condition, treatment and supervision and will not put patients in danger, either directly or indirectly, as a result of conditional registration.'

39. The Tribunal reminded itself that the hearing involved a public interest aspect and considered that an imposition of conditions on Dr Chatterjee's registration would not send a

sufficient message to the public or the profession as to the inappropriateness and seriousness of his misconduct and convictions.

40. The Tribunal also noted that Dr Chatterjee, in light of his voluntary erasure application, had indicated that he does not want to return to practice and it had received no evidence that he would co-operate with, or respond to, conditions. It noted that Dr Chatterjee's 2017 conviction was a failure to comply with requirements put in place for the protection of the public.

41. In the circumstances the Tribunal determined that a period of conditional registration would neither be workable nor send a marker to adequately protect public confidence in the profession or uphold proper standards of conduct for members of the profession.

Suspension

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

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

44. The Tribunal took account of the following paragraphs of the SG which indicate circumstances in which it may be appropriate to impose a sanction of suspension:

> *'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.'*

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

a A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.

[…]

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.'

45. The Tribunal had regard to its impairment determination and its finding that Dr Chatterjee's misconduct was a serious breach of paragraph 65 of GMP and undermined public trust in the profession.

46. The Tribunal also noted that Dr Chatterjee's misconduct and convictions had shown a deliberate and reckless disregard for GMP.

47. In the absence of evidence of remediation, the lack of expressions of regret or remorse and the absence of any evidence of insight to this Tribunal, it could not be satisfied that Dr Chatterjee did not pose a significant risk of repeating his behaviour.

48. The Tribunal determined that the seriousness of Dr Chatterjee's misconduct and convictions, lack of any evidence insight, and the continued risk that he posed were incompatible with continued registration due to the need to protect the public, to maintain public confidence and uphold proper professional standards.

49. In the circumstances, having had regard to the findings at the facts and impairment stages of this hearing, and the continued risk that Dr Chatterjee posed, the Tribunal was

satisfied that a period of suspension imposed upon the doctor's registration would not be appropriate and would not meet the overarching objective.

Erasure

50. The Tribunal considered the following paragraphs of the SG to applied to Dr Chatterjee's case:

> *'109 Any of the following factors being present may indicate erasure is appropriate.*
>
> […]
>
> *b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
>
> *c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients* […]
>
> *d Abuse of position/trust (see Good medical practice, paragraph 81: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').*
>
> *e Violation of a patient's rights* […]
>
> *j Persistent lack of insight into the seriousness of their actions or the consequences'*

51. The Tribunal noted that Dr Chatterjee's misconduct did serious psychological harm to Patient A and had impacted the chaperone in a negative way. It concluded that Dr Chatterjee's misconduct had violated Patient A's trust.

52. Furthermore, the Tribunal considered that Dr Chatterjee's convictions relating to his failure to fully disclose the details of his trips abroad and failing to register his new passport, whilst on the Sex Offenders Register, lacked integrity and showed a clear disregard for the requirement to do so. It considered that such disregard was deliberate and was evidence of a lack of respect for processes.

53. The Tribunal considered Dr Chatterjee's misconduct and convictions, the continued risk that he posed, given the lack of evidence of any regret, insight and remediation, and the doctor's continued lack of engagement with the regulatory process. The Tribunal considered those factors to be incompatible with Dr Chatterjee's continued registration as a doctor.

54. The Tribunal further noted the multifactorial nature of the case, involving both misconduct and convictions, his previous criminal and regulatory history, and Dr Chatterjee's failure to provide any apology whatsoever.

55. Having regard to all the evidence before it, the relevant paragraphs in the SG, and the statutory overarching objective, the Tribunal determined that the only appropriate and proportionate sanction was one of erasure.

56. Further, the Tribunal concluded that erasure was necessary to protect, promote and maintain the health, safety and well-being of the public; maintain public confidence in the medical profession, and to uphold proper professional standards and conduct for members of the profession.

57. The Tribunal therefore directed that Dr Chatterjee's name be erased from the Medical Register.

Determination on Immediate Order - 18/11/2024

1. Having determined that Dr Chatterjee's name should be erased from the Medical Register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Chatterjee's registration should be subject to an immediate order.

Submissions

Submissions on behalf of the GMC

2. Ms Bucklow submitted that the imposition of an immediate order upon Dr Chatterjee's registration was required.

3. Ms Bucklow argued that, given Dr Chatterjee poses a risk to the public, the imposition of an immediate order was necessary to protect the public and uphold public confidence in the profession.

4. Ms Bucklow submitted that the public would be concerned if Dr Chatterjee was allowed to continue practising in light of the gravity of the findings in this case and the sanction that had been imposed.

The Tribunal's Determination

5. In reaching its decision, the Tribunal has exercised its own judgement, and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public, is in the public interest, or is in the best interests of the practitioner.

6. The Tribunal had regard to the following paragraphs of the SG:

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they* […] *may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.'*
>
> *'173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.'*

7. The Tribunal considered that, due to the serious nature of Dr Chatterjee's misconduct and convictions, an immediate order was both necessary and proportionate.

8. It considered that, given the risk of repetition, an immediate order was necessary to protect the public, to uphold proper professional standards and conduct for members of the profession and to maintain public confidence in the profession.

9. Further, the Tribunal concluded that public confidence in the profession would be undermined if an immediate order was not imposed given the nature of Dr Chatterjee's misconduct and convictions.

10. Accordingly, the Tribunal determined to impose an immediate order upon Dr Chatterjee's registration.

11. This means that Dr Chatterjee's registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

12. The interim order will be revoked when the immediate order takes effect.

13. That concludes this case.

ANNEX A – 29/10/2024

Application to adjourn & proceeding in absence

1. This determination will be handed down in private under the provisions of Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). However, as this case concerns Dr Chatterjee's alleged misconduct and conviction a redacted version will be published at the close of the hearing.

2. At the outset of the hearing, Mr Forde KC, on behalf of Dr Chatterjee, made an application to adjourn the hearing under Rule 29(2) of the Rules. This Rule states:

> *'Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit.'*

Current allegations

3. It is alleged that on 5 May 2021, during a consultation with a female patient at Aylesford Medical Centre (the Practice) for rectal bleeding, Dr Chatterjee, undertook a rectal examination having failed to obtain informed consent; undertook an inappropriate vaginal examination without consent when it was not clinically indicated and without explanation, and without giving the patient the opportunity to ask questions. It is further alleged that his actions were sexually motivated.

4. It is also alleged that on 11 April 2017 at Sevenoaks Magistrates Court, Dr Chatterjee was convicted of four offences of failing to comply with his notification requirements as a sex offender. He was sentenced to 84 days imprisonment, suspended for 12 months with an unpaid work requirement of 200 hours and ordered to pay £200 in costs.

5. Mr Forde sought an adjournment on the basis that XXX.

Background

6. Dr Chatterjee graduated with MBBS from University of Calcutta, India in 1990. He first registered with the GMC in 1999.

7. On 28 September 2011, Dr Chatterjee was convicted of an offence of sexual assault on a female. The female concerned was not a patient but a member of staff. He was sentenced to 250 hours of community service and required to register on the Sex Offenders Register for five years. Shortly after his conviction, NHS England removed him from its GP Performers List.

8. On 3 July 2014, following an MPT hearing arising from the conviction, Dr Chatterjee was given a 9-month suspension. At the end of the 9 months, Dr Chatterjee's registration was made conditional for a further 21 months; this took him to the end of 2017.

9. Dr Chatterjee was still subject to the GMC conditions of practice when he committed the four offences of failing to comply with notification requirements under the Sexual Offenders Act 2003.

10. In early 2018, once the conditions on his GMC registration lapsed, Dr Chatterjee began to consider returning to practise as a GP. He made enquiries about being readmitted to the NHS Performers List and NHS England advised him to undertake the 2-year long Induction and Refresher (I&R) training for GPs.

11. Dr Chatterjee completed his I&R training in April 2020 and resumed GP practice once again. He took up part time employment with two GP practices, the Practice and The Vine Medical Centre (VMC).

History of Applications

12. The first MPT hearing in respect of the current allegations was listed for 27 – 29 July 2022. On 12 May 2023 Dr Chatterjee made an application to the MPTS to postpone that hearing XXX. The application was not opposed by the GMC. The MPTS agreed to postpone the hearing and directed an update XXX by 5 September 2022.

13. On 26 August 2022 Dr Chatterjee's representatives provided a letter XXX. They proposed that the hearing should be listed after the conclusion of the police investigation into the events of 5 May 2021.

14. On 30 September 2022 the MPTS requested further evidence and clarification before the matter could be determined. XXX. The Police investigation concluded with a decision to take no further action and on 6 December 2022 the MPTS advised that Dr Chatterjee's hearing had been listed for 12-14 April 2023.

15. On 20 February 2023, Dr Chatterjee's representatives wrote to the GMC to request the allegations against Dr Chatterjee either be withdrawn under Rule 28 of the GMC (Fitness to Practise) Rules 2004, or for the MPT hearing to be permanently stayed. XXX. The GMC suggested that an appropriate course might be for the defence to make an application to postpone the hearing or an application for voluntary erasure. On 27 February 2023 the defence made an application to permanently 'delist' the 12- 14 April 2023 hearing. This was opposed by the GMC and refused by the MPTS Case Manager on 9 March 2023.

16. At the start of Dr Chatterjee's MPT Hearing on 12 April 2023, the defence again applied for an adjournment and this was opposed by the GMC. The tribunal granted an adjournment of three months, XXX, which was relisted for 25-27 September 2023.

17. On 11 September 2023, the defence wrote to the GMC and MPTS seeking a postponement of the hearing, XXX . The GMC opposed this application, and it was refused by the MPTS Case Manager on 20 September 2023.

18. On 23 September 2023 the defence served a skeleton argument for a further application to adjourn, to be made at the MPT hearing on 25 September 2023. That application was opposed by the GMC XXXX. The tribunal refused that application to adjourn, but the defence made a further application to adjourn, in order to seek Judicial Review of the tribunal's decision to refuse their first application. Whilst the tribunal also refused that application, the material effect was that there was insufficient time remaining to commence the hearing proper.

19. Although the defence issued a Pre-Action protocol letter in respect of a Judicial Review of both the MPTS Case Manager's decision on 20 September 2023 and the tribunal's first decision to refuse an adjournment on 27 September 2023, they did not proceed with the Judicial Review process. It was agreed between parties that a hearing would not be relisted before 1 July 2024, and XXX. The hearing was listed for 12 August 2024 - 6 September 2024.

20. On 29 May 2024, a skeleton argument was submitted by the defence seeking a further postponement of the hearing, this time to allow representation by Dr Chatterjee's chosen counsel. The hearing was relisted for 21 October 2024 to accommodate this.

21. On 2 October 2024, the defence wrote to the GMC setting out an intention to make a further application to the tribunal to adjourn the proceedings indefinitely XXX, and that if this was refused by the tribunal consideration would be given to applying for judicial review of that refusal, meaning the hearing would be adjourned in any event. In further correspondence it was indicated that a voluntary erasure application would be made for

consideration by the Case Examiners, but not until after 14 October 2024 to accommodate a Hindu festival.

XXX

22. XXX

23. XXX

24. XXX

25. XXX

26. XXX

27. XXX

28. XXX

29. XXX

30. XXX

31. XXX

32. XXX

33. XXX

Submissions

Submissions on behalf of Dr Chatterjee

34. Mr Forde emphasised that the allegations were both serious and complex. He submitted that XXX in the current MPT hearing and that it should be adjourned.

35. XXX

36. XXX

37. Mr Forde asserted that the present situation, based upon case law and authority, was such that the current hearing must be postponed.

38. Mr Forde stated that, if the current Tribunal did not accede to the application for postponement, it was likely that time would be asked for to consider challenging a decision refusing postponement, by way of a Judicial Review. This would result in further delay caused by the necessity to draft a Pre-Action protocol letter to the GMC and the seeking of permission to judicially review both a refusal to postpone and to grant voluntary erasure on the grounds of irrationality.

39. Mr Forde reminded the Tribunal that Dr Chatterjee was currently suspended both by NHS England and the Interim Orders Panel, XXX and has not challenged his suspensions and, therefore, posed no risk to the public.

40. Mr Forde informed the Tribunal that, if his application is refused, those acting for Dr Chatterjee will apply for voluntary erasure to the Tribunal. XXX. Mr Forde directed the Tribunal to a letter sent to the GMC lawyer, dated 2 October 2024, the reasons for a proposed application were set out in detail XXX. He directed the Tribunal to the response from the GMC, dated 4 October 2024, in which he submitted the GMC dealt with timetabling issues and not the substantive issues raised. Mr Forde submitted that it had been hoped that the GMC would adopt a neutral stance or possibly support the application as the GMC lawyer, in an email dated 23 February 2023, suggested that consideration should be given to an application for voluntary erasure.

41. XXX

42. Mr Forde submitted that XXX. He referred in particular to issues around implied consent, in respect of which he would need *'a fair amount of fine detail about Dr Chatterjee's normal practice'.* Furthermore, there were contradictions in the chaperone's statement. In respect of the conviction, which he agreed was made out, there was a need to look at the surrounding circumstances.

43. XXX

Submissions on behalf of the GMC

44. Ms Bucklow reminded the Tribunal of the background to the case. She submitted that the GMC oppose the application to adjourn the current hearing. She confirmed that the GMC was applying to proceed in Dr Chatterjee's absence.

45. Ms Bucklow submitted that XXX. She submitted that if the Tribunal, XXX, then procedural fairness, giving prime importance to the fairness to Dr Chatterjee but also giving appropriate weight to fairness to the GMC and the wider public interest, requires that the application to postpone is refused. XXX.

46. Ms Bucklow argued that the intended outcome of the current applications is to indefinitely delay, or entirely prevent, proper ventilation and determination of the allegations against Dr Chatterjee at a MPT Hearing. She submitted that the history of defence applications, particularly their nature and timing, provide important context to the current application to postpone these proceedings, and any further application for voluntary erasure.

47. XXX

48. XXX

49. Ms Bucklow argued that the defence submission that the September 2023 Tribunal refused their application to adjourn on irrational grounds, by erroneously relying upon the case of *Adeogba v GMC* [2016] EWCA Civ 162, was incorrect. Whilst Mr Forde submitted that such an issue is one which should properly dealt with by way of Judicial Review, it did not form part of the defence's Pre-Action protocol letter in November 2023 for a Judicial Review that was not pursued. She stated that the guidance set out in Adeogba is entirely relevant for the consideration of whether to grant an adjournment, and the assessment of fairness in this case. Ms Bucklow submitted that the defence application to adjourn in this case is predicated on the basis that XXX. The question of fairness must take account of that potential outcome.

50. Ms Bucklow submitted that it is in in the interests of Dr Chatterjee for the longstanding GMC proceedings to be brought to a conclusion, XXX

51. Ms Bucklow submitted that Dr Chatterjee has legal representation and has had significant input and legal advice from those representing him over a number of years. This hearing was adjourned to accommodate his choice of experienced Kings Counsel. XXX

52. Ms Bucklow asked the Tribunal to consider all the evidence before it and how this could be tested in the absence of Dr Chatterjee. She submitted that this was possible with a low risk of reaching an improper conclusion. The evidence before the Tribunal includes a

certificate of conviction, an MG5 summary and police statements. A certificate of conviction is conclusive evidence of the offence, and the GMC need not re-prove the underlying events pertaining to the 2017 convictions.

53. Ms Bucklow submitted in respect of the allegations of an inappropriate vaginal examination that was not consented to, not clinically indicated and was sexually motivated, a Rule 7 response has been provided on Dr Chatterjee's behalf without instruction but testing evidence. Dr Chatterjee has also provided a prepared statement in which he accepts conducting a rectal examination of the patient, and that any contact with the vagina was accidental. She submitted that, XXX, the defence have been able to obtain further detail from Dr Chatterjee that is not included in the medical records or his prepared statement, as to what the examination of Patient A involved – *"lubrication, a gloved hand and a speculum rather than a proctoscope"*. Ms Bucklow submitted that the issues in dispute are relatively narrow, namely did any examination or touching of the vagina take place and was it accidental. The Tribunal are assisted in this by the evidence of witnesses Patient A and the chaperone and of an expert [Dr F], together with Dr Chatterjee's written response.

54. Ms Bucklow submitted that, when considering the wider public interest, this lies in the proper ventilation and determination of allegations of this nature at a hearing. She submitted that the procedural history of this case is lengthy and demonstrates that a further adjournment would serve no real purpose, XXX.

55. XXX

56. Ms Bucklow submitted that the Tribunal should consider the overarching objective, and that public confidence in the profession and the maintenance of proper professional standards will be significantly undermined if the determination of the serious allegations against Dr Chatterjee is delayed further. Particularly, in circumstances where the adjournment sought is indefinite, and the intention of the defence is to never have the matters determined by an MPT hearing.

57. Ms Bucklow further submitted that should the application for an adjournment be refused it would still be open to Dr Chatterjee to attend.

Advice from the Legally Qualified Chair

58. Under Rule 29(2) of the General Medical Council (Fitness to Practise) Rules 2004 as amended, where a hearing of which notice has been served on the practitioner in accordance with those rules has commenced, (as it now has in this case) the Tribunal considering the

matter may at any stage in their proceedings, whether of their own motion or on the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit.

59. The case involves allegations that Dr Chatterjee's fitness to practise is impaired by reason of his misconduct and criminal convictions. The Tribunal will now be considering an application made on behalf of Dr Chatterjee to adjourn the hearing XXX. The discretion of the Tribunal to grant or refuse the adjournment must be exercised judicially with fairness at its heart. Applying the principles set out in the criminal case of *CPS v Picton* [2006] the Tribunal must examine carefully the circumstances leading to the application. In that case it was said that "*it is not possible or desirable to identify hard and fast rules as to when adjournments should or should not be granted. The guiding principle must be that Justices should fully examine the circumstances leading to applications for delay, the reasons for those applications and the consequences both to the prosecution and the defence. Ultimately they must decide what is fair in the light of all those circumstances*".

60. Matters to be taken into consideration include: the reason why the application is being made and why it is being made at this stage: fairness to all parties concerned in the case, including fairness to the registrant; fairness to the GMC and fairness to any witnesses; the likely length of such an adjournment; the risk of the Tribunal reaching a wrong conclusion on the merits of the case in the absence of the doctor; the effect of delay on the memory of witnesses; the seriousness of the potential outcome of the hearing in that the doctor is at risk of being struck off the register; the general public interest, and the interests of complainants and witnesses, that the hearing should take place within a reasonable time of the events to which it relates.

61. XXX

62. XXX

63. Linked to the adjournment application is an application by the GMC for the case to proceed in Dr Chatterjee's absence. Rule 31 provides that where the practitioner is neither present nor represented at a hearing, the Committee or Tribunal may nevertheless proceed to consider and determine the allegation if they are satisfied that all reasonable steps have been made to serve the practitioner with notice of the hearing in accordance with the Rules. Rule 15 sets out the provisions relating to service. Service is not in dispute.

64. The discretion to proceed in the practitioner's absence must be exercised by the Tribunal with the utmost care and caution. It should have regard to the principles set out in *R v Jones, Hayward and Purvis*.

65. The Tribunal should therefore take into account the risk of reaching the wrong conclusion as a result of not being able to hear from Dr Chatterjee himself, the reasons for Dr Chatterjee's absence, whether Dr Chatterjee had himself sought an adjournment – in this case he has - whether an adjournment would resolve matters and within what period of time, the public interest in the proper regulation of the profession and the protection of the public, and the need in all cases for hearings to take place within a reasonable period of time.

66. The decisions in *GMC v Adeogba* [2016] and *GMC v Visivardis* [2016] emphasised the difference between criminal and regulatory proceedings. Sir Brian Leveson warned that it is important that the analogy between criminal prosecution and regulatory proceedings is not taken too far as steps can be taken to enforce the attendance of a defendant in criminal proceedings but no such option is open to the regulator against a registrant. Furthermore it would run entirely counter to the protection, promotion and maintenance of the health and safety of the public if a registrant could effectively frustrate the process and challenge a refusal to adjourn when that registrant had deliberately failed to engage in the process. In this case the Tribunal will need to decide the extent to which XXX may be the cause of his non-attendance as opposed to a deliberate refusal to attend.

67. The fair, economical, expeditious and efficient disposal of allegations made against medical practitioners is of very real importance. In addition, a further important distinction between criminal and regulatory proceedings is the clear professional obligation on registrants to engage with their regulators in relation to the investigation and the resolution of allegations made against them.

68. These are all matters which the Tribunal will need to carefully balance in reaching a fair decision.

The Tribunal's Determination

Application for Adjournment

69. Throughout its deliberations, the Tribunal was mindful of its responsibility to uphold the overarching objective as set out in the Medical Act 1983 (as amended). That objective is as follows:

a To protect, promote and maintain the health, safety and wellbeing of the public;

b To maintain public confidence in the profession; and

c To promote and maintain proper professional standards and conduct for members of the profession.

70. The Tribunal had regard to Rule 29(2) of the Rules:

> *'Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit.'*

71. Whilst taking account of the extensive history of adjournment and postponement applications in this case, the Tribunal considered the position as it is now.

72. XXX

73. XXX

74. XXX

75. XXX

76. XXX

77. The Tribunal carefully considered the public interest. It concluded that members of the public would be very concerned to discover that a doctor, previously convicted of a sexual assault and placed on the sex offenders register, had avoided proceedings based on new allegations of sexually motivated misconduct and a conviction for four offences of failing to comply with the requirements of his sex offender's registration. That offence had been serious enough for a suspended sentence of imprisonment to be imposed.

78. XXX

79. XXX

80. XXX

81. XXX

82. The Tribunal was of the view that, on balance, the evidence provided did not justify an adjournment. Furthermore, there was evidence that this would be contrary to Dr Chatterjee's best interests. XXX.

83. The Tribunal therefore determined to refuse the application to adjourn the hearing.

Application to proceed in absence

84. In making its determination the Tribunal noted that the decision as to whether or not the hearing should proceed in Dr Chatterjee's absence was a matter for its discretion and that such discretion was to be exercised with the utmost care and caution.

85. The Tribunal had regard to the legal authority of *R v Hayward, Jones & Purvis* [2001] QB 862 CA, which states that a defendant has a right to be present at a trial and a right to be legally represented but that those rights can be waived where a defendant voluntarily absents themselves from a trial.

86. The Tribunal considered the nature of circumstances of Dr Chatterjee's absence. XXX

87. XXX

88. XXX

89. XXX

90. XXX

91. The Tribunal determined from the volume of applications made over the past two years that Dr Chatterjee has been able to instruct his legal team appropriately. The Tribunal bore in mind that Dr Chatterjee had been legally represented throughout proceedings and noted that, on 29 May 2024, Dr Chatterjee had asked for a further postponement to allow him representation by his chosen counsel.

92. Furthermore, Dr Chatterjee signed a Voluntary Erasure application form as recently as 14 October 2024. In so doing, he confirmed as follows:

> *"I have read the guidance on what issues may render me liable to be referred to the General Medical Council for investigation or consideration of my fitness to practise. The information I have provided in my application is correct and true.*
> *I understand that if I have made a false declaration or given false information in my application, or to support it, the GMC may refuse to allow my name to be voluntarily erased from the Medical Register."*

93. XXX

94. XXX

95. Having decided not to adjourn the proceedings, the Tribunal went on to consider whether it would be appropriate to proceed with the hearing in Dr Chatterjee's absence pursuant to Rule 31. The Tribunal was conscious that the discretion to proceed in the absence of a doctor should be exercised with the utmost care and caution, balancing the interests of the doctor with the wider public interest. Furthermore, it must be satisfied that all reasonable efforts have been made to serve the practitioner with notice of the hearing.

96. In its deliberations, the Tribunal had regard to the cases of *R v Jones, Adeogba v GMC,* and *GMC v Hayat*. The Tribunal was aware that it has a discretion to proceed with the case in the doctor's absence, though this discretion is to be exercised with caution with the overall fairness of the proceedings in mind. The Tribunal had regard to all the circumstances including the following:

- The nature and circumstances of the doctor's behaviour in absenting himself, in particular, whether the behaviour was voluntary and therefore waived the right to be present;
- Whether an adjournment would resolve the matter;
- The likely length of any such adjournment;
- Whether the doctor, although absent, wished to be represented or whether he had waived his right to be represented;
- The extent of any disadvantage to the doctor in not being able to present his account of events;
- The risk of the Tribunal coming to an unfair conclusion in the doctor's absence;
- The public interest that a hearing should take place within a reasonable time.

97. The Tribunal considered each of these factors in turn.

Nature and circumstances of doctor's behaviour in absenting himself

98. XXX

Whether an adjournment would resolve the matter

99. Whilst the Tribunal is empathetic with Dr Chatterjee XXX, it noted that the doctor does have the benefit of legal representation. XXX. There had been an extensive history of adjournment and delays in this matter XXX.

The likely length of any such adjournment

100. In the circumstances outlined above, the Tribunal had no evidence to enable it to evaluate how long any adjournment, if granted, might last. In the circumstances, any adjournment would be for an uncertain period of time particularly given the past history of delays in this process. XXX.

Whether the doctor, although absent, wished to be represented or whether he had waived his right to be represented

101. This is not engaged as Dr Chatterjee is legally represented.

The extent of any disadvantage to the doctor in not being able to present his account of events

102. This is also not engaged as Dr Chatterjee is legally represented

The risk of the Tribunal coming to an unfair conclusion in the doctor's absence

103. This is a professional and experienced Tribunal, and it would therefore be acutely aware of the effect of the doctor's absence and would be bound to test and challenge any evidence where appropriate. Furthermore, Dr Chatterjee has had the benefits of being legally represented, and is still legally represented, therefore he would not be deprived of the ability to put forward a defence.

104. The Tribunal has accordingly found that there is no impediment to Dr Chatterjee providing instructions to his legal representatives or giving evidence himself, should he so

choose. It also took the view that it is for Dr Chatterjee's representatives to put forward his case and call any witnesses that it believes may support his case.

The public interest that a hearing should take place within a reasonable time

105. The Tribunal reminded itself of the statutory overarching objective and the public interest. The Tribunal took into account that the public interest included ensuring that a hearing should take place within a reasonable time of the events to which it relates and the fair, economic, expeditious and efficient disposal of the hearing, and this weighed against any prejudice to Dr Chatterjee. There have already been considerable delays and adjournments in this case.

Conclusion

106. In the light of its analysis set out above and balancing fairness to Dr Chatterjee with fairness to the GMC and the public interest, the Tribunal determined that it would be appropriate to proceed in Dr Chatterjee's absence. It noted that he has been legally represented throughout the proceedings, is currently represented, and it is a matter entirely for him and his legal representatives whether that representation will continue.

107. It is open to Dr Chatterjee whether or not to attend. Either way, the Tribunal will take all steps available to ensure that the hearing is fair and that his interests are protected. His absence would not in itself be held against him. The Tribunal is satisfied it could deal with the case fairly.

108. The Tribunal has considered the overarching objective taking into account the seriousness of the Allegation and the wider public interest in an expeditious and comprehensive resolution of this case. The Tribunal also took into account the need to maintain public confidence in the regulatory system.

109. Therefore, in accordance with Rule 31, and taking into account the reasons outlined above for refusing an adjournment, the Tribunal determined that the case should proceed in Dr Chatterjee's absence.

ANNEX B – 01/11/2024

Application for Voluntary Erasure

1. This determination will be handed down in private under the provisions of Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). However, as this case concerns Dr Chatterjee's alleged misconduct and conviction a redacted version will be published at the close of the hearing.

2. The GMC Voluntary Erasure/Relinquish Licence (VERL) Team Assistant Registrar referred the Voluntary Erasure (VE) application, made on behalf of Dr Chatterjee, to this Tribunal for it to decide whether to allow Dr Chatterjee to be voluntarily erased.

Evidence

3. The Tribunal considered written evidence and skeleton arguments from the GMC as well as Dr Chatterjee's representatives. The relevant documentary material included, but was not limited to, the following:

- Dr Chatterjee's VE Application, dated 21 October 2024;
- *GMC Support Vulnerable Doctors Programme* (December 2020);
- Email correspondence between Dr D and Dr Chatterjee's representatives and reference; 21 June 2021;
- Dr D's clinical notes in respect of Patient A, May 2021;
- *XXX*; and
- GMC guidance '*Guidance on making decisions on voluntary erasure applications and advising on administrative erasure'* (March 2021) ('the Guidance').

Submissions

Submissions on behalf of Dr Chatterjee

4. XXX

5. XXX

6. XXX

7. XXX

8. XXX

9. XXX

10. XXX

11. Mr Forde stated that Dr Chatterjee's VE application was a serious career-ending matter and that was precisely the penalty that the GMC was seeking, albeit against the background of factual findings. He stated that the *'stark factual reality of this'* was that Dr Chatterjee would have to reveal his regulatory history should he apply for restoration, and his fitness to practise matters would be placed before a panel and a hearing would have to be held before any restoration.

12. Mr Forde submitted that it was extremely unlikely Dr Chatterjee would ever apply for restoration and, if he did, that he would ever be restored without the current matters being determined. Therefore, in effect, there was an absolute bar to the doctor ever being restored to the register, which should allay any public fears.

13. Mr Forde referred to the Guidance and argued that VE would uphold the overarching objective. He stated that XXX. There was a complete ability for the GMC to revive the allegations, should the doctor ever apply for restoration.

14. Mr Forde argued that the public interest aspect should be balanced against Dr Chatterjee having an Article 6 compliant hearing.

15. Mr Forde also stated that Dr Chatterjee was not at an early or mid-career point and the prospect of the doctor returning to practise was *'vanishingly low'*. If he were to apply for restoration he would have to reveal his fitness to practise history.

16. Mr Forde reminded the Tribunal that, although the GMC argue it is in the public interest for this case to continue in the doctor's absence, XXX, it would be appropriate and would satisfy the public interest to grant VE. He submitted that, as far as exceptional circumstances were concerned, the Tribunal's discretion should be exercised by balancing all the relevant factors.

Submissions on behalf of the GMC

17. Ms Bucklow submitted that, such was the nature of the allegations in this case, that the public interest lies in having them ventilated at a hearing proper. She argued that public confidence would be significantly undermined if Dr Chatterjee were able to avoid the determination of these *'particularly serious'* allegations by voluntarily removing himself from

the register. Paragraphs 9-22 of the VE Guidance are essentially a summary of the overriding objective.

18. XXX

19. Ms Bucklow referred to the Guidance and said that there were categories of cases where VE should not be granted unless there are exceptional circumstances. She stated that the Guidance provides examples of cases where it would not be in the public interest to proceed with VE, except in exceptional circumstances. One such category of case is where there are convictions for serious offences. A further category of case is where there are allegations of sexual assault or indecency. She stated that all the allegations against Dr Chatterjee fell within these categories and therefore the Tribunal should consider whether there are exceptional circumstances which allow them to grant the doctor VE.

20. In her written submissions Ms Bucklow stated that two preliminary observations arise in respect of the application for VE, namely, that the application for VE was supported by a document headed 'Supplementary Information' in which there were a number of statements which, she asserted, downplayed the seriousness of Patient A's allegations and that the VE application makes references to the presence of a chaperone which she argued also downplayed seriousness.

21. Ms Bucklow argued that the application also failed to acknowledge the Tribunal's determination when refusing to adjourn these proceedings, XXX.

22. XXX

23. XXX

24. XXX

25. With regard to Dr Chatterjee's possible future intentions, Ms Bucklow submitted that the suggestion that Dr Chatterjee will give additional undertakings that he has no intention to seek restoration to the register at a future date was inappropriate. She argued that a doctor can apply for restoration to the register at any time regardless of any statements they make about their career intentions when applying for VE. She stated that Dr Chatterjee cannot be bound by any undertaking not to seek restoration at a future date, XXX.

26. Ms Bucklow submitted that at the time of making an application for VE, it is expected that the motivation of the doctor to cease practise is genuine, and is not made to avoid sanction or otherwise circumvent the fitness to practise process. She stated that, when considering Dr Chatterjee's motivation for applying for VE, the Tribunal might wish to consider the history of applications in this case, the type of application and their timings, and argued that the defence had made every application available to them which would either delay these proceedings or prevent them going ahead altogether.

27. Ms Bucklow argued that this case clearly fell within the category of cases where there was a presumption of impairment, and it was a category where it will not be in the public interest to grant VE save in exceptional circumstances.

28. Ms Bucklow concluded by emphasising that there were no exceptional circumstances and that it would not be in the public interest to grant Dr Chatterjee VE.

29. Mr Forde responded by stating that the Tribunal's previous findings were in respect of the pre-opening application, that the situation was now different and that the Tribunal was not "*functus*".

Advice from the Legally Qualified Chair

30. The Legally Qualified Chair reminded the Tribunal that, when deciding whether or not to grant the application for VE, it should as stated by the Guidance take into account the GMC's overarching objective. It also needed to balance carefully the relevant factors to decide whether or not VE was in the public interest, balancing the seriousness of the concerns against information such as:

- XXX
- the ability to revive the matter should the doctor apply for restoration.

31. The decision as to whether or not to grant the application for VE is a matter for this Tribunal alone to determine, exercising its own judgment. In reaching a decision on this matter, the Tribunal should take the Guidance fully into account and adopt a balanced approach. It should have regard to all the documentary evidence provided to it by the GMC, the completed application form for VE which includes a large amount of supplementary information and all the email correspondence and notes provided on behalf of Dr Chatterjee.

32. The Tribunal should consider carefully whether in this case, where there is an allegation that misconduct by the doctor was sexually motivated and there is a proven conviction in respect of four offences resulting in a suspended prison sentence, there are exceptional circumstances to justify allowing voluntary erasure before the conclusion of the fitness to practise proceedings which have been opened.

33. XXX

The Tribunal's Approach

34. Dr Chatterjee's representatives have made an application for Voluntary Erasure under the VE Regulations which provide that:

"Where, on the date the Registrar receives an erasure application, an allegation against the practitioner has been referred to a FTP Panel under the Fitness to Practise Rules and the hearing before the FTP Panel has commenced, the Registrar shall refer the application for determination by the FTP Panel, and the application shall be determined by the FTP Panel accordingly."

35. The Fitness to Practise Rules 2004 do not provide any specific procedure for the determination of a VE application. However, the Tribunal took account of all relevant provisions in the VE Guidance.

36. The Tribunal took account of paragraph 11 of the VE Guidance which says:

'Case examiners should be satisfied that it is right in all the circumstances to grant VE [...].

37. The Tribunal was satisfied that the relevant application for VE had been properly referred to the Tribunal in accordance with the Regulations and that it was appropriate for it to determine whether or not it should be granted.

38. The Tribunal took into account its findings in respect of the applications for an adjournment and proceeding in absence. Whilst not determinative in respect of the current application they were highly relevant and the Tribunal was aware of the need for consistency in its decision making.

39. XXX

The Tribunal's Decision

40. The Tribunal considered the seriousness of the Allegation, the lapse of time since the events in question, and the likelihood of any future application for restoration if Dr Chatterjee's registration is erased.

41. The Tribunal noted the serious and multi-factorial nature of the Allegation and took account of the following paragraphs of the Guidance which indicate circumstances in which it may or may not be appropriate to grant voluntary erasure:

'9 Case examiners should consider the following key principles when making VE decisions …….

[…]

b Case examiners must have enough information to assess whether it is in the public interest to erase the doctor. Although a doctor can apply for VE ……at any point in an investigation, case examiners should be very cautious about allowing erasure in the following circumstances.

[…]

iii VE and AE are not necessarily permanent and a doctor can apply for restoration at any time. As part of their overall assessment of the public interest, case examiners must assess the risk posed by a future restoration application. This can be done by considering the likelihood of the doctor seeking restoration and whether we will be able to revive the unresolved allegation(s) should they do so.'

'11 Case examiners should be satisfied that it is right in all the circumstances to grant VE or advise that AE can proceed. This will involve a careful balancing of the relevant factors to decide whether or not erasure is in the public interest. Case examiners will need to weigh the seriousness of the concerns against any additional information that is available regarding:

- *XXX*
- *our ability to revive the allegations should the doctor apply for restoration.'*

'12 Case examiners should assess the three different aspects of the public interest which reflect the overarching objective.'

'21 Where it is alleged that a doctor has significantly and/or persistently breached the professional standards we set for doctors, this gives rise to a public interest in the alleged breaches being properly investigated (with a public hearing held in some cases) and not evaded.'

'22 As above, however, case examiners should carefully weigh the extent to which this element of the public interest is relevant as this will vary depending on the particular circumstances of each case.'

'23 The following are examples of cases where (except in exceptional circumstances) it will not be in the public interest to allow voluntary erasure or proceed with administrative erasure before the conclusion of fitness to practise proceedings, including a MPT hearing in some cases. This is because they involve a conviction for a serious criminal offence or the allegation carries a presumption of impaired fitness to practise.

a Ongoing police investigations or convictions for serious offences. Although it is not possible to provide an exhaustive list, the key issue is whether public confidence would be undermined if the GMC did not fully investigate the matter.

b Allegations of sexual assault or indecency

This encompasses a wide range of behaviour including allegations of sexual assault and abuse […]. *This category also includes misconduct within a clinical setting where there is an allegation the doctor's behaviour was sexually motivated. For example, performing an intimate examination with no clinical justification* […].

'47 VE or AE should usually be refused in cases of a serious nature involving allegations of misconduct, ongoing police investigations or convictions and determinations by other regulatory bodies. By cases of a serious nature, we mean that public confidence in doctors would be undermined if a full investigation did not take place. Examples of cases where it will not be in the public interest to prematurely end the fitness to practise process are at paragraph 23 above'.

'53 This will usually only be relevant in cases where it would not otherwise be in the public interest to allow erasure due to the serious nature of the outstanding concerns.'

Overarching principle

VE or AE should usually be refused or advised against if the allegations against the doctor carry a presumption of impairment and the presumption is not rebutted because the allegations are too serious and/or no exceptional circumstances apply. In these cases, the fitness to practise process should be allowed to proceed in the normal way.

42. The Tribunal noted that the multifactorial Allegation relating to Dr Chatterjee's fitness to practise was serious.

43. The Tribunal reminded itself that it was alleged that Dr Chatterjee undertook a rectal examination having failed to obtain informed consent; undertook an inappropriate vaginal examination without consent when it was not clinically indicated and without explanation, and without giving the patient the opportunity to ask questions and that his actions were sexually motivated.

44. The Tribunal also reminded itself that it was alleged that Dr Chatterjee had been convicted of four offences of failing to comply with his notification requirements as a sex offender and that he was sentenced to 84 days imprisonment, suspended for 12 months with an unpaid work requirement of 200 hours and ordered to pay £200 in costs. The unpaid work requirement was an element of punishment.

45. The Tribunal was aware that the list of factors indicating a presumption of impairment is not exhaustive. It assessed the multi-factorial Allegation as a whole to be serious, because,

if proved, there is a realistic prospect of a reasonable Tribunal, properly directed as to the law, finding current fitness to practise to be impaired by reason of misconduct and conviction.

46. The Tribunal considered that, given the seriousness of the Allegation, and the presumption of impairment, the public interest was a very important factor. It found that public confidence in the medical profession would be undermined if the fitness to practise process did not proceed.

47. The Tribunal went on to consider whether there were any exceptional circumstances in this case, taking account the Guidance, in particular the following:

> *'Exceptional circumstances*
>
> *24 There may sometimes be exceptional circumstances when it is appropriate to allow voluntary or administrative erasure prior to the conclusion of the fitness to practise process, even if a case falls into one of the categories above. These may include cases:*
>
> *XXX'*

48. The Tribunal considered that it had not received sufficient evidence to establish that there was no prospect of Dr Chatterjee ever practising medicine again.

49. XXX

50. XXX

51. The Tribunal considered there were no exceptional circumstances to justify allowing VE.

52. The Tribunal went on to consider the likelihood of Dr Chatterjee returning to practice, and noted the Guidance, in particular the following:

> *'The doctor's future intentions*
>
> *29 A doctor can apply for restoration at any time regardless of any statements they made about their career intentions when applying for VE. Restoration is not automatic and any application where fitness to practise issues arise (either because of the investigation underway when erasure was granted or new concerns) would be considered by two case examiners in accordance with the relevant regulations.*

Doctors cannot be restored with conditions or undertakings and will (if agreed by two case examiners or a MPT) return to the register with unrestricted registration. Any outstanding concerns about their fitness to practise must therefore be addressed prior to the point of restoration.'

'33 Where a doctor applies for VE during the later stages of their career and has retired or can provide evidence to support their intention to retire, this is generally a strong indicator that they are unlikely to seek restoration in the future. However, caution should be applied where the doctor is at an early or mid-career point, where the prospect of a return to work is significantly higher.'

'39 It is important that case examiners assess how feasible it would be to revive the allegations against the doctor should they apply for restoration by considering the following.

a Whether there is a criminal conviction or a determination by another medical or professional regulatory body.

This will mean that the matter can easily be revived in the event of a restoration application. However, as most potential erasures involving serious criminal convictions or determinations will be refused on public interest grounds, this will likely only be relevant if the offence or regulatory matter is at the lower end of the scale in terms of seriousness.'

53. The Tribunal noted that it XXX. It considered that, although Dr Chatterjee currently states that he does not want to return to practice, this may change if the current fitness to practise proceedings were brought to an end XXX.

54. The Tribunal also noted that Dr Chatterjee is currently 60 years old and it was entirely possible that he could seek to return to work in the future.

55. In the circumstances, the Tribunal could not be satisfied that Dr Chatterjee would not wish to be restored to the register at a future date were it to grant his VE application.

56. The Tribunal went on to consider the GMC's ability to revive the matter should the doctor apply for restoration.

57. The Tribunal concluded that, as the GMC's case in respect of the sexually motivated misconduct relied heavily upon witness evidence, in particular Patient A and the chaperone, there was no guarantee that its witnesses would be available to give evidence or wish to take part in a hearing process at a possible date sometime in the future, if Dr Chatterjee were to

apply for restoration. The Tribunal was also mindful of the impact of the passage of time on the memories of witnesses.

58. In the circumstances, the Tribunal considered that it might be difficult for the GMC to effectively revive the Allegation, in relation to Patient A, should the doctor apply for restoration.

Tribunal Decision

59. The Tribunal concluded that, given the seriousness of the Allegation, the lack of exceptional circumstances, and doubts around the ability of the GMC to revive the Allegation effectively in the future, it was in the public interest to continue with the hearing in order to uphold the overarching objective and determined to refuse Dr Chatterjee's application for voluntary erasure.