PUBLIC RECORD

Dates: 11/09/2023 – 23/11/2023; 19/02/2024 – 01/03/2024; 19/06/2024; 01/07/2024 – 02/07/2024; 15/07/2024 – 18/07/2024

Medical Practitioner's name:	Mr Anthony DIXON
GMC reference number:	2805726
Primary medical qualification:	MB BS 1983 University of London

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

Summary of outcome

Suspension, 6 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Emma Boothroyd
Lay Tribunal Member:	Mr Geoff Brighton
Medical Tribunal Member:	Dr Tim Oakley

Tribunal Clerk:	Mr Matt O'Reilly Mr Rowan Barrett (19/07/2024 only)

Attendance and Representation:

Medical Practitioner:	Present and represented

Medical Practitioner's Representative:	Mr Dijen Basu, KC, and Ms Carin Hunt, Counsel, instructed by Clyde and Co Solicitors
GMC Representative:	Ms Chloe Fairley, Counsel, and Ms Jemima Stephenson, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 02/07/2024

Background

1. Mr Dixon's most recent appointment was as a Consultant Colorectal Surgeon at Southmead Hospital, appointed in May 1996. He has also held previous roles as a laparoscopic fellow at the Royal Brisbane Hospital from 1994, and as a breast research fellow, City Hospital Nottingham 1988-1990.

2. Mr Dixon obtained his MBBS in1983, and he became a fellow of the Royal College of Surgeons (FRCS) in 1987. He was appointed as a Consultant Surgeon at Frenchay Hospital in May 1996. He was awarded FRCS Eng ad eundem in 2012. Mr Dixon is an Honorary Reader in Colorectal and Pelvic Floor Surgery at the University of Bristol. He was a member of council for his subspecialty professional association (ACPGBI) 2008-16 and was elected inaugural Chairman of the Pelvic Floor Society from 2013 to 2016, and was a founder of the Society.

3. The matters which have led to the Allegation can be summarised as concerns or failures in respect of Mr Dixon's care, treatment and diagnosis in respect of six patients

(Patients A, B, D, F, G, J), between 16 December 2010 and 23 July 2016. The concerns include alleged undertaking of examinations in the absence of a chaperone, failures to obtain informed consent, performing procedures either not consented for or not clinically indicated; and failures to provide adequate post-operative care.

Performance Assessment

4. It is further alleged that following a Performance Assessment, which was conducted on 5 to 7 November 2018 and then 12 November 2018 and 11 December 2018, Mr Dixon's professional performance was unacceptable in the areas of assessment of pelvic floor patients, clinical management of pelvic floor patients and working with colleagues and a cause for concern in the areas of maintaining professional performance, clinical management of emergencies, and relationships with patients.

The Outcome of Applications Made during the Facts Stage

5. At the outset of the hearing Ms Chloe Fairley, Counsel, on behalf of the GMC, made an application pursuant to Rule 34 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to admit hearsay evidence from Patient G. Mr Dijen Basu KC, on behalf of Mr Dixon, objected to the application. The Tribunal determined that Patient G's evidence in relation to paragraphs 20a-c, 21a-c, 23 and 24a of the Allegation should remain as it was not the sole and decisive evidence for those allegations. It determined however that it would be unfair to Mr Dixon if the hearsay evidence remained in respect of paragraphs 23a-c and 24b of the Allegation, subject to Patient G attending to give oral evidence. The Tribunal's full written decision can be found at Annex A.

6. On day 2 of the hearing, Ms Fairley made an application pursuant to Rule 17(6) of the Rules to withdraw paragraphs 8b(i) &(ii) of the Allegation as they were an error. Mr Basu made no objection to the application. The Tribunal determined to grant the application.

7. Mr Basu made an application for Patient A and Patient B not to be anonymised during these proceedings as one had spoken to a newspaper and one on television about these matters and were not anonymised. Ms Fairley confirmed that neither patient had any concerns about their names being used or wanted to be anonymised. The Tribunal considered that in the interests of open justice individuals should not be anonymised unnecessarily. In these circumstances neither patient had any concerns, and the parties were in agreement that they could be referred to by name. The Tribunal granted the application.

8. On day 15, Friday 28 September 2023, Ms Fairley made an application for Dr K, Performance Assessor, not to give evidence, as scheduled on that day. In summary, she submitted that given the volume of documents provided on behalf of Mr Dixon at such a late stage prior to his evidence, that he had not had sufficient time to read and consider those documents. Mr Basu objected to the application, submitting that Dr K only needed to give evidence on the Performance Assessment Report which he wrote and will have had time to read prior to giving his evidence. The Tribunal determined to grant the application to allow Mr K further time to consider all the recently disclosed documents placed before him and not give evidence on Day 15. It determined that it would be fair to allow Mr K this time to review the documents and for his evidence to be heard at a later date, provisionally proposed to be 12 November 2023.

9. On day 23, Ms Fairley made an application to amend paragraphs 4a, 5, 6, 8, 22 and 24 of the Allegation, and withdraw paragraphs 12, 13, 14, 15 and 23 of the Allegation. Mr Basu made no objections to the application. The Tribunal granted the application, its full written decision can be found at Annex C.

10. On day 40, Ms Fairley made an application to withdraw paragraphs 4a and 4b(i)1 of the Allegation in respect of Patient A, and paragraphs 20a, b and c in respect of Patient G. She submitted that this application was following consideration of the expert evidence. Mr Basu made no objection. The Tribunal determined that there would be no injustice caused by the withdrawal of these allegations and that it was fair to parties. It determined to grant the application.

The Allegation and the Doctor's Response

11. The Allegation made against Mr Dixon (as amended) is as follows:

Clinical Misconduct

Patient A

1. On 16 December 2010 you performed a rectal examination on Patient A:
    a. in the absence of a chaperone; To be determined
    b. and you failed to:
        i. ask Patient A if she would like a chaperone to be present; To be determined

ii. (in the alternative to allegation 1a and 1bi) record that:

1. you had asked Patient A if she would like a chaperone to be present; To be determined

2. Patient A had declined a chaperone. To be determined

2. On 12 February 2011 you performed a laparoscopic ventral mesh rectopexy ('LVMR') on Patient A ('Patient A's First Procedure') and you failed to:

a. arrange for Patient A to undergo a proctogram in advance of Patient A's First Procedure; To be determined

b. obtain informed consent from Patient A in that you did not advise Patient A of:

i. non-surgical treatment options; To be determined

ii. the risks associated with Patient A's First Procedure; To be determined

c. (in the alternative to paragraph 2b) record taking the steps described at paragraph 2b. To be determined

3. On 25 October 2011 you performed a rectal examination on Patient A:

a. in the absence of a chaperone; To be determined

b. and you failed to:

i. ask Patient A if she would like a chaperone to be present; To be determined

ii. (in the alternative to paragraph 3a and 3bi) record that:

1. you had asked Patient A if she would like a chaperone to be present; To be determined

2. Patient A had declined a chaperone. To be determined

4. On 18 November 2011 you performed a laparoscopic sub-total colectomy on Patient A ('Patient A's Second Procedure') and you failed to:

~~a. ensure that a CT scan was undertaken to exclude other causes of her symptoms ensure that a transit study had been undertaken to confirm your diagnosis of slow transit constipation ensure that a CT scan~~; Withdrawn pursuant to Rule 17(6)

b. obtain informed consent in that you:

i. did not advise Patient A of:

1. ~~non-surgical treatment options;~~ Withdrawn pursuant to Rule 17(6)

2. the risks associated with Patient A's Second Procedure; To be determined

ii. obtained written consent on the day of Patient A's Second Procedure; To be determined

c. (in the alternative to paragraph 4bi) record providing the advice outlined at paragraph 4bi. To be determined

5. Before performing the ~~a revision rectopexy~~ revision surgery on Patient A in December 2013 you failed to: Amended pursuant to Rule 17(6)

a. carry out a full re-investigation; To be determined

b. discuss Patient A's case with colleagues from other disciplines. To be determined

Patient B

6. On or around 20 ~~22~~ March 2012 you performed a rectal examination on Patient B: Amended pursuant to Rule 17(6)

a. in the absence of a chaperone; To be determined

b. and you failed to:

i. ask Patient B if she would like a chaperone to be present; To be determined

ii. (in the alternative to paragraph 6a and 6bi) record that:

1. you had asked Patient B if she would like a chaperone present; To be determined

2. Patient B declined a chaperone. To be determined

7. In June 2016 you consulted with Patient B and you failed to:

a. adequately advise Patient B about her underlying:

i. diagnosis; To be determined

ii. prognosis; To be determined

b. adequately outline options for treatment, including:

i. non-operative treatments; To be determined

ii. providing no treatment at all; To be determined

c. with regards to the proposed treatment, outline the:

i. purpose; To be determined

ii. expected benefit; To be determined

iii. associated risks; To be determined

d. (in the alternative to paragraph 7a-7c) record taking the steps at paragraph 7a-7c. To be determined

8. On 15 July 2016 you performed ~~a revision~~ a hindgut resection and ~~revision of Patient B's~~ LVMR ('Patient B's Procedure') and you failed to: Amended pursuant to Rule 17(6)

a. ensure Patient B's procedure was clinically indicated in that you did not arrange all necessary tests and investigations beforehand; To be determined

b. obtain informed consent in that you:

~~i. rushed through the information contained on the consent form when discussing it with Patient B;~~
Withdrawn pursuant to Rule 17(6)

~~ii. did not allow Patient B to ask any questions;~~
Withdrawn pursuant to Rule 17(6)

~~iii. did not advise Patient B that a very poor result was possible;~~
Withdrawn pursuant to Rule 17(6)

iv. had previously only told Patient B that you would perform a surgical resection; To be determined

v. did not discuss the risks associated with Patient B's Procedure; To be determined

vi. did not make a legible copy of the consent form; To be determined

vii. obtained consent on the day of Patient B's Procedure;
To be determined

c. (in the alternative to paragraph ~~8biii and~~ 8bv), record taking the steps at paragraph ~~8biii and~~ 8bv. Amended pursuant to Rule 17(6) / To be determined

9. After Patient B's Procedure you consulted with Patient B and her husband, Mr C, and you inappropriately stated to Mr C that you could have 'got [Patient B] pregnant' on the operating table, or words to that effect. To be determined

10. On 23 July 2016 you consulted with Patient B and you:

a. dismissed Patient B's post-operative symptoms by stating:

i. it 'can't be all that bad', or words to that effect;
To be determined

ii. Patient B was being an 'drama queen', or words to that effect;
To be determined

b. inappropriately patted Patient B on her bottom when entering a lift with her after the consultation had ended. To be determined

11. You failed to provide adequate post-operative care to Patient B following Patient B's Procedure in that you:

a. inappropriately stated to Mr C that he should 'go home and fill her up' in reference to Patient B and Mr C's sex life; To be determined

b. did not adequately investigate Patient B's concerns regarding possible faecal fistula. To be determined

~~Patient D~~

~~12. On 15 May 2013 you consulted with Patient D and you communicated inappropriately with Patient D in that you:~~

~~a. continuously interrupted Patient D as he tried to answer questions;~~
Withdrawn pursuant to Rule 17(6)

~~b. asked Patient D's wife 'don't you feel like strangling [Patient D]?', or words to that effect.~~ Withdrawn pursuant to Rule 17(6)

~~13. On 6 March 2014 you performed a rectopexy procedure on Patient D ('Patient D's Procedure') and you failed to:~~

~~a. obtain informed consent in that you:~~

~~i. did not advise Patient D of:~~

~~1. other treatment options;~~
Withdrawn pursuant to Rule 17(6)

~~2. the expected benefits of Patient D's Procedure;~~
Withdrawn pursuant to Rule 17(6)

~~3. the risks associated with Patient D's Procedure;~~
Withdrawn pursuant to Rule 17(6)

~~ii. rushed through the information contained on the consent form when discussing it with Patient D;~~
Withdrawn pursuant to Rule 17(6)

~~iii. did not allow Patient D to ask any questions;~~
Withdrawn pursuant to Rule 17(6)

~~iv. obtained consent on the day of Patient D's Procedure;~~
Withdrawn pursuant to Rule 17(6)

~~b. (in the alternative to paragraph 13ai) record taking the steps at paragraph 13ai.~~ Withdrawn pursuant to Rule 17(6)

~~14. On 24 April 2014 you consulted with Patient D and you:~~

~~a. were dismissive when Patient D complained about ongoing pain, advising that 'everything had gone well', or words to that effect;~~
Withdrawn pursuant to Rule 17(6)

~~b. ignored Patient D when he advised that the physical examination you were performing on him caused him pain.~~
Withdrawn pursuant to Rule 17(6)

~~15. On 21 October 2014, you consulted with Patient D and you dismissed Patient D's complaint that he was having difficulties defecating, advising that 'you're getting better then', or words to that effect.~~
Withdrawn pursuant to Rule 17(6)

Patient F

16. On 16 December 2015 you performed a stapled haemorrhoidectomy on Patient F ('Patient F's Procedure'), which was not:

a. treatment which has been previously discussed with Patient F; To be determined

b. clinically indicated; To be determined

c. performed adequately in that you excised a full-thickness section of the wall of the rectum. To be determined

17. You failed to obtain informed consent for Patient F's Procedure in that you:

a. did not communicate to Patient F that the consent form detailed Patient F's Procedure and not the treatment options previously discussed with her; To be determined

b. did not adequately communicate the risks associated with Patient F's procedure; To be determined

c. obtained written consent from Patient F on the day of Patient F's Procedure. To be determined

18. (in the alternative to paragraph 17a-17b) you failed to record taking the steps outlined at paragraph 17a-17b. To be determined

19. Following Patient F's Procedure, you failed to:

a. arrange a biopsy of Patient F's ulcerated haemorrhoid; To be determined

b. communicate that you had made a technical error in excising a full-thickness section of the rectal wall during Patient F's Procedure:

i. to Patient F; To be determined

ii. within your department's morbidity review in accordance with your department's governance framework; To be determined

c. adequately respond to Patient F's communications regarding her post-operative concerns in that you:

i. advised Patient F she 'was lucky [you] performed [Patient F's Procedure]', or words to that effect; To be determined

ii. dismissed Patient F's pain by stating:

1. she had an 'abnormal pain response', or words to that effect; To be determined

2. the 'bowel does not feel anything', or words to that effect; To be determined

iii. dismissed Patient F's complaint regarding:

1. full-thickness bowel resection as being 'what [Patient F's Procedure] entailed', or words to that effect; To be determined

2. the removal of a 3cm wedge of her bowel as being 'just a piece of bowel', or words to that effect; To be determined

iv. advised Patient F that her abnormal post-operative MRI findings were:

1. 'completely normal', or words to that effect; To be determined

2. 'artefactual', or words to that effect; To be determined

d. acknowledge that Patient F's unremitting symptoms suggested possible post-operative complications. To be determined

Patient G

~~20. On 24 February 2015 you consulted with Patient G and you failed to:~~

~~a. take into account Patient G's family history, including her younger sister's history of pre-cancerous polyp~~;
Withdrawn pursuant to Rule 17(6)

~~b. arrange a colonoscopy~~; Withdrawn pursuant to Rule 17(6)

~~c. arrange a proctogram~~. Withdrawn pursuant to Rule 17(6)

21. On 16 December 2015 you performed a stapled trans-anal rectal resection ('Patient G's Procedure') which was not clinically indicated in that you failed to:

a. adequately investigate her presenting symptoms; To be determined

b. trial non-surgical interventions; To be determined

c. perform a less invasive procedure. To be determined

22. You failed to record obtaining Patient G's informed consent for Patient G's Procedure in that you did not record explaining:
Amended pursuant to Rule 17(6)

    a. the expected benefits of Patient G's Procedure; To be determined

    b. non-surgical treatment options; To be determined

    c. the risks associated with Patient G's Procedure. To be determined

23. (in the alternative to paragraph 22) you failed to record taking the steps outlined at paragraph 22.
To be determined (as amended in the stem of paragraph 22)

24. Your post-operative care of Patient G was inappropriate in that you:

    a. failed to adequately engage in Patient G's aftercare~~;~~.
    To be determined

    ~~b. stated that Patient G was being 'very emotional', or words to that effect, when she was re-admitted on or around 20 December 2015~~.
    Withdrawn pursuant to Rule 17(6)

Patient J

25. On 1 June 2015 you performed an LVMR on Patient J ('Patient J's Procedure') for which you failed to obtain informed consent from Patient J in that you:

    a. did not advise Patient J of:

        i. other treatment options; To be determined

        ii. the expected benefits of Patient J's Procedure;
        To be determined

        iii. the risks associated with Patient J's Procedure;
        To be determined

    b. obtain written consent on the day of Patient J's Procedure.
    To be determined

Performance assessment

26. You underwent a General Medical Council assessment of the standard of your professional performance over the following dates:

    a. 5-7 November 2018; To be determined

b. 12 November 2018; To be determined

c. 11 December 2018. To be determined

27. Your professional performance was unacceptable in the following areas:

a. assessment of pelvic floor patients; To be determined

b. clinical management of pelvic floor patients; To be determined

c. working with colleagues. To be determined

28. Your professional performance was a cause for concern in the following areas:

a. maintaining professional performance; To be determined

b. clinical management of emergencies; To be determined

c. relationships with patients. 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 respect of paragraphs 1- 25; To be determined

b. deficient professional performance in respect of paragraphs 26-28. To be determined

Witness Evidence

12. The following witnesses provided oral evidence on behalf of the GMC to the Tribunal:

- Patient A, in person. Patient A also provided a witness statement, dated 4 February 2019;
- Patient B, via MS Teams. Patient B provided a witness statement, dated 2 June 2019;
- Mr C (husband of Patient B), via MS Teams. Mr C provided a witness statement, dated 30 May 2019;
- Patient F, in person. Patient F also provided a witness statement, dated 23 August 2018;
- Patient J, in person. Patient J provided a witness statement, dated 20 August 2018.
- Patient D's (not called to give oral evidence) witness statement, dated 23 December 2018, and attached exhibits;
- Patient G's witness statement (not called to give evidence), dated 30 September 2023, and attached exhibits;

Expert Evidence

13. The Tribunal received expert evidence from two experts. Colonel L, Consultant Colorectal Surgeon, on behalf of the GMC, and Professor M, Consultant Colorectal Surgeon, on behalf of Mr Dixon.

14. Colonel L provided expert reports in respect of Patients F, J, G and D dated 27 August 2018; Patients A and D dated 20 June 2019; Patient B dated 6 March 2020; Patients A, B, D and J dated 9 December 2021; and addendum reports in respect of Patient F dated 4 August 2023 and 2 November 2023.

15. Professor M provided expert reports in respect of Patient A dated 27 September 2023; Patient B dated 29 September 2023; Patient D dated 29 September 2023; Patient F dated 29 September 2023; Patient G dated 29 September 2023; and Patient J dated 29 September 2023.

16. Colonel L and Professor M also provided joint expert reports in respect of Patient F dated 26 October 2023; Patient A dated 30 October 2023; Patient B dated 30 October 2023, Patient G dated 30 October 2023 and Patient J dated 30 October 2023.

Performance Assessor

17. The Tribunal also had before it a Performance Assessment Report ('PA'). The assessment was conducted between 5 to 7 November 2018, and on 12 and 11 December 2018. The Performance Assessors also provided oral evidence to the Tribunal; Dr K, Team Leader; Dr N, Medical Assessor; and Mrs O, Lay Assessor.

Documentary Evidence

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

On behalf of the GMC

- Exhibits attached to the witness statements of Patient's A, B, F and J;
- Patient A's witness statement, dated 4 February 2019, and attached exhibits;
- Patient B's witness statement, dated 2 June 2019, and attached exhibits;
- Patient D's witness statement, dated 23 December 2018, and attached exhibits;
- Patient F's witness statement, dated 23 August 2018, and attached exhibits;

- Patient G's hearsay witness statement, dated 30 September 2023, and attached exhibits;
- Patient J's witness statement, dated 20 August 2018, and attached exhibits;
- Medical records of Patient's A, B, D, F, G and J;
- Handbook for Performance Assessors – May 2017.

On behalf of Mr Dixon

19. Mr Dixon provided oral evidence to the Tribunal, he also provided several witness statements with exhibits for: Patients A, B, F, G, H and J, undated and unsigned. Mr Dixon also provided a witness statement in respect of the PA, undated and unsigned. The Tribunal also received screenshots of Mr Dixon's website, various literature and abstracts of studies undertaken.

The Tribunal's Approach

20. In reaching its decision on facts, the Tribunal has borne in mind the statutory overarching objective:

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

The Tribunal's Analysis of the Evidence and Findings

21. 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.

Clinical Misconduct

Patient A

22. Relevant clinical history summarised from Professor M's background of Patient A's case:

23. Patient A was born in 1960 and had three children by vaginal delivery between 1982 and 1998. She is noted to have abdominal symptoms from before age 40, had undergone two

laparoscopies, and been assessed for bowel issues by colonoscopy in 2000 and again in 2007 for a family history of bowel cancer. In 2009 at Conquest Hospital, Hastings, she was noted to have a 10 year history of constipation and underwent further colonoscopy. Subsequently, she was referred to the colorectal pelvic floor team at St Thomas' Hospital and underwent transvaginal repair of rectocele with Permacol biological graft. Patient A made a steady recovery from this surgery but within 12 months she had further problems with constipation characterised by a difficult evacuation, abdominal pain and distension. In 2010, Patient A underwent assessment by anorectal physiology, endoanal ultrasound and defaecating proctography. Mr P referred Patient A to a specialist nurse for instruction in rectal irrigation and bowel management advice.

24. In December 2010, Patient A contacted Mr Dixon through his website. Mr Dixon assessed Patient A and identified high grade internal rectal prolapse ('IRP') and intussusception. Investigations from St Thomas' were reviewed and discussed with colleagues and the option of examination under anaesthetic to assess prolapse as suspected was arranged with a view to performing laparoscopic ventral mesh rectopexy (LVMR) to treat said prolapse. This was undertaken in February 2011 having secured NHS funding for this procedure in Bristol. EUA demonstrated high grade internal rectal prolapse and a standard LVMR was performed.

25. Patient A was initially reported to have a good result after LVMR, however, within a few months there was a return of abdominal bloating, pain and difficulty with evacuation. Mr Dixon advised treatment with prucalopride which promotes colonic transit. He requested Patient A's GP to arrange a transit study locally and proposed that if this confirmed slow transit, surgery in the form of colectomy and ileo-rectal anastomosis should be considered. This plan was overtaken by events and Patient A was admitted urgently to Bristol in November 2011 under Mr Dixon's care and underwent laparoscopic colectomy and ileorectal anastomosis. Patient A was slow to recover from this procedure, developed a postoperative ileus and had CT and then laparoscopy to exclude small bowel damage. The results were essentially normal, and Patient A's condition improved.

26. Patient A was well at review in February 2012, but in subsequent months she developed troublesome frequent loose stools, anal discomfort and lethargy. Around mid 2013, Patient A developed abdominal boating and pain suggestive of intermittent small bowel obstruction. She had many hospital attendances and three admissions with obstruction to Conquest Hospital. She was investigated with small bowel MRI, abdominal CT and flexible sigmoidoscopy. She was scheduled for abdominal surgery (laparotomy) to manage this, but surgery was deferred.

27. In November 2013, Patient A was admitted as an emergency to Frenchay Hospital under Mr Dixon's care, and the following day underwent laparotomy, the indication being small bowel obstruction. At operation, the cause of obstruction was identified as intussusception of small bowel immediately above the ileo-rectal anastomosis into the rectum. This is a rare occurrence and Mr Dixon had the option to resect the anastomosis and form an end ileostomy but instead choose to stabilise or fix the intussuscepting bowel by suturing a synthetic mesh across the anastomosis and attaching this to the iliac bone. This avoided formation of an ileostomy. This procedure was a "pexy" but it was not a revision rectopexy. Patient A made a slow postoperative recovery with ileus.

28. Over the next 2 years, Patient A suffered episodic abdominal pain and variable bowel habit (loose then constipated) and abdominal pain for which she was assessed and treated for functional bowel disease, with medical gastroenterology input, at Conquest Hospital. In March 2015, Patient A was admitted and underwent laparotomy the indication being small bowel obstruction which was secondary to small bowel becoming adherent and trapped in a space between the two meshes - one for rectopexy, the other for "ileo-rectopexy".

29. Patient A initially made a reasonable recovery following discharge from hospital, her bowel function and abdominal distension settled. However, symptoms returned, and she was referred to St Thomas' Hospital for assessment. Over these months she underwent incisional hernia repairs in St Thomas's Hospital and also in Conquest Hospital.

30. In 2016 she was reassessed with pelvic floor functional tests, leading to rectal irrigation and she also had further repair of recurrent incisional hernia.

31. In June 2017, Patient A was seen by Miss Q, Urogynaecologist at University College London Hospital, essentially presenting with the same symptoms of abdominal pain, erratic bowel habit and abdominal distension. In November 2017, after thorough investigation, Miss Q and Mr R, Colorectal Surgeon, UCLH performed laparotomy, proctectomy (removal of rectum, leaving the anus and some rectum in place), removal of pelvic mesh and formation of ileostomy. During follow up, Patient A reports to Mr R that the original pain had gone but she had new pain, which is different and in 2018 Miss Q records that Patient A is struggling with pain. In 2018, Patient A received more input from chronic pain service and had further repair of recurrent incisional hernia, and, in 2019, completion proctectomy through the perineum. Patient A later underwent further repair of incisional hernia and cholecystectomy in London. Her care then reverted to gastroenterology at Conquest Hospital.

Paragraph 1 of the Allegation

1. On 16 December 2010 you performed a rectal examination on Patient A:

   a. in the absence of a chaperone; **Determined and found proved**

   b. and you failed to:

      i. ask Patient A if she would like a chaperone to be present; **Determined and found not proved**

      ii. (in the alternative to allegation 1a and 1bi) record that:

         1. you had asked Patient A if she would like a chaperone to be present; **Determined and found proved**

         2. Patient A had declined a chaperone. **Determined and found proved**

32. In respect of paragraph 1a, Patient A stated in her witness statement and in oral evidence that Mr Dixon performed a rectal examination on her in the absence of a chaperone. This was unchallenged by Mr Dixon and he provided a qualified admission in so far as he accepted that the examination was in fact undertaken without a chaperone.

33. Accordingly, the Tribunal found paragraph 1a of the Allegation proved.

Paragraph 1bi of the Allegation

34. The Tribunal noted that there was no documentary evidence in Patient A's medical notes of a record having been made relating to the fact as to whether she had been offered a chaperone by Mr Dixon.

35. It was Mr Dixon's evidence that it was his usual practice to offer a chaperone when doing a rectal examination, but that if one was declined, he did not record that in the medical notes. He said that there were signs on the walls in the waiting room and the consultation room telling patients that they could ask for a chaperone.

36. Mr Dixon said that he would have offered Patient A a chaperone as per his usual practice but that she had declined the offer.

37. In cross examination by Mr Basu, Patient A provided the following evidence:

"Q …So Tony Dixon said he needed to examine your bottom and perform a sigmoidoscopy?

A *Yes.*

Q *It may be that by this stage, you knew what a sigmoidoscopy was?*

A *Yes*

Q *Yes, but sometimes surgeons refer to a sigmoidoscope as a telescope that they put up your bottom, if the patient doesn't know what it is. He asked if you wanted a nurse to come in while he did that.*

A *I don't recall that.*

Q *You don't recall?*

A *No.*

Q *Tony Dixon says that you said words to the effect – "Patient said in response" you stood up to go to the examination couch, and said, "No, that's okay. I've had it done many times.*

A *No.*

Q *No? Okay. Would it be right that – some people perhaps would say, "I may or may not want a chaperone". Some people may say, "I would always want a chaperone. I would never have a doctor examine me without a chaperone." Do people maybe, in different shades of that continuum or different position along that line, are you able to say where you are on that?*

A *In the past, I've had a chaperone so I would expect a chaperone, or a female nurse to be present.*

Q *Which are really effectively a chaperone.*

A *Yes.*

Q *It could be a medical student, it could be another doctor, just another person?*

A *Yes.*

Q *Have you ever declined a chaperone that's been offered to you?*

A *No.*

Q *You've never declined?*

A No.

Q You said that really quickly, and I don't want to put words into your mouth. It's not a trick, but are you quite sure? Why do you say that so affirmatively, "No, I've not" ---

A Because if I'd been offered a chaperone for an examination like that, then I would have said yes.

Q By "an examination like that", would you include a rectal examination?

A Yes.

Q Especially by a male doctor?

A Yes.

Q Okay. Who is Dr [S]?

A I don't know.

Q Would that be a GP of yours?

A Not that I'm familiar with.

38. Mr Basu then referred Patient A to her medical records in respect of a consultation with Dr S in which she was complaining about rectal pain and he was to undertake an examination of her. The exchange continued:

Q "Chaperone offered".

A Yes.

Q "Chaperone refused".

A Yes.

Q Accurate?

A Yes, accurate.

Q So that's an example, isn't it, of a time when offered a chaperone, you refused?

A Yes, I refused because I had had, by that stage, a permanent ileostomy and I was in severe rectal pain. I didn't feel that – I felt that the only way he could diagnose what was happening to me was to do that examination.

Q That's what that is. So that's the examination this doctor did. He offered a chaperone, and you declined. But when I just asked you, "If you'd been offered

a chaperone for an examination like that, would you have declined it?", you said, "No", quite immediately.

A *This was my GP. It's a bit different to somebody that I don't know.*

Q *Why not say, "I wouldn't refuse a chaperone, except if it's a GP or someone I know reasonably well"?*

A *Why not say it?*

Q *Yes?*

A *Because I didn't say it.*

Q *I know you didn't say it, but it would have been the more complete answer, I suggest. Why not say that?*

A *This is going back – you're going back quite a few years. So it's very difficult sometimes to say now what I would have felt then."*

39. Patient A in her witness statement dated 4 February 2019 Patient A said, *"He examined me by putting his fingers up my bum. I believe he used a sigmoidoscope without any anaesthetic. No nurse or other type of chaperone was present for this exam, which I thought was odd. He did not offer a chaperone at any point. He did not tell me what he was ging to do beforehand or what he was doing during the exam."* In her oral evidence Patient A accepted that Mr Dixon did tell her that he was going to examine her and use a sigmoidoscope.

40. Patient A initially said that she did not recall whether she had been offered a chaperone by Mr Dixon, she then said that she would never have declined a chaperone in any circumstances where there was a rectal examination had she been offered one.

41. The Tribunal noted that this was in contrast to the documentary evidence in Patient A's GP notes where she had been offered and refused a chaperone for a rectal examination by Dr S on 20 February 2019. Patient A sought to explain this refusal as arising because she was familiar with her GP, despite initially stating that she did not know who Dr S was. The Tribunal was therefore unable to conclude that it was likely that Patient A would always have accepted a chaperone had she been offered one for an intimate examination.

42. The Tribunal considered that given the length of time that had passed since these incidents it could not rely on Patient A's recollection of events as accurate. Although she was unable to recall a chaperone being offered, the Tribunal considered that was equally likely that Patient A had been offered a chaperone by Mr Dixon, declined it, and had forgotten that she had done so, as she had done in respect of her examination by Dr S.

43. The Tribunal considered that there was insufficient evidence before it to conclude that Mr Dixon had not offered Patient A a chaperone at all.

44. The Tribunal was of the view that the GMC had failed to discharge its burden to demonstrate, on the balance of probabilities, that Mr Dixon had failed to ask Patient A if she would like a chaperone to be present on 16 December 2010 when he performed a rectal examination.

45. Accordingly, the Tribunal found paragraph 1bi of the Allegation not proved.

Paragraphs 1bii (1) and (2) of the Allegation

46. There was no evidence before the Tribunal to demonstrate that Mr Dixon had recorded whether he had asked Patient A if she would like a chaperone, nor was there any evidence that he had recorded that Patient A declined a chaperone. Mr Dixon accepted in his oral evidence that he did not record these details in the medical notes as a matter of routine and that he should have made a record of this information. The Tribunal considered that notes relating to the offer of a chaperone is important information that should be included within the notes for the protection of both the doctor and the patient and therefore there was a duty to record such information.

47. Accordingly, the Tribunal found paragraphs 1bi (1) and (2) of the Allegation proved.

Paragraph 2 of the Allegation

2. On 12 February 2011 you performed a laparoscopic ventral mesh rectopexy ('LVMR') on Patient A ('Patient A's First Procedure') and you failed to:

   a. arrange for Patient A to undergo a proctogram in advance of Patient A's First Procedure; **Determined and found not proved**

   b. obtain informed consent from Patient A in that you did not advise Patient A of:

      i. non-surgical treatment options;
      Determined and found not proved

      ii. the risks associated with Patient A's First Procedure;
      Determined and found proved

   c. (in the alternative to paragraph 2b) record taking the steps described at paragraph 2b. **Determined and found not proved**

48. In respect of paragraph 2a of the Allegation, Colonel L opined in his expert opinion in his report:

> *"[Patient A] consulted with Mr Dixon on 21 December 2010 complaining of rectal pain and obstructed defaecation. Her symptoms were refractory to rectal irrigation. Mr Dixon noted that she had undergone investigation prior to the rectocele repair with anorectal physiology and a transit study, both of which were normal at that time. Mr Dixon appropriately examined her and formed the opinion that her symptoms were due to obstructed defaecation because of recto-rectal intussusception. He documents that he would: "normally repeat her proctogram.."; however, in the absence of a specialist radiographer he elected to conduct an examination under anaesthetic and proceed to further surgery based on his operative findings. This is not reasonable. Mr Dixon should have undertaken the appropriate confirmatory investigations in order to assess the patient and be in a position to appropriately consent her for surgery. Not to do so falls seriously below the standard expected of a reasonably competent consultant in General Surgery."*

49. In cross examination by Mr Basu, it was Colonel L's evidence:

> *"Q You are aware that what then takes place is that he says that he would want to try and organise a Proctogram, but he makes a phone call and the person that usually does it for him isn't available, so the patient will have to come back. It is then that – I think [Patient A] accepted this – she told Mr Dixon her travel time is about five hours to see him. She lives in East Sussex and these are consultations in Bristol, so the journey is about five hours round trip and she said to Mr Dixon that she'd rather not go through all that again. She found the examination, the Proctogram, unpleasant and it would be the third one she had had with a five hour round trip.*
>
> *Do you accept that, presuming the Tribunal find that that is what happened, it's a reasonable alternative to offer in those circumstances where the patient has expressed those feelings, to conduct an examination under anaesthesia with a view to potentially conducting an LVMR operation if the EUA confirms an intussusception? That is a reasonable alternative, isn't it, in these circumstances?*
>
> *A I think ideally or optimally a confirmatory Proctogram would have been arranged."*

50. Whilst it was not disputed that there was no third proctogram arranged by Mr Dixon prior to Patient A's LVMR on 12 February 2011, the Tribunal considered whether there was a failure by Mr Dixon in not arranging a proctogram. In response to question from Mr Basu, Colonel L opined:

"Mr Basu. Right. He will say that the difference, if there is one, is that if there is no PCT [Primary Care Trust] funding for the LVMR then he can't, on the NHS, perform that operation, so he would have to stop after the EUA whatever he found, but if the funding is in place, which it eventually was, then he is able to proceed directly to the LVMR. I just wondered whether there is something wrong in itself with that approach that you have the funding in place, so you do the operation. You know that Mr Dixon's case is that he appropriately discussed all the risks with the patient etc. Is there anything intrinsically wrong with the idea, having done all those things, if the Tribunal accept that, of undertaking an EUA, if you see the appropriate signs on the EUA to then proceed with the LVMR?

A I was interpreting the handwritten note as diagnostic uncertainty and a plan where ordinarily a confirmatory Proctogram would be arranged or an EUA followed at some point by a potential rectopexy, but it seems that was not Mr Dixon's intention, that he would do a confirmatory EUA and proceed directly to a lap rectopexy.

Q Are you suggesting he should have performed the EUA, found the signs that gave the green light to an LVMR, stopped, then had the patient into the clinic having had perhaps an MDT meeting to discuss what he'd seen on the EUA and then planned at some point in the future to have an LVMR performed on the patient? Is that really what you're suggesting or is it acceptable, when you see the appropriate degree of intussusception on the EUA, having considered the patient for the LVMR and obtained NHS funding for it to perform the LVMR rather than have two separate operations?

A Yes, sir, I agree that that is reasonable. My interpretation of the two different letters on the same day, I saw the EUA as clarification of the diagnosis and then a potential lap rectopexy as an operation that is still perhaps in doubt.

Q Perhaps if he had written in those terms to [Patient A] that might perhaps change things, as he is indicating a level of uncertainty but it's to the previous consultant he is keeping informed and not to the GP and not to the patient. So what he did on the thesis I've given you is: proper consent, I know it's disputed,

and seeing what he saw on the EUA, his performing the LVMR immediately after the EUA is reasonable in the circumstances.

A Yes, I concede that."

51. It was Professor M's evidence following questions from Mr Basu that:

"Q In terms of the proctogram, if Mr Dixon has made the decision that a proctogram will assist in relation to this patient, it could be re-arranged, couldn't it, to another day?

A I'm sure.

Q You talk about it being an unpleasant procedure for a patient, but if the patient doesn't express any concern about that or is happy for it to happen, then would you agree that it should be undertaken in those circumstances?

A I personally wouldn't undertake it, because I think if you've had two proctograms that have not been diagnostic, the likelihood of a third proctogram not being diagnostic is very high, but that's my own practice. I did note that it was stated that a proctogram would be valuable and I guess that reflects a variation in practice, but I certainly wouldn't undertake it."

52. The Tribunal noted that Patient A had had two previous proctograms which had not been diagnostic, and Professor M was clear in his opinion that a third would have been unlikely to have been useful.

53. Both experts agreed that that if the proctogram was not undertaken, an EUA could be performed. Therefore, when considering whether Mr Dixon failed to undertake a proctogram it considered that if it was an acceptable option for either a proctogram or an EUA, then there could not have been the sole duty to undertake a proctogram.

54. Accordingly, the Tribunal found paragraphs 2a of the Allegation not proved.

Paragraphs 2bi and ii of the Allegation

55. It was Colonel L's clear opinion that Patient A should have been advised of the non-surgical options available to her and encouraged to engage with these and that every effort should have been made to avoid surgery.

56. The Tribunal had regard to the letter sent from Mr Dixon to Patient A, dated 14 December 2010, which stated:

"Just a brief not (sic) *to say that I discussed your case together with you* (sic) *physiology etc as forwarded by Mr [P] with my BRI colleagues in today's MDT. Given that the physiology on two occasions wasn't consistent with a diagnosis of anismus (non relaxation of the pelvic floor at strain) as suggested by the proctogram and the absence of response to biofeedback, the continued rectocele, my findings of an oedematous rectal-anal prolapse and possible enterocele, we were of the opinion that if you continue not to derive any benefit from rectal irrigation/biofeedback it would then be appropriate to offer you an EUA and if it confirms the above prolapse changes proceed to ventral mesh rectopexy as discussed and you are familiar with. Provided there was no enterocoele, Mr [T] was a little less sceptical about the merits of STARR. If there were no significant prolapse, then the consensus is to offer Botox.*

Surgery provides some degree of benefit in about three quarter in terms of improving evacuation and unlike a conventional rectopexy, rarely makes thing worse. Unless they relate to the presence of the oedematous prolapse, the surgery will have no effect on the rectal pains. lf you were to require additional biofeedback post surgery then the plan would be to contact the team at St Thomas'. The major morbidities of the surgery relate to new onset urinary stress incontinence, non resolution of any associated piles together with mesh infection, erosion, pain etc. The surgery rarely causes new onset pelvic pain or dyspareunia. l look forward to reviewing the situation once we have heard from the PCT re funding here at Frenchay."

57. It was Colonel L's opinion that from the December 2010 appointment to the procedure in February 2011, Mr Dixon had not allowed sufficient time for biofeedback and that the trial should have been for a number of months as opposed to number of weeks.

58. Attached to a letter from Dr U, St Thomas' hospital, to Patient A's GP, dated 15 December 2010, was a 'pelvic floor assessment report' in which it stated:

"…There is a small non-significant anterior rectocele but the main abnormality is that of poor coordination and anismus defaecatory pattern all of which will benefit with biofeedback retraining and this will be arranged for her."

59. The Tribunal also had regard to the letter sent from Mr Dixon to Mr P, dated 21 December 2010, which stated:

"Thank you very much for your copy letter regarding the above patient to include the normal physiology. I suspect that [Patient A's] proctogram is a false +ve for anismus and that her continued problems relate to a missed prolapse; both digital examination and rigid sigmoidoscopy having demonstrated an obvious and traumatised rectal anal intussusception. This could perhaps explain why she derived only short-term benefit

following her rectocele repair. If she fails to respond to further biofeedback and rectal irrigation I have offered her an EUA here in Bristol to clarify the anatomy, followed at some point by a potential laparoscopic mesh rectopexy."

60. Mr Dixon then had a telephone consultation with Patient A on 28 January 2011 in which he recorded:

"28/1 tel consult
- No help with BFB [biofeedback]
- Struggling R/I [rectal irrigation]; makes worse
- Colonoscopy N[ormal]
"Decided on Lap VMRpxy"

61. There is a letter from Dr V sent to Mr Dixon, dated 2 February 2011, in which he stated:

"I understand from [Patient A] that there is a twenty week waiting list for her procedure and as she is still having a lot of problems despite using enemas and Peristeen anal irrigation system, Movicol and Bisacodyl etc she is still not opening her bowels.

She is aware that if she is running into problems she needs to go to the local A&E Department but she would be grateful if you could expedite her appointment for the operation if at all possible."

62. In her oral evidence, Patient A told the Tribunal that biofeedback was not working and that she was surviving on rectal irrigation.

63. Professor M was of the view that everything in respect of biofeedback had been done. Further, Patient A's GP was requesting that Mr Dixon expediate Patient A's appointment for her operation to happen as soon as possible. In the joint expert report Professor M stated:

"The risks associated with LVMR were adequately discussed with [Patient A] as noted in the clinical notes and the letter to [Patient A] on 14/12/2010 summarising discussion with [Mr Dixon]'s colleagues."

64. Mr Dixon also set out to Patient A in that letter that her case had been discussed at an MDT in which it was agreed that if biofeedback was not working, then surgery should be discussed as an option.

65. The Tribunal was satisfied from the correspondence on 14 December 2010, 21 December 2010 and the telephone call on 28 January 2011, that Mr Dixon had clearly discussed biofeedback, which is a nonsurgical treatment, with Patient A and her GP.

66. Whilst the Tribunal noted Colonel L's opinion that biofeedback should have been given a longer period to be effective, Patient A had already been undertaking both biofeedback and rectal irrigation for a considerable period. Further, the Tribunal accepted Professor M's opinion that biofeedback is unlikely to be of any benefit where the issue is anatomical and the effectiveness or otherwise of biofeedback is usually apparent in a few weeks. The Tribunal was satisfied on the basis of the documentary evidence before it that Mr Dixon did advise Patient A of non-surgical treatments and that those conversations, as indicated in the correspondence and record of the telephone consultation, had taken place.

67. Accordingly, the Tribunal found paragraphs 2bi of the Allegation not proved.

Paragraph 2bii of the Allegation

68. In respect of the alleged failure by Mr Dixon to obtain informed consent from Patient A in that Mr Dixon did not advise Patient A of the risks associated with Patient A's First Procedure, Colonel L stated in his expert report:

> *"It should be noted that published professional standards for consent have evolved in recent years. GMC Guidance and Good Surgical Practice Standards were published in 2008. GSP guidance was updated in 2014 and further clarified in 2016. The principles of consent are that a pre-operative discussion should occur between surgeon and patient. This discussion should cover:*
>
> - *The patient's diagnosis and prognosis*
> - *Options for treatment, including non-operative care and no treatment*
> - *The purpose and expected benefit of the treatment*
> - *The likelihood of success*
> - *The clinicians involved in their treatment*
> - *The risks inherent in the procedure, however small the possibility of their occurrence, side effects and complications. The consequences of nonoperative alternatives should also be explained.*
> - *Potential follow up treatment*
>
> *Surgeons are also advised to "provide written information to patients to enable them to reflect and confirm their decision. You should also provide advice on how they can obtain further information to understand the procedure and their condition. This can*

include information such as patient leaflets, decision aids, websites and educational videos"

I have seen evidence [X] that Mr Dixon signposted his patients to a website for information about laparoscopic ventral mesh rectopexy. Additional sources of information such as websites can be very helpful adjuncts to the consent process, but are not a substitute for it. The discussion for consent should take place well in advance of planned surgery (when possible) and the discussion should be confirmed by co-signatory of a form. On the day of surgery, the surgeon should confirm that nothing has changed and then surgery may go ahead.

Acknowledging the evolution in published standards of consent, I believe that I have seen evidence that Mr Dixon's standard of consent sometimes fell seriously below the standard expected. Good Surgical Practice Guidance recognises that: "Surgeons must establish and maintain effective relationships with patients and, where appropriate, with their supporters. Before surgery, surgeons should strive to have an honest and sensitive discussion with patients about their options for treatment that leads to informed and deliberate consent". Consent is not simply the signing of the form and "is the process of providing the information that enables the patient to make a decision to undergo a specific treatment. Consent should be considered informed decision making, or informed request. It requires time, patience and clarity of explanation". As such, signing the consent form on the day of surgery (as appears to Mr Dixon's practice) falls below the standard expected and his failure to record appropriate discussions of risk with patients falls seriously below the standard expected. Not to record any potential risks on a consent form for surgery … falls seriously below the standard expected.

Whilst all patients undergoing operations should have appropriate consent, it is (in my opinion) particularly important that patients recommended to have planned surgery to correct functional (but not life-threatening) health deficits, such as pelvic floor disorders, should be particularly well informed."

69. In their joint expert report, dated 30 October 2023, Colonel L and Professor M opined, respectively:

Colonel L

"The concept of EUA and proceed directly to LVMR (or STARR or botox depending on findings) is noteworthy as it would have been reasonable to discuss options when a diagnosis had been made. Nevertheless, consent is thorough; however, it is based on

the expectation of improvement of the patient in c. 75% of instances, inferring no improvement in 25% but stating 'rarely makes things worse'. This does not adequately explore the impact of low likelihood but high consequence complications, such as bowel obstruction."

Professor M

"The risks associated with LVMR were adequately discussed with [Patient A] as noted in the clinical notes and the letter to [Patient A] on 14/12/2010 summarising discussion with [Mr Dixon's] colleagues."

70. Mr Basu cross examined Patient A in respect of what associated risks Mr Dixon had advised her of in respect of the procedure:

"Q Is it right, do you accept this, that Mr Dixon was there telling you the complications, or one of the complications immediately after surgery is you have urinary retention?

A Yes.

…

MR BASU: --- and. "USI" is "Urge stress incontinence". I'm looking at Mr Dixon now.

DR DIXON: "Urinary".

MR BASU: Yes, "Urinary stress incontinence", sorry.

A Yes.

Q He described that risk to you, as well?

A Yes.

Q You were aware anyway from the website?

A Yes.

Q Half of those resolve.

A *Sorry?*

Q *He told you that half of those resolve ---*

A *I don't remember that comment.*

Q *So the next thing is:*

"Occ [occasionally] catheter 5/7"

So what he described to you was occasionally, you'd have a catheter in for up to five days?

A *Yes.*

Q *Yes. He described to you that in a laparoscopic operation, a risk is of, I don't know what, we'll see what you say about the wording, but "visceral" or "vascular" injury. He might have said, "a risk of damage to the internal organs and big blood vessels".*

A *Yes.*

Q *Yes, but he explained to you that that risk was rare?*

A *Yes.*

Q *Especially in someone who's perhaps a pioneer of these sorts of operations ---*

A *Yes.*

Q *--- doing them since 1996. He also explained to you that 75 to 80% of people benefit?*

A *Yes.*

Q *That's kind of a discussion you'd had before, as well?*

A *Yes.*

Q *It says, "who don't". So he took a stab at the sort of people who might not benefit so much, and then:*

"10 – 15% [have] recurrent symptoms"

He described that to you.

A *I don't remember that.*

Q *Yes, okay. A small number, can you see it says, I think it's "a smaller number", in fact, because it's:*

"Smaller no – STC"

Can you see that bit?

A *I can see it, but I don't know what it means.*

Q *Okay. "STC" is "slow transit constipation".*

A *Okay.*

Q *So he explained to you that, "There are small number of people who develop slow transit constipation".*

A *I don't remember that.*

Q *Okay, but do you remember him saying, "That was a possibility, that had been suggested by Mr [P]"?*

A *No.*

Q *Because Mr [P] floats that possibility in a letter that we've already looked at, that there may be a ---*

A *Can I just say, I do remember that. But they did a test, a six-marker test, and it came out that I didn't have slow transit constipation.*

Q *At the earlier stage when you …*

A *Yes.*

Q *Absolutely. But what was being floated by Mr [P] was, "Was that a possibility?" What Mr Dixon was suggesting was sometimes what happens is when you solve the anorectal intussusception that's causing the obstructive defecation syndrome, you unmask the other problem, which is of a slow transit constipation. So that's what he was ---*

….

Q *Okay, fine. He said that, "If that were to happen, there would be a reinvestigation and a possibility of a colectomy".*

A *No.*

Q *Did he say something like, "Result, you still have to take laxatives"? So in other words, even after this operation, you might still need to use laxatives?*

A *I don't remember that.*

Q *You might still need to continue with biofeedback techniques?*

A *No.*

Q *He didn't say that?*

A *No.*

Q *He talked about the mesh complications. Can you see there, it says:*

> *"Mesh = FB [foreign body] [leads to] infection"*

So what he was saying there was, "We're putting a foreign body, ie this polyester mesh, in you, and that can lead to an infection."

A *I was told the complications of the surgery would be an infection, but not that it would be caused by the mesh.*

Q *Okay. I suggest that what's recorded here by Mr Dixon was what he told you about what they do about that, which is, therefore, they use antibiotics. They cover – these antibiotics cover – to prevent that from happening.*

A *No, I wasn't told that.*

Q *Then can you see where it says:*

"0 allergies"

A *Yes.*

Q *Do you have no allergies to penicillin and ---*

A *No.*

Q *You don't have any allergies?*

A *No, I do have an allergy, but not to penicillin.*

Q *No, and so he was checking for that, because that's when you (Inaudible) you need to check for allergies. Then another complication is "erosions / exposure". We can just about see it. Where the ∴ sign, under "abx", which is antibiotics, that, we say, is "therefore". No, that's, "erosions / exposure". Probably "exposure" is easier to see. But the first word is "erosions". Is that something he told you about for mesh?*

A *No.*

Q *There can be erosions?*

A *No.*

Q *Okay. Was that something you were told about the Permacol procedure?*

A *No.*

Q *Then he said that's a risk that's 1 to 2%, and the treatment is to remove the mesh laparoscopically.*

A *No.*

Q *Then just so everyone knows where I'm getting that from, there's a squiggle:*

"1-2% Rx lap"

Then he described all the need for prophylaxis, in other words preventing clots with:

"Clexane, TEDS [stockings, that you'd be very familiar with], [special] boots"

A *I was given those after.*

Q *Did he say, "We have to do all the usual things you're used to – the TED stockings"?*

A *No.*

Q And a drug to prevent clotting?

A No."

71. Patient A's evidence demonstrated that Mr Dixon had advised her of some of the risks associated with her procedure. The Tribunal bore in mind Colonel L's evidence that Mr Dixon's advice did not adequately explain the impact of low likelihood high consequence risks such as serious life threatening complications.

72. The Tribunal had regard to the GMC's *'Consent: patients and doctors making decisions together'* (2 June 2008) ('the 2008 Guidance'), which stated:

> *"28 Clear, accurate information about the risks of any proposed investigation or treatment, presented in a way patients can understand, can help them make informed decisions. The amount of information about risk that you should share with patients will depend on the individual patient and what they want or need to know. Your discussions with patients should focus on their individual situation and the risk to them.*
>
> *29 In order to have effective discussions with patients about risk, you must identify the adverse outcomes that may result from the proposed options. This includes the potential outcome of taking no action. Risks can take a number of forms, but will usually be:*
>
> *a side effects*
>
> *b complications*
>
> *c failure of an intervention to achieve the desired aim.*
>
> *Risks can vary from common but minor side effects, to rare but serious adverse outcomes possibly resulting in permanent disability or death.*
>
> *…*
>
> *32 You must tell patients if an investigation or treatment might result in a serious adverse outcome, **9** even if the likelihood is very small. You should also tell patients about less serious side effects or complications if they occur frequently, and explain what the patient should do if they experience any of them."*
>
> > *"**9** An adverse outcome resulting in death, permanent or long-term physical disability or disfigurement, medium or long-term pain, or*

admission to hospital; or other outcomes with a long-term or permanent effect on a patient's employment, social or personal life."

73. The Tribunal considered that paragraph 28 of the 2008 Guidance suggests it is an evaluative judgement as to how much information the clinician wishes to share. However, it had particular regard to paragraph 32 and footnote 9 of the 2008 Guidance.

74. The Tribunal was satisfied that there was a discussion in respect of some of the risks associated with the LVMR procedure. Colonel L conceded that in 2011 it would not have been unusual to have obtained consent on the day of a procedure although this was not ideal, particularly in relation to patients who were having elective procedures.

75. Whilst the opinion of the experts differed, the Tribunal did prefer the evidence of Colonel L on the basis that low likelihood, high consequence risks should be explained. This was supported by the 2008 Guidance in place at the time as referred to by Colonel L. This guidance confirms that doctors '*must*' tell patients if an investigation or treatment might result in a serious adverse outcome, even when the likelihood is relatively low.

76. While the Tribunal found that there had been some discussion about risks, this was confined to the more common risks and no information was given in relation to serious adverse outcomes as required by paragraph 32 footnote 9 of the guidance. It was also not contested that those risks were not provided to Patient A. The Tribunal considered that this guidance gave rise to a duty for Mr Dixon to adequately explain these risks to Patient A.

77. The Tribunal therefore determined that, on that basis, Mr Dixon did fail to obtain informed consent from Patient A in that he did not advise Patient A of the risks associated with Patient A's First Procedure.

78. Accordingly, the Tribunal found paragraph 2bii of the Allegation proved.

Paragraph 2c of the Allegation

79. In respect of paragraph 2c of the Allegation, the Tribunal had already found paragraph 2bii proved, in that Mr Dixon failed to obtain informed consent as he had not adequately explained the risks associated with Patient A's First Procedure. As this matter has been considered and found proved, the Tribunal concluded that it was not required to make a second finding on this paragraph of the Allegation which is charged as an alternative.

80. Accordingly, the Tribunal found paragraph of 2c of the Allegation not proved.

Paragraph 3 of the Allegation

3. On 25 October 2011 you performed a rectal examination on Patient A:

a. in the absence of a chaperone; **Determined and found proved**

b. and you failed to:

i. ask Patient A if she would like a chaperone to be present; **Determined and found not proved**

ii. (in the alternative to paragraph 3a and 3bi) record that:

1. you had asked Patient A if she would like a chaperone to be present; **Determined and found proved**

2. Patient A had declined a chaperone. **Determined and found proved**

81. In respect of paragraph 3a, for the same reasons as set out in respect of paragraph 1a of the Allegation, the Tribunal was satisfied that factually, there was no dispute that Mr Dixon had performed a rectal examination on Patient A in the absence of a chaperone on 25 October 2011.

82. Accordingly, the Tribunal found paragraph 3a of the Allegation proved.

Paragraph 3bi of the Allegation

83. In respect of paragraph 3bi of the Allegation, Patient A stated in her witness statement:

> *"10. I attended this further consultation with Dr Dixon with my ex-husband. As with the first consultation, Dr Dixon performed an exam on my bum and again with no nurse present. Once again he did not offer a chaperone or a nurse and none were present during the exam…"*

84. In her oral evidence, Patient A stated:

> *"Q Having taken the history, as happened before in the first consultation we talked about, Tony Dixon said that he would examine you. Again, I know you dispute this, but I have to put Tony Dixon's case, he offered you a chaperone, and you said it wasn't really necessary.*
>
> *A I don't remember.*
>
> *Q You don't remember?*
>
> *A No."*

85. The Tribunal considered that Patient A's oral evidence was inconsistent with her witness statement. She initially indicated that she was not offered a chaperone and then she told the Tribunal that she could not remember whether she was offered a chaperone.

86. In re-examination by Ms Carin Hunt, Counsel, Mr Dixon said:

"Q I just have a few questions with you first. Do you accept that on two occasions you conducted rectal examinations of Patient A without a chaperone – that is on 16 December 2010 and 25 October 2011?

A Yes, I do.

Q Do you accept that on one occasion, on 20 March 2012, you conducted a rectal examination of Patient B without a chaperone?

A That is correct.

Q You have explained in your witness statement that on those occasions you offered Patient A and Patient B a chaperone and they had declined.

A Yes, that is correct.

Q Do you accept that you did not record the fact that you had made the offer and that it had been declined on those occasions?

A Yes. I should have recorded the offer and the fact that it was declined, just as I should have recorded those patients where I did offer it and it was accepted or a chaperone was there – I should have recorded it."

87. The Tribunal could not be satisfied that it could rely on the evidence of Patient A given her account to the Tribunal which was inconsistent with her witness statement. The Tribunal considered that Patient A's memory of this consultation could not be relied upon as accurate given the time that has passed. The Tribunal took into account that considerable time had passed since the consultation, and it was not an issue that was raised by Patient A until her witness statement in 2019. For this reason and those set out in relation to paragraph 1bi, the Tribunal determined that this allegation could not be proved on a balance of probabilities.

88. Accordingly, the Tribunal found paragraph 3bi of the Allegation not proved.

Paragraphs 3bii (1) & (2) of the Allegation

89. There is no evidence within Patient A's medical notes that Mr Dixon recorded that he had asked Patient A if she would like a chaperone to be present or that Patient A had declined a chaperone. Mr Dixon in his evidence accepted this was the position.

90. Accordingly, the Tribunal found paragraphs 3bii (1) and (2) of the Allegation proved.

Paragraph 4 of the Allegation

4. On 18 November 2011 you performed a laparoscopic sub-total colectomy on Patient A ('Patient A's Second Procedure') and you failed to:

b. obtain informed consent in that you:

i. did not advise Patient A of:

2. the risks associated with Patient A's Second Procedure; **Determined and found proved**

ii. obtained written consent on the day of Patient A's Second Procedure; **Determined and found not proved**

c. (in the alternative to paragraph 4bi) record providing the advice outlined at paragraph 4bi. **Determined and found not proved**

91. In respect of paragraph 4b of the Allegation, Mr Dixon stated in his witness statement:

"[Patient A] booked an emergency review through Spire bookings and, accompanied by her husband, was seen on 25 October 2011…

A transcript of my notes is outlined below:

25/10/11. Emergency Ref [erral]
Seen with H [usband]
Not coping, Pain/colic/bloating.
No BO[bowel opening] for 4/52 in spite of laxatives/ Prucalopride / Rectal irrigation, Picolax
Back pain. Can't sleep for it
Feels awful.
Occ [asional] liquid stool
Husband very worried

Very distended - Colon. BS[bowel sounds] not obstructed
Empty rectum. Sigmoid[oscopy] -> Release loose stool
Distended but soft

P: Transit study, Prucalopride
—> Stoma (Yes),
Lap STRC [sub total colectomy]

Risks leak etc/ stoma
May not work long-term
—> Try & get done Spire
Will get back to us"

92. The Tribunal noted that the only risk noted by Mr Dixon in the medical record were that of *"Risks leak etc/stoma".*

93. In the joint expert report, Colonel L stated that consent was not adequately obtained, and Professor M stated that:

> *"[Patient A] arranged her own urgent/emergency admission to Spire hospital as an NHS patient with a provisional arrangement for surgery on the same day. The nature of that operation was described in the booking form and had been discussed with [Patient A] and shared with her GP."*

94. In his oral evidence, Colonel L said:

"Q Again accessibly, and then on page 39, "What are the risks of surgery?" "Relatively low risk surgery because no bowel is removed". It is explained the older versions of rectopexy involved removing sections, segments of the bowel which could cause a leak, but that is less likely to happen here. Do you see on page 40, "Is laparoscopic ventral mesh rectopexy safe?" and then it sets out, "All types of surgery carry a risk, including importantly general anaesthesia", which of course in a very small proportion of people kills them, doesn't it? Going under a general anaesthetic can unpredictably, very rarely just kill you, cant it? Maybe one in a 100,000.

A It doesn't just kill you.

Q The complication of the anaesthetic can result in you dying on the operating table.

A I agree.

Q Quite unrelated to the operation itself.

A It is related directly to the anaesthetic.

Q Yes, just an unwarranted complication, often very hard to treat, can result in death of.

A It is rare.

Q *Rare but presumably death is a high impact complication of an operation so presumably you tell people when you operate on them that it is possible, although very rare indeed, to die on the operating table because of the anaesthetic, quite unrelated to the operation. Is that what you tell your patients?*

A *Yes, I do. I don't use the word "die" because, again, talking about the worst possible outcomes is a sensitive matter.*

Q *What do you say instead?*

A *Have a life-threatening complication.*

Q *The life-threatening, doesn't that give somebody the idea that it is life threatening but he's not talking about actually dying itself, which potentially is quite serious and needs to be specifically ---*

A *In terms of risk of general anaesthetic, I typically say that there is about a one in 100,000 incidence of serious and immediately life-threatening complications from general anaesthetic itself.*

Q *Have I understood that statistic correctly, the one in 100,000 is the risk of death?*

A *Yes.*

Q *Right, so if I cross the road incompetently and get hit by a bus it's life threatening. I've got a reasonable hope of surviving that if it is simply life threatening but if it is fatal, I'm not here tomorrow, so why don't you explain that in those very rare circumstances you can just die of the anaesthetic?*

A *Well, you don't just die. There is an immediately potentially life-threatening issue due to the anaesthetic, either it's a loss of the airway or an idiosyncratic reaction to medicines but those instances are treatable potentially."*

And further:

"When there is a progressive distension that would otherwise proceed to rupture, it's usually the cecum that ruptures because of the physical configuration of the cecum, which means that it's more likely to distend than other segments of the bowel.

Q *It's the spilling of bowel contents that causes the potentially catastrophic outcome of the peritonitis and sepsis ---*

A Indeed.

Q --- and potentially death in a significant proportion of patients. Does that not outline – so this is now using hindsight, but it's fortuitous, isn't it? We can be pleased that [Patient A] had this operation sooner rather than later, given the serosal splitting?

A Of course. Nobody would wish her to have a salvage operation when the colon had perforated.

Q No-one would wish to be waiting for a CT scan while that happens either?

A Well, I agree with your suggestion, but in emergency surgical practice that isn't – I have never seen a patient's colon perforate whilst waiting for a scan. It's not a circumstance that any reasonable surgeon would entertain."

95. Colonel L's opinion was that life threatening complications and adverse outcomes should be explained to patients as per the 2008 Guidance at paragraph 32(9), as has already been set out previously in respect of Paragraph 2bii.

96. It is not disputed that Mr Dixon did not explore the impact of low likelihood high consequence complications with Patient A. As the Tribunal has previously set out in its reasoning above it has found that pursuant to the 2008 Guidance there was a duty to do so.

97. Accordingly, the Tribunal found paragraph 4bi (2) of the Allegation proved.

Paragraph 4bii of the Allegation

98. When considering whether Mr Dixon obtained informed written consent on the day of the second procedure, it first had regard to the joint expert report, in which Professor M stated:

"Risks of anastomotic leak, sepsis, and uncertain outcomes were discussed on 25/10/2011 and again on the day of surgery.

Consent on the day is against published standards but widely practiced and this was day of her urgent admission, the details of the procedure having been discussed previously."

99. Following questions from Ms Fairley, Colonel L stated that:

Q *In terms of obtaining consent on the day of the patient's second procedure – this is an aspect that you have dealt with in a number of cases – your position is that it's not appropriate but not unheard of.*

A *Yes, it doesn't meet the published standard but in elective practice to consent patients on the day – to get written consent on the day certainly has been in widespread practice in the profession. I think that has now largely gone but certainly at the time of her treatment that would have been widely practised.*

Q *In terms of consent on the day of the procedure, that would have required the full range of risks that you have already set out to have been explained.*

A *Yes. If it is an emergency and the patient has presented hyper acutely, so on the same day as the requirement for surgery, then clearly that is a different setting and consent is obviously taken on the day of surgery, but when the surgery can be planned then consent should be undertaken and recorded prior and then confirmed on the day of the operation."*

And Further:

"Q *The expectation, you would say, as I understand it, is that consent would have been obtained in a pre-surgical consultation and the patient had time to consider it and then confirmed on the day of surgery.*

A *It is obviously correct to say that consent isn't a moment in time; it is a process, but the discussion of the perceived benefits, the alternatives, the nature of the surgery and the risk of the surgery should be undertaken in advance and documented, so witnessed consent, signed for, in advance of the day of the operation to allow patients to go to other sources of information such as a website or other materials, to reflect with their loved ones or partner, to consider the options; and then confirm on the day that nothing has changed materially for the patient and that they understand what they going in for and they confirm on the day. It is a full discussion which is done and documented and then there is a period of time for those other reflections; and then confirmation that nothing has changed on the day."*

100. The Tribunal had regard to the circumstances which led to Patient A's admission for this second procedure. The Tribunal noted that Patient A had consulted with Mr Dixon 25 October 2011 and the notes of that consultation confirm that there had been a discussion about the need for this procedure. The evidence in the documentation to Patient A's GP sets out what operation was being planned, Patient A knew what operation she was going in for,

though at the point of the surgery it was not on an elective basis. Patient A presented with acute symptoms and had been admitted on an emergency basis on the day of surgery.

101. The urgency of the presentation was accepted by both experts and Colonel L conceded that the acuity of Patient A's presentation altered the position and he agreed that it was not a failure for written consent to be taken on the day of surgery in circumstances that faced Mr Dixon on 18 November 2011 with Patient A.

102. Accordingly, the Tribunal found paragraph 4bii of the Allegation not proved.

Paragraph 4c of the Allegation

103. In respect of paragraph 4c of the Allegation, the Tribunal has already found paragraph 4bi (2) proved, in that Mr Dixon failed to obtain informed consent in that he did not advise Patient A of the risks associated with Patient A's Second Procedure on 18 November 2011. As this matter has been considered and found proved, the Tribunal concluded that it was not required to make a second finding on this paragraph of the Allegation.

104. Accordingly, the Tribunal found paragraph 4bc of the Allegation not proved.

Paragraph 5 of the Allegation

5. Before performing the revision surgery on Patient A in December 2013 you failed to:

   a. carry out a full re-investigation;
   Determined and found not proved

   b. discuss Patient A's case with colleagues from other disciplines.
   Determined and found not proved

105. In respect of paragraph 5a of the Allegation, Colonel L and Professor M stated in their joint expert report:

Colonel L

> *"Confusing situation, no preoperative diagnosis. Should have taken time to re-evaluate.*
>
> *Other surgical options could have been considered."*

Professor M

> *"[Patient A] was adequately investigated at Conquest (having had emergency admissions) ultimately identifying intermittent bowel obstruction at the ileo-rectal anastomosis. [Patient A] was admitted to Conquest for laparotomy and surgery to*

determine the nature and deal with this obstruction, but after waiting 5 days for an emergency slot she was discharged on morphine for analgesia.

[Patient A]'s condition was discussed with colleagues at Conquest

The definitive diagnosis of intussusception of small bowel through the ileorectal anastomosis was made intraoperatively- as would have been the case had she had surgery at Conquest Hospital. The mesh pexy procedure was not a standard approach; however, it is neither careless nor dangerous considering other surgical options available and was an intra-operative decision."

106. In his expert report, Professor M, opined:

"7.45 [Patient A] was assessed in the Emergency Department in Frenchay Hospital Bristol on 30/11/2013 and admitted under Mr Dixon's care, as he appeared to be "on take" for emergencies for that period.

7.46 [Patient A] underwent laparotomy in view of the background of intermittent small bowel obstruction and the extensive recent investigation, which had shown distended small bowel to a width of 5cm (around twice the normal diameter).

7.47 In my opinion, [Patient A] had been extensively and correctly investigated in the months preceding her admission leading to surgery in December 2013, and this had identified small bowel obstruction of uncertain cause and surgical intervention was appropriate.

7.48 Discuss with colleagues from other disciplines.

7.49 The care of [Patient A] had been shared between Mr Dixon and the Conquest Hospital team. In view of the repeated admissions with recurrent obstruction of the small bowel, surgical intervention was indicated. It is not essential, or even practicable, to discuss acute surgical conditions with colleagues, but there are occasions when this may be valuable. However, in my opinion the decision to undertake surgery was reasonable and a discussion limited to those surgeons and anaesthetists on the on call team seems appropriate. This scenario is quite different from a recurrent pelvic floor condition that would be considered at the pelvic floor MDT.

7.50 The operation performed would be considered as "bespoke". There is a literature on using mesh to fix or "pexy" small bowel (eg ileal pouches) which have prolapsed and the use in this case would not be considered as common practice.

However, in this case it avoided the take down of the ileo-rectal anastomosis and formation of an ileostomy."

107. In cross examination by Mr Basu, Colonel L was asked about his and Professor M's respective opinions:

"Q Do I read here in the light of what you just said that in the light of an MRI scan you might have a plan. You might be able to base a plan on that in terms of which of the three options to adopt?

A Yes, that's what I mean.

Q Professor M has said:

"[Patient A] was adequately investigated at Conquest (having had emergency admissions) ultimately identifying intermittent bowel obstruction at the ileo-rectal anastomosis. [She] was admitted to Conquest for laparotomy and surgery to determine the nature and deal with this obstruction, but after waiting 5 days for an emergency slot she was discharged on morphine for analgesia.

[Her] condition was discussed with colleagues at Conquest. [I think he means by Mr Dixon].

The definitive diagnosis of intussusception of small bowel through the [IRA] was made intraoperatively- as would have been the case had she had surgery at Conquest Hospital."

That's got to be right logically, hasn't it?

A Yes.

Q Ms [AO] would have seen the same thing:

"The mesh pexy procedure was not a standard approach; however, it is neither careless nor dangerous..."

Let me just park that for just a second. In terms of the decision whether or not to undertake a further MRI, would you accept that it's open to a reasonably competent colorectal surgeon in these circumstances to proceed to a

laparotomy with the three options we've discussed without first undertaking an MRI scan?

A *I think an MRI scan should have been undertaken.*

Q *I see you say that, but is it open to a reasonably competent consultant colorectal surgeon who knows the patient, has operated on them previously in these circumstances to take the decision to proceed without first undertaking an MRI examination?*

A *Well, I appreciate that is Professor M's position.*

Q *Is that open to a reasonably competent consultant colorectal surgeon to adopt that plan?*

A *It's not an* opinion *that I share."*

Q *I haven't been clear. I fully accept that you take a different view. It's a firmly held and genuine personal view based on your expertise and experience, but would you accept that it's open for another competent consultant colorectal surgeon to take a different view, to take the view that Mr Dixon and Professor M have taken in these circumstances?*

A *I would concede that."*

108. Following questions from the Tribunal, Colonel L stated:

"Q *When a surgeon isn't able to undergo all the steps in the evaluation suggested, is it reasonable for them to proceed with surgery?*

A *That is where the multidisciplinary review of the issue is important, where, if there is a radiologist perhaps in the room who is aware of these recommendations and knows how to access them, that is where advocating along the lines of that pathway would be reasonable.*

Q *Are you saying in the absence of those studies an MDT would be an acceptable alternative?*

A *I am suggesting that an MDT might have raised the requirement for that more sophisticated study.*

Q *I can't recall whether there was an MDT discussion, but what would a reasonable surgeon do in the circumstances though? Would they proceed with surgery or would they defer?*

A *It depends on one's enthusiasm for an operation. I think it would have been beholden on the surgeon to be cautious and only proceed on the basis of a completely evaluated patient.*

Q *Again, is that a variation of practice among surgeons, or is that a common position and it would be unreasonable to go forward with the surgery?*

A *We have heard of other successful uses of colectomy in patients with slow transit constipation. We discussed the high levels of satisfaction in other centres. It may well be that that reflects better selection in terms of the full evaluation of patients who are submitted to surgery."*

And further:

"Q *Why was it necessary to discuss it with colleagues prior to proceeding, in your opinion?*

A *Because they might have dissuaded you from going ahead. That is the whole point of the MDT, to have the critical friend.*

Q *In your opinion, would a reasonably competent colorectal surgeon proceed straight to surgery, in your opinion, in those circumstances?*

A *I have expressed the view that repeating the MRI scan would have been what I would have expected and recommended, then taking a view, trying to achieve a consensus in terms of diagnosis and treatment options before proceeding with an operation."*

109. Following questions from Ms Fairley, Professor M opined:

"A *I think there are two elements when we talk of things being made worse. In terms of – for most patients that we'll see, they are interested in, if we select patients carefully, they are interested in what the chances are of it improving. You have this problem, there's a 75 per cent chance that it will improve. It's important to explain that clearly, i.e. it's not 100 per cent chance that your symptoms will improve. 75 per cent of patients who have this procedure will be*

much better or better and 25 per cent will not be better. There's lots of reasons for that 25 per cent who do not improve. Then layered on top of that, the potential complications that can come from any surgery that may not relate to the specific functional problems that the patient is presenting with, but they are common to all laparoscopic procedures, for example, such as damage to a major vessel, damage to small bowel, infection.

There are those which may be more specific to rectopexy, where there's perhaps a mesh complication. There's a great list. Often those generic problems from surgery would be captured in an information leaflet or website or would form part of the discussion. I'm not sure that we would – in fact, I'm sure – that they are not always noted carefully in the correspondence to the GP, but certainly patients should be aware that every operation we do, laparoscopic appendicectomy as an emergency, you can have a catastrophic outcome from it. It's very rare, but it's there."

And further:

"Q When you're in a position where you're considering doing something that is bespoke, would you agree that is precisely the time that you should discuss what's going to happen with colleagues? I appreciate that might require ---

A I think it's a balance of risks and an intraoperative decision. We often make those decisions in emergency cases, not elective cases, with discussion with perhaps the registrar fellow who's assisting or perhaps someone if they are around or we'll make the decision on our own. That's very much surgery. If we look at a case where, let's say someone is an emergency and they have diverticulitis and a perforated colon. We open the tummy and we look at the pathology and we are going to remove the pathology. There are risks and benefits to making a join or making a colostomy. I wouldn't phone a colleague to say, what do you think? I'd base it on my own assessment of that situation. I know that's slightly different, because we are dealing with two options that are well-recognised operations. But to put mesh, to support an intussusception with mesh, doesn't strike me as careless or ...

Q In relation to this patient, prior to being in that position, wouldn't it have been important to have discussed her – she's a complex patient – with colleagues?

A As I understood from the records available to me, there was a diagnosis made in Conquest. That diagnosis appears to have been communicated to Mr Dixon. The patient was scheduled to have surgery, but it was deferred, presumably

because of pressures on an emergency list and it was deemed not to be high priority. The problem there, she's a complex patient, but it's quite a specific patient and sometimes complex patients will have a problem that's actually in itself not complex; she had a bowel obstruction, that bowel obstruction was due to the intussusception of the anastomosis. It's on a very complex background, but there's a limited option for how we deal with it and that option would either be, we do as we discussed earlier, re-do the join, with the risks that come with that; make an ileostomy, with the outcome for the patient, or provide this pexy procedure which, during the operation we would see if that prevented the intussusception.

Q *The discussion of those options with colleagues would have assisted.*

A *I'm not sure that you would actually reach a decision there based on, if two colleagues said do an anastomosis, that you'd do an anastomosis. I think that is a much more complex decision-making process that would be made during the operation with the balance of risks and the condition of the patient and also understanding the patient's wishes, thoughts from the discussion they had beforehand. I don't think there was a capture, but at this point, there was quite a long relationship with this patient. They were presumably familiar with one another and understood what was desirable. If the patient had said, "I want the simplest procedure and I'm happy to have a stoma", then to take her down and make a stoma would have been the best thing to do, regardless of what the discussion with colleagues said."*

110. The Tribunal accepted that the decision to undertake revision surgery had already been decided by another colorectal consultant at Conquest hospital. It was not disputed that Patient A had already been booked in for that procedure but had been discharged before it could be carried out because of lack of operating resources. The Tribunal accepted the evidence of Professor M that Patient A had been adequately investigated by Conquest Hospital and there was no duty on Mr Dixon to carry out any further re-investigation in these circumstances.

111. Colonel L's main criticism of Mr Dixon was that he did not discuss Patient A with other colleagues at an MDT before operating. He stated that this would be good practice as an MDT would act as a "critical friend" and may provide alternatives to surgery. In his oral evidence Colonel L agreed that it was open for other professionals to take a different view to him and he conceded that it would not be unreasonable to take the view that was adopted by Professor M that further investigations and discussions were not necessarily required. The Tribunal considered that on the basis of the evidence before it, the GMC had not established

that there was a duty to undertake an MDT discussion or carry out a full re-investigation before proceeding to operate.

112. Accordingly, the Tribunal found paragraphs 5a and b of the Allegation not proved.

PATIENT B

113. Relevant clinical history summarised from Professor M's background of Patient B's case:

114. Patient B was born in 1949 and had two children by vaginal deliveries, one of which caused a perineal tear. She underwent total hysterectomy and bilateral salpingo-oophorectomy in 1996 at age 47, thus having surgically induced menopause for which she was later treated with hormone replacement therapy until around 2005.

115. She was first noted to have gastrointestinal symptoms (bloating, pain and constipation) attributed to irritable bowel syndrome in 2005 and was investigated with colonoscopy which was normal. In 2010, new symptoms of incomplete rectal emptying (tenesmus), variable bowel habit and sticky stools that floated, in keeping with malabsorption of fat from the gut, developed. A repeat colonoscopy was normal and Patient B was referred to gastroenterology. Faecal elastase testing confirmed as pancreatic insufficiency i.e. not enough enzymes secreted into the bowel to enable fat absorption. This was treated with enzyme replacement (Creon). There was an initial response to this, but the impact reduced. During this period Patient B was seen by three specialist gastroenterologists and a dietitian in two different NHS trusts and in both NHS and private settings, often moving between these. The investigations undertaken were exhaustive and many treatments were explored with the involvement of several specialists.

116. Dr W arranged proctography to determine if rectal prolapse (internal rectal prolapse, IRP or intussusception) was contributing to Patient B's symptoms and this identified high grade IRP. A transit study did not identify slow transit, but there was faecal loading throughout the colon. Dr W referred Patient B to Mr Dixon in March 2012 initially as a private patient.

117. Mr Dixon noted symptoms of obstructed defection with repeat visits to the lavatory, incomplete emptying, a feeling of "wearing a nappy" and occasional faecal incontinence. Symptoms were worse at the end of the day and were now limiting her activities. These are consistent with high grade IRP.

118. Mr Dixon advised correction of the IRP with laparoscopic ventral mesh rectopexy (LVMR). This was to be undertaken as an NHS patient which required an exceptional funding request and this required further workup with anorectal physiology testing and biofeedback

(pelvic floor retraining). These were arranged but in the interim Patient B opted to have LVMR performed as a private patient in May 2012.

119. Patient B's symptoms improved but by early 2013 she was sufficiently troubled to seek further help from Dr W who ordered a transit study, proctogram and CT scan. These demonstrated delayed transit with markers retained in the left colon, faecal loading of the colon and normal proctography, i.e. the previous prolapse was corrected by LVMR. Around this time, Dr W noted that Patient B was likely to have chronic functional bowel disorder and visceral hypersensitivity. Symptoms at this point were difficult rectal evacuation requiring occasion digitation, abdominal pain and bloating. Patient B was commenced on prucalopride to promote colonic motility and had further dietetic input. By 2014 Patient B's symptoms were improved but not consistently so she sought an opinion from Mr X, Consultant Colorectal Surgeon, regarding surgery for slow transit constipation. He advised avoiding surgery and continuing under Dr W's care.

120. Patient B was seen by Mr Dixon in 2016, suffering with constipation (took prucalopride intermittently), difficult evacuation, abdominal pain and bloating. Mr Dixon advised a trial of rectal irrigation, additional laxatives, and arranged a proctogram and transit study as an NHS patient. He also raised the possibility of surgery to remove the left colon which appeared to be the cause of the delayed transit and he proposed that this was secondary to the effects of hysterectomy. Transit study showed a delay with almost half the markers retained, however, Patient B had a very good response to irrigation in terms of bowel emptying, but she still had bouts of abdominal pain.

121. Following the third review in this period by Mr Dixon he noted the recurrent bouts of abdominal pain and distension, despite the ongoing use of irrigation, and discussed the option of surgical resection of the colon on the left side, making a join between the transverse colon and the rectum. He explained the potential complications of anastomotic leak (5%), sepsis requiring intensive care, bleeding and stoma formation, and the uncertainty of the functional outcome of this procedure.

122. Surgery was undertaken in July 2017. The procedure was laparoscopic. At surgery, the mesh from LVMR appeared stretched and it was removed as felt to no longer be contributing, plus its removal facilitates bowel resection and anastomosis. Therefore, the original synthetic mesh was removed and the resection performed. A new biological mesh was placed in the site of the old mesh, sutured to the vagina and rectum, and fixed to the inside of the backbone (sacral promontory) as is standard. This supports the rectum and vagina, reducing the likelihood of recurrent prolapse, particularly vaginal vault prolapse and enterocele.

123. In the post-operative period Patient B developed loose frequent stools as a consequence of removing the left colon. She continued to suffer bloating and abdominal

pain. Patient B complained of vaginal discharge and on one occasion presented Mr Dixon with a photograph of a sanitary pad which appeared to have faecal staining, implying an abnormal connection between the rectum and the vagina as a result of the surgery, and it was proposed that this was a fistula from anastomotic leak. The symptoms were improving, culture of the vagina showed no faecal organisms but no investigation such as examination under anaesthetic or scans were performed. An alternative possibility is that this discharge was related to fluid exudate from the biologic mesh which is a common occurrence with this material.

124. Patient B's vaginal discharge settled and her bowel function became acceptable, following which there is a note of thanks from her to Mr Dixon.

125. Subsequent to this, Patient B's care fell to other specialists (colorectal surgery, urology, gastroenterology and psychological medicine) in Bristol under whom she had many investigations of small bowel, residual colon and pelvis, and treatments including sacral nerve neuromodulation.

Paragraph 6 of the Allegation

6. On or around 20 March 2012 you performed a rectal examination on Patient B:

    a. in the absence of a chaperone; **Determined and found proved**

    b. and you failed to:

        i. ask Patient B if she would like a chaperone to be present; **Determined and found not proved**

        ii. (in the alternative to paragraph 6a and 6bi) record that:

            1. you had asked Patient B if she would like a chaperone present; **Determined and found proved**

            2. Patient B declined a chaperone. **Determined and found proved**

126. For the same reasons as set out in respect of paragraphs 1a and 3 of the Allegation, and that factually it is not disputed by Mr Dixon, the Tribunal is satisfied that he did perform a rectal examination on Patient B in the absence of a chaperone on or around 20 March 2012.

127. Accordingly, the Tribunal found paragraph 6a of the Allegation proved.

Paragraph 6bi of the Allegation

128. In her witness statement, Patient B stated:

> *"5. Paragraph 4 of My Account notes that my first consultation with Dr Dixon took place in April 2012. I have checked my email correspondence with the Spire Hospital in Bristol and the date of this initial consultation was actually 22 March 2012. I attended this initial consultation at Spire Bristol with my husband, [Mr C]. During this consultation, Dr Dixon examined my rectum privately behind a screen and confirmed that I had a rectal prolapse. My husband [Mr C] was in the room at the time but at the other side of the screen. At no time during the consultation did Dr Dixon offer me a chaperone and none was present at the time of the rectal exam."*

129. Patient B also provided an undated, initial account of events which preceded her witness statement to the GMC. In her witness statement to the GMC she also stated:

> *"3. In 2018 and again in 2019, I provided written accounts of the care and treatment provided to me by Dr Dixon. The first account dated 27 March 2018 is headed 'IBS History – Medical Summary' was provided to XXX Solicitors for them to assess whether a case could be made for damages against the Spire and Dr Dixon in respect of the mesh operations. This account was re-drafted with slightly more detail into another account dated 22 February 2019 and is headed '[Patient B – Personal Statement to The Independent Medicines and Medical Devises Safety Review' (herein referred to as 'My Account'). I can confirm that My Account is accurate to the best of my knowledge save for the additions included in this statement as detailed below."*

130. The Tribunal noted that within Patient B's initial account, there is no reference to a chaperone not having been offered or present during her consultation with Mr Dixon, that the reference only appears in her GMC witness statement.

131. In oral evidence under cross examination by Mr Basu, Patient B stated:

> *"Q I just asked you a moment ago, there then came a point where he needed to examine you and so he said to you effectively, "I will need to examine you", and he offered you a chaperone, didn't he? He asked if you wanted a chaperone to sit in on the examination?*
>
> *A I can't recall. I can't recall.*
>
> *Q You didn't require a chaperone, perhaps because you'd been examined intimately by doctors a number of times previously, but you said, "No, thank you"?*

A *My husband is always there. He was always there in all the appointments. My husband is always there in appointments. However, the curtain will be pulled, I've got to say. I think the only time we had a chaperone, I had a chaperone was the latter part and that was unusual because I thought I've never been offered a chaperone before and that was in the 2016 time, after that. So, that was quite unusual, yes.*

Q *Are you saying that you weren't offered chaperones when you were previously examined by other doctors?*

A *I think there was once when I didn't need one but I think that was a testing of the – you know, when they do your heart testing when they put these plastic things on your chest. I think at one point – that was – gosh, anyway, I remember saying, "Don't worry" because again – no, I don't think my husband was around, I didn't feel threatened by that because it wasn't anything internally. I remember not agreeing to one then, vaguely*."

…

Q *Can we just go back over that then just to avoid any doubt at all. Do you accept that Mr Dixon offered you a chaperone or do you not remember?*

A *I don't recall being offered, I don't remember.*

Q *He will say that he offered or asked you if you wanted a chaperone and you said you didn't want one, didn't need one. What do you say to that?*

A *I'm sure I would have accepted if I was offered one, but I don't recall being asked anyway."*

132. In his oral evidence, Mr C, Patient B's husband also told the Tribunal that he could not recall if Patient B had been offered a chaperone by Mr Dixon.

133. Mr C was asked by the Tribunal whether there was ever a chaperone present, he said there was not. He said that there may have been on one occasion towards the end, but that there was not one there ordinarily. He was asked whether there was a chaperone in Patient B's first consultation with Mr Dixon, around March 2012, he said that he did not remember there being one available or present, nor did he recall that one was offered and declined.

134. There was no contemporaneous documentary evidence before the Tribunal to suggest that Mr Dixon had asked Patient B if she would like a chaperone. As previously noted, Mr Dixon said in his evidence that it was his usual practice to ask a patient if they would wish to have a chaperone present for an examination, but that he did not record in the medical notes if they had declined.

135. Patient B's oral evidence undermined her witness statement, which could also not be supported by either her initial account, or the evidence of Mr C.

136. The Tribunal determined that there was insufficient evidence to support the claim of Patient B that Mr Dixon failed to ask Patient B if she would like a chaperone, and that the GMC had not discharged its burden to demonstrate on the balance of probabilities that Mr Dixon had failed in this regard.

137. Accordingly, the Tribunal found paragraph 6bi of the Allegation not proved.

Paragraphs 6ii (1) and (2) of the Allegation

138. There was no evidence within Patient B's medical notes recording that Mr Dixon had asked Patient B if she would like a chaperone present, or that Patient B declined a chaperone. For the same reasons as set out earlier relating to Patient A the Tribunal considered that this was information that should have been recorded and that Mr Dixon accepted should have been recorded but was not.

139. Accordingly, the Tribunal found paragraphs 6bii (1) and (2) of the Allegation proved.

Paragraph 7 of the Allegation

7. In June 2016 you consulted with Patient B and you failed to:

   a. adequately advise Patient B about her underlying:

      i. diagnosis; **Determined and found not proved**

      ii. prognosis; **Determined and found not proved**

   b. adequately outline options for treatment, including:

      i. non-operative treatments;
      Determined and found not proved

      ii. providing no treatment at all; **Determined and found proved**

   c. with regards to the proposed treatment, outline the:

      i. purpose; **Determined and found not proved**

      ii. expected benefit; **Determined and found not proved**

iii. associated risks; **Determined and found not proved**

d. (in the alternative to paragraph 7a-7c) record taking the steps at paragraph 7a-7c.
Determined and found proved in respect of 7bii, 7ci and ii only

Paragraphs 7ai and ii of the Allegation

140. in respect of paragraphs 7ai and ii of the Allegation, Patient B stated in her witness statement:

> *"11. At paragraph 5 of My Account I note that between 2012 and 2015 my condition worsened significantly. I was left unable to return to work XXX due to my condition, as the work was ad hoc and my symptoms meant that I could not commit to work on this basis. I was very down physically and mentally. I also note at paragraph 5 that I attended a consultation in 2015 with Mr [X] for a second opinion. At this stage and having put up with the pain for so long even after the procedure with Dr Dixon I just wanted to see what other options were available to me and wanted a second opinion. At the back of my mind I was worried that something may have gone wrong with the procedure performed by Dr Dixon, which is why I thought someone else's input was important. Mr [X] advised against further surgery at this stage and although he didn't go into depth about why he thought this, he did suggest I try a series of non-surgical treatments first, including suppositories.*
>
> *12. Despite the use of suppositories, my condition continued to get worse and so I decided to get back in touch with Dr Dixon in 2016 to see if he could recommend anything else.*
>
> *13. The consultation with Dr Dixon took place on 28 January 2016. I attended again with my husband [Mr C]. We discussed what else I could do to alleviate my symptoms and Dr Dixon suggested a colonic irrigation trial, alongside a further colon transit study. He said that the colonic irrigation might ease my pain…*
>
> *14. At paragraph 6 of My Account I detail how the colonic irrigation trial only provided very limited relief from my symptoms and so I reverted to Dr Dixon to see what else could be done. In email communication with Dr Dixon in March 2016 he suggested a further surgical procedure, this time a 'surgical resection'…*
>
> *16. At the end of paragraph 6 of My Account, I note that I continued to be unaware if the concerns regarding the use of mesh. At the time this was true but with hindsight I have learned of the very real risks of mesh surgery and applying it to my*

condition. None of this at all was explained in any detail at the time by Dr Dixon prior to either surgery. The advocacy of mesh using laparoscopic means by Mr Dixon in 2012 was very blasé, there was no mention of any risks. I only became aware of any problems in 2017. The risk discussed prior to the operation in 2016 centred on the re-section operation and possibility of a failure of the anastomosis, resulting in the need for a temporary colostomy or ileostomy instead. There was no discussion of the potential failure and replacement of the original mesh, and the risks associated with that. Since then Dr [T], from whom I have since received treatment for my ongoing condition, has educated me in that the repeated insertion, removal and re-insertion of mesh and a bowel re-section can severely deplete the limited number of active nerve channels operating the bowel area, probably resulting the very limited motility I now suffer from. If I had known that prior either of the operations and the irreversible harm that can cause I would have taken a different path."

141. In her oral evidence, following questions from Ms Fairley, it was Patient B's evidence that:

"Q You have a consultant surgeon not only explaining the risks and the fact that the result is unpredictable, at least on this page, and despite that you seem to still be exploring the option of surgery. Why is that?

A Okay, I'll give you an answer. Something wasn't quite right, something wasn't right, and I needed what was wrong to put right. I just didn't get it. I mean, most people surely will go for second, third opinion, we're all entitled to that. Some people can always be right all the time, I just needed to get an answer, I need to be better.

Q Is it right to say that this reflects the fact that, despite being told about the downsides of surgery, you are the sort of realistic person that will accept the risk of that downside of surgery in favour of the potential benefits of surgery when the risks are explained to you?

A Sorry, I didn't know the risks. If I knew the risks, no, I wouldn't have gone ahead with the surgery. I didn't know the risks would be so severe as I know now.

Q He says he's discussed the role of this operation in slow transit constipation. He seems to refer to having had a discussion about surgery with you and its role.

A With whom?

Q Mr [X] who we are talking about here, the author of this letter.

A *He didn't go into too much detail, to be honest with you. He just told me how it was and how he knew and I guess it was down to me to go away and think about it. He didn't examine me, he just listened, he just gave me his opinion as we see in the letter, the letter goes away, goes away for many years, then it brings back memories, and it's hard on memories, so, yes, so you can kick yourself. I mean, it's right, isn't it? Staring you in the face, isn't it?*

Q *When he discussed the role of subtotal colectomy and ileorectal anastomosis, did he explain to you how that surgery, in his mind ---*

A *No, no ---*

Q *--- could be carried out?*

A *He said he wouldn't recommend it and that was good enough for me, but obviously again I didn't listen to what that was about. I should have gone away and thought about it, talked about it and asked about it and asked him about it. This is always should have, ought to have, and maybe perhaps. I live with this guilt every day, and when I see this, it is distressing and upsetting.*

Q *Well, when Mr Dixon later explained to you the risks of surgery and that a poor result was possible, it didn't put you off any more than Mr X put you off, did it?*

A *I didn't recall the extent of risk, we went through this at the beginning of today, this morning. I didn't have an extensive risk factor and I didn't have the literature which supposedly had come to me from Mr Dixon.*

…

Q *So, he examined you in a similar way to before and then sat you down to have a discussion. In fairness to you, you just said that you can't remember him examining you. I was just seeing whether, thinking about it, you recall that you would have had an examination and then a discussion with Mr Dixon and your husband about what the options were?*

A *Of course I can remember him examining me, but I can't recall dates and times and anything else and the conversation we had. I think that's probably a bit much to ask me. Again, I can look back to my records and stuff and see when I came in to give you the right answer, which dates and what happened. I just really can't recall anything of what you're asking specifically to give you an answer. I'd like to and I wish I could.*

Q *Did he tell you that the diagnosis seemed to him – sorry, that his findings were that the prolapse that you'd previously had appeared to be controlled?*

A *I don't recall that either, sorry. I do apologise, I just don't recall that.*

…

Q *He said that he told you that what seemed to him to be the difficulty, the problem, was an evolving slow transit constipation. Do you recall that discussion?*

A *I know I have slow transit, I'm aware of slow transit, but I don't recall any conversation in depth. I'm not saying it didn't happen, but to give you the correct answer, which I'd like to do, I'd rather say I don't recall what's happened, what's said.*

Q *Do you recall him saying that this is likely a result of the hysterectomy which can cause denervation?*

A *He did, yes, he said that's probably – he sees a lot of ladies, he was quite upbeat about it and I was very thrilled when he said that, not because of other people, he said he had a lot of this with ladies coming in with the same problem, "But never mind, we can get it sorted, you know, I have the type of thing that would work for you and we'll be up and running and off you go". So, it was really good to hear that, it was really elating to hear that, I was over the moon, literally over the moon, thinking, "Thank heavens, I've got an answer to my prayer."*

Q *Is it right that he was discussing removing all or part of your colon as a potential solution to your constipation, worsening constipation problem?*

A *He said he'd just remove it because the colon was dead and all the transit markers are stuck in the hindgut. So, again, that was still going – I thought, oh my word, maybe that's what's been going wrong and obviously when you have a dead colon, you can't leave it in there. Again, I have faith and trust and I thought, well, it's got to go, I can't have this, I can't have a dead colon, it's no use to me at all, so that's why I had it done, I agreed to have the colon removed because that's what I was told, it's dead.*

Q *I'm not doubting that you took away from the conversation that the colon was dead, but can I suggest to you that that's not a phrase that Mr Dixon would have used. For a surgeon to say a part of your insides is dead is quite a serious and big thing. I suggest he didn't express himself in that way, although you might well have taken it away from the conversation. Can I suggest what he would have said to you and see whether you accept that that's, on reflection ---*

A *I can recall that he did say the colon was dead. I have it in several – in the paperwork I've got. So, I wouldn't just make it up, and that word made me sick really.*

Q *There are many things that you say you can't remember, not surprisingly from seven years ago, seven and a half years ago. Might it not be that you have misremembered this and in fact he said to you that the hysterectomy, as sometimes happens, through no fault of the surgeon, can cause denervation of the colon, so he was telling you that the nerves were damaged, not that the colon was dead, it was denervated?*

A *I didn't hear that terminology.*

Q *Might it be that you misunderstood what he was telling you when he was explaining how the hysterectomy had, in his view, caused this problem with the colon?*

A *The colon was 2016, if we're talking about the first one, hysterectomy is before 2012. Some of my literature, I make a statement about the large – it was effectively dead. I have done that with several literature in the past few years.*

Q *I realise you've said that in various statements, but it's not really whether you've written it down several times, it's whether you remember him actually saying to you that your colon is dead. It's quite a big thing for a surgeon to say. People's bowels can effectively die and that's an emergency and it's incredibly painful.*

A *It was an emergency for me if it was not working. Yes, quite worrying. So, the resection sort of made sense, I had to do it, I had to get on with it, and bite the bullet and go without a colon.*

142. Patient B's oral evidence in answer to questions from Mr Basu was as follows:

"Q Yes, that's the email we looked at yesterday, [Patient B], from a couple of days before this consultation. The next thing written on the page is "Denervated". So just underneath where it says, "hind gut", underlined, "Denervated". What that means ---

A What does that mean, that word?

Q Firstly, is that a word that you recall hearing Mr Dixon use or explain to you? This is a long time ago, of course.

A Can you say the word again, please? I'm just not familiar with the word that you've asked me.

Q "Denervated".

A Okay.

Q What it means is that whatever the organ, or structure, or part of the body we're talking about, it has its nerve supply interrupted or terminated.

A Right, okay. I don't recall that word being mentioned. But it might be someone's explained that to me."

…

I don't recall that too much depth of what's going to happen. I'm not saying he didn't, but I don't recall the depth of how what else can happen during and after. I'm sure he mentioned risks, which most consultants do but I don't recall in-depth what we're reading here too much

Q Do you recall that he mentioned that you might be so poorly as to need intensive care treatment?

A No, I don't recall that at all, about intensive care or A&E, no.

Q (Pause) . Then the next thing, I think, says if you don't take enough bowel out the constipation would get worse – sorry, would remain, rather – but if you take too much, you can cause other problems. So he was talking to you there about the fact that he'd need to take out the right amount of bowel that was denervated and not take too little, so there's some bowel that's not functioning

properly left, or take too much, where you can cause other problems. Do you recall that discussion, or that sort of discussion?

A *No, I don't recall that in depth. I don't recall that at all, in depth.*

Q *(Pause) . He explained to you this was keyhole surgery, using the same port sites – in other words, the same holes, or areas for holes, that have been used previously. You'd obviously previously had keyhole surgery. He explained to you this was very similar and he'd make the same holes. Does that sound familiar to you?*

A *It doesn't. I don't recall that amount of familiarity.*

Q *Do you recall being told it was keyhole surgery or laparoscopic surgery?*

A *I was aware of it, anyway, keyhole surgery so he may well have. I'm not saying he didn't, but I don't recall this in depth of what's going on.*

Q *Did he explain that he would need to cut away the top third of your rectum, using a stapler machine, and that that might mean that he'd have to do something with the mesh that was attached there from the previous operation?*

A *No, I don't recall that, at all. I don't recall that, at all.*

Q *Did he say to you that the parts of the bowel that he took out would be removed through your tummy button, or umbilicus?*

A *No, I don't recall that either. No.*

Q *Did he explain to you, do you recall, that there was a potential benefit in about 80% of patients of this sort of surgery?*

A *No, I don't recall that at all.*

Q *You were concerned about the outcome because you knew about the risks that Mr Dixon had explained to you and also Mr [X] had explained to you.*

A *Do you know what? I just wanted to get that colon out because it was dead. That's all I was concerned about. I had to put up with what happened*

afterwards. I just have to make amends, cope after an operation your bowel was "dead".

A *Yes.*

Q *I wanted to ask about that. You have made a video statement that's online, I think published by your solicitors, XXX Solicitors, where you describe your experience of these operations, and you talk about Mr Dixon. That's all correct, isn't it?*

A *I can't recall naming him much in that video. I've just given my story of what my experience was. I will still stick to my word – the word "dead" was used.*

Q *Have you seen that online another patient, called [Patient A], has also made a video statement, I think also through the same solicitors that you share.*

A *No, I didn't.*

Q *Talking about her experiences of operations.*

A *What's her name? Sorry, I don't really watch a lot of other people's, and what's her name, sorry?*

Q *You might know her as [Patient A].*

A *No, I don't. I don't know her at all, personally or otherwise.*

Q *Because she's also claimed that Mr Dixon told her that she had dead bowel.*

A *No, I'm not aware of her, and that's the honest truth. I am not aware of this. I've never heard of it. I've never heard of her."*

143. In his letter of the appointment with Patient B of 19 February 2015, to her GP, Mr X, Consultant General and Colorectal Surgeon, stated:

"[Patient B] requested an appointment at the Spire for a further opinion regarding management of her difficult bowel symptoms. She complains of constipation and difficult bowel actions which have been troublesome for about 11 years…

She has had a number of investigations and treatments with Dr [W]. Previously proctograms bad shown an intussusception and she had what sounds like a ventral mesh rectopexy under Mr Dixon's care previously. This helped to a certain extent and reduced the amount of problems she was having with loose stools. She is now predominantly affected by constipation. If she has a normal meal she tends to get abdominal bloating which is quite severe and comes on immediately after the meal. It can last several days. She does not tend to get any spontaneous bowel actions and has to resort to digital evacuation to empty the rectum. She has been trying Prucalopride recently which has helped to a certain extent in that it sometimes is associated with her having a spontaneous bowel action. A lot of the time now she tends to avoid eating regular meals and just takes light meals to try to avoid the abdominal bloating.

In terms of treatments, she has a dietitian and had advice about her diet and has sensitivities to lactose and wheat. She has tried antispasmodics and Amitriptyline and the probiotic VSL and is now trying Prucalopride. She has a healthy lifestyle and tends to do a lot of walking. She has also tried hypnotherapy. None of e treatments she has tried have been particularly helpful.

In terms of investigation, we would normally want to know that her calcium level is normal and that she has had her thyroid function checked. I assume that has already been done but she is going to check that her thyroid function has been assessed. I do not think there would be a lot to offer by re-imaging the bowel which has been done thoroughly in the past including a transit study which I understand was equivocal initially and then showed slow transit subsequently. I do not think there is a place for surgery in managing her condition. We did discuss the role of subtotal colectomy and ileo-rectal anastomosis in slow transit constipation but I would not recommend this in general or in her case in particular because of the unpredictable result and the associated morbidity. Because she has a specific problem with digital evacuation it may well help to use suppositories to try to initiate spontaneous rectal evacuation. I therefore suggested she tries initially glycerine suppositories moving on to Bisacodyl or Microlax enemas if these are ineffective. One other option would be to see the continence advisors at Southmead and consider rectal irrigation if nothing else helped. Otherwise I think she has tried the great majority of the evidence bases treatments already under Dr [W]'s care."

144. It was the case of Mr Dixon, as set out in Mr Basu's written submission, that Mr X must have had in mind an open (sub)total colectomy (i.e. removal of all of the colon), as opposed to a laparoscopically performed hindgut resection (removal of the distal third of the colon), which he does not perform and which is less invasive (although it still carries the same risk of life-threatening anastomotic leak). Patient B was copied into this letter and would have been aware of its content prior to seeing Mr Dixon.

145. In his letter to Patient B's GP, dated 29 March 2016 (clinic date 24 March 2016), Mr Dixon stated:

> *"I met up with [Patient B] and her husband today and went through her recent results. Essentially she has got a normal proctogram and she is evacuating normally but with a transit study that shows slow transit constipation in the left hand colon. There are no markers on the right hand side. We then had a chat about where we can take things forward. I have already referred [Patient B] for a trial of rectal irrigation and think she should keep an open mind and see if it has any impact on her symptoms. If it didn't or she found the whole thing abhorrent then yes we could consider her for a laparoscopic resection of the hind gut. That of course would expose her to risks of an anatomises and an operation. There is also some uncertainty as to what impact that will have in terms of function. If she did very well from that operation there is a risk in the medium term that she would then develop problems on the right hand side. Whilst she is awaiting the rectal irrigation I have suggested that she try some good old fashioned Magnesium Sulphate and see if that is much more effective than what she is using now"*

146. In his note of the consultation with Patient B on 14 June 2016, Mr Dixon recorded:

> "*Doing well with rectal irrigation. Better than before LVMR,*
> *but painful +++*
> *Abdominal distension —> Review. <—-> miserable.*
> *Epsom salts - No better*
> *Doesn't sound like a volvulus.*
> *Discussion about resection,*
> *Anastomotic leak,*
> *Sepsis / bleed or Stoma*
>
> *Encouraged to continue with RI [rectal irrigation]*
> *If pain continues get back [to me]*"

147. In his follow up letter to Patient B's GP from this consultation, dated 16 June 2016, Mr Dixon wrote:

> *"I met up with [Patient B] and her husband today and I must say I was delighted to hear and see that her rectal irrigation has been effective. She is coping really well and this seems to have transformed her life. The only issue is that she has had a further attack of abdominal pain associated with gross abdominal distension; this event precipitating the review tonight. We have had a long chat about the ins and outs of resection and the risks involved but given the overall improvement in her affect and*

quality of life I have encouraged her to persevere with the rectal irrigation for a little bit longer. If she has another bad attack within a month I have suggested she contact my secretary direct and we can then book her in for a laparoscopic resection."

148. In his expert report, Colonel L opined:

"…At best, Dr Dixon did discuss undertake appropriate consent discussion (including discussion of all material risks of this major surgery) with Patient [B] at the clinic visit in June 2016; however, he failed to adequately document them. At worst, he did not comply with RCS guidelines and did not adequately counsel Patient [B] about her underlying diagnosis and prognosis, he did not adequately outline options for treatment, including non-operative care and no treatment, did not explicitly outline the purpose and expected benefit of the treatment, the likelihood of success and the risks inherent in the procedure, however small the possibility of their occurrence."

149. In his expert report, Professor M opined:

"7.10 Between 2013 and 2016, [Patient B] was under the care of Dr [W], Consultant Gastroenterologist, who had undertaken repeat proctography, colonic transit study and CT colonography and as early as May 2013, and had provided the diagnosis of slow transit constipation, based on delayed transit and faecal loading on CT examination of the colon, the latter to exclude any serious new conditions such as bowel cancer or inflammatory bowel disease.

…

7.12 [Patient B] was seen by Mr [X], Consultant Colorectal Surgeon, in 2015 to discuss the management of her condition which he notes to be slow transit constipation confirmed by transit study. Mr [X] discussed the option of bowel resection to manage this condition but advised [Patient B] against this, suggesting she continues with non-surgical measures under the care of Dr W.

7.13 Therefore, in my opinion, the diagnosis of slow transit constipation was established prior to referral to back to Mr Dixon in 2016 and [Patient B] had already tried non-surgical treatments and had a discussion of the role of bowel resection to manage this condition."

150. In their joint expert report in respect of Patient B, dated 30 October 2023, Colonel L and Professor M stated:

Colonel L

"Diagnosis of slow transit constipation was assumed in 2012 (letter from Dr [W]), but transit study normal at that time.

Subsequent abnormal transit study considered by Mr Dixon to be 'unrelated to the LVMR' (para 64 AD statement)."

Professor M

"Diagnosis of Slow Transit Constipation from multiple sources and had been treated with prucalopride which is specifically for this condition before seeing [Mr Dixon].

The prognosis is unpredictable, but as with most functional bowel conditions, the condition usually deteriorates with time unless the underlying problem is addressed, or symptom management improved."

151. In response to questions from Mr Basu, Colonel L in his oral evidence stated:

Q "He recommends Movicol etc. So that's the picture that's about a year or so out from the LVMR operation. She has those studies and if we look at page 45, same bundle, four out of ten – it has a date of 19 April – it has various dates, but the first one you see is 19 April; do you have that – 25 markers remaining (41 per cent)?

A Yes.

Q Mr Dixon will say that that's actually not within normal parameters. That's actually outside two standard deviations from normal and therefore this is slow transit constipation that's indicated by this result of 41 per cent of retained markers?

A I agree it's not a normal study.

Q Is it consistent with slow transit constipation?

A It is, but not completely diagnostic of it.

Q The defecating proctogram is above that and it doesn't show any abnormality of any muscle function in the anorectum or of the anatomy itself; would you agree?

A Yes, I would agree.

Q *Page 46, please, CT scan – that's consistent with constipation what we see there?*

A *Yes, it's consistent with…*

…

A *I don't know of Mr [X] or his practice although I would align with his opinion. I don't think this particular patient would have – could have reasonably expected a good outcome with colectomy, open or laparoscopic.*

Q *Mr Dixon at this consultation advises [Patient B] that if slow transit constipation or signs consistent with it are confirmed in a second transit study and a repeat proctogram demonstrates no internal rectal prolapse, then she could consider having a laparoscopic colectomy. I take it you're saying that's not a reasonable approach to take – or are you saying so?*

A *As I've just said, I would align with Mr [X]'s opinion that this particular patient with her long history of gastrointestinal disorders is a patient who would be – you would have to be very careful to do a colectomy on because the functional outcome of that is likely to be poor, irrespective of the perioperative morbidity attendant with the operation.*

…

Q *Mr Dixon will say that he explained to [Patient B] that an operation such as a colectomy is not without risks and he outlined specifically the risk of an anastomotic leak with its sequelae and that would be reasonable to do. I realise you disagree with him about the floating of the operation, but having floated it, it is appropriate to discuss that risk?*

A *It's already been floated across Mr [X]'s bows, if that's the correct way of describing it, so it's reasonable to seek a further opinion, I think for the patient and that's a discussion about what the – the specialist's opinion, the perspective and the perceived risk and benefit – it's entirely reasonable for her to take.*

Q *It's appropriate for Mr Dixon to have told her that this is a form of surgery with an uncertain outcome?*

A *Yes.*

...

Q *You're right to qualify his initially optimistic sounding comment about surgical resection by saying this has to be balanced by risks, firstly, and potential failure. So taking that statement overall, he's accurately set out this uncertain picture for surgery and there are risks; correct?*

A *Yes, I'd agree.*

...

Q *He explains the risk – I'll try and go a bit faster because we've gone through a few of these – an anastomosis with five per cent risk of that and you can become very ill and he's referred to ITU, saying the word, "Intensive care treatment sometimes being necessary", so emphasising the gravity of that complication. He's right to do that, isn't he?*

A *Yes, that is an example of likelihood and impact being combined.*

Q *He's right, if he didn't mention death explicitly – I heckled you a few times about that – it's possibly going a bit too far to be so stark with people. As long as you're clear enough that it's a really serious complication and you can end up in intensive care that adequately explains the risk to people?*

A *The patient understands that it's potentially life-threatening requiring, you know, with a critical illness and uncertain outcome that's – that covers it, yes.*

Q *Lay people understand intensive care potentially ends in good, medium or terrible result – it's common knowledge, isn't it; you don't need to explain much more than that. "You might end up in intensive care" is quite a good way of explaining it's life-threatening?*

A *I'm not sure what her interpretation was of course.*

Q *You've not had to explain in great detail to somebody how ill you have to be and how much risk there must be to your life to end up in intensive care?*

A *I think critical illness is understood.*

...

Q *Just to introduce a point, but you'll have a chance to look at the paper or we'll supply it to you – the UK study has a figure of 67 per cent, so I'm going to suggest to you that, in fact, to say 80 per cent overall is not an unrealistic figure to give to a patient?*

A *Again it's how that 80 per cent success is – how the alternative of that is presented to the patient. If it's presented as 20 per cent doesn't work, then that's – I don't think that's reasonable because the outcomes can be very poor. This is a sort of zero sum gain. It's not that 80 per cent are okay, you know effective, and 20 per cent just doesn't work. That's why the UK surgical community has not traditionally or conventionally not been enthusiastic; it's because some of the outcomes are, indeed, extremely poor and in terms of – not in terms of death or life, but in terms of functional outcome and quality of life.*

Q *Would you agree with Professor [M]'s 7.32 that – well, he's recording the view you've signed up to:*

> *"Many surgeons [including you] consider surgery of this nature is best avoided. However, it continues to be practised, and is supported by some specialists in the UK and internationally."*

Would you accept that is a correct statement?

A *Yes, I do.*

Q *So it's open to a reasonably competent colorectal surgeon/consultant to favour this form of surgery?*

A *I think the conventional approach would be one of extreme caution. Typically a very careful review of the exact nature of the problem and the discussion in a complex multidisciplinary team environment to make sure that all the Is are dotted and all the Ts are crossed before embarking on a radical solution."*

152. Dr W diagnosed Patient B with slow transit constipation, this diagnosis was supported by Mr X, though Mr X advised against a resection.

153. Professor M's view was that by the time Patient B had seen Mr Dixon, her diagnosis was unchanged. Patient B had been told what the diagnosis was by three different clinicians.

154. The Tribunal was satisfied that the diagnosis of slow transit constipation was well established by the time of the consultation in June 2016. The content of the letter in June 2016 is all about Patient B's diagnosis. The Tribunal was therefore satisfied that Patient B was adequately informed about her diagnosis and there was no duty on Mr Dixon to have done anything further.

155. In respect of Patient B having stated in her witness statement and in oral evidence that Mr Dixon had told her that she had a 'dead bowel', the Tribunal noted that in her initial account she had said Mr Dixon referred to a 'lazy bowel' and it was not until her GMC witness statement that the term 'dead bowel' appeared.

156. Mr Dixon saw Patient B on 24 March 2016, his recorded note of the consultation reads:

> *"47% [markers retained] L colon = STC [Slow transit constipation}.*
> *Segmental, No prolapse [or enterocoele/sigmoiocoele seen on proctogram] and evacuating normally.*
> *Try rectal irrigation now. ? benefit will continue.*
> *? Lap[aroscopic] resection hind gut; denervated*
> *No need for STC / IRAnast [sub total colectomy and ileorectal anastomosis].*
> *Risks - anastomosis ~ 5%; can be ill/ITU [treatment]*
> *[if] Don't take enough [bowel] constipation remains; too much XXX [?]. Cant predict Epsom salts*"

157. It was Mr Dixon's evidence that he did not and would not say to a patient that they had a 'dead bowel'. His medical notes recorded the term 'denervated bowel'. The Tribunal determined that on the balance of probabilities it was unlikely that a colorectal surgeon of Mr Dixon's experience would use the term 'dead bowel'. The Tribunal concluded that it was likely that Patient B's recollection of Mr Dixon's use of the term 'dead bowel' was mistaken.

158. In terms of the prognosis, at the consultation in June 2016 Mr Dixon advised Patient B that she should proceed with the rectal irrigation and epsom salts. The Tribunal was satisfied that this was adequate advice which was consistent with Mr Dixon's opinion that Patient B had slow transit constipation. The Tribunal also noted the letter to Patient B's GP as set out above which referred to Mr Dixon's 'long chat about the ins and outs of resection and the risks involved', together with his encouragement to persevere with the rectal irrigation. The Tribunal noted that this discussion was recorded in Mr Dixon's note of the consultation and it accepted Mr Dixon's evidence that these matters were discussed. In these circumstances the Tribunal was satisfied that Mr Dixon had adequately advised Patient B during the consultation in June 2016 about her prognosis following a resection to deal with her diagnosis of slow transit constipation.

159. Accordingly, the Tribunal found paragraphs 7ai and ii of the Allegation not proved.

Paragraph 7bi of the Allegation

160. When considering whether Mr Dixon adequately outlined options for treatment, including non-operative treatments when he consulted with Patient B in June 2016, the Tribunal considered that it was Colonel L's evidence that there had been insufficient focus on the option of continuing with the rectal irrigation in a patient who was responding to it. He also said that if Patient B had been encouraged to continue with rectal irrigation by Mr Dixon, it might have avoided the need for surgery and led to a better outcome for Patient B.

161. The Tribunal noted that both Dr W and Mr X had tried a number of non-surgical options. Mr Dixon had also suggested colonic irrigation, epsom salts and prucalopride and only if they did not work, then to think about a surgical option.

162. It was Colonel L's criticism that Mr Dixon did not give rectal irrigation long enough before discounting it as ineffective. Mr Dixon had however suggested that rectal irrigation should continue for as long as Patient B could tolerate it.

163. In oral evidence, Colonel L stated:

> *"Q You set out in your report your criticism that Mr Dixon didn't give the irrigation long enough. Again we have obviously touched upon this in terms of non-surgical treatment options, but in terms of what length of time would you have expected irrigation to have been tried?*
>
> *A Again, I will go back to my previous answer: that it's not just about the time period, it is about a perception of what is best for the patient, so this patient apparently did respond to rectal irrigation. If she had been encouraged to continue with that and really invest in it then I think that would have avoided the requirement – might have avoided the requirement for surgery and would have led to a better outcome for the patient.*
>
> *Q There is reference in the allegation at (b)(ii) to providing no treatment at all. Was that an option in respect of Patient B at this juncture?*
>
> *A That has always been the conventional treatment for evacuatory disorders when there weren't surgical options that were perceived as helpful. Then optimising non-surgical treatments, doing nothing, as if doing nothing is the wrong way of presenting the option to the patient – to optimise the non-surgical treatment is always an option.*

Q *That should be explicitly explained to the patient in clear terms, that that is an option they should consider.*

A *Yes.*

Q *You set out again in your report that it was an overly optimistic view of the expected benefit of surgery*

A *I do acknowledge Mr Dixon's technical expertise, his mastery of surgery and I think that he had perhaps been seduced by his own technical brilliance and felt that this was the answer to patients' problems, particularly in his hands. I think when one is a technical expert and becomes very adept with a surgical procedure then it gives the positive reinforcement that it is the right thing for the patients because "You've got a problem, I am technically brilliant at a procedure – put those two together and everything will be great," so surgeons can become overly optimistic about the outcome of their operations."*

164. The Tribunal considered the context of these circumstances. Patient B was under the belief that Mr Dixon was performing this surgery because she had either a 'lazy' or a 'dead' colon. Mr X had advised against a surgical option and he and Dr W said that Patient B had slow transit constipation and would have to learn to live with it.

165. It was Colonel L's opinion that Mr Dixon, as a 'master of surgery', thought he would be able to fix the problem with surgery without first outlining options for treatment including non-surgical options, and giving them enough time to work.

166. Between January and June 2016, Mr Dixon encouraged Patient B to use rectal irrigation, try colonic irrigation, epsom salts and prucalopride and only then, if they did not work, think about a surgical option.

167. The Tribunal was satisfied that Mr Dixon did not proceed with a surgical intervention until the non-surgical options were no longer working for Patient B.

168. Accordingly, the Tribunal found paragraph 7bi of the Allegation not proved.

Paragraph 7bii of the Allegation

169. When considering whether Mr Dixon adequately outlined options for treatment, including providing no treatment at all, the Tribunal had before it no documentary evidence that the option of providing no treatment was put to Patient B by Mr Dixon at any point. The note of the consultation records the discussion and the Tribunal was satisfied that it was likely that the option of providing no treatment at all was not discussed.

170. Accordingly, the Tribunal found paragraph 7bii of the Allegation proved.

Paragraphs 7ci, ii and iii of the Allegation

171. When considering Mr Dixon's alleged failure in that when he consulted with Patient B in June 2016, he failed to outline the purpose, expected benefit, or associated risks of the proposed treatment, the Tribunal had regard to his consultation note of 24 March 2016. In it he recorded:

172. In his consultation note of 24 March 2016, Mr Dixon recorded:

> "*47% [markers retained] L colon = STC [Slow transit constipation}.*
> *Segmental, No prolapse [or enterocoele/sigmoiocoele seen on proctogram] and evacuating normally.*
> *Try rectal irrigation now. ? benefit will continue.*
> *? Lap[aroscopic] resection hind gut; denervated*
> *No need for STC / IRAnast [sub total colectomy and ileorectal anastomosis].*
> *Risks - anastomosis - 5%; can be ill/ITU [treatment]*
> *[if] Don't take enough [bowel] constipation remains; too much XXX [?]. Cant predict Epsom salts*"

173. Mr Dixon made reference to associated risks of the proposed treatment. It was Mr Dixon's case that identifying that there is the possibility of ITU treatment post procedure indicates the potential for a serious or potentially life-threatening outcome.

174. In his note of the consultation with Patient B on 14 June 2016, Mr Dixon recorded:

> "*Doing well with rectal irrigation. Better than before LVMR,*
> *but painful +++*
> *Abdominal distension —> Review. <—-> miserable.*
> *Epsom salts - No better*
> *Doesn't sound like a volvulus.*
> *Discussion about resection,*
> *Anastomotic leak,*
> *Sepsis / bleed or Stoma*
>
> *Encouraged to continue with RI [rectal irrigation]*
> *If pain continues get back [to me]*"

175. Mr Dixon made reference to associated risks, including sepsis, of the proposed treatment and discussion about the resection.

176. The Tribunal again had regard to Mr Dixon's follow up letter to Patient B's GP from this consultation, dated 16 June 2016. In it, he recorded that:

> *"…We have had a long chat about the ins and outs of resection and the risks involved but given the overall improvement in her affect and quality of life I have encouraged her to persevere with the rectal irrigation for a little bit longer…"*

177. The Tribunal was satisfied that there was documentary evidence of a discussion of the purpose, expected benefit, and associated risks, including admission to ICU, of the proposed treatment.

178. Accordingly, the Tribunal found paragraphs 7ci, ii and iii of the Allegation not proved.

Paragraph 7d of the Allegation

179. In respect of whether Mr Dixon recorded that he adequately advised Patient B about her underlying diagnosis (7ai); Patient B had an ongoing diagnosis throughout the consultation with Dr W, Mr X and during the continuing transit study, there had been no change or challenge to this diagnosis. The Tribunal did not accept Colonel L's opinion that there was a duty on Mr Dixon to record this diagnosis at the consultation in June 2016 as it was evident in Patient B's earlier medical records.

180. In respect of whether Mr Dixon recorded that he adequately advised Patient B about her underlying prognosis (7aii); in terms of the progression of Patient B's slow transit constipation, this was set out in the consultations in respect of the January 2016 and June 2016 notes. The Tribunal was of the view that Mr Dixon made it clear in those records that Patient B had denervation of the colon causing slow transit constipation. Further, the Tribunal noted that Mr Dixon had recorded in a letter to Patient B's GP, a discussion with Patient B at the June 2016 consultation about 'the ins and outs' of surgery and options for non-surgical treatment. The Tribunal was satisfied that there was evidence that Mr Dixon had recorded both in his notes of the consultations and in his letter to the GP, the steps he had taken to explain to Patient B about her prognosis.

181. In respect of whether Mr Dixon recorded that he adequately outlined options for treatment, including non-operative treatments (7bi); Mr Dixon had recorded that Patient B should try rectal irrigation, epsom salts and prucalopride and only if they did not work, then think about a surgical option. The Tribunal was satisfied that Mr Dixon had recorded taking steps to outline options for treatment, including non-operative treatments.

182. In respect of whether Mr Dixon recorded that he adequately outlined options for treatment, including providing no treatment (7bii); as this allegation is in the alternative and 7bii has been found proven. As this matter has been considered and found proved, the

Tribunal concluded that it was not required to make a second finding on this paragraph of the Allegation.

183. In respect of whether Mr Dixon recorded that he outlined the purpose of the proposed treatment (7ci); the Tribunal could see no documentary evidence that he had recorded taking such steps.

184. In respect of whether Mr Dixon recorded that he outlined the expected benefits of the proposed treatment (7cii); the Tribunal could see no documentary evidence that he had recorded taking such steps.

185. In respect of whether Mr Dixon recorded that he outlined the associated risk of the proposed treatment (7ciii); the Tribunal had before it documentary evidence that he had recorded the risks as outlined above.

186. Accordingly, the Tribunal found 7d of the Allegation proved in respect of paragraphs 7bii, 7ci and ii only.

Paragraph 8 of the Allegation

8. On 15 July 2016 you performed a hindgut resection and LVMR ('Patient B's Procedure') and you failed to:

   a. ensure Patient B's procedure was clinically indicated in that you did not arrange all necessary tests and investigations beforehand; **Determined and found not proved**

   b. obtain informed consent in that you:

      iv. had previously only told Patient B that you would perform a surgical resection; **Determined and found not proved**

      v. did not discuss the risks associated with Patient B's Procedure; **Determined and found not proved**

      vi. did not make a legible copy of the consent form; **Determined and found proved**

      vii. obtained consent on the day of Patient B's Procedure; **Determined and found not proved**

   c. (in the alternative to paragraph 8bv), record taking the steps at paragraph 8bv. **Determined and found not proved**

187. In respect of paragraph 8a of the Allegation, Colonel L's opined in his expert report:

"In my opinion, the bowel resection operation should only have been considered after specialist review at a MDT, after full re-evaluation and after exhausting all other alternatives and with explicit consent that a "very poor" result was possible.

In 2012, Patient [B] was referred to Dr Dixon by a respected gastroenterologist who had undertaken a thorough work-up. I note that Patient [B] had also undergone anorectal manometry in April 2012 (although I have not seen the results of this investigation). I note that a proctogram had been arranged by Dr [P], consultant gastroenterologist, which is reported a showing "sleeving of the rectum" (Dr [P]'s letter to the patient dated 3 Mar 2012). The medical term for this condition is internal rectal intussusception. Patient [B] states that Dr Dixon confirmed the presence of internal recto-rectal intussusception with a rigid sigmoidoscope in the clinic. At the time of the procedure, a laparoscopic ventral rectopexy was a reasonable treatment for this condition. Based on this evidence, I consider that Dr Dixon took a thorough history, undertook an appropriate specialist examination of the patient and offered a valid and reasonable specialist opinion.

In 2016, Dr Dixon undertook a colonic transit study and a repeat proctogram as investigation. In an email dated 16 March 2016, Dr Dixon informed Patient [B] that the "proctogram/evacuatory bit is OK The ctransit study showed a lot of hold up in the left colon". He arranged Patient [B] to have a trial of rectal irrigation and then appears to have recommended a major colorectal resection without repeating full re-evaluation (including anorectal manometry) or recourse to a multi-disciplinary review or trial of other alternatives. I do not think that this is reasonable and falls seriously below the standard expected of a reasonably competent consultant surgeon.

In my opinion, the laparoscopic ventral mesh rectopexy undertaken in May 2012 was clinically indicated and the care provided met the standard expected of a reasonably competent consultant surgeon. However, in my opinion, the laparoscopic anterior resection and redo ventral mesh rectopexy and sacrocolpopexy undertaken on 15/07/2016 was not clinically indicated as Patient [B] had not been fully evaluated and had not undergone a trial of alternatives to surgery and therefore the care provided falls seriously below the standard expected of a reasonably competent consultant surgeon."

188. In his oral evidence, Colonel L said that:

"Q So it's open to a reasonably competent colorectal surgeon/consultant to favour this form of surgery?

A I think the conventional approach would be one of extreme caution. Typically a very careful review of the exact nature of the problem and the discussion in a complex multidisciplinary team environment to make sure that all the Is are dotted and all the Ts are crossed before embarking on a radical solution."

189. Professor M opinion in his expert report:

"7.38 [Patient B] was adequately investigated before this surgery with two colonic transit studies (both showing delay), a CT colon scan which showed faecal loading in the colon and a proctogram, which excluded material recurrence of the original internal rectal prolapse. A working diagnosis of IBS with a tendency to slow transit constipation was indicated by Dr [W] in May 2013, and the diagnosis was of slow transit was not challenged by Mr [X] in February 2014, but rather, he did not support a surgical option for its treatment.

7.39 In my opinion, Mr Dixon demonstrated that there was a clinical indication for this surgery. The purpose of the operation is described in the notes of Mr Dixon and the criteria for considering colonic resection for slow transit constipation are met as outlined by NICE and employed in major centres offering surgery for constipation."

190. The Tribunal noted that Colonel L was more conservative in his view, and whilst he would not have undertaken the procedure himself, it was noteworthy that a number of investigations and tests had already previously been done by Dr W, Mr X and then by Mr Dixon himself. Mr Dixon had told Patient B about non-surgical options and that he would only proceed with surgical options once she was no longer happy that non-surgical options were working.

191. The Tribunal recognised that there was a difference of medical opinion as to whether or not this procedure was clinically indicated. However, it accepted the opinion of Professor M that in Patient B's case the criteria (as outlined by NICE and employed in major centres offering this type of surgery) for considering colonic resection for slow transit constipation were met.

192. Colonel L said that a hind gut resection was something which would be done as a last resort with patients suffering with slow transit constipation. Professor M disagreed that there was any need for further investigations. The Tribunal considered that it was for the GMC to demonstrate that if further investigations were needed, what other options were available and why then the procedure was not clinically indicated as Colonel L's view was one among a number of professionals who disagreed.

193. The Tribunal considered that Dr W had said to Patient B she had slow transit constipation, tried a number of non-surgical options and there was no more he could do for her and discharged her from his care. Mr X advised against surgery and suggested that Patient B learn to live with her condition. Mr Dixon then satisfied himself that all the necessary tests and treatments had been tried and they were not working for Patient B before undertaking the procedure, which he considered was clinically indicated. Professor M observed that the procedure met the criteria set out by NICE, and was clinically indicated, which the Tribunal accepted.

194. Accordingly, the Tribunal found paragraph 8a of the Allegation not proved.

Paragraph 8biv of the Allegation

195. In respect of the allegation that on 15 July 2016 Mr Dixon performed a hindgut resection and LVMR, and failed to obtain informed consent in that he had previously only told Patient B that he would perform a surgical resection, the Tribunal had regard to Patient B's witness statement:

> *"16. At the end of paragraph 6 of My Account, I note that I continued to be unaware if the concerns regarding the use of mesh. At the time this was true but with hindsight I have learned of the very real risks of mesh surgery and applying it to my condition. None of this at all was explained in any detail at the time by Dr Dixon prior to either surgery. The advocacy of mesh using laparoscopic means by Mr Dixon in 2012 was very blasé, there was no mention of any risks. I only became aware of any problems in 2017. The risk discussed prior to the operation in 2016 centred on the re section operation and possibility of a failure of the anastomosis, resulting in the need for a temporary colostomy or ileostomy instead. There was no discussion of the potential failure and replacement of the original mesh, and the risks associated with that. Since then [Mr T], from whom I have since received treatment for my ongoing condition, has educated me in that the repeated insertion, removal and re-insertion of mesh and a bowel re-section can severely deplete the limited number of active nerve channels operating the bowel area, probably resulting the very limited motility I now suffer from. If I had known that prior either of the operations and the irreversible harm that can cause I would have taken a different path."*

196. In cross examination by Mr Basu, it was Patient B's evidence:

> *"Q I'm about to come on to the sketch, actually. But just make sure we're on the right one. 61, 12 July 2016.*
>
> *A Yes, the one we spoke about, all the diagrams on, and everything.*

Q *Yes, and so these diagrams, what they are, what they represent is Mr Dixon, as he sat with your husband and yourself, drew sketches to explain what was involved in the surgery. So the left-hand sketch is the one he drew, showing the colon right through, around to the rectum, and showing which bit he would cut out in this sort of operation. Do you accept he showed you that diagram, in order to explain the operation?*

A *I can't recall this specific one. I can't recall that. I do remember him doing some sort of diagram, but I can't recall this specific diagram. I'm not saying he didn't, but I'm just saying I can't recall it.*

Q *He explained that the risks were bleeding, sepsis and ileus.*

A *No. I didn't have that explanation. Again, I wouldn't have gone ahead with it. If I had all these complications, I've got enough going on, as it was, at the time, and even so now. No, I wouldn't have gone ahead with it. It was just such a worry. I won't even repeat "hindsight" because I know it's a word that has been used quite a lot today.*

…

A *Can I just add, after the operation he said to myself jovially that his accountant's going to have a bit of a head fit – not necessarily those words – because he used a biological mesh, and it was not part of the budget to use that. So, therefore, I don't believe that the mesh was going to happen. So that was quite a shock to me, and I think to him, because he did tell me verbally after, that's what he had to do, in a sort of manner, which was an okay manner – that his accountant's going to have a bit of a flip because he's overbudgeted. So that was a surprise to me.*

Q *So you're denying that he said he would put a biological graft ---*

A *I have never (inaudible). He just told me after, that's what he did, and that's all I can give you.*

Q *But you dispute that he said so beforehand?*

A *I'm not disputing anything. I'll use the usual words, "I don't recall that". But what I do recall ---*

Q You don't?

A --- he's told me.

Q The next thing down says, "Anastomosis unlikely" (sic) , and that reflects, Mr Dixon will say, a discussion where he explained to you that there was a risk that – I hope I said "Ileostomy unlikely", I may have said the wrong word. But there was a risk of an ileostomy, ie having to use a bag, but he felt that was unlikely to happen.

A I do remember ---

Q I think you've accepted that that's a risk that you had discussed with him?

A He did mention that, and I was grateful for that, and it didn't happen, the bag. So I'll repeat that: I still am grateful, that he didn't do that."

197. In his witness statement, undated, Mr Dixon stated:

"102. [Patient B] was admitted to the Spire Hospital Bristol on the morning of 15 July 2016 where I saw her first thing at around 7.30am. I had a pre- operative discussion with [Patient B], and she was consented for surgery again. I note that [Patient B] says she did not see me before surgery, but this is not correct.

103. I explained the intended surgery to [Patient B] again: it would involve a laparoscopic resection of her hind-gut, which had impaired motility, and then the distal two thirds of her transverse colon would be joined to the upper third of the rectum. I also explained the rationale of the surgery again: to remove the denervated segment responsible for her slow transit constipation. I also explained that if the right colon was heavily constipated, or if there was problem with its blood supply when it came to the join, then I might need to remove all the colon and join her small bowel to the top of the rectum, but that this was unlikely. I explained that in the process of carrying out the surgery I might need to revise the mesh if this were adherent to the rectum as this couldn't be incorporated into the anastomosis. I then re-iterated those serious risks and adverse outcomes posed by an anastomotic leak (circa 5%); visceral, vascular injury meaning injury to associated structures or bleeding which was very uncommon but potentially serious; continuation of her symptoms if I didn't remove enough colon, or recurrence of her symptoms should she develop slow transit constipation in her remaining colon. I then gave [Patient B] the opportunity to ask any questions, but she did not have any."

198. Mr Dixon had a consultation with Patient B on 12 July 2016. His note of that consultation states:

> *"[C/O] "?? Twist"*
> *Not coping; - Pain / bloating, - Laxatives ? Rectal irrigation*
> *Understanding more.*
> *Arranged op[eration] with [Patient B] 8/7 [admission] for Friday*
> *Understands surgery & Requests it.*
> *[Mr C] , "the right way forward"*
> *Remove*
> *Bleeding, sepsis, ileus, Anastomotic leak ~ 4%, Uncertainty of outcome,*
> *Laparoscopic, port site pain/hernia, XXXX*
> *May need to revise mesh mesh for anastomosis / stretched etc*
> *Recurrent prolapse*
> *As anastomosis = use a biologic*
> *Ileostomy unlikely.*
> *Full [bowel] prep".*

199. It was Mr Dixon's evidence that he was not entirely sure about whether he would do the hind gut resection until he had had the chance to see what the situation was following the examination under anaesthesia.

200. Patient B's evidence was that she did not know about the potential use of a mesh until she had woken up and that Mr Dixon had mentioned about being in trouble with the hospital for the type of mesh he had used.

201. The Tribunal noted however that in Mr Dixon's consultation notes made on 12 July 2016 he had recorded *"May need to revise mesh for anastomosis / stretched etc".*

202. Patient B did not remember revision of mesh being discussed, but there was a contemporaneous note for her consultation with Mr Dixon in which this requirement was recorded. The Tribunal was satisfied that the contemporaneous note of the consultation was accurate and that Mr Dixon did discuss with Patient B that a revision of the mesh was a part of the procedure.

203. Accordingly, the Tribunal found paragraph 8biv of the Allegation not proved.

Paragraph 8bv of the Allegation

204. In respect of the allegation that on 15 July 2016 Mr Dixon performed a hindgut resection and LVMR, and failed to obtain informed consent in that he did not discuss the risks

associated with Patient B's Procedure, the Tribunal had regard to the expert report of Professor M:

> *"7.40 The notes indicate that the risks of this procedure were discussed, specifically anastomotic leak and sepsis. The possibility of replacing the LVMR mesh was noted and specifically that the replacement would be a biological graft/mesh rather than a synthetic mesh."*

205. The Tribunal relied on the expert opinion of Professor M and on the note of the consultation on 12 July 2016 as set out above. It was satisfied that Mr Dixon told Patient B in that consultation that he may need to revise the LVMR mesh.

206. The Tribunal considered the reasoning to be the same as that set out in respect of paragraph 7ciii as the context is no different and was therefore satisfied that the risks of the procedure were discussed with Patient B.

207. Accordingly, the Tribunal found paragraph 8bv of the Allegation not proved.

Paragraph 8bvi of the Allegation

208. In respect of the allegation that on 15 July 2016 Mr Dixon performed a hindgut resection and LVMR, and failed to obtain informed consent in that he did not make a legible copy of the consent form, the Tribunal considered the consent form.

209. The Tribunal considered that if Patient B was unable to read Mr Dixon's handwriting on the consent form, she would not have known what she was signing and could not therefore have provided informed consent. With knowledge of this case and what Patient B's concerns were, the Tribunal were able to make out some of what Mr Dixon had written, though it did need to refer to his typed note to decipher what he had written on the consent form.

210. In his witness statement, Mr Dixon stated:

> *"104. Having satisfied myself that [Patient B] had made an informed decision to proceed with surgery, I asked her to sign and date the Consent Form for ''Laparoscopic hind gut resection, or colectomy/ileorectal''. The benefits are recorded on the Consent Form as ''Remove dilated bowel /slow transit constipation'' and the serious or frequently occurring risks section records ''Anastomotic leak, visceral vascular injury, continuation of problems/ recurrence".*

211. Colonel L commented that Mr Dixon's handwriting was difficult to decipher but conceded that the legibility of the consent form was a secondary consideration in light of his

more serious criticisms of Mr Dixon's process for obtaining consent from Patient B for this procedure.

212. The Tribunal considered that as it was necessary for Mr Dixon to decipher his own handwritten notes for this Tribunal, and the Tribunal had found it difficult to read his handwritten notes, then it was likely that Patient B would also have found it difficult.

213. The Tribunal was of the view that where there is a record for the patient to read for their understanding, there is an expectation incumbent on the doctor for them to make it legible, particularly where it involves informed consent to a procedure.

214. Accordingly, the Tribunal found paragraph 8bvi of the Allegation proved.

Paragraph 8bvii of the Allegation

215. In respect of the allegation that on 15 July 2016 Mr Dixon performed a hindgut resection and LVMR, and failed to obtain informed consent in that he obtained consent on the day of Patient B's Procedure; the Tribunal had regard to the consultation between Mr Dixon and Patient B on 12 July 2016.

216. While the consent form was signed on 15 July 2016, this followed a consultation on 12 July 2016 in which Patient B was provided with information regarding the planned operation and confirmed she was happy to proceed with the procedure in the knowledge of the risks.

217. The expert evidence was that consent on the day of a procedure was not ideal but if it was an emergency, consent would necessarily be taken on the day.

218. Patient B had, however, been through a pre-operative assessment and in the view of the Tribunal had undergone an adequate consent procedure up to the point of the signing of the form. The Tribunal considered that the process of obtaining informed consent (providing and discussing information relevant to the proposed surgery) had occurred over a period of time prior to the day of the operation. Patient B's consent process began in January 2016 and progressed during the course of subsequent consultations, during which she was given all the relevant information. The Tribunal determined that obtaining informed consent was a process which included, but was not limited to, the signing of the consent form and consequently the consent had been obtained during consultations and culminated with the signing of the consent form on the day of surgery.

219. Accordingly, the Tribunal found Paragraph 8bvii of the Allegation not proved.

Paragraphs 8b and 8c of the Allegation

220. In respect of the allegation that on 15 July 2016 Mr Dixon performed a hindgut resection and LVMR, and failed to record taking the steps at paragraph 8bv, the Tribunal has

already found that Mr Dixon did obtain informed consent having discussed the risks associated with Patient B's procedure based on what he recorded in the medical notes.

221. Accordingly, the Tribunal found paragraph 8c of the Allegation not proved.

Paragraph 9 of the Allegation

> 9. After Patient B's Procedure you consulted with Patient B and her husband, Mr C, and you inappropriately stated to Mr C that you could have 'got [Patient B] pregnant' on the operating table, or words to that effect. **Determined and found not proved**

222. In her initial account, Patient B stated:

> *"…He said to me post operatively, that he could have got me pregnant when on the operating table"*

223. In her witness statement, Patient B stated:

> *"32. …Dr Dixon also made a remark to my husband about him being able to get me pregnant on the operating table. This was when I saw Dr Dixon directly after the procedure on 15 July 2016…."*

224. In her oral evidence, Patient B stated:

> *Q It is a difference in language and it may just be a mistake but you say there:*
>
> > *"He said to me post operatively, that he could have got me pregnant when on the operating table."*
>
> *A I think it was directed at [Mr C] but it was about me anyway, so it was my wording.*
>
> *Q What was your response to that; what did you say back to him?*
>
> *A I didn't say anything back to him; I was just bemused why that happened. I just really was very bemused by it all. I never challenged Mr Dixon; I had quite a lot of trust with him. I guess [Mr C] and I talked about it afterwards, we talked through things, and what we really wanted to do is get me better. We wanted to get me better so I needed Mr Dixon to help support with that, so I didn't make a fuss of anything.*
>
> *…*

Q What did your husband say in response to Mr Dixon saying this to him?

A I think again it is best that you ask him. We don't talk about it too much because this is all going on at the moment, so we are keeping very open-minded ourselves. So I think it is best for you to ask him that rather than me. We obviously just talked about it afterwards and just shook our heads aghast, but other than that ---

Q That isn't really my question. You are saying that the comment is about you but it is directed to your husband and this surgeon is saying something quite extraordinary. You have explained that you didn't say anything in response to it and I was just wondering what your husband said in response to being told this by Mr Dixon.

A I can't quite recall what he said at the time. I think again maybe when you speak to him on Friday, I believe, it might be worth you asking him that.

Q Surely it was something that would stick in your mind if a surgeon said something like this to you and what would stick in your mind is also what the response was.

A Of course things stick in your mind, but I like to put things at the back of my mind when I am trying to recover. I am still trying to recover now. I do appreciate you are asking me these questions but I can't recall what he actually said to me, but we do say things but we just ignore (inaudible – distortion) to get through. I know my husband really wanted me to get better rather than make a big issue of everything."

225. In her initial account Patient B stated that Mr Dixon had made the remark to her, but in her witness statement, she said that he had said it to Mr C. However, Mr C did not mention it in his witness statement.

226. In his witness statement, Mr Dixon stated:

"53. [Patient B] has also alleged that I told her husband "I was able to get her pregnant on the operating table", which I deny. I recall that [Patient B] initially alleged this comment as having been made in theatre at the time of the LVMR on 4 May 2012, after she had left theatre - and not having been made to her husband. At the time, Dr [Y] (anaesthetist) and I attributed this to the effects of the propofol anaesthetic and Fentanyl. I remember explaining to [Patient B] that evening when I visited her on the

ward that she must have been mistaken as no such conversation had occurred and that it probably related to the drugs. Nonetheless, I apologised. I don't recall [Patient B] being present at the time of this conversation. At the time I pondered that this might have related to something that she had read on the website about LVMR not affecting the ability to get pregnant."

227. This allegation was not put to Mr Dixon by the GMC during his oral evidence.

228. Mr Dixon's case was that when patients are coming round from anaesthetics, their recall may be unreliable or confused and he suggested this may be the explanation for Patient B's allegation. He said that similar to the way people can have perfectly normal hallucinations when drifting off to sleep or when waking up, sometimes people hear and see things as a result of the anaesthetic.

229. The Tribunal also noted that following the conclusion of her treatment pathway with Mr Dixon, Patient B sent a thank you card to him. On the cover of the card it said "A million and one thanks". Inside the card Patient B wrote:

"Dear Tony, more than a good doctor, I valued the fact that you were a good listener. More than being just professional I respected your attitude which was exceptional. Thank you for your effective analysis and diagnosis else I would never have been able continue living life normally. Not only are you a good surgeon you are a great human being. Thank you [Patient B] XXX".

230. The Tribunal also considered that if Mr Dixon had made this comment, it would have been unlikely that Patient B would have sent such a thank you card with such kind sentiments about him being more than a professional and respecting his attitude which was "exceptional" and being a "great human being".

231. The Tribunal was satisfied that Mr Dixon's explanation was the most plausible reason for what Patient B has alleged in respect of Mr Dixon stating that he could have got Patient B pregnant on the operating table, to Mr C. The Tribunal also considered that had Mr Dixon said that to Mr C about Patient B, it would have expected to have seen that in Mr C's witness statement. Mr C was a careful witness and made no mention of this very serious unprofessional comment.

232. The Tribunal concluded that it was inherently unlikely that this kind of comment would be made by a consultant in these circumstances in the context that Patient B was in the recovery room, recovering from a major operation. The Tribunal considered that although Patient B recalled the comment, it did not appear to have been described by Mr C despite being addressed directly to him. The Tribunal considered that given Patient B was

recovering from surgery, on medication and in considerable pain her recollection may have been affected.

233. Accordingly, the Tribunal found paragraph 9 of the Allegation not proved.

Paragraph 10 of the Allegation

10. On 23 July 2016 you consulted with Patient B and you:

a. dismissed Patient B's post-operative symptoms by stating:

i. it 'can't be all that bad', or words to that effect;
Determined and found not proved

ii. Patient B was being an 'drama queen', or words to that effect;
Determined and found not proved

b. inappropriately patted Patient B on her bottom when entering a lift with her after the consultation had ended. **Determined and found not proved**

234. In respect of paragraphs 10ai and ii of the Allegation, Mr C stated in his witness statement:

> *"31. I recall that it was a Saturday morning and when Mr Dixon appeared at the door he called Patient [B] a 'drama queen' and said 'what's all this about'. He told Patient [B] that it 'can't be that bad' when to me it appeared that Patient [B] was on death's door. She was really unwell and her symptoms appeared to be very bad. I said that I thought it might have leaked and Mr Dixon said 'oh no she would be far worse that this' and played everything down."*

235. In his oral evidence in cross examination, Mr C stated:

> *"A I can't recall chapter and verse about every action or every statement, what I can recall are the key sentiments which I have captured in my witness statement. I am not able to give any further detail than what you read in the statement. Those are the points of fact of what he said but not the exact detail of every motion or action.*
>
> *Q Mr Dixon's recollection is different. First of all, he does remember the words "drama queen" being used but his recollection is it was used on a different occasion but not by him but by [Patient B] in a self-deprecatory way, saying "I'm probably just being a drama queen but ..." What do you say to that?*
>
> *A I have no recollection of that happening.*

Q *He says that on whichever occasion it took place his response was to say in effect "You're not being a drama queen".*

A *I never heard him say that.*

Q *Because on this day he was sympathetic and concerned about [Patient B], wasn't he?*

A *I can't get inside his mind so I can't comment on that … I can tell you what I saw. He had some concern so he did examine [Patient B] on the bed and he did provide advice and reassurance that the concerns she had at that time of a potential leak – that was what was going through our minds because it was a risk described – that he reassured her that he felt that wasn't the case, that she would be worse than she was exhibiting, so she was reassured. So if that can be described as sympathetic then I agree."*

236. Whilst Patient B did not address either of these comments in her initial account or her witness statement, in her oral evidence she said:

"Q *You've suggested that Mr Dixon said to you you were a drama queen, or called you a drama queen.*

A *Yes.*

Q *Can I suggest to you that, in fact, he remembers a different occasion, about a month later, when you were reviewed by Mr Dixon and he saw you, where you, yourself, used the phrase "drama queen"? So you were self-deprecatingly referring to yourself as "a drama queen", and he reassured you that wasn't the case?*

A *I can't recall --*

Q *Does that sound – is that something, a phrase you use?*

A *No.*

Q *"I'm sorry, I don't mean to be a drama queen."*

A *I don't use "a drama queen" to myself, no. No, and I don't expect a consultant to tell me that either. It's not – I'm not a drama queen. I don't do things ---*

Q *But what Mr Dixon will say is that you – in fact, on a different occasion, as he's recalls it – were somewhat self-deprecatory and you said something like, "I don't mean to be a drama queen", and he reassured you of the exact opposite, that you weren't being overdramatic.*

A *No, I can't recall that at all. Sorry, I can't recall that.*

Q *But at any rate he disputes ever saying to you, or calling you a drama queen, or suggesting that things weren't all that bad. That just isn't how he is with his patients. Are you prepared to accept that you might have misremembered that?*

A *He did say that. He did say that. I won't recall anything, and I won't reach out to him. He did say "You're a drama queen".*

...

Q *...It is only [Mr C] who says or uses this phrase "drama queen", as far as I can see, not you.*

A *Well, I was there.*

Q *Are you sure you are not sort of relying on his recollection of things?*

A *No, categorically not. I was there laid out when he came around to see me when I was on the bench. My husband was sat on the chair by the door and Mr Dixon came around to the front of me and I was on my left-hand side and that's when he said "You're a drama queen", very jovial, I must say, it wasn't a drama thing, it was very jovial, and then he asked me what was going on and then he tested my tummy and just said, you know, it will all settle, so peace of mind that was for me, okay, nothing was seriously wrong.*

Q *Well, let's for the time being go with your evidence that you say that he called you a drama queen. I think you are saying, even on your evidence, it was jovial rather than a sort of unpleasant ---*

A *It is normally the way he pronounces things. It is all very, you know, upbeat, not a big thing. Maybe that is his personality, I don't know, but I was there. I was the patient and I was laid out and he was talking down to me, being laid down."*

237. The Tribunal noted that Patient B said that 'drama queen' was not a phrase she would have ever used, though she told the Tribunal that Mr Dixon said it to her in a jovial way. This was corroborated by Mr C who said that Mr Dixon was trying to reassure Patient B and if that can be considered as sympathetic then it was sympathetic. When outlining the 'inappropriate and unprofessional behaviour' of Mr Dixon in her initial account, Patient B did not mention the phrases 'drama queen' or 'can't be all that bad'. If he had said those phrases, the Tribunal would have expected Patient B to have put them in her initial account when detailing the unprofessional behaviour.

238. It was also alleged that Mr Dixon was dismissive of her concerns in the post operative period by making these comments, however the Tribunal was mindful that Patient B still sent Mr Dixon the thank you card referring to him in glowing terms as set out above. This seems to the Tribunal to be unlikely sentiments to express in the context of having her concerns dismissed and being called a "drama queen". By Mr C's own account Mr Dixon was being reassuring to Patient B.

239. In the medical notes of that consultation the Tribunal noted that Mr Dixon offered Patient B reassurance, a treatment plan, he gave her a sedative for nausea and a future follow up appointment. It appeared to the Tribunal that Mr Dixon was reassuring Patient B that everything was fine with the procedure, reassured her about leaks, and that it was only a matter of time until things settled down. It appeared from the notes that Mr Dixon took Patient B's concerns seriously and took appropriate action. The Tribunal did not consider this to be consistent with being dismissive of Patient B's concerns.

240. The Tribunal determined that whilst the words, or something approaching them, as set out in the allegation may have been said by Mr Dixon, it did not consider they were said in anything other than a jovial and/or reassuring manner in an attempt to allay Patient B's concerns that something was very wrong. The Tribunal was not satisfied that they were said in a manner dismissive of Patient B's concerns or her post operative symptoms. This was clearly at odds with the contemporaneous documentary evidence which demonstrated that Mr Dixon acted on those concerns, provided reassurance and medication and informed Patient B's GP of the action he had taken.

241. Accordingly, the Tribunal found paragraphs 10ai and ii of the Allegation not proved.

Paragraph 10b of the Allegation

242. In Patient B's initial account she stated that:

"He patted me on the bottom when entering a lift at the Bristol Spire when departing after a consultation"

243. In her witness statement, Patient B stated:

"31. I also note that on one occasion, Dr Dixon patted me on the bottom when entering a lift at Bristol Spire Hospital. This was at a follow up consultation after the second procedure on 23 July 2016. He patted the right side of my buttocks…"

244. In her oral evidence, Patient B stated:

"Mr Dixon came in and took a look at me. He just had a look at my tummy and I explained to him I am not feeling at all well; I am really worried, I am really scared; I am not eating – in fact I was probably eating Complan and baby puree food at the time. So that was the point when he called me a drama queen and the incident I am talking about is [Mr C] got up when we left the room; he went off to approach the lift. I was in front and Mr Dixon came out the door and at that point that is where I felt the little tap on the bottom, whereupon I froze. [Mr C] was just going into the lift and turned round. I was really scared and I looked round to see if I could see Mr Dixon but I couldn't see him. It wasn't until I got down to the bottom of the stairs I told [Mr C]. I was really, really distraught and upset, quite vulnerable, isolated, shocked."

245. In his witness statement Mr C stated:

"33. After a couple of hours Patient [B] had recovered enough to leave the hospital and return home. It was at this point that that the first incident of what I considered to be inappropriate behaviour had occurred. As we entered the lift and the doors closed Patient [B] looked at me and said that Mr Dixon had just patted her on the bottom as she had stepped in. We sort of couldn't believe what had happened and didn't really do anything about it and passed the incident off. This was the first real instance of inappropriate behaviour…"

246. In his witness statement, Mr Dixon stated:

"116. I also note that it is alleged that I touched [Patient B]'s bottom when entering a lift with her after the consultation had ended. I vehemently deny this. I do recall an occasion (on 3 December 2016, not 23 July 2016) when the hand of a colleague, Mr

[Z], Consultant Orthopaedic Surgeon, accidentally brushed against [Patient B] when she was exiting a lift into a group of hospital nursing staff talking excitedly about their Christmas party, when I was trying to clear a way through for [Patient B]. I recall my colleague Mr [Z] saying to [Patient B], "Have you been goosed" whilst he raised his arms, and then apologising to her, as did I, as I had seen it happen. [Mr C] was parking his car at the time."

247. The Tribunal again noted that Patient B had sent Mr Dixon a thank you card in very complimentary terms at the end of her patient journey, and after this alleged highly unprofessional incident had taken place. The Tribunal did not consider that this card could be explained on the basis that Patient B was dependent on Mr Dixon for her care and simply wanted to get well. Patient B stated that she sent cards to everyone. The Tribunal noted the difference in sentiments contained in the card sent by Patient B after her first operation which was quite formal, compared with the very detailed compliments in the later card. The Tribunal considered that this was evidence of how Patient B felt about Mr Dixon at that time and her perception may have now altered in light of subsequent events. The Tribunal considered it was unlikely that Patient B would have sent such a card if Mr Dixon had patted her on the bottom as alleged.

248. The Tribunal was of the view that there was a lack of persuasive evidence in relation to this allegation, that Patient B said that she felt a pat on the bottom and when she turned around there was no one there. She also said that she was the only one who witnessed it. The fact that Patient B said that she told Mr C immediately upon getting into the lift does not assist the Tribunal with whether the incident occurred as alleged. Mr C told the Tribunal that he did recollect Patient B telling him, but that he was ahead of her with his back turned and did not see the event. The Tribunal considered that it was unlikely that Mr Dixon patted Patient B on the bottom in the presence of her husband and that Mr Dixon was not visible when she turned round. The Tribunal considered that Patient B had made an assumption that it was Mr Dixon who had patted her on the bottom. The Tribunal also noted that she followed this alleged serious event with a thank you card remarking that he was an 'amazing human being.' This appeared to the Tribunal to be inconsistent and undermined her account of an alleged serious assault.

249. The Tribunal could not be satisfied, on the balance of probability, that Mr Dixon patted Patient B on the bottom when she was entering the lift after a consultation on 23 July 2016 had ended.

250. Accordingly, the Tribunal found paragraph 10b of the Allegation not proved.

Paragraph 11 of the Allegation

11. You failed to provide adequate post-operative care to Patient B following Patient B's Procedure in that you:

    a. inappropriately stated to Mr C that he should 'go home and fill her up' in reference to Patient B and Mr C's sex life;
    Determined and found proved

    b. did not adequately investigate Patient B's concerns regarding possible faecal fistula. **Determined and found not proved**

251. In respect of paragraph 11a of the Allegation, Patient B stated in her initial account:

"In the presence of my Husband he regularly asked about our sex life, and on the last occasion he said to my husband that he should "fill her up".

252. In his witness statement, Mr C stated:

"44. Mr Dixon would often ask us about our sex life and whether or not we were having sex…

45. When we saw Mr Dixon last he asked if we were having sex as we were leaving the consultation room and when we told him no he told me to 'go home and fill her up'. This was not a very nice thing to say given all that we have had to endure. He displayed a complete lack of empathy and the comment was completely unwarranted given the history. I didn't say anything in response and I have challenged myself on a number of occasions as to why I didn't do so. I think the honest answer is that I just want Patient [B] to get well again and felt that I couldn't have a fight with Mr Dixon because we are so dependant on him and needed his support."

253. In his witness statement, Mr Dixon stated:

"115. I was also surprised and alarmed to read the accusation that, following [Patient B]'s surgery in 2016, I made the inappropriate and overtly sexual comment to her husband that he "go home and fill her up". [Patient B] describes this as happening at this appointment. In her statement, [Patient B] attributes this comment to "the last ever consultation she had with [me]" which she incorrectly dated as 23 July 2016. My last consultation with [Patient B] was on 17 August 2017 and, outside of the initial consultation on 20 March 2013, it was the only occasion when I enquired about her 'sex life'. On both of these occasions, I recorded that neither [Patient B] nor her

husband were sexually active but they were not bothered about this. When I saw [Patient B] with her husband on 17 August 2017 (having performed a surgical correction, or LVMR of multi compartment pelvic organ prolapse followed by an anterior resection, complicated by a self-resolving anastomotic - vaginal fistula) it was pertinent and appropriate to enquire, not only about any continued vaginal discharge, pelvic pain, or any continued evacuatory and voiding dysfunction that she might be experiencing, but also about her sexual function and dyspareunia. I suggested that if Mr [C] and [Patient B] wanted to re-engage in sexual activity it was better not to delay this and in doing so I used the phrase, "As the urologists and gynaecologists say, use it or lose it". My recollection is that [Patient B] replied, "We are not bothered and haven't done that for ages." When I glanced at Mr [C] I noted he was smiling. I am not a rude or a crude man and deny saying the words "go home and fill her up"."

254. The Tribunal considered that it was not in dispute that Mr Dixon had asked Patient B and Mr C about their sex life. It was agreed by both experts that questions in relation to sexual functioning were appropriate in the context of the history of the problems experienced by Patient B. However, both experts agreed that a comment to *"go home and fill her up"* would be inappropriate.

255. The Tribunal considered that the account provided by Mr C was more likely than not to be correct given his recollection of events as stated in his witness statement and his oral evidence. Mr C recalled that he considered the comment was inappropriate at the time and that he regretted not dealing with it in the consultation. Mr C stated that he had questioned himself since about to why he did not say something to Mr Dixon. The Tribunal considered that his explanation that he did not want to make an issue of it because he was focussed on his wife's recovery was credible. It was, however, in the view of the Tribunal, a comment which had stuck in Mr C's mind as inappropriate. The Tribunal considered that his recollection was more likely than not to be accurate in these circumstances.

256. The Tribunal considered that Mr C's evidence was credible and plausible. The Tribunal noted that Mr Dixon had a longstanding relationship with Patient B and her husband. The Tribunal was satisfied that Mr Dixon made this comment in an offhand way at the end of the consultation in the context of an earlier legitimate discussion about sexual functioning.

257. Accordingly, the Tribunal found paragraph 11a of the Allegation proved.

Paragraph 11b of the Allegation

b. did not adequately investigate Patient B's concerns regarding possible faecal fistula.

258. In their joint expert report, Colonel L stated that Mr Dixon should have done an MRI scan. Professor M stated that:

> *"b. Thorough (and repeated) clinical exam suggested it was likely to be a haematoma discharging with mesh related fluid discharge (which is common with biologic graft/mesh).*
>
> *CC would have done a MR in the post operative period, but the conservative approach was reasonable, particularly as symptoms were settling by the time a concern over faecal fistula was identified at 7-8 weeks post op. MRI at this stage would not have changed outcome."*

259. The Tribunal accepted that there was a difference in approach between Colonel L and Professor M in that the former considered that an MRI would have reassured Patient B and confirmed the presence or absence of a fistula. Colonel L accepted in his oral evidence that an MRI would not have changed the clinical management of Patient B and the appropriate response would have been to allow the fistula to resolve itself as Mr Dixon suggested.

260. Professor M was also of the view that the approach taken by Mr Dixon was open to a reasonable competent consultant surgeon as Mr Dixon did examine Patient B on more than one occasion and had given an account of his findings in relation to that examination and his conclusions. Mr Dixon's notes of that consultation and his recollection was that he did not find anything when he examined Patient B that would suggest the presence of a fistula. In his view, Patient B had a haematoma. When Patient B showed Mr Dixon a photograph on her telephone of a pad soiled with faeces he apologised and agreed that there might be a fistula but repeated his advice that this would resolve itself with no further treatment. The Tribunal accepts the opinion of Professor M and Mr Dixon that following repeated clinical examinations which did not reveal any indications of a fistula there was no duty to order an MRI scan. The Tribunal considered that Mr Dixon did adequately investigate Patient B's concerns when she reported them to him and reassured her on the basis of his clinical findings and opinion. Accordingly, the Tribunal found paragraph 11b of the Allegation not proved.

PATIENT F

261. Relevant clinical history summarised from Professor M's background of Patient F's case:

262. Patient F was referred to Mr Dixon for assessment and management of rectal bleeding and an area of ulceration on a haemorrhoid close to the anus. Anal pain was not a feature. Patient F, XXX, was assessed by Mr Dixon on 22 January 2015. He confirmed the presence of haemorrhoids and noted high resting tone in the pelvic floor muscles. Mr Dixon

proposed an examination under anaesthetic and limited haemorrhoidectomy and in his correspondence, which was copied to Patient F, he indicated that he may undertake a recto-anal mucopexy. On the booking form for surgery, Mr Dixon included EUA/RAR-Haemorrhoidectomy, that is, examination under anaesthetic/recto-anal repair (equivalent to a recto-anal mucopexy). The details of the haemorrhoidectomy component are not specified in the booking form.

263. Patient F then sought a second opinion from Dr AB, Colorectal Surgeon, in Cambridge on 25 February 2015 who broadly agreed with Mr Dixon's assessment and plan to assess under anaesthetic with excision of the bleeding and prolapsing haemorrhoid. However, in view of Patient F's desire to avoid surgery, she advised a period of pelvic floor retraining, regular laxatives, and reassessment of this in 6 months, then review with Mr Dixon.

264. Pelvic floor physiology (manometry) was undertaken in December 2015. High resting tone and rectal hypersensitivity were noted, and Patient F was advised about her defaecatory habit. Patient F stated that surgery had been deferred on several occasions pending biofeedback.

265. Patient F was admitted for surgery as a day case on 16 December 2015. She met with Mr Dixon and his registrar and consent was obtained for EUA Rectum +/- limited haemorrhoidectomy, PPH (procedure for prolapse and haemorrhoids) or rectal mucopexy.

266. At operation, Mr Dixon found circumferential grade 4 haemorrhoids and undertook a PPH procedure, which is also known as a stapled haemorrhoidectomy or stapled haemorrhoidopexy. When Patient F was wakened from anaesthesia she was in severe pain which was subsequently slowly controlled with opiate prior to being discharged home.

267. The nature of Patient F's complaint was that she was unaware that PPH was a stapled haemorrhoidectomy, there was no informed consent, and the procedure was undertaken to an inadequate standard.

268. Patient F had asked for a specimen to be sent to XXX in histopathology.

269. Patient F's husband arranged an MRI scan to assess the rectum around 10 weeks after the procedure. The results from these investigations were reported to indicate that the procedure undertaken was closer to a STARR (stapled transanal resection of rectum) rather than a PPH/ stapled haemorrhoidectomy.

270. Patient F developed a chronic pain condition and received several opinions in the management of her pain. These have indicated a multifactorial causation, with the initial acute surgical pain being the initiator, propagated by central nervous system modification, aggravated by secondary pudendal nerve involvement, prolonged muscle tension and the psychological effects of this experience, noted by Dr AN as anger and frustration.

Paragraph 16 of the Allegation

16. On 16 December 2015 you performed a stapled haemorrhoidectomy on Patient F ('Patient F's Procedure'), which was not:

    a. treatment which has been previously discussed with Patient F; **Determined and found proved**

    b. clinically indicated; **Determined and found not proved**

    c. performed adequately in that you excised a full-thickness section of the wall of the rectum. **Determined and found not proved**

271. In respect of paragraph 16a of the Allegation, Patient F stated in her witness statement:

> *"7. I attended clinic in January 2015 to discuss how to treat my haemorrhoids. After examining me in clinic Mr Dixon informed me that he was going to undertake an examination under anaesthetic ('EUA') and Sigmoidoscopy and I signed a form agreeing to have this procedure in the future. I understood from discussions with him that he may also proceed to undertake a limited haemorrhoidectomy at the time. Mr Dixon was very vague about the risks of the procedure. I attended the clinic with my husband (who is also a medic) and we asked him what the risks and complications are with the hemorrhoidectomy as I was aware that some patients are left incontinent after their haemorrhoids had been removed and also that a lady had died undergoing such a procedure. Mr Dixon told me that all of these complications only happen "if a monkey does it," and that the usual complications are bleeding and infection.*
>
> *8. Following this appointment I received a letter stating that he would carry out an EUA and limited haemorrhoidectomy and may also carry out a recto-anal mucopexy if I was found to have internal prolapse. I note that internal prolapse was not noted in his examination of me in clinic and recto-anal mucopexy was not discussed at all with me in clinic.*
>
> *9. On 16 December 2015 I attended Southmead Hospital for day surgery. Mr Dixon's registrar approached me with a consent form that had been pre-filled by Mr Dixon. At no point in time was I made aware by the Registrar nor Mr Dixon that*

there was anything on the consent form, that I was not made aware of beforehand. I specifically told the registrar, prior to signing the consent form, that I did not want staples or anything permanent left in my body and was told that 'staples' was just a misnomer and that they use dissolvable sutures. I went into theatre believing that I was having a limited haemorrhoidectomy +/- recto-anal mucopexy, if required.

10. After the operation I learned that Mr Dixon had actually performed a Stapled Haemorrhoidectomy. At no stage were the details of this procedure discussed with me. I was not made aware of the pros and cons of this operation, nor was I given a choice of treatment options, nor was I warned about the risks of chronic pain and other sequalae that I experienced after the procedure. Indeed it was weeks/months before I came to understand what the procedure entailed and what was actually performed on me, without my knowledge nor consent."

272. In cross examination by Mr Basu, it was Patient F's evidence that:

"Q Then he conducted a rigid sigmoidoscopy, using a sigmoidoscope. You know what they are ---.

A Yes.

Q --- and insufflation, so the surgeon will pump it up with some air, or pump you up with some air so that he can look inside. Do you recall that, or accept it happened?

A I remember I had an investigation and I remember there was an instrument, in clinic, yes.

Q He did some sort of endoscopy through that end, to have a look. Yes?

A Probably – I'm so sorry; it's such a long time ago, but he examined me; he examined me for sure.

Q Do you recall him releasing the air from the sigmoidoscope and asking you to strain as he withdrew that instrument?

A No.

Q Then after the examination, you got dressed, sat back down with your husband and Mr Dixon?

A Yes.

Q There then followed a very lengthy discussion, didn't there?

A *Well, followed with us trying to understand what he would recommend and we were getting – it was like trying to get blood out of a stone in terms of what procedure he was going to do, what the risks were. I mean I had quite a lot of concerns, which I expressed to him. My godfather had, probably only two months before I saw Mr Dixon, died following a colorectal operation. Whilst I was a registrar, there was a lady who came in for a post mortem. I didn't carry it out myself but she had died as a result of a haemorrhoidectomy. So I had quite a lot of concerns because, as soon as he mentioned that I might need an operation, I was just like, "Oh, my God," you know, "What are we going to do? What if I get an infection, will you give me antibiotic cover?" "What if you take some anal muscle and I end up incontinent," and he just dismissed. He gave no information about details of the procedure, which is something that I would like to have known, and he gave no information as to what the likely risks were. At some point when I was telling him what about this risk, what about that risk, it was like, "Oh well, only if a monkey does it," like. You know, "This is no big deal whatever I'm going to do, and you're going to be fine," and there was….. As I said, I have to admit, when he gave me the consent form – I had to sign a form, "Examination under anaesthetic and sigmoidoscopy" – I was actually relieved that there wasn't anything else on that consent form because he hadn't really explained a lot to me during that appointment. So mainly we spent a lot of time trying to find out information but certainly left a little bit confused. I discussed a conventional, limited haemorrhoidectomy with him but only because that's what I knew. He didn't mention anything about the procedure. He didn't mention anything about any other procedure or something non- surgical, even, that I could have had to try and help the bleeding side of things, let's say. There was, you know – yes.*

…

Q *Would you accept that more than one operation, more than one procedure was discussed?*

A *No.*

Q *All right. Would you say ---*

A *I was quite surprised when I got the clinic letter, actually, and he had written the limited haemorrhoidectomy plus or minus recto-anal mucopexy. I'd never heard of that before and I had to ask [Dr AB] about it.*

Q So the only operation that was discussed by either of you – is this right ---

A Yes.

Q --- was a limited excision haemorrhoidectomy?

A Yes.

Q That's the only operation any of you – that's including your husband – discussed. Right?

A Yes.

Q Even that, you understood to be an unpleasant operation?

A Yes, and he dismissed wholly. I was there, saying I was worried about a, b and c and he dismissed it, all of it, said, like, it never happens, as I have already said to you, he said to me, "Only if a monkey does it." So he did not at all tell me it would be a difficult operation or give me any cause to have any concern about any risks of a limited haemorrhoidectomy."

273. It was Mr Dixon's evidence that the stapled haemorrhoidectomy operation had previously been discussed with both Patient F and her husband, that they had reviewed the material on Mr Dixon's website as well as literature which they were given to take away. Mr Dixon's evidence was that he discussed a number of procedures with Patient F and her husband during that consultation and outlined the risks and benefits of each one. Mr Dixon stated that he recalled the consultation very well because it took a long time due to the questions that were asked by Patient F. Mr Dixon told the Tribunal he remembered that a nurse came in to hurry him along as he was getting behind with his clinic.

274. The Tribunal had regard to Mr Dixon's notes of that consultation. They were written on the GP referral letter and are extremely brief. The notes do not detail any examination findings, or set out any discussion about any operation.

275. The Tribunal noted that following the consultation Mr Dixon had with Patient F on 22 January 2015, he wrote a letter to Patient F's GP on the 6 February 2015 which was copied to Patient F in the following terms,

"Many thanks for asking me to see this very nice lady who I saw with her husband today. She presents with a two year history of fresh post defecatory rectal bleeding. She is 36, has had two full term vaginal deliveries, neither of which was a forceps

extraction. She has no major symptoms of OGS. She does feel uncomfortable on incomplete emptying, but she is only opening her bowels about twice a day. She has no post defecatory soiling, no faecal urgency, faecal incontinence, or urinary symptoms.

Examination today demonstrates some disruption of the right anterolateral anal cushion. She has got a complete external anal sphincter with a high resting pressure, with paradoxical contraction on straining. This is probably situational as [Patient F] has not been doing lots of pelvic floor exercises. Sigmoidoscopy demonstrated no evidence of significant internal rectal prolapse. She does however have this disrupted anterior anal cushion and everted anal canal which is seen to prolapse externally.

I have explained the problem to [Patient F] and have offered her EUA with a view to carrying out a limited haemorrhoidectomy. It is conceivable at EUA that she may have some internal prolapse. If that is the case, I will carry out a rectal anal mucopexy at the same time. If she does have prolapse, we will arrange for her to have some postoperative biofeedback instruction."

276. The Tribunal noted that this letter provides further detail not contained in the notes about the content of the consultation. Mr Dixon and Patient F had no further consultations or discussions until the morning of the procedure on 16 December 2015.

277. There is no documentary evidence before the Tribunal to indicate that a stapled haemorrhoidectomy had been discussed as a treatment option for Patient F prior to the procedure on 16 December 2015. The clinic letter indicates that Mr Dixon may undertake a limited haemorrhoidectomy but there is no mention of a stapled haemorrhoidectomy, either within that letter or the brief notes of the consultation. The Tribunal considered that it was more likely than not that the clinic letter was an accurate reflection of the discussion which was that an EUA was offered with a view to carrying out a limited haemorrhoidectomy. This accords with Patient F's recollection.

278. In addition, when Patient F saw Dr AB for a second opinion it is reasonable to infer that she explained what had occurred at the consultation with Mr Dixon a month before and what the outcome was. Dr AB's letter of 24 February 2015 states, *"I have explained that Mr Dixon's recommended course of action would be the normal recommendation. Having an examination under anaesthesia with excision of the bleeding and prolapsing haemorrhoidal cushion would achieve both resolution of her symptoms and also provide an excision biopsy for histological confirmation that there was no other abnormality present."* The Tribunal noted that there was no mention of a stapled procedure within this letter and it is likely that Patient F would have requested Dr AB's opinion on such an option if it had been discussed with her by Mr Dixon.

279. The Tribunal also considered that Patient F's recollection about the use of staples being mentioned on the morning of the surgery was likely to be accurate. In his evidence Mr Dixon recalled that Patient F stated, *"so you are going to use staples on me."* This suggested to the Tribunal that this was not a procedure that had been discussed beforehand. The Tribunal considers it was likely that if a stapled haemorrhoidectomy had been discussed with Patient F she would have been aware of what the procedure entailed.

280. The Tribunal concluded that given Patient F's consistent accounts, and the fact that there is no documentary evidence to support the assertion that Mr Dixon had previously discussed a stapled haemorrhoidectomy, it determined on the balance of probabilities, that he did not discuss that procedure with Patient F prior to performing it on 16 December 2016.

281. Accordingly, the Tribunal found paragraph 16a of the Allegation proved.

Paragraph 16b of the Allegation

282. When considering whether the stapled haemorrhoidectomy Mr Dixon performed on Patient F on 16 December 2015 was clinically indicated, the Tribunal had regard to the expert report of Colonel L, in which he stated:

> *"8. Was Mr Dixon's procedure was fit for purpose?*
>
> *No. There is a significant discordance between the preoperative assessment from both Mr Dixon and the Cambridge surgeon and Mr Dixon's documented findings on the operation note. On the operation note, he describes finding: "circumferential fourth degree haemorrhoids" (for which a stapled haemorrhoidectomy would be reasonable); whereas, his preoperative assessment and that of the second opinion was of a much lesser degree of pathology. I appreciate there was a delay of 10 months between his clinic assessment and the operative procedure; however, firstly, I do not think that the stapled haemorrhoidectomy was warranted and, secondly, I do not believe it was carried out appropriately."*

283. In his expert report, Professor M opined:

> *"7.1 Previous discussion of procedure. There is no written record of stapled haemorrhoidectomy being discussed with [Patient F] prior to the day of surgery. [Patient F] signed a consent form which included the operation "PPH" and there is no documented evidence as to whether the stapled procedure was discussed on the morning of surgery.*
>
> *7.2 Clinically indicated. The presence of circumferential haemorrhoids, estimated to be grade IV, is considered a reasonable indication for stapled haemorrhoidectomy.*

Therefore, on this basis, there was a reasonable clinical indication in terms of severity of haemorrhoids.

7.3 Alternative haemorrhoid operations such as Milligan-Morgan (excision) haemorrhoidectomy would have been extensive and very painful. In fact, in my experience, under these circumstances Milligan-Morgan haemorrhoidectomy is more painful than stapled haemorrhoidectomy and this would have presented its own spectrum of pain and problems for [Patient F].

284. In their joint expert report Colonel L and Professor M opined:

"1. Indication for stapled haemorrhoidectomy

[Colonel L] and [Professor M] agree that a finding of circumferential haemorrhoids is an indication for stapled haemorrhoidectomy. [Colonel L] maintains that the patient did not want this procedure."

285. The evidence before the Tribunal in the operation note is that during the examination under anaesthetic Mr Dixon observed circumferential haemorrhoids, estimated to be grade IV. Although a lesser degree of pathology was observed in January and February 2015 those examinations were not an EUA. There is no evidence before the Tribunal that the information contained in the operation note is incorrect. The Tribunal was satisfied that this was the pathology seen and recorded by Mr Dixon on the morning of the operation. The Tribunal noted that Patient F did not want a procedure involving staples. It has made findings above that this procedure was not discussed with her, nevertheless, the Tribunal was persuaded by the joint expert opinion that the procedure was clinically indicated for Patient F in these circumstances.

286. Accordingly, the Tribunal found paragraph 16b of the Allegation not proved.

Paragraph 16c of the Allegation

287. When considering whether the Mr Dixon performed the procedure adequately in that he excised a full-thickness section of the wall of the rectum in the procedure on Patient F on 16 December 2015, the Tribunal had regard to the expert evidence of Colonel L, who stated in his expert report:

"9. Did Mr Dixon adequately assess the patient post-operatively?

At the end of his op note, Mr Dixon wrote: "No SOPD (Surgical Outpatient Department) unless problems". The discharge letter confirmed this recommendation.

This is the routine practice across the NHS and thus reasonable. There was a clinic consultation on 05 April 2016 at which Mr Dixon states that the patient was: "blaming me for all her post-operative problems". The problems he documents are: "post operative pain……predictable post-operative faecal urgency that we warned her of". Mr Dixon states that the patient had "over-interpreted the histopathology" (which documented excision of muscularis propria) and he states: "it is not surprising that there were in parts be some muscularis propria. This is what the operation entails". I disagree with this statement; excision of muscle should not be part of stapled haemorrhoidectomy. Mr Dixon examined Patient [F] and documents his findings as:" it all feels perfectly normal". Mr Dixon concludes that he recommends treatment with pain modulators and that the patient:" may need to be seen in the pain clinic with the clinical psychologists". He also suggested that he would consider botulinuim toxin injection to the pelvic floor and referred her for specialist pelvic physiotherapy.

Mr Dixon appears to have rejected any acknowledgement that the surgery was not what Patient [F] was expecting and rejects any suggestion that it was conducted inappropriately. Mr Dixon appears to be blaming Patient [F] for her poor postoperative outcome.

288. In his expert report, Professor M stated:

"7.5 Performed PPH adequately. The procedure of stapled haemorrhoidectomy appears to have been performed to an adequate standard. The description of the procedure was in keeping with a standard procedure. The depth of excision is determined by the depth of sutures in the wall of the bowel, and it is impossible to confine this to the mucosa, inevitably some deeper muscle fibres will be included by the sutures. This has been demonstrated in several series examining pathology from stapled haemorrhoidectomy surgeries, such as, Naldini et al 2009, which found the presence of muscle fibres in 90% of the presented series of 241 patients and 53.5% of a larger literature review of 987 patients. No link with complications was identified. The description of pathology is consistent with stapled haemorrhoidectomy and does not indicate a STARR procedure."

289. In their joint expert report, it was stated:

Colonel L

"[Colonel L] maintains that the purse string was placed too deeply in one sector of the ring and that this directly led to a full thickness excision of the muscular wall of the rectum and that this amounts to a technical error."

Professor M

"The operation was performed in a standard fashion and there was no evidence of technical complication.

In a published series of 241 PPH cases, 90% included muscularis propria. Therefore, inclusion of muscularis propria cannot be considered a technical error. In my own practice and discussion with colleagues undertaking PPH, the presence of muscle fibres is accepted as normal."

290. The Tribunal considered the academic literature and studies that were before it. The evidence therein suggested that excising a limited full thickness section of the wall of the rectum is a frequent occurrence with these procedures although it may not have been what was intended; and it was not necessarily an indication of an inadequate operation.

291. The Tribunal also noted the context of this charge and in particular the fact that histology and MRI scans are not routinely carried out post operatively for this operation.

292. The Tribunal heard evidence that the procedure is very difficult to do precisely as the excision depends on where you are in the mucosa and how deeply the sutures go.

293. The Tribunal relied on the evidence of Professor M and the literature put before it. It concluded that because Mr Dixon had taken a full thickness section of the wall of the rectum that this did not necessarily mean that the procedure was performed inadequately.

294. Accordingly, the Tribunal found paragraph 16c of the Allegation not proved.

Paragraph 17 of the Allegation

17. You failed to obtain informed consent for Patient F's Procedure in that you:

    a. did not communicate to Patient F that the consent form detailed Patient F's Procedure and not the treatment options previously discussed with her; **Determined and found proved**

    b. did not adequately communicate the risks associated with Patient F's procedure; **Determined and found proved**

    c. obtained written consent from Patient F on the day of Patient F's Procedure. **Determined and found proved**

295. In respect of paragraph 17a of the Allegation, the Tribunal noted that Mr Dixon had not spoken to Patient F in the period between the consultation on 22 January 2015, and the day of the procedure, 16 December 2015. The Tribunal has already determined that Mr Dixon did not discuss undertaking a stapled haemorrhoidectomy with Patient F at the January consultation and so it follows that he did not obtain informed consent at that time. There is no suggestion in the contemporaneous documentary evidence to indicate that on the

morning of surgery Mr Dixon made it clear to Patient F that the operation he was proposing to undertake was different from the limited excision haemorrhoidectomy that had previously been discussed.

296. On the day of the procedure there were discussions between Patient F and Mr Dixon. Mr Dixon told the Tribunal that he reminded Patient F of what the operation entailed and went over the risks and benefits again and Patient F was fully informed. Mr Dixon stated that Patient F was relaxed and engaged on the morning of the surgery and did not indicate to him that she was in any way anxious. Mr Dixon explained in his evidence to the Tribunal that when he went to see Patient F on the morning of surgery, she was conversing in XXX with his Registrar Mr AA. Mr AA told Mr Dixon after he left the consultation that he did not really know what was planned and Patient F was asking lots of difficult questions that he could not answer.

297. The consent form signed on the day of surgery suggests that there would be an EUA and then either a limited haemorrhoidectomy, PPH or rectal mucopexy. There is no evidence in the contemporaneous documents for the morning of surgery to indicate that Mr Dixon discussed all of these options with Patient F and the risk and benefits associated with them or that he specifically explained that these were different options to those discussed in the January 2015 clinic appointment.

298. Patient F recalls that she was not told at any point that she was having a stapled haemorrhoidectomy and she recalls telling Mr AA that she did not want staples.

299. The Tribunal preferred the evidence of Patient F which is consistent with the documentary evidence. The Tribunal is satisfied that Mr Dixon had not explained the PPH procedure to Patient F or what it entailed at the January clinic and he did not explain it on the morning of surgery. The Tribunal considered that had he done so, given Patient F's concerns about surgery and her general disposition to ask lots of questions and seek advice, she would have recalled the conversation and been aware of the procedure that was proposed. Instead, Patient F continued under the impression that a limited haemorrhoidectomy was the proposed procedure. Patient F has consistently maintained that she was not made aware of the PPH procedure and complained immediately that this was not an operation that was discussed with her or that she wanted.

300. The Tribunal was satisfied that Mr Dixon did not obtain informed consent for Patient F's Procedure in that he did not communicate on the morning of surgery to Patient F that the consent form detailed Patient F's Procedure and not the treatment options previously discussed with her.

301. Accordingly, the Tribunal found paragraph 17a of the Allegation proved.

Paragraphs 17b and c of the Allegation

302. It was Mr Dixon's evidence that he would have gone through the risks with Patient F on the day when he she signed the consent form. In his witness statement, Mr Dixon stated:

> *"50. [Patient F] did not tell me not to do a PPH or a stapled haemorrhoidectomy and if it were true, as she claims, that she did not know what 'PPH' meant (despite my having previously shown her my website, the NICE guidance and my 2007 publication), she did not ask at the time I explained it to her.*
>
> *51. In line with my usual practice, I then reminded [Patient F] of the risks associated with these interventions namely bleeding circa 2% which rarely needed treatment; warned her that the surgery was immediately painful, particularly an excision haemorrhoidectomy and that she would be given appropriate analgesia and a local anaesthetic block to mitigate this. I explained that the severe pain of a stapled haemorrhoidopexy would be short lived following which she might for a few days feel as though she had been kicked, but that in perhaps 1% it may persist and require early resort to amitriptyline, or gabapentin; faecal urgency circa 20% and again usually self-limiting as the surgical trauma resolved, and finally recurrent haemorrhoids circa 2%. It would have been my usual practice to have also explained that a sutured mucopexy or RAR was equally painful in 30% and might need to be addressed in a similar way and that both RAR and an excision haemorrhoidectomy would lead to a self-limiting anal discharge best managed by social washing and a panty liner.*
>
> *52. I then completed the serious risks section of the consent form as discussed, "Bleeding, pain, faecal urgency and recurrence" [CB, 22-23]. I then read through each aspect of the consent form in turn to [Patient F], and, after asking her if it were OK, handed it to her to read, which she did."*

303. As outlined above there is no contemporaneous documentary evidence to support Mr Dixon's account and there is nothing within Patient F's notes which detail that discussion. The Tribunal was of the view that Mr Dixon's account was undermined by the lack of evidence to support it, and by the consistent evidence of Patient F for the reasons set out above. The Tribunal considered that as noted by Dr AB, Patient F was risk averse and was keen to avoid surgery. The Tribunal considered that had Mr Dixon explained the risks of a PPH in the terms suggested in his statement, this would have been a discussion that Patient F recalled. The Tribunal considered it was likely she would have requested further details and it would have been a matter she discussed in the consultation with Dr AB before deciding to proceed with the surgery.

304. The Tribunal also noted that the risks set out by Mr Dixon did not include the potential of more serious outcomes.

305. The Tribunal noted that "PPH" was included on the consent form which was signed on the day of surgery. Even if Mr Dixon did have a conversation with Patient F in general terms about a PPH and the risks and benefits of that procedure on the morning of surgery, the Tribunal considers that this would not be sufficient to amount to informed consent. On the day of surgery Patient F did not have an opportunity to fully consider that procedure or the risks and benefits associated with it. The Tribunal has already found that it was not discussed with Patient F beforehand. In these circumstances obtaining written consent to the PPH by asking Patient F to sign the consent form on the day of surgery is, in the view of the Tribunal a failure to obtain informed consent.

306. Accordingly, the Tribunal found paragraph 17a, b and c of the Allegation proved.

Paragraph 18 of the Allegation

> 18. (in the alternative to paragraph 17a-17b) you failed to record taking the steps outlined at paragraph 17a-17b. **Determined and found not proved**

307. As set out above, the Tribunal has found paragraphs 17 a and 17 b of the allegation proved. As this matter has been considered and found proved, the Tribunal concluded that it was not required to make a finding on this paragraph of the Allegation which is charged as an alternative.

308. Accordingly, the Tribunal found paragraph 18 of the Allegation not proved.

Paragraph 19a and b of the Allegation

> 19. Following Patient F's Procedure, you failed to:
>
> a. arrange a biopsy of Patient F's ulcerated haemorrhoid; **Determined and found not proved**
>
> b. communicate that you had made a technical error in excising a full-thickness section of the rectal wall during Patient F's Procedure:
>
> i. to Patient F; **Determined and found not proved**
>
> ii. within your department's morbidity review in accordance with your department's governance framework; **Determined and found not proved**

309. In respect of paragraph 19a of the Allegation, the Tribunal noted that one of Patient F's concerns in January 2015 which had led to her seeking specialist medical help was that she had noticed an ulcerated patch on a prolapsing haemorrhoid. This was of concern to her and prompted a GP visit. The GP made a subsequent referral to Mr Dixon under the two

week wait rule and in the letter to Mr Dixon the GP specifically refers to this ulcerated patch which was described as "a 1cm ulcerated patch with a yellowish warty appearance."

310. Mr Dixon saw Patient F on the 22 January and his notes of that consultation are brief. There is no record that the ulcerated patch was noted or discussed as part of that consultation. Mr Dixon in his oral evidence indicated that he did not raise it as part of his consultation. There is no mention of this ulcerated patch in the letter to Patient F's GP.

311. On 24 February 2015 Patient F saw Dr AB for a second opinion. Dr AB wrote to Patient F's GP following that consultation and stated, *"There is an anterior tag present with some associated mucosal prolapse and an area of healing ulceration… if symptoms did not improve within about six months, and the lump was still present with slight ulceration then it should be biopsied at that time."*

312. In their joint report the experts stated:

Colonel L:

> *"[Mr Dixon] mis-interpreted her request and hadn't understood her concerns."*

Professor M

> *"There was no ulcerated haemorrhoid to biopsy on the day of surgery, but AD had agreed to send whatever he removed."*

313. Both experts agreed that if there was no ulcerated lesion, then it could not be sent for histology. They also agreed that ulcerated patches on haemorrhoids can come and go so it was not possible to say whether Mr Dixon missed an ulcer that was present at the time of surgery or whether it had healed and gone away. The letter from Dr AB also supported the possibility that the "lump" may go away by itself and that the ulceration was, at that point, healing.

314. The Tribunal considered that it was noteworthy that there did appear to have been some confusion on the part of Mr Dixon about the exact nature of the sample that Patient F had requested to go to histology and there had been no discussion between Mr Dixon and Patient F about the ulcerated patch. Mr Dixon stated that he had not seen the letter from Dr AB at the time and he did not see an ulcer or anything of concern either at the initial consultation or at the point of surgery in December 2015.

315. The Tribunal could not be satisfied, on the balance of probabilities, that an ulcerated haemorrhoid was in fact present when Mr Dixon undertook the procedure on Patient F in December 2015, for him to send for biopsy.

316. Accordingly, the Tribunal found paragraph 19a of the Allegation not proved.

Paragraphs 19bi and ii of the Allegation

317. In respect of paragraph 19a of the Allegation, the Tribunal had regard to the joint expert report:

Colonel L

> *"[Colonel L] maintains that the purse string was placed too deeply in one sector of the ring and that this directly led to a full thickness excision of the muscular wall of the rectum and that this amounts to a technical error."*

Professor M

> *"The operation was performed in a standard fashion and there was no evidence of technical complication.*
>
> *In a published series of 241 PPH cases, 90% included muscularis propria. Therefore, inclusion of muscularis propria cannot be considered a technical error. In my own practice and discussion with colleagues undertaking PPH, the presence of muscle fibres is accepted as normal."*

318. At paragraph 16c of the Allegation the Tribunal has found that excising a full-thickness section of the rectal wall during this procedure was not uncommon as evidenced in the literature. The Tribunal preferred the evidence of Professor M and the literature. The Tribunal had no determinative evidence before it of the extent of full thickness excision. The histology report for Patient F stated it was *"present in some blocks".* In excising an element of full thickness section of the rectum wall this outcome was not unusual and in line with procedures carried out by other colorectal surgeons, and, as such, the Tribunal did not consider this amounted to a technical error.

319. The Tribunal therefore determined that there was no failure to communicate as there was no technical error in excising a full-thickness section of the rectal wall during Patient F's Procedure.

320. Accordingly, the Tribunal found paragraphs 19bi and ii of the Allegation not proved.

Paragraph 19c of the Allegation

> 19. Following Patient F's Procedure, you failed to:
>
> c. adequately respond to Patient F's communications regarding her post-operative concerns in that you:
>
> i. advised Patient F she 'was lucky [you] performed [Patient F's Procedure]', or words to that effect; **Determined and not found proved**

ii. dismissed Patient F's pain by stating:

1. she had an 'abnormal pain response', or words to that effect; **Determined and not found proved**

2. the 'bowel does not feel anything', or words to that effect; **Determined and not found proved**

iii. dismissed Patient F's complaint regarding:

1. full-thickness bowel resection as being 'what [Patient F's Procedure] entailed', or words to that effect; **Determined and not found proved**

2. the removal of a 3cm wedge of her bowel as being 'just a piece of bowel', or words to that effect; **Determined and not found proved**

iv. advised Patient F that her abnormal post-operative MRI findings were:

1. 'completely normal', or words to that effect; **Determined and not found proved**

2. 'artefactual', or words to that effect; **Determined and not found proved**

321. The Tribunal considered the evidence of what procedure had taken place and what procedure Patient F believed she had undergone.

322. The results of a histopathology report, dated 4 March 2016, for Patient F stated:

"AN ADDENDUM HAS BEEN ENTERED AT THE END OF THIS REPORT
MRI Pelvis Rectum : Report by Dr [AC], Consultant Radiologist, RUH Bath NHS Foundation Trust

…

There appears to have been a STARR procedure with lower rectal staple line.

…

Ring of mucosa, submucosa and muscularis propria with a maximum external diameter of 30mm x 12mm thick, with an attached tongue of mucosa, submucosa and muscularis propria measuring 35x10x9mm…"

323. The Tribunal noted that the histopathologist stated that "There '*appears*' to have been a STARR. It noted though that the case was being argued by both parties as this meaning the histopathologist meant that it was a STARR procedure.

324. In Mr Dixon's letter to Patient F's GP (Patient F copied in), clinic date 5 April 2016, Mr Dixon stated:

> *"I met up with [Patient F] and her husband today and as you might predict they were very angry blaming me for all her post-operative problems. What has happened is that she has developed post-operative pain that is improving but it is still an issue if she is on her feet and is physically active etc. Her pain is eased by lying flat with symptoms that we would normally associate with a degree of prolapse or stretch of her pelvic floor. She developed the predictable post-operative faecal urgency that we warned her of but this has started to reduce in frequency. She has also had a significant improvement in her bleeding.*
>
> *One of the problems that we have had is that [Patient F] has over-interpreted the histopathology which we would not normally have sent but we did so at her request. Given what she had which was a stapled haemorroidopexy it is not surprising that there were in parts be some muscularis propria. This is what the operation entails. Sadly the radiologist who looked at her MRI scan has interpreted as being consistent with a STARR procedure. I have shown [Patient F] the operation note which just describes a stapled haemorrhoidopexy as treatment as her fourth degree haemorrhoids. She did not have a STARR procedure. Eventually I was able to persuade [Patient F] to allow me to examine her and the findings are as we had preoperatively for a high resting pressure within her ana! canal and pelvic floor including levator ani.*
>
> *She has got a normal palpable staple line approximately 2cms above her dentate line which should be insensate. There is no evidence of any dog ears and it all feels perfectly normal. It was very difficult to explain the MRI scan which is probably a misrepresentation of what is happening. I think the issues here are that she has had a painful intervention and with her high pressure in her pelvic floor her pain has got a little bit out of control and this perception of the pain or interpretation of the pain has got worse as a consequence of her receiving the pathology report and the MRI report.*
>
> *I would expect these symptoms all to resolve but I am concerned that [Patient F] is at serious risk of developing a chronic regional pain syndrome and sensitisation and to try and prevent this I think it would be very important that she seriously thought as to having either some Pregabalin or possibly some Nortriptyline and try and get on top of the situation. If it doesn't improve with this then she may need to be seen in the pain*

clinic with the clinical psychologists but as I said earlier I would hope that this is not going to happen. Another approach if the Pregabalin didn't help would be to consider putting some Botulinum toxin into her levator ani.

I have also copied this letter to our specialist women's health physic to see if she is happy to see [Patient F] and trying some exercises to reduce the pressure within her pelvic floor."

325. In a letter from Patient F's GP to Dr AD, Consultant Radiologist, Royal United Hospital, dated 9 May 2016, Dr AD stated:

"I would be grateful for your review and further report of the MRI scan of this 38 year old XXX. She had a haemorrhoidectomy performed at the end of last year and has been unhappy with the results of the surgery and subsequent pain she has had, with little follow-up. She has most recently been seen by Mr [T] at The Spire Hospital in Bristol and I attach his clinic letter for your further information Mr [T] has referred her on to a pain specialist in London."

326. The Tribunal considered that the letter from Mr Dixon to Patient F's GP clinic date 5 April 2016, was a contemporaneous and balanced account from what appears to have been a challenging consultation for all present. Mr Dixon explains about Patient F's pain and pain management options. The Tribunal did not however consider that to have been a dismissive response.

327. The Tribunal was of the view that the GMC would have to demonstrate that the post operative MRI was abnormal, and it was Mr Dixon's account that it was normal.

328. In his addendum report, dated 2 November 2023, Colonel L stated:

*"**Summary.** In a written addendum for the Tribunal dated 18 Oct 23, I stated: "In their review from 2009, Naldini and co-workers found muscle fibres in 217 of 241 (90%) of the examined specimens after stapled haemorrhoidectomy. In this series, early complications occurred in 27/241 patients (11%) and complications were more likely in the group with smooth muscle tissue in the resected specimens than without (25% and 9.6%, respectively)". This is incorrect… this correction does not materially alter my opinion.*

…

***Unchanged opinion**: Incorporation of some muscle is common, to a lesser or greater extent; however, it is not intended within the 'classical' description of the technique.*

Incorporation of muscle does not appear to lead to complications per se and may be "of little consequence for most patients"; however, full thickness excision of the rectal wall exposes the patient to the risk of severe complications such as failure of the suture-line and subsequent severe sepsis. If incorporation of muscle is seen as inevitable, then patients should be informed as part of the consent process (in para 14 of his witness statement about this patient, Mr Dixon states: "I then spoke to her about the nature of the procedure: it involves the use of a staple gun which excises a ring of rectal mucosa from above the haemorrhoids and then staples the cut ends together….."). Patients should also be informed that incorporation of full thickness muscle may rarely lead to severe complications.
For this patient, in my opinion, taking full thickness of the rectal wall was not intended, and as to do so increases risk of some of the rare but "specific" risks of the technique, I believe this aspect of the operation amounted to a technical error."

329. In this oral evidence, Colonel L stated:

"Q He is doing the best he can as to explain what is written in the report of the MRI but theorises that were this a STARR, one would see the signs of that perhaps in the MRI scan which the report didn't really suggest in terms of asymmetric staple lines anteriorly and posteriorly. Do you agree that's what you'd expect to see from a STARR operation given what is involved with it, two staple lines front and back? Yes?

A Yes, I do not think we believed there was a STARR undertaken.

Q He also explained that if there was some sort of overlap seen, if it wasn't an artefact, it would be likely at the site of maximal prolapse which would be preferentially pulled into the PPH 03 staple gun, just naturally as a result of how the looser tissues would react to being gathered up by the purse-string. Do you agree with that explanation?

A No. I think the inclusion of the full thickness segment of the rectal wall is because of a placement of a deep suture, not dependent on an area of prolapse at that site but rather the depth of the placement.

Q He explained to the patient it wouldn't be unusual to find muscularis propria in a PPH specimen and he was right to say that, wasn't he?

A Yes.

Q *He told the patient that in his view this didn't affect functional outcome or cause pain. He was right to say that as well, wasn't he?*

A *That's a matter of dispute that we have covered this morning, Mr Basu.*

Q *… he explained that the staple line was above the dentate line and therefore would be insensate and he was right to explain that, wasn't he?*

A *We have discussed this point and I don't agree with this. As we mentioned, the lower rectum is insensate to direct pressure, but that doesn't mean to say that pain won't be experienced by the patient. The direct sensation on the lining is different from the pain of ischemia, for example, or distention of the organ in question. There are other mechanisms for pain to be perceived other than direct pressure on the lining, so I absolutely agree that to touch or biopsy or otherwise apply pressure to the lining of the lower rectum in an otherwise healthy patient, the patient doesn't experience any sensation there, but this is a different issue. This is pain from the stapling of the tissue and so the excision and the resultant stapling undertaken at the time of surgery.*

…

Q *Maybe the next part will assist you. Mr Dixon will say he explained that the pain was probably coming from the pelvic floor, which she was holding very tightly and saying that this has developed as a result of a secondary response to a painful intervention, namely the operation, with poor pain control. It may not be the full technical explanation, but is that broadly a fair explanation for the problem?*

A *Again I don't agree with that point. I will refer you back to the paper that we did discuss this morning and the quote, "…inappropriate placement of the purse-string may result in incorporation of rectal muscle and nerves, resulting in pain after surgery", so my position is that this is a specific consequence of the excision and subsequent stapling of the full thickness of the rectal wall in one sector of the circle."*

330. It was Professor M's opinion that the only difference for the radiologist on an MRI scan is that a PPH would have the appearance of one staple line whereas a STARR would have the appearance of two staple lines. In his expert report he stated:

"7.11 There is correspondence from [Patient F]'s GP, Dr [AE], requesting review of the MRI, on 09/05/2016 which was reported by Dr [AD]. Dr [AD] describes a "3cm overlapping tongue of rectal wall (which) extends alongside the posterior and left

lateral wall of the distal rectum from 3.5 to 6.5cm above the level of the anorectal junction".

7.12 This abnormality was not described by Dr [AC] and I am uncertain exactly what this abnormality amounts to, and I have requested to review the images. I suspect it may be the effect of the staple line which brings together the cut mucosal layers together, causing a shortening or "concertina" of the surrounding muscle layer of the bowel, which is mainly intact.

7.13 The report of this scan was subsequently considered by Mr [T] and Professor [AF] and taken as evidence that an extensive full thickness excision was undertaken, which is not the case. As we note from Mr [T]'s examination under anaesthetic, the staple line had healed well and to my interpretation appeared normal. He did state that there was "? Sl (slight) tethering" on the left posterior site, but this seems a marginal abnormality, if it is one at all.

7.14 It is not common to undertaken MRI scan in the post operative period after stapled haemorrhoidectomy, and I am uncertain how much expertise is available to inform what is the "normal" appearance after these procedures. Of course, identifying abscess, fistula or perforation will be relatively simple, but these were not present in this case."

331. The Tribunal had regard however to a number of papers of studies recording histopathology of stapled haemorrhoidectomy specimens, which Colonel L had sight of and was asked to comment upon in his oral evidence. The Tribunal had regard to:

2007 - Blouhos (2007) 'Uncontrollable Intra-Abdominal Bleeding Necessitating Low Anterior Resection of the Rectum After Stapled Hemorrhoidopexy

"Report of a Case
Case report intra-abdominal hemorrhage without overt rectal bleeding. The depth and height of the purse-string suture appears critical to ensure that an adequate "doughnut" is removed, and the staple line lies at an appropriate height. The incorporation of smooth muscle in the ring of tissue removed may be of little consequence for most patients, but it carries the potential for catastrophic complications if there is a leak from the staple line."

George (2002) (Oxford group) 'Histopathology of stapled haemorrhoidectomy specimens: a cautionary note'

"No deep smooth muscle should be included in the resected tissue. If a small amount of muscle is included in the resected tissue, this should be rectal smooth muscle, rather than internal anal sphincter.

Four specimens contained mucosa and submucosa only. The other 22 specimens (85%) also contained some smooth muscle. Eleven comprised circular smooth muscle only; 11 contained circular smooth muscle, myenteric plexus and longitudinal muscle.

This study has also indicated that full-thickness rectal wall may be resected. Although the amounts are small there is therefore a risk of leakage from the staple line."

Faucheron (2012) 'Rectal perforation with life-threatening peritonitis following stapled haemorrhoidopexy' - Systematic review.

"40 patients with life-threatening septic complications following stapled haemorrhoidopexy.
The causes of severe sepsis can be classified into four groups: full-thickness resection, delayed staple-line dehiscence, bleeding and obstruction. Rectal perforation with peritonitis is specific to stapled haemorrhoidopexy. To avoid these potential hazards the authors recommend the following. To prevent full thickness resection it is imperative that the purse-string be placed within the submucosal plane, as advocated by Longo in addition, true rectal prolapse must be excluded."

Giordano (2009) 'Long-term Outcomes of Stapled Hemorrhoidopexy vs Conventional Hemorrhoidectomy' - Systematic review of published randomized controlled trials of conventional haemorrhoidectomy vs. SH with a minimum follow-up of 12 months (1201 patients)

"Outcomes at 1 year showed a significantly higher rate of prolapse recurrence in the stapled group.

SH patients 1.9 times more likely to undergo further treatment to correct recurrent prolapse compared to conventional haemorrhoidectomy. Tenesmus more likely in stapled patients at year.

When SH involved excision of muscle layers, no correlation was found between recurrences, postoperative pain, and continence. The fact that a variable thickness of muscular layer was sometimes trapped into the stapler did not

seem to have a deleterious effect on anal function and was not related to any change in anal pressure or continence."

332. The Tribunal considered that in the light of the academic literature it was common that a stapled haemorrhoidectomy procedure often has some incorporation of smooth muscle within the *"bite"* taken by the stapler. The literature further suggested that there is a risk of this encompassing a full thickness resection. The Tribunal considered that this was a known aspect of this procedure and that it would be a matter which would be required to be incorporated into the consent process given the risk of sepsis if a full thickness section was taken.

333. It was Mr Dixon's case that he did not do a STARR, but that he did a PPH, which is a completely different operation. Both experts agreed that a STARR was not undertaken. Mr Dixon explained to the Tribunal that a histology report would not usually be provided to a patient and as Patient B was XXX and her husband was a XXX, they arranged for an MRI scan. It was Mr Dixon's case that the radiologist mistook the PPH as a STARR.

Paragraph 19ci of the Allegation

334. In respect of whether Mr Dixon failed to adequately respond to Patient F's communications regarding her post-operative concerns in that he advised Patient F she 'was lucky he performed Patient F's Procedure', or words to that effect, the Tribunal had regard to Mr Dixon witness statement:

"101. I did not say that [Patient F] "was lucky I performed [the procedure]". I said something to the effect of, she was lucky I had not done an excision haemorrhoidectomy, which would have been more painful."

335. The Tribunal considered that the sentence above could be interpreted in a number of different ways depending on which words the emphasis was placed. The Tribunal was of the view that whilst words to that effect may have been said, it could not be satisfied that they amounted to an inadequate response to Patient F's post operative concerns. Particularly in the context of the conversation when Patient F was in pain following the procedure.

336. Accordingly, the Tribunal found paragraph 19ci of the Allegation not proved.

Paragraphs 19cii (1) and (2) of the Allegation

337. In respect of whether Mr Dixon failed to adequately respond to Patient F's communications regarding her post-operative concerns in that he dismissed Patient F's pain by stating that she had an 'abnormal pain response', or words to that effect; and /or the

'bowel does not feel anything', or words to that effect; the Tribunal noted that these words were said in the context of a wider conversation.

338. In the context of the conversation they were having, the Tribunal was satisfied that Mr Dixon was not dismissive of Patient F's pain. Both experts agreed, Patient F did have an abnormal pain response.

339. Mr Dixon also explained to Patient F that the staple line was above the dentate line and therefore would be insensate, he also talked about future treatment and a referral to the pain specialist.

340. The Tribunal did not therefore consider that Mr Dixon was being dismissive about Patient F's pain and as such there was no failure.

341. Accordingly, the Tribunal found paragraphs 19cii (1) and (2) of the Allegation not proved.

Paragraph 19ciii (1) of the Allegation

342. In respect of whether Mr Dixon failed to adequately respond to Patient F's communications regarding her post-operative concerns in that he dismissed her complaint regarding full-thickness bowel resection as being 'what [Patient F's Procedure] entailed', or words to that effect.

343. It was Mr Dixon's case that he was attempting to explain to Patient F that he did not take a full-thickness bowel resection, but that there was some muscle taken in the PPH procedure, which can occur.

344. It appeared to the Tribunal that Mr Dixon and Patient F were at crossed purposes as Patient F was talking about a STARR procedure, as muscle tissue was taken, and Mr Dixon was talking about a PPH, in which muscle tissue should not be taken but that it can occur.

345. The Tribunal was of the view that Mr Dixon was not dismissing Patient F, rather he was trying to explain what he had done in what would have been a challenging interaction for both.

346. Accordingly, the Tribunal found paragraph 19ciii (1) of the Allegation not proved.

Paragraph 19ciii (2) of the Allegation

347. In respect of whether Mr Dixon failed to adequately respond to Patient F's communications regarding her post-operative concerns in that he dismissed Patient F's

complaint regarding the removal of a 3cm wedge of her bowel as being 'just a piece of bowel', or words to that effect; the Tribunal had regard to Mr Dixon's witness statement:

> *"96. I then reverted to discussing the histology and explained that it would not be unusual to find some elements of muscularis propria in a PPH specimen and that the same did not affect functional outcome or cause pain, and did so with the caveat that I had not seen Dr [AG]'s report as it was not filed in [Patient F]'s notes. I then explained that, had it been a STARR, then I would have used two staple guns and that there would be two separate and substantial full thickness rectal specimens each of which would be covered with extra rectal fat and that this had not been the case with her specimen. [Patient F] then insisted that in her opinion it was a full thickness resection and that I taken another 3cm. I then explained that the latter was integral to the one specimen and was the site of the maximal prolapse that had been preferentially pulled into the staple gun. I did not refer to it as "just a piece of bowel".*

348. The Tribunal considered that Mr Dixon's account was credible and he was unchallenged on his recollection regarding this allegation. In the context of the conversation he and Patient F were having the Tribunal accepted Mr Dixon's account.

349. Accordingly, the Tribunal found paragraph 19ciii (2) of the Allegation not proved.

Paragraph 19iv (1) of the Allegation

350. In respect to whether Mr Dixon failed to advise Patient F that her abnormal post-operative MRI findings were 'completely normal', or words to that effect, following her procedure; the Tribunal had regard to the joint expert report, it was the opinion of Colonel L and Professor M that:

> *"[Colonel L] does not think that the MRI findings were completely normal or artefactual, but rather the images display the consequences of a full thickness excision of a section of rectal wall.*
>
> *[Professor M]'s interpretation of the reports is that there is no abnormality that suggests there has been a major disruption of the rectal wall or other complication.*
>
> *Interpretation of MRI images is a highly specialist matter and clinical correlation is extremely important. The significance of the MR images is a matter for debate.*
>
> *[Colonel L] and [Professor M] agreed that the interpretation of MRI reports influenced the patient's perception of the surgery."*

351. It was the opinion of Professor M that there was nothing abnormal about Patient F's abnormal post-operative MRI findings. In his expert report he stated:

> *"7.14 It is not common to undertaken MRI scan in the post operative period after stapled haemorrhoidectomy, and I am uncertain how much expertise is available to inform what is the "normal" appearance after these procedures. Of course, identifying abscess, fistula or perforation will be relatively simple, but these were not present in this case.*
>
> *7.15 A further MRI was arranged by Dr [AN] on 03/06/2016, specifically to assess the pudendal nerve. In that scan no abnormality is reported in the rectal wall, but an area of abnormality is noted on the left side of the sphincter muscle, in the ischio-anal space. This abnormality is remote from the site of PPH surgery which lies above this, in the lower rectum."*

352. Patient F's husband had read the MRI report and it was through him that Patient F understood there to be an abnormality shown on the MRI. The evidence before the Tribunal was that it would take a specialist to read and interpret an MRI scan following this procedure and it was unclear whether Patient F's husband was such a specialist.

353. The Tribunal relied on the opinion of Professor M, who did not consider the MRI to demonstrate abnormal post-operative findings.

354. The Tribunal was of the view that the GMC had failed to demonstrate that the MRI scan demonstrated abnormal post-operative MRI findings

355. Accordingly, the Tribunal found paragraph 19iv (1) of the Allegation not proved.

Paragraph 19iv (2) of the Allegation

356. In respect of whether Mr Dixon advised Patient F that her abnormal post-operative MRI findings were 'artefactual', or words to that effect, the Tribunal has already found that the MRI scan was not abnormal.

357. Given that that Patient F's post-operative findings were not abnormal, and relying on Professor M's report at paragraph 7.14 set out above, the Tribunal was satisfied that there was no failure. The GMC failed to prove their case on the balance of probabilities.

358. Accordingly, the Tribunal found paragraph 19iv (1) of the Allegation not proved.

Paragraph 19d of the Allegation

19. Following Patient F's Procedure, you failed to:

d. acknowledge that Patient F's unremitting symptoms suggested possible post-operative complications. **Determined and found proved**

359. In the post-operative consultation in which Patient F challenged Mr Dixon as to what procedure he had performed, she was understandably upset and in pain during what would have been a challenging interaction.

360. Mr Dixon failed to consider or acknowledge the fact that a full excision resection might be the cause of Patient F's pain or that her pain may have been due to the surgery he had performed. He seemed instead to discuss with Patient F whether a STARR had or had not been performed, citing *"I may have explained that an abnormal pain response is the central sensitisation or the Christmas tree effect meaning that her whole cerebral cortex and central nervous system was lit up by the pain, as well as her peripheral nerves"*, rather than whether the pain was due to the operation in and of itself.

361. The Tribunal noted the evidence of Colonel L who stated in his oral evidence:

"The severe pain is the poor outcome that she has had; that is the complication. That can happen when a stapled haemorrhoidectomy is undertaken as intended, so it is rare but it does happen. Of course, patients must be counselled for that eventuality…"

362. Colonel L also stated in his report of 18 October 2023 *"The poor outcome experienced by Patient F is a direct result of the operation undertaken by Mr Dixon rather than the patient's underlying disease."*

363. In these circumstances the Tribunal preferred the evidence of Colonel L that Patient F's symptoms suggested possible post operative complications, and this was not acknowledged or addressed by Mr Dixon.

364. Accordingly, the Tribunal found paragraph 19d of the Allegation proved.

PATIENT G

365. Relevant clinical history summarised from Professor M's background of Patient G's case:

366. Patient G was born in 1975 and had three babies by vaginal deliveries. Patient G presented with rectal bleeding, the description of which suggests it was of large volume, frequent and intrusive. Her grandmother is stated to have had colorectal cancer and her sister a bowel polyp.

367. Patient G was seen by Mr Dixon in February 2015. He did not examine her as she was menstruating. He offered reassurance that her symptoms probably arose from haemorrhoids

but may also be as a result of an internal rectal prolapse. He wrote in the letter to Patient G's GP that if this is the case a STARR may be considered. He arranged a flexible sigmoidoscopy which he intended to undertake himself, which would allow a thorough assessment of the anus and rectum during the same procedure and possibly proceeding to banding of haemorrhoids if appropriate.

368. In April 2015 the flexible sigmoidoscopy was undertaken by a gastroenterology colleague who did not complete banding of haemorrhoids. There followed a period during which Patient G and her GP chased the hospital for a plan. In August 2015 Mr Dixon wrote two letters, one planning to arrange a proctogram and clinical review depending on the results, the other an examination under anaesthetic (EUA) and treatment as indicated by findings, be this banding of haemorrhoids or "recto-anal mucopexy".

369. In December 2015, Patient G was booked for an EUA and attended for this on 12 December. She was consented for EUA, and any of the following procedures: banding of haemorrhoids, recto anal repair, and STARR. She was seen by Mr Dixon twice on the morning before surgery as she was anxious and had called her friend and husband for advice as to whether she should proceed with the surgery.

370. She proceeded with surgery which showed large haemorrhoids (Grade IV) and a high grade internal rectal prolapse. Mr Dixon elected to treat this with a STARR procedure, which was undertaken in a standard technique with excision of two full thickness sections of the rectal wall. Patient G had severe pain immediately postoperatively. She required an overnight stay (it is usually a day case procedure) and was still in pain on discharge.

371. Patient G had three emergency department attendances in the next 10 days and then a 5 day hospital admission during which her pain improved at times but this was not sustained.

372. Patient G has developed a complex chronic pain syndrome and has subsequently received multidisciplinary input into this.

Paragraph 21 of the Allegation

21. On 16 December 2015 you performed a stapled trans-anal rectal resection ('Patient G's Procedure') which was not clinically indicated in that you failed to:

    a. adequately investigate her presenting symptoms; **Determined and found proved**

    b. trial non-surgical interventions; **Determined and found proved**

c. perform a less invasive procedure.

Determined and found proved

373. In terms of the procedure performed by Mr Dixon, Colonel L was of the opinion that the STARR procedure was entirely inappropriate, and it was Professor M's opinion that to do a less restrictive procedure would have been reasonable (even preferable). The Tribunal relied on the evidence of the experts, and in particular of Colonel L. It was satisfied that the STARR procedure was not clinically indicated at the time of surgery.

374. Colonel L and Professor M both agreed that whilst an EUA would have confirmed the diagnosis, Mr Dixon proceeded to undertake the procedure without the discussion of those findings with Patient G. Mr Dixon did not carry out a proctogram and did not undertake a physical examination of Patient G before proceedings to surgery. The Tribunal therefore concluded that Mr Dixon had failed to adequately investigate Patient G's presenting symptoms.

375. The Tribunal noted that no non-surgical interventions such as bio-feedback was canvassed with Patient G in any of the consultations or with any of the other clinicians who saw her. This was evident from Patient G's clinical notes and would have been clear to Mr Dixon.

376. The Tribunal noted the context of this patient's journey to surgery which had been extremely unsatisfactory. The Tribunal accepted that other clinicians missed opportunities to try less restrictive procedures with Patient G. However, at the point at which Mr Dixon saw Patient G the Tribunal considered that it was his responsibility to ensure that the surgery was clinically indicated in the light of the clinical picture. Mr Dixon decided to proceed to surgery without the benefit of required investigations and before less invasive procedures had been attempted.

377. The Tribunal was of the view that the banding of Patient G's haemorrhoids ought to have been attempted and that although it did not happen prior to 16 December 2015, the experts agreed that it remained a reasonable option, in place of the STARR procedure.

378. Mr Dixon appeared to have already decided to undertake the STARR procedure at the same time as the EUA. The Tribunal noted that Mr Dixon told Patient G that he had made arrangements for the STARR procedure to be filmed. The Tribunal concluded that he had taken Patient G's consent for the STARR procedure without providing the patient the information that would have been available following the EUA.

379. Further, Professor M said that although the STARR procedure had been mentioned in a consultation in February 2015, too much time had elapsed for a procedure in December for that to have been effective consent.

380. The Tribunal therefore concluded that Mr Dixon had failed to adequately investigate Patient G's symptoms and trial non-surgical interventions and perform a less invasive procedure. Accordingly, the Tribunal found paragraphs 21a, b and c of the Allegation proved.

Paragraph 22 of the Allegation

22. You failed to record obtaining Patient G's informed consent for Patient G's Procedure in that you did not record explaining:

a. the expected benefits of Patient G's Procedure;
Determined and found proved

b. non-surgical treatment options;
Determined and found proved

c. the risks associated with Patient G's Procedure.
Determined and found proved

381. The Tribunal had before it no documentary evidence to demonstrate that Mr Dixon had recorded explaining the expected benefits of Patient G's Procedure or non-surgical treatment options.

382. In respect of recording the risks associated with Patient G's Procedure, risks of pain, bleeding and faecal urgency had been set out on the consent form. However, this had been signed on the day of surgery and Patient G had not had sufficient time to consider the risks and benefits of the procedure. The consent form also did not contain any high-risk low frequency outcomes.

383. The Tribunal noted that Mr Dixon had a very brief consultation with Patient G in February 2015 during which he had not documented any explanation about the risk and benefits associated with a STARR procedure. The Tribunal also accepted Professor M's opinion that in any event the consultation in February 2015 was too far from the date of the surgery to be considered informed consent.

384. The Tribunal was satisfied therefore that Mr Dixon had failed to record obtaining Patient G's informed consent for her Procedure in that he did not record explaining the expected benefits of Patient G's Procedure, non-surgical treatment options, or the risks associated with her Procedure.

385. Accordingly, the Tribunal found paragraphs 21a, b and c of the Allegation proved.

Paragraph 23 of the Allegation

23. (in the alternative to paragraph 22) you failed to record taking the steps outlined at paragraph 22. **Determined and found not proved**

386. In respect of paragraph 23 of the Allegation, the Tribunal has already found paragraph 22 proved, in that Mr Dixon failed to record obtaining Patient G's informed consent for her Procedure. As this matter had been considered and found proved, the Tribunal concluded that it was not required to make a finding on this paragraph of the Allegation which is charged in the alternative.

Paragraph 24 of the Allegation

24. Your post-operative care of Patient G was inappropriate in that you:

a. failed to adequately engage in Patient G's aftercare.

Determined and found not proved

387. In opinion of the experts in their joint expert report for Patient G, dated 30 October 2023, states:

Colonel L:

"Mr Dixon's position appears to be that her pain was caused by: 'poor pain management' rather than surgery. This is not reasonable".

Professor M

"Postoperative engagement by Mr Dixon was reasonable and she was appropriately referred to pain specialists".

388. The Tribunal considered that following Patient G's operation there was little more Mr Dixon could or should have done. Colonel L agreed in cross examination that Mr Dixon did have significant interaction with Patient G in the post operative period. It was suggested in the joint report by Colonel L that the criticism of Mr Dixon was that he ought to have acknowledged that Patient G's pain could have been caused by the surgery. However, he conceded in oral evidence that he had no technical criticism of the surgery. It was Colonel L's opinion that the procedure could have been the cause of Patient G's pain, but there was no way of knowing whether this was actually the case. The Tribunal noted that Mr Dixon did respond to Patient G's concerns about ongoing pain and appropriately referred Patient G to a pain specialist. The Tribunal preferred the evidence of Professor M that the post operative engagement by Mr Dixon was reasonable in the circumstances, given that there was no evidence to suggest that the surgery was the cause of Patient G's pain.

389. Accordingly, the Tribunal found paragraph 24a of the Allegation not proved.

PATIENT J

390. Relevant clinical history summarised from Professor M's background of Patient J's case:

391. Patient J was referred to a surgical clinic in 2014 for management of recurrent, severe rectal bleeding despite previous excisional haemorrhoidectomy in 2006, and stapled haemorrhoidectomy in 2011. There was a history of constipation and the presence of melanosis coli which indicated chronic use of stimulant laxatives.

392. In 2014, Patient J's GP referral noted the diagnosis of rectoanal intussusception (internal rectal prolapse), along with perineal descent. This had been investigated by repeat proctography arranged by Mr AH, Registrar to Mr Dixon who discussed this with Mr Dixon. Repeat proctography demonstrated a deterioration in the intussusception, from grade III to IV and a large rectocele (bulge from the rectum into the vagina).

393. These findings were discussed with Patient J in clinic in January 2015 and laparoscopic ventral mesh rectopexy (LVMR) was advised and Patient J agreed to proceed with this surgery. The rationale was that rectoanal intussusception was aggravating her haemorrhoids, accounting for the failure to have a sustained benefit from haemorrhoid surgery. This consultation was with Ms AI, Mr Dixon's registrar, who discussed the plan with Mr Dixon.

394. Patient J became anaemic from haemorrhoidal bleeding, was admitted for a blood transfusion, and had banding of haemorrhoids as an inpatient which was not effective. During this admission Patient J reported in her history that her prolapse was pressing on her large haemorrhoid.

395. Funding for LVMR was approved and Patient J, through her GP, requested LVMR surgery be expedited leading to LVMR being performed on 1 June 2015 by Mr Dixon. She remained an inpatient for 4 days. Mr Dixon noted at operation that Patient J's colon and rectum were dilated and described this as a megacolon. This indicated a motility problem and was consistent with the chronic use of stimulant laxatives which was indicated by the presence of melanosis coli.

396. Patient J was readmitted on 6 June 2015 as a surgical emergency patient, suffering constipation, severe abdominal pain, and distension, with concerns that her bowel had become twisted or damaged at LVMR surgery. She underwent a CT scan and then laparoscopy and mini-laparotomy on 7 June, at which no definite abnormality was identified, but there was a suspicion that the bowel had twisted in the pelvis which was described on CT. Patient J made a slow recovery from this surgery and was discharged on 17 June 2015, only to be readmitted on 18 June 2015.

397. During this admission, Patient J was managed with intravenous fluids and nasogastric aspiration, and was discharged on 24 June 2015.

398. Patient J's subsequent care was transferred to Mr Dixon's colleagues. She suffered from constipation and had further rectal bleeding over subsequent years and episodes of bowel obstruction requiring admission to hospital.

Paragraph 25 of the Allegation

25. On 1 June 2015 you performed an LVMR on Patient J ('Patient J's Procedure') for which you failed to obtain informed consent from Patient J in that you:

    a. did not advise Patient J of:

        i. other treatment options; **Determined and found not proved**

        ii. the expected benefits of Patient J's Procedure; **Determined and found not proved**

        iii. the risks associated with Patient J's Procedure; **Determined and found proved**

    b. obtain written consent on the day of Patient J's Procedure. **Determined and found not proved**

399. In their joint expert report, Colonel L and Professor M opined:

Colonel L

> *"Consent not done or not recorded adequately"*

Professor M

> *"Complex condition with evidence of longstanding functional bowel problems and chronic laxative use.*
>
> *Deteriorating prolapse & severe recurrent haemorrhoids symptoms for which other management options (operative and non-operative) had been tried.*
>
> *Treatment options included do nothing and STARR procedure, but CC would support preference for LVMR in [Patient J].*
>
> *Evidence in the notes that [Patient J] and her GP were aware of the rationale and anticipated benefits from LVMR.*
>
> *There was a request for exceptional funding for LVMR.*
>
> *Details of the risks and benefits were summarised on the consent form."*

Their joint opinion

> "*Concur that LVMR was a reasonable treatment option.*
>
> *Recording of the discussion of risks and benefits by registrars not recorded.*
>
> *Agree that if [Patient J] was adequately counselled but this was not recorded, consent process is below the published standard, but not seriously below.*
>
> *Consent on day was widespread"*

400. The Tribunal had sight of a letter from Ms AI (Mr Dixons' Registrar) in respect of the clinic on 13 January 2015, to Patient J's GP (and which Patient J was copied into), which stated:

> *"I saw this lady in our colorectal clinic today. She has a past history of having a stapled haemorrhoidectomy in 2011 and prior to that an open haemorrhoidectomy in 2000 for problems with PR bleeding. She returned to our clinic in September of last year with ongoing problems with quite severe PR bleeding which had left her with a Haemoglobin of 94 and a Ferritin dropping to 19 despite taking oral iron supplementation. At review at that time, it was noted that her previous proctogram report from 2012 showed a grade 3 internal intussusception. It was suspected that her bleeding might be the result of internal prolapse with perineal descent and a repeat flexible sigmoidoscopy and proctogram was arranged . The flexible sigmoidoscopy performed in September of last year showed haemorrhoids only and the repeat defecating proctogram also in September last year showed a large anterior rectocele with a grade 4 recto-anal intussusception entering at the top of the anal canal and obstructing the rectocele.*
>
> *This lady's case was meant to be discussed at our pelvic floor MDT, but unfortunately this has not happened as of yet. I discussed her case with Mr Dixon in clinic today who has explained that her haemorrhoids are likely to be aggravated by the problems of the rectocele during defecation, and that by repairing this with a laparoscopic mesh rectopexy, we should hopefully be able to improve her symptoms of bleeding. I have explained this to [Patient J] today in clinic who Is happy and keen to proceed with surgery, so we have put her on our waiting list and we hope to see her shortly."*

401. On 11 March 2015 Patient J was admitted to hospital and was seen by Mr AK, Consultant, North Bristol NHS Trust. In the medical note Mr AK stated:

> *"DIAGNOSIS – Primary, Secondary, and presenting symptoms – pr bleed*
>
> *SUMMARY…*

11/3/15 – admitted with pr bleed on background of 7 month history of pr bleeding. Currently awaiting definitive surgery under Mr Dixon – previous flexi sig showed that rectal prolapse pressing on haemorrhoids likely source of bleed.

Admission Gb was 83, and improved to 104 after 2 units of blood

13/3 – flexi sig performed at Southmead hospital – 4 bands applied
Good recovery and discharged later on the same day"

402. In his letter of the consultation on 7 April 2015 to NHS South Gloucestershire Individual Funding Request Team, Mr Dixon stated:

"This lady first presented to us in 2011, having previously had a Milligan Morgan haemorrhoidectomy, stapled haemorrhoidectomy as treatment of bleeding haemorrhoids. The bleeding being sufficient to cause anaemia. She also had a history of obstructed incomplete evacuation with pelvic pain and faecal incontinence. Unfortunately this lady has failed to respond to conservative measures and when seen at the end of last year she has progression of her internal rectal prolapse, so that now she has what amounts to an overt external prolapse.

I can confirm that this lady's case was discussed at the Bristol Pelvic Floor MDT on 24th March and the support for surgical intervention was unanimous. Given that this lady's symptoms have progressed over the time period along with her anatomical abnormalities, we would be grateful if you could look upon this request favourable, particularly as it is interfering with her work as a University Lecturer."

403. The Tribunal noted that in his letter requesting funding, Mr Dixon confirms that Patient J's case had been discussed and considered by an MDT on 24 March 2015. Patient J indicated in her complaint letter that she was aware of this letter at the time.

404. Dr AJ at Concord Medical Centre sent a letter to Mr Dixon, dated 9 April 2015 (Patient J was copied in), which stated:

"This woman is on your waiting list for a repair of her rectal prolapse. She was admitted to Southmead for 3 days on 10th March with anaemia due to blood loss and was transfused 2 units. She also had 4 piles banded. She is still having rectal bleeding and suffering with the prolapse and is anxious to get a definitive treatment for the problem. She is a University lecturer and feels that the prolapse is interfering significantly with her ability to do her job.

I would be grateful if you could possibly arrange to expedite the date for surgery."

405. By the time Mr Dixon received this letter in April 2015 Patient J had seen no improvement in her symptoms and had consulted a number of other doctors to manage the condition without surgery. It appears to the Tribunal that there had been a period for consideration of other treatment options but the unanimous view of the MDT in March 2015 was to proceed to surgery. The documentary evidence confirms that Mr AK had also come to the conclusion that surgery was the treatment pathway for Patient J in March 2015. It was also Patient J's view that at this point surgery was the only option to deal with her symptoms.

406. Colonel L in his evidence to the Tribunal agreed that the LVMR was a reasonable treatment option for Patient J and did not explain what further treatment options Mr Dixon ought to have discussed with Patient J at the point of surgery in June 2015. It was not in dispute that Patient J had seen a number of other doctors to discuss her condition and the proposed surgery.

407. The Tribunal notes that on the day of surgery Patient J stated in her evidence that she wasn't aware of what was happening and stated that she had never heard of "rectopexy". Patient J's evidence was that she had to google it on the morning of the surgery. Patient J said in her witness statement, "Before the operation Mr Dixon told me that there wouldn't be any discomfort. He did not warn me about any of the side effects or risks associated with the operation. I did not know anything about the mesh or any of the potential alternatives."

408. The Tribunal considered that Patient J's recollection was inconsistent with the contemporaneous documentary evidence. Further, in her oral evidence Patient J accepted that "netting" was discussed with her prior to the operation by Mr AH. In cross-examination she stated:

> *"Do you know something? I saw him, and I saw him twice, Mr [AH]. I think it was on the second occasion when he talked about the fact that you could put in what was the equivalent of industrial strength netting into your bowel, and it would hitch things up, so I said, "Why?" He said, "Because then it will – if we put industrial strength netting in, it will stop possible pressure on the haemorrhoids."*

409. The Tribunal accepted that at the time of these events Patient J's symptoms were significantly interfering with her life. However, the Tribunal considered that her recollection of what was explained to her at that time, particularly before the surgery could not be relied upon given the time that had passed. In addition, the contemporaneous medical records and, in particular, the letter of 13 January 2015 set out that Patient J was given a full explanation of the surgery and the expected benefits.

410. Given all these factors, the Tribunal did not consider that Mr Dixon had failed to obtain informed consent from Patient J in that he did not advise Patient J of other treatment options in respect of her procedure on 1 June 2015. The Tribunal considered that Patient J

was adequately consented by other doctors prior to the surgery and there was no duty upon Mr Dixon to suggest alternatives at that stage.

411. Accordingly, the Tribunal found paragraph 25ai of the Allegation not proved.

Paragraph 25aii of the Allegation

412. In respect of whether Mr Dixon failed to obtain informed consent from Patient J in that he did not advise Patient J of the expected benefits of Patient J's Procedure, the Tribunal had reference to the letter of 13 January 2015, sent from Ms AI, Registrar. In that letter she sates that she had spoken to Mr Dixon about Patient J's case and with *"a laparoscopic mesh rectopexy, we should hopefully be able to improve her symptoms of bleeding."*

413. The Tribunal considered that Patient J's recollection of events seemed to be inconsistent and that her explanation of 'netting' is an approximation of what the surgery is. This would be consistent with the documentary evidence that the rectopexy was explained to her in clinic. In addition, Patient J had been copied in to the letter from Ms AI on 13 January 2015 in which it was set out that Mr Dixon would do a laparoscopic mesh rectopexy and the letter stated: "*I have explained this to [Patient J] today in clinic who Is happy and keen to proceed with surgery".* The Tribunal also noted that this letter was dated some five months before the surgery so Patient J was informed at that stage the name of the procedure.

414. The Tribunal no reason to doubt that this letter was sent although it accepted that Patient J's evidence was she had not seen it. The Tribunal concluded that it was more likely that Patient J did not recall this letter given the time that had passed. The Tribunal has relied upon the letter as a contemporaneous record that Patient J attended the consultation with Dr AI and it is evidence of what was discussed.

415. The letter from Dr AI out the expected benefits. Further, the letter from Dr AJ dated 9 April 2015 sets out the understanding of what the benefits of the surgery would be. In addition, Patient J was admitted for a blood transfusion as a result of the bleeding and she explained that she was aware that her prolapse was pressing on her large haemorrhoid and she was awaiting an operation.

416. On the day of the procedure Mr Dixon was faced with a patient who had been consented by at least two other doctors and the documentation confirmed that the procedure had been explained. The Tribunal considered that it was a reasonable judgement given the consultations that Patient J was aware of the operation and was consented adequately.

417. The Tribunal also took into account the conversations between Patient J and Mr Dixon on the day of surgery. The Tribunal accepted that there was likely to have been a discussion about the risks and benefits of surgery. Patient J's witness statement confirms that she asked

Mr Dixon some questions about the procedure on the day of surgery. However, there is no evidence that she raised concerns that she did not know what the operation was for or that she had any concerns about proceeding despite there being a significant period of time after seeing Mr Dixon before the surgery began for her to raise those concerns. There was nothing in the evidence before the Tribunal that would have alerted Mr Dixon that Patient J was not aware of the rationale and benefits of her operation.

418. The Tribunal was satisfied Mr Dixon had not failed to obtain informed consent from Patient J and that she had previously been advised of the expected benefits of her procedure.

419. Accordingly, the Tribunal found paragraph 25aii of the Allegation not proved.

Paragraph 25aiii of the Allegation

420. In respect of whether Mr Dixon failed to obtain informed consent from Patient J in that he did not advise Patient J of the risks associated with her procedure, the Tribunal noted from the documentation that the only time some of the risks were discussed with Patient J was on the day of the procedure. These were set out in the consent form as *''Voiding, evacuatory and mesh problems to include rejection, erosion and infection''*.

421. The Tribunal noted that there was no reference in the notes of previous consultations or the consent form to the high-risk low frequency outcomes as set out in the 2008 Guidance. The Tribunal considered that consent was therefore below the published standard. The Tribunal considered that in accordance with that guidance these risks should have been explained to Patient J and she should have had time to consider and reflect on all the risks involved with her treatment. The Tribunal considered that there was a failure to obtain informed consent as Patient J should not have been advised of these on the day of the procedure given that this was not an emergency but an elective procedure.

422. The Tribunal determined therefore that Mr Dixon failed to obtain informed consent as he did not advise Patient J of all of the risks associated with her procedure nor was adequate time granted to allow Patient J to properly reflect on the risks.

423. Accordingly, the Tribunal found paragraph 25aiii of the Allegation proved.

Paragraph 25b of the Allegation

424. When considering whether Mr Dixon failed to obtain informed consent from Patient J in that he obtained written consent on the day of Patient J's procedure, the Tribunal reminded itself that consent is a process where the patient must be adequately counselled. In the view of the Tribunal, which was supported by the expert evidence it is not a failure to obtain a patient's signature on the consent form on the day of the procedure if the patient has been adequately counselled prior to the procedure and is fully aware of what is proposed. The Tribunal accepts that this would be suboptimal in terms of published

standards but accepted that it was widely practised for reasons of practicality. The Tribunal considered that whilst it would have been preferable for Patient J to have signed the consent form prior to the day of surgery, obtaining a signature to the consent form on the day does not necessarily and of itself mean there is a failure to obtain informed consent if the patient has previously had all of the risks and benefits explained.

425. Given that the Tribunal has already found that Mr Dixon did not obtain informed consent from Patient J in respect of outlining the risks of her procedure on 1 June 2015, the Tribunal considered that to find this paragraph proved was double counting the same failure. The Tribunal concluded that in obtaining Patient J's signature to the consent form on the day of surgery Mr Dixon did not undermine the consent process that had preceded it.

426. Accordingly, the Tribunal found paragraph 25b of the Allegation not proved.

Performance assessment

Paragraph 26 of the Allegation

26. You underwent a General Medical Council assessment of the standard of your professional performance over the following dates:

    a. 5-7 November 2018; **Determined and found proved**

    b. 12 November 2018; **Determined and found proved**

    c. 11 December 2018. **Determined and found proved**

427. These were factual allegations that were not disputed relating to the timing of the performance assessment.

428. Accordingly, the Tribunal found paragraphs 26a, b and c of the Allegation proved.

Paragraph 27 of the Allegation

27. Your professional performance was unacceptable in the following areas:

    a. assessment of pelvic floor patients;
    Determined and found not proved

    b. clinical management of pelvic floor patients;
    Determined and found not proved

    c. working with colleagues. **Determined and found not proved**

429. The Tribunal had regard to the summary of concerns in the Performance Assessment report ('PA'). In dealing with this allegation the Tribunal considered the methodology of the

Performance Assessment as well as considering whether the conclusions were supported by the evidence.

430. Dealing first with the methodology, it was the subject of significant criticism by Mr Basu that the Performance Assessment Team were not provided with sufficient medical records to carry out their assessment. 40 records were requested across the spread of Mr Dixon's work but only 32 were provided despite numerous requests to the relevant hospitals. The medical records were reviewed by the medical members of the Performance Assessment Team. They concluded within the report,

> *"The team reviewed 32 records. The team agreed there was sufficient material to produce the report. There was a delay in providing the records and this led to some delay in producing the report."*

431. In oral evidence, Dr K, the lead performance assessor, set out the difficulties with obtaining the medical records. He was clear in his evidence that he and his colleague Dr N considered that they had sufficient records to carry out a fair assessment of Mr Dixon's performance. He specifically rejected any suggestion that the records had been *"cherry-picked*" by Mr Dixon's former employer to paint Mr Dixon in a poor light. Mr K stated that when it was brought to his attention that the records included one of the patients that had made a complaint to the GMC, this was removed from the performance assessment.

432. Mrs O provided evidence to the Tribunal that when she was present on Trust premises the records appeared to have been stored in a "chaotic" way with "files everywhere". Mrs O stated,

> *"A You might have thought so, but if you'd seen the room that we were in and the records, and what was going on, and we were getting trolley-loads of stuff coming through. It was absolutely chaotic is the only way I would put it. The performance assessment officer was in touch with so many people – this was during the assessment – to try and get more records. I've never seen anyone, in any assessment, trying as hard as they did on this one to get the records. Then we get records which are patients where Mr Dixon wasn't involved…"*

433. The Tribunal took the view that the Performance Assessors were in the best position to ascertain whether they could conduct a fair analysis of Mr Dixon's performance using the records they obtained. The Tribunal considered that there was no evidence to support that the records had been unfairly chosen or were not representative of Mr Dixon's work. There was no evidence that the records reviewed skewed the outcome of the performance assessment. When Mr Dixon was asked about the medical records within the case based discussion he was able to recall details and answer questions. There was no suggestion in the

report that Mr Dixon was unfamiliar with the topics discussed or they were not representative of his work.

"2.3 Mr Dixon's performance in the OSCEs was equal to 75th percentile in 9 of the 12 stations. It was below 25th percentile in 3 stations.

2.4 Mr Dixon made extensive comments on the TPI. These were taken into account.

2.5. Mr Dixon's performance has been deficient because of unacceptable performance in assessment and management of pelvic floor conditions relating specifically to LVMR procedures. Mr Dixon used unconventional methods to diagnose internal rectal prolapse and offered this operation without trying conservative treatments. Mr Dixon's performance was also unacceptable in the category of colleagues. There were concerns around Mr Dixon's management of emergencies. There were also concerns about Mr Dixon obtaining informed consent for LVMR procedures in the category of patients.

Mr Dixon is fit to practise on a limited basis.

2.6 Mr Dixon's practice relating to pelvic floor conditions should be restricted and closely supervised.

Mr Dixon should draw up a personal development plan with an educational supervisor. These would be based on the areas of remediation like obtaining informed consent, following MDT recommendations, timely review of emergencies and becoming familiar with guidelines relevant to his work."

…

"Medical Record Review

The team requested the records of 40 consecutive patient encounters from NBT working backwards from May 2017 and records of 10 consecutive patient encounters from Spire Hospital working backwards from August 2017. The break up from NBT was 15 cancer cases, 15 pelvic floor cases, 5 endoscopy and 5 others including emergencies. From Spire Hospital 5 miscellaneous and 5 pelvic floor records were requested. This was thought to be appropriate considering the spread of Mr Dixon's NHS and private work.

…

Case Based Discussion

Due to technical difficulties in reviewing the medical records the CBD had to be postponed to a later date.

Mr Dixon was given the 12 sets of notes to be used in the CBD at approximately 6.30pm on 10 December 2018 to enable him to review them prior to the CBD, taking place the following day.

In an email from Mr Dixon's solicitor to the PAO she referred to the fact that one of the CBD cases related to a patient who had made a complaint to the GMC. The PAO explained that the team had no knowledge of this. The team decided to exclude the case and told Mr Dixon that the team would use 11 CBD cases, which he accepted.

Knowledge Test

Mr Dixon undertook a 2 hour test of 120 single best answer questions. The questions were chosen by RDME and were either taken from the GMC item bank or sourced from the appropriate college. The test was invigilated by the Lay Assessor. Prior to the test starting, the Team Leader went through the instructions and an example question with Mr Dixon to ensure he was comfortable with the format of the test. Although Mr Dixon was told that he could have an extra half an hour to do the test because of XXX, he did not take any extra time.

OSCEs

The scenarios used in the OSCE stations were chosen from a list of possible scenarios by the Team Leader, in consultation with the assessment team and RDME, to reflect a range of cases in the specialty, including a compulsory Basic Life Support station. The role players were briefed by the Team Leader and Medical Assessors to ensure they knew their roles."

434. The Tribunal then noted what the PA set out in respect of the second and third interviews that:

"Second and Third Interviews

With the agreement of Mr Dixon, the Second and Third Interviews were merged into a single interview which took place on 11 December 2018 after the CBD. This was because all the medical records were not available for review as set out in the timetable.

Mr Dixon was aware that he was entitled to have a supporter present during the interview. He opted not to have a supporter present."

435. In respect of the second and third interviews, the GMC Handbook for performance assessors (May 2017) states:

> *"Second and third interviews with the doctor*
> *The second and third interviews lets the assessment team add the doctor's comments to the evidence gathered from other instruments. The team should plan questions carefully to make sure:*
> - *questions are generally open rather than closed to allow the doctor to describe their performance in their own words*
> - *answers are likely to make useful contributions to the database for report writing*
> - *answers are likely to help assessors distinguish acceptable and unacceptable performance when making judgements.*
>
> *Questions might:*
>
> - *explore areas that haven't been fully explored by other instruments, such as audit, appraisal, keeping up to date, or teaching*
> - *be an opportunity for the doctor to comment on general criticisms made by others or in third party interviews (bearing in mind that the assessment is not an investigation of complaints)*
> - *explore the doctor's understanding of his or her professional performance*
> - *contextual issues, such as factors that might affect the doctor's performance (eg workload or locum work), or career plans.*
>
> *If necessary, the assessment team might remind the doctor of any previous agreement to produce additional information such as a personal development plan or audit report.*
>
> *The interviews are also an opportunity for the doctor to give the team feedback about the overall conduct of the assessment so far. The doctor may also ask questions of the team and offer new, relevant information.*
>
> *You should tell the doctor about the next steps of the process including, where appropriate, the opportunity to submit written comments on third party interview transcripts or on receipt of the report."*

436. It appeared to the Tribunal that the purpose of the second and third interviews was to obtain the doctors comments on issues raised in the medical records which the individual assessors considered would inform their judgements about whether the doctor's

performance was acceptable. The Tribunal considered that looking at the guidance and where the interviews were placed within the process, it was an opportunity for the doctor and assessors to explore any issues raised within those records which may be known to the doctor and not the assessors.

437. Following questioning of the lead assessor Mr K, it appeared that the content of the questions for both the second and third merged interviews followed an 'agenda' contained within the performance assessors folder. It was unclear to the Tribunal the status of this agenda and it appeared to have superseded the guidance and formed the basis of a misinterpretation of the purpose of the second and third interviews in Mr K's mind. The agenda stated as follows:

> *"Agenda (chaired by the lay assessor)*
> *Introduction by lay assessor:*
>
> - *Explain the purpose of the interview.*
> - *Has the doctor any questions or comments about the process or conduct of the visit? ·*
> - *Has the doctor any questions for the Team or want to offer any other relevant information. Record these on the last page.*
>
> *The Team Leader should advise the doctor about the next steps of the process including, where appropriate, the opportunity to comment on third party interview transcripts or on receipt of the report."*

438. The Tribunal also had regard to the August 2015 version of the assessor handbook:

> *"9. THIRD INTERVIEW WITH THE DOCTOR*
>
> *Chair: Lay Assessor*
>
> *Purpose*
>
> *This interview gives the doctor the opportunity to present any further relevant information to the team. The team add these comments to the evidence gathered from other instruments*
>
> *NB: UNLIKE THE FIRST INTERVIEW THIS INTERVIEW IS PART OF THE ASSESSMENT"*

439. The assessors during the merged second and third interviews asked Mr Dixon only three questions.

"Do you have any comments?

How did you feel about the assessment?...

What are your future plans?..."

440. At this stage the assessors had not received all the medical records and had gone ahead with the second and third combined interview. Mr Dixon had not been offered the opportunity to clarify any points. It appeared to the Tribunal that the assessors had not used the opportunity of the interviews to request any information which may have assisted them to reach judgements when reviewing the medical records or considering the third party interviews. It was clear to the Tribunal as a result of further questions that Mr K, in particular, did not consider these interviews to be a part of the performance assessment and considered that it was simply an opportunity for the doctor to give "feedback" about the conduct of the process.

441. Mr Basu cross examined Dr K at length about the purpose of the second and third interviews:

"Q How does the - how do the second and the third interviews feed into the process of arriving at a performance assessment report?

A These questions and answers - these answers are not judged, they are taken into context, and then when the report is being prepared, that context would be mentioned in the report.

Q You've used the word "context" and there is - there are parts of the instructions that suggest that context is separate from either acceptable or unacceptable performance or evidence of that.

A That is correct.

Q Are you using the word in that special sense of context?

A We're not judging the answers, if that makes sense.

Q So you're not judging the answers. So does it follow that the answers - neither the questions nor the answers are directed towards seeking to get a better idea about the performance of the doctor you're assessing?

A *This is not an instrument to judge performance. This is more to do with updating and to have a discussion about how the interview is - how the performance assessment is being done.*

442. During the exchange between Mr Basu and Dr K the Tribunal considered that it was apparent that Dr K had a different view about the importance and purpose of the second and third interviews which was at odds with the published guidance.

443. The Tribunal then asked Mr K, furthers questions about the second and third interviews:

"THE CHAIR: We'll just stay with these for the moment. In terms of the process, if it had gone according to plan, where did the second and third interviews fall in the process?

A *The second interview happens, so we do the first interview. We do the medical records review on the same visit. We do the site visit if need be. We do the third party interviews, and then on the second day we would then have a selection of case based discussions and ask the doctor to come for a case based discussion and do the second interview at that point.*

Q *At that point, at the point that you do the second interview, you've had the first interview which I understand is about getting context and isn't a performance assessment. Am I correct?*

A *Yes.*

Q *You will have had the medical records review and the case based discussion and the third party interviews. Is that correct?*

A *Some of the third party interviews, not all.*

Q *As many of them as you can reasonably do?*

A *Yes.*

Q *You will then have the second interview, and then the next part of the process is the knowledge test and the OSCEs. Am I correct?*

A *Yes.*

Q *Then the third interview. In terms of the second interview, if you look at the guidance that you've probably got open at C33, you will see the last two paragraphs, they say:*

> *"The interviews are also an opportunity for the doctor to give the team feedback about the overall conduct of the assessment so far."*

That's what you've indicated you see as what you were doing in that interview we've been talking about?

A *Correct.*

Q *Do you see that as the primary purpose of the second and third interview? Have I understood that correctly?*

A *Absolutely correct, yes.*

...

Q *If what you say is the primary purpose of the second and third interviews, which is for the doctor to give feedback of the process, how does it help you assess the doctor? How is it a performance assessment tool?*

A *The comments made by the third party interviews are judged by the assessors, and the doctor gets a transcript of the interviews and is asked to comment if they have any comments on that, and that would then be taken on board when we write the report.*

Q *When you were asked about it by my colleague you indicated that that was, the comments on the third party interview were only in relation to context. You were only looking for something from the doctor in relation to, "I've seen these comments. This is what I think about it," or what have you, but if you have concerns that are feeding into your performance assessment that are based on the third party interviews, are you saying that you don't explore those with the doctor in this interview process?*

A *No.*

Q *Is there a reason for that?*

A *I don't think the process asks us to do that. Because the team, the assessors are making independent assessments on the interviews, and I think exploring*

as far as possible from the person giving the interview to make a judgement on the basis of the answer in exploring further questions from the interview. We do not then the doctor gets a transcript, and the doctor could come up, could come back to say that was factually wrong or there is a misleading element there, and that then would be taken on board by the team.

Q *What I'm getting at, and I'm probably not making myself very clear at all, is that if the purpose of the second and third interview is only for the doctor to essentially give you feedback on how the process has gone, how is it an effective assessment tool? What are you looking at assessing with this second and third interview because they're very clearly described to the doctor as forming part of the assessment in a way that the first interview is not. The first interview is described to the doctor as, "This does not form part of the assessment," and Ms Fairley took you to where it's described, and you also indicated in this report that the third interview, as it's described, was also context. It was not used as a performance assessment tool. Am I making myself clear?*

A *You are. I'm trying to answer this. The question you are asking here is the second and third interview, what is in the interviews which would help you to make better judgements.*

Q *What's the purpose of them?*

A *The purpose of these interviews are* ***to explain to the doctor*** [emphasis added] *any concerns about the process or anything going forward, what the next steps would be, for the doctor to explain to the team any elements of the process which the doctor feels went well or could have been done better or he disagrees with. If the doctor says for instance, I'm just thinking aloud, if the doctor says, "That case based discussion was not correct," or we shouldn't have collected that case or the questions were not correct or, "My answers what I gave meant these," that would have then been noted and would have influenced the report.*

Q *Why do you have to do that twice?*

A *Because the judgements have already been made by the assessors, but this is taking into account the doctor's views on that.*

Q *I understand that, but I don't understand why you have to have two interviews to do that?*

A Oh, I see. I think the second interview is part of the assessment. I think that's how they are laid out. I'm sorry, the assessment is done in the way where there is an intermediate first interview is fact gathering, second is to talk about the process so far, and the third is to summarise it and to say when the report will be available and the steps going forward. They have split it into second and third, and there have been instances where I've been involved with previous assessments where you're allowed to merge the second and third if there are logistic problems with the process in the assessment."

444. The Tribunal was of the view that Mr K's understanding of the second and third interviews was incorrect in terms of the 2017 Handbook and published guidance, as set out above, that should have been followed for Mr Dixon's PA. In the view of the Tribunal the purpose of the second and third interviews was an opportunity for the performance assessment team to explore with the doctor any matters that would assist when forming a judgement following their initial review of the medical records and third party interviews.

445. An example of this is contained in the performance assessment with regard to the review of medical record MRR19. It was explored with Dr N, for what appeared to be the first time during this hearing, that the patient was initially admitted under the care of another consultant and had undergone an operation to drain a perineal abscess by that consultant. Mr Dixon saw the patient had become unwell 2 days later whilst doing a ward round as an emergency surgeon. Mr Dixon took over the care of this patient and they were returned to theatre for a further operation. The patient was then "handed back" to the original consultant. Dr N had no recollection of this explanation but agreed that if this were correct then there could be no criticism of Mr Dixon. There was no evidence within the performance assessment report that this explanation was considered and also no evidence that Mr Dixon's recollection of events was disputed:

"Q But seeing this picture of the medical records, you'd want to know, wouldn't you, why Mr Dixon hadn't seen the patient until two days later?
A Yes.

Q If he gave the explanation I've just told you he would say he did give, that's a complete answer to the criticism that's set out there, isn't it?
A Yes.

Q Assuming that he's right about this, that is an entirely unfair criticism of Mr Dixon, isn't it?
A If that is the case, yes. Yes."

446. This suggested to the Tribunal that this criticism could not be substantiated.

447. Further, an exchange with Dr K about the questions asked during the case based discussions was as follows,

> *"Q You speak through your report and when we look at your report, page 23, you say "He did not refer to the BSG guidelines".*
>
> *A Which he did not.*
>
> *Q That is wrong, isn't it; he plainly referred to the guidelines, didn't he?*
>
> *A He did but it would have been what guideline and which guidelines and I don't think we got that answer.*
>
> *Q What Mrs O has written down is simply, "I knew the guidelines said" etc. Let us assume he didn't say the BSG Guidelines on Safety and Sedation, what other guidelines could he have been referring to? You aren't suggesting that he was just guessing and said "Oh, just guidelines – I don't know."*
>
> *A There are other guidelines, there are JAG guidelines as well. There are other guidelines.*
>
> *Q Couldn't you ask him which guidelines he was talking about, just to make sure he was familiar with the right set of guidelines, to say "Which ones are you talking about?"*
>
> *A He wasn't asked.*
>
> *Q There is a risk, isn't there, that if you don't specifically ask about something the person may not give that answer even though they do know it. Do you see that?*
> *A I see that.*
>
> *Q Do you remember I asked you at the beginning what guidelines you followed. I wouldn't want to be unfair to you by saying you didn't mention the Good medical practice that I have waved around, you didn't mention the Fitness to Practise Rules, you didn't mention the handbook. You said that there were guidelines and you had had some training on it. Do you see that because I didn't give you a chance, or I didn't*

ask you specifically you didn't mention those things although you plainly must be aware of them. It wouldn't be fair for me to say you weren't.

A When we start the case-based discussion before every question or set of questions there is clarification as to what we are aiming to expect from those questions and this comes under "must be familiar with guidelines and developments that affect your work". This is clearly spelt out to the doctor that this is the category we are assessing.

Q Did you have a self denying ordinance if someone mentioned, or Mr Dixon mentioned guidelines with no explanation of which ones they were that you wouldn't ask him to expand on that. Was there a decision not to say which guidelines.

A No, there wasn't any discussion on saying we won't ask what guidelines.

Q Do you accept that you didn't say to him "Which guidelines are you talking about?"
A No. I accept that this probably has been written by Mrs O and we may have missed that word here."

448. It appeared to the Tribunal that even if it had been overlooked in the case based discussion, the second and third interviews would have been an opportunity to explore with Mr Dixon any criticism related to his knowledge of relevant guidelines. It was clear from the written notes of Mrs O that Mr Dixon had mentioned guidelines. In the view of the Tribunal it was unfair and artificial to suggest that because the premise of the question was about "guidelines" a failure by Mr Dixon to refer to them in full by name was sufficient to inform a judgement that he was not familiar with them when his answer was in accordance with those guidelines.

449. In relation to the third party interviews, Mrs O and Dr N agreed the comment attributed to Mr AL that Mr Dixon "shut-up" juniors was a misquote and it was unfair to Mr Dixon and should not be in the report. This was not something that was explored with Mr Dixon during the interviews and although he was given a transcript, any issues arising from those interviews were not explored with him during the second and third interview to allow the assessors to gain any insight from him regarding his performance.

450. Dr N in his cross examination resiled from a significant proportion of the criticisms that were contained within the performance assessment report. His evidence was noteworthy in that he conceded that criticisms had found their way into the report which he now considered should not be there.

451. The Tribunal was of the view that the approach of the assessors was inconsistent with the approach set out in the 2017 GMC Handbook for performance assessors and that this had had a significant impact on the judgements they had made. The assessors did not allow themselves the opportunity to review and question Third Party Interviews with Mr Dixon and allow him the opportunity to provide further information. The Tribunal identified no less than two examples within the Third Party Interviews where the assessors would have benefitted in their judgement from a third interview with Mr Dixon allowing him the opportunity to provided clarification and more information which may have changed the finding. It determined that the findings relating to the Third Party Interviews was therefore undermined.

452. The assessors also denied themselves the opportunity to question Mr Dixon in respect of the Medical Record Review, nor allow him the opportunity to provide further information. The Tribunal identified no less than three examples within the Medical Record Review where the assessors would have benefitted in their judgement from a third interview with Mr Dixon allowing him the opportunity to provide clarification and more information which may have changed the finding. The Tribunal determined that the findings made relating to the Medical Record Review category were also undermined.

453. In terms of Case Based Discussions and the OSCE's the Tribunal considered the contribution of Mr Dixon within the second and third interview is not as significant.

454. In the view of the Tribunal, by combining the second and third interviews, and by deviating from the Handbook for Performance Assessors 2017, the assessors had denied themselves an opportunity to explore with Mr Dixon pertinent matters which would have assisted them to form more balanced judgements on the matters within the report. Given that the assessors were prepared to concede that some of the criticisms of Mr Dixon could not be maintained in the light of the further evidence presented to them at the hearing, the Tribunal considered that this placed the overall judgements of the performance assessment in doubt.

455. The Tribunal was not in a position to "second guess" what might have been the outcome had the correct process been followed. What was clear, was that a number of the criticisms could not be maintained, and the Tribunal was unable to determine how those judgements had been weighted in relation to the overall conclusions. The Tribunal accepted that there were likely to be some legitimate criticisms of Mr Dixon but it was unable to say whether these would amount to unacceptable performance or cause for concern in any given area. To do so, would be to unfairly carry out a performance assessment without having the expertise to do so.

456. The Tribunal considered that it could not rely on the conclusions as contained within the performance assessment report as some criticisms were not supported by the evidence and further targeted discussions with Mr Dixon may have changed the outcome in relation to others. Accordingly, the Tribunal found paragraphs 27a, b and c of the Allegation not proved.

28. Your professional performance was a cause for concern in the following areas:

a. maintaining professional performance;
Determined and found not proved

b. clinical management of emergencies;
Determined and found not proved

c. relationships with patients. **Determined and found not proved**

457. For the same reasons as set out in respect of paragraph 27a, b, and c, the Tribunal, it follows that paragraph 28, a, b and c are not proved.

The Tribunal's Overall Determination on the Facts

458. The Tribunal has determined the facts as follows:

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

Clinical Misconduct

Patient A

1. On 16 December 2010 you performed a rectal examination on Patient A:

a. in the absence of a chaperone; **Determined and found proved**

b. and you failed to:

i. ask Patient A if she would like a chaperone to be present;
Determined and found not proved

ii. (in the alternative to allegation 1a and 1bi) record that:

1. you had asked Patient A if she would like a chaperone to be present; **Determined and found proved**

2. Patient A had declined a chaperone. **Determined and found proved**

2. On 12 February 2011 you performed a laparoscopic ventral mesh rectopexy ('LVMR') on Patient A ('Patient A's First Procedure') and you failed to:

   a. arrange for Patient A to undergo a proctogram in advance of Patient A's First Procedure; **Determined and found not proved**

   b. obtain informed consent from Patient A in that you did not advise Patient A of:

      i. non-surgical treatment options;
      Determined and found not proved

      ii. the risks associated with Patient A's First Procedure;
      Determined and found proved

   c. (in the alternative to paragraph 2b) record taking the steps described at paragraph 2b. **Determined and found not proved**

3. On 25 October 2011 you performed a rectal examination on Patient A:

   a. in the absence of a chaperone; **Determined and found proved**

   b. and you failed to:

      i. ask Patient A if she would like a chaperone to be present;
      Determined and found not proved

      ii. (in the alternative to paragraph 3a and 3bi) record that:

         1. you had asked Patient A if she would like a chaperone to be present; **Determined and found proved**

         2. Patient A had declined a chaperone.
         Determined and found proved

4. On 18 November 2011 you performed a laparoscopic sub-total colectomy on Patient A ('Patient A's Second Procedure') and you failed to:

   ~~a. ensure that a CT scan was undertaken to exclude other causes of her symptoms ensure that a transit study had been undertaken to confirm your diagnosis of slow transit constipation ensure that a CT scan~~; **Withdrawn pursuant to Rule 17(6)**

   b. obtain informed consent in that you:

      i. did not advise Patient A of:

         ~~1. non-surgical treatment options;~~ **Withdrawn pursuant to Rule 17(6)**

2. the risks associated with Patient A's Second Procedure; **Determined and found proved**

ii. obtained written consent on the day of Patient A's Second Procedure; **Determined and found not proved**

c. (in the alternative to paragraph 4bi) record providing the advice outlined at paragraph 4bi. **Determined and found not proved**

5. Before performing thea ~~a revision rectopexy~~ revision surgery on Patient A in December 2013 you failed to: **Amended pursuant to Rule 17(6)**

a. carry out a full re-investigation; **Determined and found not proved**

b. discuss Patient A's case with colleagues from other disciplines. **Determined and found not proved**

Patient B

6. On or around 20 ~~22~~ March 2012 you performed a rectal examination on Patient B: **Amended pursuant to Rule 17(6)**

a. in the absence of a chaperone; **Determined and found proved**

b. and you failed to:

i. ask Patient B if she would like a chaperone to be present; **Determined and found not proved**

ii. (in the alternative to paragraph 6a and 6bi) record that:

1. you had asked Patient B if she would like a chaperone present; **Determined and found proved**

2. Patient B declined a chaperone. **Determined and found proved**

7. In June 2016 you consulted with Patient B and you failed to:

a. adequately advise Patient B about her underlying:

i. diagnosis; **Determined and found not proved**

ii. prognosis; **Determined and found not proved**

b. adequately outline options for treatment, including:

i. non-operative treatments; **Determined and found not proved**

ii. providing no treatment at all; **Determined and found proved**

c. with regards to the proposed treatment, outline the:

i. purpose; **Determined and found not proved**

ii. expected benefit; **Determined and found not proved**

iii. associated risks; **Determined and found not proved**

d. (in the alternative to paragraph 7a-7c) record taking the steps at paragraph 7a-7c. **Determined and found proved in respect of 7bii, 7ci and 7cii only**

8. On 15 July 2016 you performed ~~a revision~~ a hindgut resection and ~~revision of Patient B's~~ LVMR ('Patient B's Procedure') and you failed to: **Amended pursuant to Rule 17(6)**

a. ensure Patient B's procedure was clinically indicated in that you did not arrange all necessary tests and investigations beforehand;
Determined and found not proved

b. obtain informed consent in that you:

~~i. rushed through the information contained on the consent form when discussing it with Patient B;~~ **Withdrawn pursuant to Rule 17(6)**

~~ii. did not allow Patient B to ask any questions;~~
Withdrawn pursuant to Rule 17(6)

~~iii. did not advise Patient B that a very poor result was possible;~~
Withdrawn pursuant to Rule 17(6)

iv. had previously only told Patient B that you would perform a surgical resection; **Determined and found not proved**

v. did not discuss the risks associated with Patient B's Procedure;
Determined and found not proved

vi. did not make a legible copy of the consent form;
Determined and found proved

vii. obtained consent on the day of Patient B's Procedure;
Determined and found not proved

c. (in the alternative to paragraph ~~8biii and~~ 8bv), record taking the steps at paragraph ~~8biii and~~ 8bv. **Amended pursuant to Rule 17(6) / Determined and found not proved**

9. After Patient B's Procedure you consulted with Patient B and her husband, Mr C, and you inappropriately stated to Mr C that you could have 'got [Patient B] pregnant' on the operating table, or words to that effect. Determined and found not proved

10. On 23 July 2016 you consulted with Patient B and you:

    a. dismissed Patient B's post-operative symptoms by stating:

        i. it 'can't be all that bad', or words to that effect;
        Determined and found not proved

        ii. Patient B was being an 'drama queen', or words to that effect;
        Determined and found not proved

    b. inappropriately patted Patient B on her bottom when entering a lift with her after the consultation had ended. Determined and found not proved

11. You failed to provide adequate post-operative care to Patient B following Patient B's Procedure in that you:

    a. inappropriately stated to Mr C that he should 'go home and fill her up' in reference to Patient B and Mr C's sex life; Determined and found proved

    b. did not adequately investigate Patient B's concerns regarding possible faecal fistula. Determined and found not proved

~~Patient D~~

~~12. On 15 May 2013 you consulted with Patient D and you communicated inappropriately with Patient D in that you:~~

~~a. continuously interrupted Patient D as he tried to answer questions;~~
Withdrawn pursuant to Rule 17(6)

~~b. asked Patient D's wife 'don't you feel like strangling [Patient D]?', or words to that effect.~~ Withdrawn pursuant to Rule 17(6)

~~13. On 6 March 2014 you performed a rectopexy procedure on Patient D ('Patient D's Procedure') and you failed to:~~

~~a. obtain informed consent in that you:~~

~~i. did not advise Patient D of:~~

~~1. other treatment options;~~
Withdrawn pursuant to Rule 17(6)

2. ~~the expected benefits of Patient D's Procedure;~~
Withdrawn pursuant to Rule 17(6)

3. ~~the risks associated with Patient D's Procedure;~~
Withdrawn pursuant to Rule 17(6)

ii. ~~rushed through the information contained on the consent form when discussing it with Patient D;~~ Withdrawn pursuant to Rule 17(6)

iii. ~~did not allow Patient D to ask any questions;~~
Withdrawn pursuant to Rule 17(6)

iv. ~~obtained consent on the day of Patient D's Procedure;~~
Withdrawn pursuant to Rule 17(6)

b. ~~(in the alternative to paragraph 13ai) record taking the steps at paragraph 13ai~~. Withdrawn pursuant to Rule 17(6)

14. ~~On 24 April 2014 you consulted with Patient D and you:~~

a. ~~were dismissive when Patient D complained about ongoing pain, advising that 'everything had gone well', or words to that effect;~~ Withdrawn pursuant to Rule 17(6)

b. ~~ignored Patient D when he advised that the physical examination you were performing on him caused him pain.~~ Withdrawn pursuant to Rule 17(6)

15. ~~On 21 October 2014, you consulted with Patient D and you dismissed Patient D's complaint that he was having difficulties defecating, advising that 'you're getting better then', or words to that effect.~~ Withdrawn pursuant to Rule 17(6)

Patient F

16. On 16 December 2015 you performed a stapled haemorrhoidectomy on Patient F ('Patient F's Procedure'), which was not:

a. treatment which has been previously discussed with Patient F;
Determined and found proved

b. clinically indicated; Determined and found not proved

c. performed adequately in that you excised a full-thickness section of the wall of the rectum. Determined and found not proved

17. You failed to obtain informed consent for Patient F's Procedure in that you:

a. did not communicate to Patient F that the consent form detailed Patient F's Procedure and not the treatment options previously discussed with her; **Determined and found proved**

b. did not adequately communicate the risks associated with Patient F's procedure; **Determined and found proved**

c. obtained written consent from Patient F on the day of Patient F's Procedure. **Determined and found proved**

18. (in the alternative to paragraph 17a-17b) you failed to record taking the steps outlined at paragraph 17a-17b. **Determined and not found proved**

19. Following Patient F's Procedure, you failed to:

a. arrange a biopsy of Patient F's ulcerated haemorrhoid; **Determined and found not proved**

b. communicate that you had made a technical error in excising a full-thickness section of the rectal wall during Patient F's Procedure:

i. to Patient F; **Determined and found not proved**

ii. within your department's morbidity review in accordance with your department's governance framework; **Determined and found not proved**

c. adequately respond to Patient F's communications regarding her post-operative concerns in that you:

i. advised Patient F she 'was lucky [you] performed [Patient F's Procedure]', or words to that effect; **Determined and found not proved**

ii. dismissed Patient F's pain by stating:

1. she had an 'abnormal pain response', or words to that effect; **Determined and found not proved**

2. the 'bowel does not feel anything', or words to that effect; **Determined and found not proved**

iii. dismissed Patient F's complaint regarding:

1. full-thickness bowel resection as being 'what [Patient F's Procedure] entailed', or words to that effect; **Determined and found not proved**

2. the removal of a 3cm wedge of her bowel as being 'just a piece of bowel', or words to that effect;
Determined and found not proved

iv. advised Patient F that her abnormal post-operative MRI findings were:

1. 'completely normal', or words to that effect;
Determined and found not proved

2. 'artefactual', or words to that effect;
Determined and found not proved

d. acknowledge that Patient F's unremitting symptoms suggested possible post-operative complications. **Determined and found proved**

Patient G

~~20. On 24 February 2015 you consulted with Patient G and you failed to:~~

~~a. take into account Patient G's family history, including her younger sister's history of pre-cancerous polyp~~; **Withdrawn pursuant to Rule 17(6)**

~~b. arrange a colonoscopy~~; **Withdrawn pursuant to Rule 17(6)**

~~c. arrange a proctogram~~. **Withdrawn pursuant to Rule 17(6)**

21. On 16 December 2015 you performed a stapled trans-anal rectal resection ('Patient G's Procedure') which was not clinically indicated in that you failed to:

a. adequately investigate her presenting symptoms;
Determined and found proved

b. trial non-surgical interventions; **Determined and found proved**

c. perform a less invasive procedure. **Determined and found proved**

22. You failed to record obtaining Patient G's informed consent for Patient G's Procedure in that you did not record explaining: **Amended pursuant to Rule 17(6)**

a. the expected benefits of Patient G's Procedure; **Determined and found proved**

b. non-surgical treatment options; **Determined and found proved**

c. the risks associated with Patient G's Procedure.
Determined and found proved

23. (in the alternative to paragraph 22) you failed to record taking the steps outlined at paragraph 22. **Determined and found not proved**

24. Your post-operative care of Patient G was inappropriate in that you:

    a. failed to adequately engage in Patient G's aftercare~~;~~.
    Determined and found not proved

    ~~b. stated that Patient G was being 'very emotional', or words to that effect, when she was re-admitted on or around 20 December 2015~~. Withdrawn pursuant to Rule 17(6)

Patient J

25. On 1 June 2015 you performed an LVMR on Patient J ('Patient J's Procedure') for which you failed to obtain informed consent from Patient J in that you:

    a. did not advise Patient J of:

        i. other treatment options; Determined and found not proved

        ii. the expected benefits of Patient J's Procedure;
        Determined and found not proved

        iii. the risks associated with Patient J's Procedure;
        Determined and found proved

    b. obtain written consent on the day of Patient J's Procedure.
    Determined and found not proved

Performance assessment

26. You underwent a General Medical Council assessment of the standard of your professional performance over the following dates:

    a. 5-7 November 2018; Determined and found proved

    b. 12 November 2018; Determined and found proved

    c. 11 December 2018. Determined and found proved

27. Your professional performance was unacceptable in the following areas:

    a. assessment of pelvic floor patients; Determined and found not proved

    b. clinical management of pelvic floor patients;
    Determined and found not proved

    c. working with colleagues. Determined and found not proved

28. Your professional performance was a cause for concern in the following areas:

a. maintaining professional performance; **Determined and found not proved**

b. clinical management of emergencies; **Determined and found not proved**

c. relationships with patients. **Determined and found not proved**

Determination on Impairment - 16/07/2024

459. 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, Mr Dixon's fitness to practise is impaired by reason of misconduct.

The Evidence

460. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. It received a testimonial bundle on behalf of Mr Dixon which included: testimonials from colleagues, medical staff, patients and patient's relatives. Mr Dixon also provided a Stage 2 witness statement, dated 14 July 2024. He then confirmed the contents of his witness statement under affirmation. No questions were asked by Counsel for GMC or the Tribunal.

Submissions on behalf of the GMC.

461. Ms Fairley reminded the Tribunal that whether Mr Dixon's fitness to practise is impaired was a matter for the Tribunal's professional judgment alone, that there was no burden or standard of proof at this stage. She said that when considering impairment, the Tribunal would no doubt keep in mind the statutory overarching objective. Ms Fairley said that at this stage there was a two-stage test, whether there has been misconduct and if that was serious misconduct, the Tribunal should then go on to consider whether Mr Dixon's fitness to practise is currently impaired. She also referred the Tribunal to the relevant case law when considering misconduct and impairment.

462. Ms Fairley submitted that the following paragraphs of Good Medical Practice (2013) ('GMP') were engaged in this case:

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

15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient…

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.

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.
49. You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:
a. their condition, its likely progression and the options for treatment, including associated risks and uncertainties
61. You must respond promptly, fully and honestly to complaints and apologise when appropriate.

463. Ms Fairley also reminded the Tribunal that it had found that Mr Dixon had breached paragraphs 28, 29 and 32 of the *'Consent: patients and doctors making decisions together'* Guidance (2008), which was also highly relevant at this stage.

464. Ms Fairley submitted that in respect of Patient F, a number of the Tribunal's findings clearly represented serious misconduct. She said that as Colonel L had indicated, the procedure undertaken by Mr Dixon was not an emergency procedure but an elective one to treat functional but not life-threatening health deficiencies. She submitted that it was in this context, with the failure to obtain informed consent that Mr Dixon failed to explain the procedure. She said it was clear from the evidence that Patient F would not have agreed to the procedure had she been informed as to what it entailed. Ms Fairley submitted that Mr Dixon's failure to discuss a procedure, and then going onto perform it clearly denied Patient F her fundamental right to choose whether or not to proceed with that treatment. She said this procedure clearly had a devastating and profound effect upon Patient F's life. She submitted that this represented a fundamental breach of one of the tenets of the profession and clearly amounted to serious misconduct.

465. In respect of Patient G, Ms Fairley submitted that the findings of the Tribunal, in and of themselves, represented serious misconduct. She reminded the Tribunal of Colonel L's opinion that Mr Dixon's decision to examine Patient G under anaesthetic and then decide which anorectal procedure would be most appropriate, was the very antithesis of modern shared decision making. Further, that he described the difference in surgical magnitude and risk between banding of haemorrhoids and a STARR procedure as enormous. Ms Fairley said Mr Dixon's conduct was particularly egregious when considering Patient G was someone, even on Mr Dixon's own evidence, who had expressed anxiety on the day of the procedure itself. Ms Fairley said that it was clear from Patient G's statement that the procedure Mr Dixon had undertaken had a profound effect upon her life. She submitted that Mr Dixon's actions in this respect amounted to serious misconduct.

466. In respect of the Tribunal findings of Mr Dixon's failings regarding Patients A and J, Ms Fairley reminded the Tribunal that it referred to the 2008 consent guidance in which it explicitly mandated that doctors tell patients if their treatment might result in a serious adverse outcome. Ms Fairley said that it was Colonel L's opinion that there was a clear failure to record the appropriate discussions of risks which fell seriously below the standard expected. She submitted that this represented serious misconduct.

467. In respect of the finding that Mr Dixon made a comment to Mr C that he should *'go home and fill her up'* referring to Patient B, Ms Fairley reminded the Tribunal that both experts were of the view that this comment was entirely inappropriate. She reminded the Tribunal that Mr C's evidence that it he had been troubled because he had not challenged Mr Dixon at the time. Ms Fairley said that whilst Mr Dixon denied that he said those words, and had described them as inappropriate. Although he accepted the findings of the Tribunal, it was concerning that Mr Dixon continued to describe the phrase as a throwaway comment. She submitted that this language was wholly inappropriate, clearly distressing for the patient and her partner, and amounted to serious misconduct.

468. In respect of Patient B and Mr Dixon's failure to consider the option of no treatment at all, Ms Fairley referred to Mr Dixon's Stage 2 witness statement in which he stated that he had assumed Patient B had rejected the option of doing nothing because she had come to him to discuss surgery. Ms Fairley said that this possibly reflects Mr Dixon's focus on surgical options as opposed to a wholesale review of all the options available to a patient, a position reflected in the evidence of Patient F.

469. In respect of Mr Dixon's failure to offer chaperones, Ms Fairley submitted that it was the expert evidence that it was not reasonable to undertake an examination without a chaperone present. If one had been offered and declined it would have been necessary to document that. She acknowledged however that these failings would not in and of themselves represent serious misconduct, but they did demonstrate another aspect of Mr Dixon's conduct, namely a disregard for the appropriate standards with respect to more than one single patient. She submitted that the Tribunal's findings in this regard represented a number of instances which properly characterised as serious misconduct.

470. When considering impairment, Ms Fairley acknowledged that Mr Dixon was entitled to defend himself from the allegations against him and that should not be held against him. She submitted, however, that his apparent acceptance of the findings and his insight in his reflections were at odds with the views reflected in his detailed witness statements at Stage 1. She said that in respect of Patient F, whilst Mr Dixon accepted that the Tribunal preferred the evidence of Patient F regarding the allegations relating to his consultation with her, he continued to characterise matters as a difference of recollection. Ms Fairley said that in his reflection document, Mr Dixon acknowledged that he failed to understand Patient F was risk averse, but that he did not examine the failings in his own conduct which led to that position, nor did he reflect on the dismissive attitude he displayed to risks that Patient F described during the course of her evidence. She said it appeared that Mr Dixon considered his failure

lay more with the letter which followed, rather than the consultation itself, and his conduct and manner within it. She submitted that there must be serious question marks as to the extent to which Mr Dixon truly accepted the findings regarding this patient. She said that Mr Dixon displayed a lack of insight into the effect that his conduct may have had on, and continued to have on, Patient F's health.

471. In respect of Patient G, Ms Fairley submitted that again Mr Dixon's reflections were at odds with the evidence before this Tribunal and that it appeared his acceptance of the expert opinion was qualified. She submitted there must be caution in accepting that Mr Dixon truly accepted his wrongdoing in respect of Patient G. She said there was no reflection on the opinion of Colonel L that the STARR procedure was at the extreme end of complexity. She said that it appeared Mr Dixon maintained much of his account of that day and there is an absence of genuine reflection as to why he took the course he did without an opportunity for Patient G to provide informed consent.

472. Ms Fairley said that whilst Mr Dixon said in his reflections that he had revisited the consent guidance on numerous occasions over the last seven years, that suggested reflection and increased awareness was not obviously demonstrated in his evidence before this Tribunal prior to its findings on the facts. Ms Fairley submitted that the extent to which the Tribunal can have confidence in the expressions of insight and remediation must therefore be qualified. She submitted that given the very recently developed and somewhat qualified insight shown by Mr Dixon, there must be a risk of repetition of this behaviour. She said that the misconduct found proved reflected repeated failings involving five different patients, and failures to obtain informed consent for highly invasive elective procedures, with potentially life changing risks. She said that these were not single incidents, but occurred with a number of patients who were denied the chance to make fully informed choices about their treatment, and that the Tribunal's findings represented clear breaches of fundamental tenets of the profession.

473. Ms Fairley submitted that the allegations relating to Patients F and G in particular, strike at the heart of the doctor patient relationship and undermined the concept of shared decision making. She submitted that this was clearly a case where all three limbs of the overarching objective were engaged and that a finding of impairment was necessary in the particular circumstances of this case.

Submissions on behalf of Mr Dixon

474. Mr Basu submitted that there is no burden of proof at this stage. He said however that the rules require the Tribunal to hear evidence if it is provided by the doctor at this stage. He said that Mr Dixon had provided further evidence. At the findings of fact stage the Tribunal heard evidence from the GMC to counter the evidence of Mr Dixon, and that at this stage Mr Dixon has provided further evidence. He said if the GMC dispute that evidence they should challenge it and Mr Dixon's Stage 2 evidence has not been challenged. He said that the proper time to criticise somebody for their expressions of insight and to cast doubt on what they say would be when the doctor was giving evidence so that they can explain what they mean, and not the for the first and only time in submissions. Mr Basu submitted that Mr Dixon did not have the opportunity of answering questions from anyone in respect of his reflections and that it would be unfair for there to be adverse findings against him in that regard.

475. Mr Basu submitted that Mr Dixon has had to defend himself against a number of very serious allegations and that it was reasonable for him to do so. He said however that Mr Dixon accepted the Tribunal's findings and that it could be seen from Mr Dixon's witness statement that he has given considerable thought to the concerns identified. Mr Basu conceded that the totality of the findings of fact amounted to misconduct, and that conduct would be considered deplorable by other members of the profession. He said that Mr Dixon has accepted that and apologised to the patients.

476. Mr Basu submitted that often human experience shows that people misremember things, and their recollections can be unreliable. He said a good example of this was Patient F, where the Tribunal accepted Patient F's version of what took place on some matters and Mr Dixon's on some others. Mr Basu submitted that it was Mr Dixon's unfortunate situation that he remembered a couple of these conversations differently but accepted the Tribunal's judgment. He said that this was not however something that demonstrated impairment on the part of Mr Dixon, or a failure to reflect on what has happened to an honest doctor. Mr Basu said that in respect of Patient B's husband, Mr C, Mr Dixon was perfectly frank that the comment of *'go home and fill her up'* was completely unacceptable, and whilst he accepted the Tribunal's decision, his recollection of this was different. Mr Basu said that Mr Dixon was criticised for referring to this as a '*throwaway'* comment when he should have probably used the word as an '*offhand'* comment and that Mr Basu himself considered those terms to be similar and Mr Dixon should not be criticised in that regard.

477. Mr Basu said that in accepting serious misconduct, the main question at issue was whether today, Mr Dixon's fitness to practise is impaired. He said that the conduct went back

as far as 2010 up to the start of 2016. He referred the Tribunal to Mr Dixon's unchallenged witness statement and testimonial evidence. He submitted that the witness statement clearly demonstrated that these matters have been remedied and that there was no likelihood of repetition. He said that in essence Mr Dixon was charged with '*botching*' the operation of Patient F and he was required to defend himself against many serious allegations, some of which had not been proved. He submitted that this process, undertaken with the full glare of publicity has had a very significant effect on Mr Dixon and has been a salutary lesson. Mr Basu referred the Tribunal to the testimonial evidence which he said included the demonstration of Mr Dixon's motivations with patients, his prowess as a surgeon and his strengths as a communicator with patients.

478. Mr Basu submitted that Mr Dixon did not set out to do anything other than give his best for these patients and that the Tribunal could see in Mr Dixon's reflections that he has recognised where he went wrong. He submitted that whilst recognising the seriousness of all these matters, Mr Dixon's fitness to practise is not impaired today. Mr Basu invited the Tribunal to be cautious when considering harm to patients and that this should only be considered where there is evidence that harm had been caused. He accepted however that there was a risk of harm inherent in any operation, but that Mr Dixon was not acting through malice. Mr Basu invited the Tribunal to consider Mr Dixon's self-observation that he identified that he was too solution focused and not sufficiently patient focused on a number of occasions, leading him not to hear very important concerns from Patients F and G.

479. Mr Basu submitted that Mr Dixon had acknowledged the damage to the reputation of the medical profession caused by his misconduct; that he was remorseful; had apologised for what had happened; and provided an unreserved and genuine apology. Mr Basu submitted that when the Tribunal read the testimonials it will see that Mr Dixon is a doctor who wants to help patients, one who has helped likely many tens of thousands of patients, many in life preserving circumstances. Mr Basu reminded the Tribunal that these matters have been hanging over Mr Dixon for seven years, but also acknowledged that these were matters that had been hanging over the patients for seven years too. Mr Basu submitted that as Mr Dixon has had seven years to reflect on what he has done this had removed the risk of any repetition. He also invited the Tribunal to consider Mr Dixon's previous good character.

The Relevant Legal Principles

480. 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 judgment alone.

481. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct and that the misconduct was serious, and then whether the finding of misconduct, which was serious, could lead to a finding of impairment.

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

483. With regard to impairment, the Tribunal considered the test laid out by Dame Janet Smith in *The Fifth Shipman Report,* cited in *CHRE v NMC and P Grant [2011] EWHC 927 (Admin)*:

a) *Whether the registrant 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;*

b) *Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;*

c) *Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession;*

d) *Whether the registrant has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

484. The Tribunal also considered the wider public interest in considering impaired fitness to practise and the observations of Mrs Justice Cox, in the Fifth Shipman Report in which she stated that:

> *"In determining whether or not a practitioner's fitness to practise is impaired by reason of misconduct, the relevant tribunal should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and*

public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances".

485. In reaching its decision at this stage, the Tribunal has borne in mind the statutory overarching objective:

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

The Tribunal's Determination on Impairment

Deficient Professional Performance

486. Although the Tribunal has found the factual particulars at paragraph 26a-c of the Allegation proved, it is in relation to the undertaking of the Performance Assessment only. In these circumstances the Tribunal did not consider that these facts could amount to deficient professional performance and did not consider this aspect further.

Misconduct

487. The Tribunal considered whether the facts found proved amounted to misconduct. In so doing, it had regard to the submissions of Ms Fairley and Mr Basu and also to the fact that Mr Dixon accepted that his actions found proved amounted to serious misconduct, and that he accepted that his conduct amounted to a falling short of the standards expected of a reasonably competent consultant colorectal surgeon. The Tribunal reminded itself, however, that it was a matter for its own judgment as to whether Mr Dixon's actions amounted to misconduct.

488. The Tribunal was satisfied that Mr Dixon actions in relation to the facts found proved breached paragraphs 12, 15a, 17, 19, 21a-e, 31, 32, 49a and 61 of GMP, as submitted by Ms Fairley in her submissions. In addition, the Tribunal also determined that Mr Dixon had also breached paragraphs 46 and 47, in respect of his comment to Mr C that he should *'go home and fill her up'* in respect of Patient B:

"46. You must be polite and considerate.
47. You must treat patients as individuals and respect their dignity and privacy."

489. In addition, the Tribunal also reminded itself of its finding that Mr Dixon breached paragraphs 28, 29 and 32 of the *'Consent: patients and doctors making decisions together'(2008)*, In respect of Patients A, G, F and J, which it identified:

> *"28 Clear, accurate information about the risks of any proposed investigation or treatment, presented in a way patients can understand, can help them make informed decisions. The amount of information about risk that you should share with patients will depend on the individual patient and what they want or need to know. Your discussions with patients should focus on their individual situation and the risk to them.*
>
> *29 In order to have effective discussions with patients about risk, you must identify the adverse outcomes that may result from the proposed options. This includes the potential outcome of taking no action. Risks can take a number of forms, but will usually be:*
>
> *a side effects*
>
> *b complications*
>
> *c failure of an intervention to achieve the desired aim.*
>
> *Risks can vary from common but minor side effects, to rare but serious adverse outcomes possibly resulting in permanent disability or death.*
>
> *…*
>
> *32 You must tell patients if an investigation or treatment might result in a serious adverse outcome, 9 even if the likelihood is very small. You should also tell patients about less serious side effects or complications if they occur frequently, and explain what the patient should do if they experience any of them."*
>
> *"9 An adverse outcome resulting in death, permanent or long-term physical disability or disfigurement, medium or long-term pain, or admission to hospital; or other outcomes with a long-term or permanent effect on a patient's employment, social or personal life."*

490. The Tribunal has determined that low likelihood, high consequence risks should be explained, as supported by this guidance. The guidance confirmed that doctors '*must'* tell patients if an investigation or treatment might result in a serious adverse outcome, even when the likelihood is relatively low. The Tribunal found that whilst there may have been some discussion about risks, this was confined to the more common risks and no information was given in relation to serious adverse outcomes. It also found that the guidance gave rise

to a duty for Mr Dixon to adequately explain these risks to Patients A, G, F and J, at paragraphs 2bii, 4bii, 17a-c, 22 a-c and 25aiii of the Allegation.

491. It was the Tribunal's judgment that where it had found that Mr Dixon failed to obtain informed consent in that he did not advise Patients A, G, F and J, of the risks involved in their respective procedures, those actions amounted to serious misconduct. Mr Dixon's conduct deprived Patients A, G, F and J of the opportunity to have a meaningful conversation about the proposed surgery and make a fully informed decision about whether it was appropriate for them in their particular circumstances.

492. The Tribunal considered that Mr Dixon's conduct in relation to Patient G in failing to have a conversation with her following the examination under anaesthetic and instead carrying out a STARR procedure was not patient focused and deprived Patient G of her right to decide for herself about the appropriate procedure. The Tribunal took into account the unsatisfactory nature of Patient G's experiences prior to the day of surgery which were not the fault of Mr Dixon. However, Mr Dixon allowed that to cloud his judgment and he took away a fundamental right of the patient to participate fully in the consent process as he mistakenly relied on his own belief that surgery would be in her best interests. This was particularly concerning when Patient G had expressed anxiety on the day of the procedure itself and it should have alerted Mr Dixon that she had not been properly consented. This procedure had a profound effect upon Patient G's life largely as a result of feeling that she had not been listened to as set out in her interview at the hospital.

493. The Tribunal was of the view that for Patients F and G to have woken up from an operation which they were not expecting because Mr Dixon had not adequately undertaken the consent process would be considered deplorable by fellow medical professionals. The psychological impact on these Patients was significant and may have exacerbated the physical symptoms they experienced following the surgery. The Tribunal was satisfied that this conduct amounted to serious misconduct.

494. The Tribunal considered in respect of Mr Dixon's comment to Mr C that he should *'go home and fill her up'* in respect of Patient B, that this was a wholly inappropriate comment in any context either as part of a consultation or as an offhand remark at the end of a consultation in an attempt at humour. The Tribunal considered that this was unprofessional and was a violation of Patient B's dignity and amounted to serious misconduct. This had an effect on Mr C and caused him to feel upset and angry at his failure to challenge the remark at the time.

495. The Tribunal noted that it had found proved that there were instances where Mr Dixon did not record that a chaperone for intimate examinations had been offered and declined. The Tribunal accepted the expert opinions of Colonel L and Professor M that although this conduct fell below the standards expected as this was important information that ought to have been recorded it did not amount to serious misconduct.

496. The Tribunal has therefore concluded that Mr Dixon's conduct fell so far short of the standards of conduct to be expected of a reasonably competent consultant colorectal surgeon so as to amount to misconduct. It also considered that Mr Dixon's conduct would be considered deplorable by fellow practitioners.

497. Accordingly, the Tribunal found that the facts found proved, save for those in respect of offering patients a chaperone, amounted to misconduct.

Impairment

498. The Tribunal went on to consider whether, as a result of those facts found proved amounting to serious misconduct, if Mr Dixon's fitness to practise is currently impaired.

499. The Tribunal was satisfied that limbs a and b of the Dame Janet Smith test in the case of *Grant* were met in this case, namely that Mr Dixon; 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, has in the past brought and/or is liable in the future to bring the profession into disrepute. The Tribunal was satisfied that Patients F and G and Mr C did experience harm as a result of Mr Dixon's conduct.

500. The Tribunal was satisfied that as Mr Dixon's misconduct was remediable. When considering whether he had remedied his misconduct, the Tribunal considered Mr Dixon's Stage 2 witness statement which included his reflections on the Tribunal's finding of facts. Mr Dixon accepted the findings of the Tribunal and that they amounted to serious misconduct. He also set out his reflections on what he would do differently in the future. The Tribunal also accepted that Mr Dixon had demonstrated genuine regret and remorse for his actions and had expressed an apology to his patients. Mr Dixon's witness statement also set out empathy for the position of his patients which the Tribunal considered was genuine, considered and insightful.

501. In his reflections Mr Dixon also stated that he was committed to learning from his mistakes and to maintaining genuine changes and that it was his utmost priority to regain people's trust and to continue working towards becoming once again the ethical and trustworthy doctor that every patient deserves, and one that he was previously recognised for. He stated that he has and always will be deeply committed to the profession and his patients. He stated that irrespective of the Tribunal's decisions on impairment and sanction, he planned to highlight his experiences and the relevant learning points to prevent similar situations developing with other doctors. He stated that he planned to provide mentorship, be that through on-line forums, podcasts, e-learning or face to face discussions. He said that he would happily volunteer to support other doctors who have found themselves in a similar position and that the most important piece of advice he could give was to be totally honest, open, have insight and own any mistakes.

502. The Tribunal had regard to the fact of the passage of time since these events which occurred between 2010 and 2016, and Mr Dixon's assertion that he has been reflecting on his conduct since that time. It accepted that the length of time that these proceedings have been ongoing and the associated impact this has had both in relation to Mr Dixon's career and his personal life. The Tribunal is in no doubt that this process will have been a salutary lesson to him. It also accepted that Mr Dixon's reflections and commitment that he would change his practice and would not repeat his misconduct was genuine and he was committed to improvement and change.

503. The Tribunal considered however that whilst Mr Dixon recognised that he had been more outcome focused as opposed to patient focused, it had no independent objective evidence before it as to how he would address this or the steps he has taken to change his style of communication. Further, in respect of his comment to Mr C about Patient B, the Tribunal had concerns that this was an entrenched behaviour and was the way in which Mr Dixon had communicated with patients in situations where he had an established relationship.

504. The Tribunal noted that whilst most of the testimonials confirmed that Mr Dixon communicated well with colleagues and patients his communication style was described by others as follows:

a *"direct approach"*,

"*not everyone's cup of tea*",

"*manner could sometimes be seen as forthright*",

"*brusque manner*",

"*Mr Dixon's approach with patients tended to be relaxed. He could at times be lighthearted or appear informal once he knew the patient. For some patients this had a positive effect but others did not respond to this approach. At no point did I feel any comments were motivated by anything other than the best intentions.*"

"*I am aware that with patients Tony was straight talking, which was appreciated by some but not by all. He could appear somewhat blunt in that he strove to be honest and upfront with patients.*"

505. The Tribunal had before it no evidence of any continuous professional development ('CPD'), courses or any other learning and development undertaken by Mr Dixon. There was no evidence that Mr Dixon had taken any steps to apply his reflections. It considered that this evidence went beyond "window dressing" as described by Mr Basu and would have provided the Tribunal with independent objective evidence to demonstrate not only that Mr Dixon had recognised and understood the concerns but taken practical and measurable steps to remedy them. The Tribunal did not consider that the undertaking of CPD courses to address concerns was "window dressing", rather that they could provide important objective evidence to demonstrate insight and remediation.

506. The Tribunal also considered that Mr Dixon could have provided evidence of reflection or discussion from an appraiser or mentor or other professional demonstrating how he was addressing the concerns raised and that he had effected changes. The Tribunal was not satisfied that purely on the basis of a reflective statement alone, without any additional supporting evidence, that it could be assured that Mr Dixon's level of insight was complete.

507. The Tribunal was not satisfied that Mr Dixon had fully remediated his conduct and whilst he has some insight into his actions, that insight was developing and had yet to be tested. The Tribunal therefore considered that there remained the risk of repetition.

508. The Tribunal reminded itself that when determining a practitioner's fitness to practise, it should not only consider whether the practitioner continues to present a risk to

members of the public, but whether the need to uphold proper professional standards and public confidence would be undermined if a finding of impairment were not made in the particular circumstances of a case.

509. The Tribunal determined that given the seriousness of its findings, a finding of impairment was necessary to uphold proper professional standards and public confidence in the medical profession in the circumstances of this case. The Tribunal noted that there has been a full investigation and hearing and a determination of misconduct, however the Tribunal did not consider that this was sufficient of itself to uphold proper professional standards. Mr Dixon's misconduct was not at the lower end of the scale as it encompassed a number of patients and involved significant failures to appropriately communicate key aspects relevant to consent. The Tribunal considered that public confidence in the profession would be undermined in these circumstances if a finding of impairment were not made.

510. The Tribunal has therefore determined that Mr Dixon's fitness to practise is currently impaired by reason of misconduct.

Determination on Sanction - 18/07/2024

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

The Evidence

512. The Tribunal has taken into account all the evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction. The Tribunal also received an email link to a website for 'Mentoring Medics', which offered services to medical professionals.

Submissions on behalf of the GMC

513. Ms Fairley submitted that the decision as to the appropriate sanction, if any, to impose in this case was a matter for the Tribunal, exercising its own independent judgment. She said that there was no burden or standard of proof at this stage. She referred the Tribunal to the relevant paragraphs of the Sanctions Guidance (5 February 2024) ('SG'). She

said that the reputation of the profession as a whole was of more important than the interests of an individual doctor.

514. Ms Fairley acknowledged that the Tribunal noted Mr Dixon's expressions of genuine regret into his conduct and the positive testimonial evidence in its Stage 2 decision. She said that when considering sanction, the Tribunal must start by considering the least restrictive in terms of no action. She submitted that this was clearly not a case where there were exceptional circumstances and that taking no action would not be appropriate. In respect of conditions, Ms Fairley submitted that a period of conditional registration would not be sufficient or proportionate to satisfy public interest in light of the misconduct in this case. She said that this was also a case where there was limited evidence of remediation.

515. Ms Fairley submitted that suspension may be appropriate where the misconduct was serious but falls just short of being incompatible with continued registration. She submitted that the misconduct found in this case was so serious that it was not compatible with continued registration and therefore that suspension would not be appropriate. Ms Fairley submitted that the appropriate sanction in this case was one of erasure.

516. Ms Fairley submitted that the following paragraphs of the SG were engaged in this case in respect of erasure:

> *"108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.*
>
> *109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.*
>
> *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…"*

517. Ms Fairley submitted that whilst the Tribunal acknowledged Mr Dixon demonstrated some expression of regret and insight, it also noted there remained a risk of repetition and that Mr Dixon had not taken proactive steps to remediate. She submitted that the failures found in relation to Mr Dixon were fundamentally incompatible with continued registration and that the misconduct represented multiple breaches of Good Medical Practice ('GMP') in respect of five separate patients.

518. Ms Fairley reminded the Tribunal of its decision at Stage 2 and the impact of Mr Dixon's actions on Patients A, G, F and J. She said that the Tribunal have found multiple instances of misconduct that would be considered deplorable by fellow practitioners and that the misconduct found proven in this case was so serious that no sanction lower than erasure would be sufficient to fulfil the statutory overarching objectives, namely, to protect patients, to promote and maintain public confidence in the profession and to promote and maintain proper professional standards and conduct for members of the profession. Ms Fairley submitted that the sanction of erasure would send the appropriate signal to the profession regarding those standards of conduct and behaviour and that no sanction lower than that would adequately meet the very serious misconduct in this case.

Submissions on behalf of Mr Dixon

519. At the outset of his submissions, Mr Basu said that the Tribunal had fallen into error in relation to aspects of the Stage 2 determination. His submissions were made on the basis that Mr Dixon reserved his position in relation to those matters. In particular, he submitted that the Tribunal had drawn an adverse conclusion in respect of the comment which Mr Dixon had found was said to Mr C, regarding Patient B, and this had been considered by the Tribunal as entrenched behaviour. He submitted that this was unfair to Mr Dixon and should not be relied on further.

520. Mr Basu submitted that Mr Dixon is of good character in two senses, because there were no previous findings against him, and that he was of positive good character. He said that the Tribunal have heard the very positive things about him in the testimonial evidence; his skills; his abilities with people; his kindness to people; his work in the profession and in his subspecialty; his work with cancer patients; and how he has treated his patients. Mr Basu stressed the importance of taking all those matters which were set out in considerable detail in the testimonial bundle. He took the Tribunal through them at length, citing references to where Mr Dixon was described as; *'highly skilled'*; *'life preserving'*; and, *'an excellent surgeon'*.

521. Mr Basu reminded the Tribunal of the relevant principles it should follow when determining what sanction, if any, to impose. Mr Basu said that when patients complained or

got upset, as happened with Patients F and G, the Tribunal heard how Mr Dixon remained focused on achieving a resolution of the symptoms rather than "*palming them off*" to someone else. He said that this was in keeping with how Mr Dixon had been described in the testimonials, was an important example of mitigation and that Mr Dixon had now provided evidence that he understood the problem and had insight.

522. Mr Basu referred the Tribunal to a website link for 'Mentoring Medics', which offered mentoring services to the medical profession, promoting reflective practice to improve communication resilience in their in their practice. He said that this service was provided by Mr AM, a retired consultant urologist. Mr Basu said that as he understood it, Mr AM said that he would be willing to provide his mentoring and coaching services to Mr Dixon. Mr Basu said that this was evidence of concrete steps Mr Dixon was willing to take to address the communication problems, solution focus at the expense of patient focus, the failures in consent, and more wide communication issues. Mr Basu said that when considering Mr Dixon's Stage 2 statement, it was evident that Mr Dixon understood that his actions were wrong, that he set out how he wished to change, explained what he is doing about that, and understood the way to change was in his thinking and his approach.

523. Mr Basu said that Mr Dixon had very importantly admitted the facts, had made an unreserved apology, recognised the effect on the patients having to go through this process, and was plainly very thoughtful and reflective. He reminded the Tribunal to be careful in relation to any assertions about harm being caused to patients as it had not heard any expert evidence about this aspect. Mr Basu said that the Tribunal must take into account the lapse of time since the relevant incidents occurred, between seven and thirteen and a half years ago, which he said was significant. He said that Mr Dixon was someone who has always sought to learn, keep learning and teach others.

524. Mr Basu submitted that none of the aggravating features as set out in the SG apply in this case. He said that Mr Dixon was a surgeon who has had a striking fall from grace, that he was extremely well thought of, a leading light in his subspecialty, and effectively an associate professor in his subspecialty. He said the Tribunal had made a decision about the facts, a decision that Mr Dixon has committed misconduct, which was serious, meaning that colleagues would consider that conduct to be deplorable, and that his fitness to practise impaired. Mr Basu said that all those findings were made publicly. He reminded the Tribunal that in its Stage 2 decision it stated that it was in no doubt that this process will have been a salutary lesson for Mr Dixon and that his misconduct was remediable. He suggested that the testimonial evidence demonstrated Mr Dixon's skills, personal qualities, and that his only priority was to help patients. Mr Basu submitted that when balancing the public interest, Mr

Dixon still had a great deal to offer, whether it was surgically in certain areas of surgery, or in terms of mentoring and teaching other people.

525. Mr Basu submitted that for those reasons this was one of those exceptional cases where no action was required. He submitted that if he were wrong on that, the Tribunal had the power to impose conditions on Mr Dixon's registration. Mr Basu submitted that they were not necessary but that if the Tribunal decided to impose conditions, this would be one of those cases where conditions could be fashioned to ensure no repetition and would serve the public interest requirements. He said that the Tribunal could impose conditions both on Mr Dixon's practice and in relation to how he improves himself. Mr Basu submitted that at worse, this was a case where conditions may be justified, though not actually necessary. He submitted that any sanction higher than conditions were not necessary.

The Tribunal's Determination on Sanction

526. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken the SG into account and has borne in mind the overarching objective.

527. The Tribunal reminded itself that the main reason for imposing any sanction was to protect the public and that sanctions are not imposed to punish or discipline doctors, even though they may have a punitive effect. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Mr Dixon's interests with the public interest.

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

529. In respect of mitigating factors in this case, Mr Dixon gave an apology at an early stage in these proceedings. In his witness statement in respect of Patient A provided to the Tribunal on Day 3 of these proceedings (13 September 2023), he stated: *"I am sorry to hear of the difficulties and experiences that the complainants have encountered since their surgery".*

530. Mr Dixon was of previous good character and the Tribunal did not have before it any evidence of previous adverse regulatory findings against him.

531. The Tribunal considered what weight to attach to Mr Dixon's testimonial bundle which included testimonials from colleagues, medical staff, patients and patient's relatives, and whether they could be considered in mitigation. It noted they were from a broad

spectrum of people and the testimonials from medical professionals were from a number of different areas of practice. They all attested to Mr Dixon's exceptional technical skill and afforded him high praise for his interactions with patients and colleagues. The testimonials did demonstrate knowledge of the allegations and a smaller number had knowledge of the findings made. The Tribunal considered that these did carry significant weight and it was clear to the Tribunal that Mr Dixon was regarded as a technically excellent surgeon who had successfully treated a number of complex cases and been a leader in his field.

532. The Tribunal reminded itself that Mr Dixon was entitled to defend himself against the allegations brought against him by the GMC, and he stated that he accepted the Tribunal's findings once it had made its determination on the facts of the case.

533. The Tribunal considered that Mr Dixon had not however taken the necessary steps to remediate his conduct. The Tribunal noted that the SG defines remediation as:

> *"31 Remediation is where a doctor addresses concerns about their knowledge, skills, conduct or behaviour. Remediation can take a number of forms, including coaching, mentoring, training, and rehabilitation (this list is not exhaustive), and, where fully successful, will make impairment unlikely."*

534. In his reflections, Mr Dixon had said what he aimed to do in the future, but had not provided any evidence of remediation save for a link to a website for 'Mentoring Medics'. This was only provided at the outset of Mr Basu's submissions on sanction. The Tribunal noted that Mr Basu indicated, that as he understood it, Mr AM said that he would be willing to provide his mentoring and coaching services to Mr Dixon. The Tribunal recognised that Mr Dixon had only recently received the Tribunal's decision on misconduct and impairment, but also noted there was no objective evidence before it that Mr AM had agreed to mentor Mr Dixon or what that mentoring would involve. The Tribunal had no evidence of any other steps that Mr Dixon had taken to improve his knowledge and skills.

535. The Tribunal noted the lapse of time since these incidents occurred, but it also noted that it had been told that Mr Dixon had not been practising since approximately 2017. It was of the view that since he has not been practising, he had not been able to demonstrate that his practise had changed from the conduct which led to these proceedings. It did therefore not consider the lapse of time to be a mitigating factor in these circumstances.

536. The Tribunal did not consider there to be any aggravating factors in all the circumstances of this case.

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

No action

538. The Tribunal first considered whether to conclude the case by taking no action.

539. The Tribunal was mindful that where a doctor's fitness to practise had been found to be impaired, there must be exceptional circumstances to justify taking no action. The Tribunal noted that the circumstances Mr Basu relied upon for the Tribunal to take no action included the extremely positive testimonial evidence, Mr Dixon's previous good character, his excellence as a surgeon, and his developing insight. The Tribunal was of the view that all the factors Mr Basu relied upon did not amount to exceptional circumstances.

540. The Tribunal could identify no exceptional circumstances in this case. It concluded that it would not be sufficient, proportionate nor in the public interest to take no action given the seriousness of the matters found proved.

Conditions

541. The Tribunal next considered whether to impose conditions on Mr Dixon's registration. It had regard to the relevant paragraphs of the SG when considering whether to impose conditions and noted that any conditions would need to be appropriate, proportionate, workable and measurable. It had regard to the following paragraphs of the SG:

> *"81 Conditions might be most appropriate in cases:*
>
> *…*
>
> *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*
>
> *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."*

542. The Tribunal considered that there were shortcomings in specific areas of Mr Dixon's practice. The Tribunal had already determined that Mr Dixon's misconduct was remediable, that he had developing insight and had expressed a willingness to remediate. The Tribunal had no evidence to suggest that Mr Dixon would not comply with any conditions imposed upon his registration.

543. The Tribunal determined however that whilst it may have been possible to formulate conditions to address some of its concerns, it could not formulate a set of conditions to address all the concerns identified, particularly in relation to Mr Dixon's own identified failing that he had been too "solution focussed" rather than "patient focussed". The Tribunal considered that the failings in relation to properly explaining matters to patients before surgery was not possible to adequately address with conditions. The Tribunal considered that this was a fundamental communication skill and it had no objective evidence that Mr Dixon had taken any steps to change his practice in this area. The Tribunal determined that measurable and workable conditions could not therefore be formulated in this case.

544. Further, the Tribunal did not consider that a period of conditional registration would be sufficient to mark the seriousness of the misconduct found and would not satisfy the overarching objective, public interest or uphold public confidence in the profession. The Tribunal considered that the matters found proved, particularly in relation to Patient F and Patient G were serious and a period of conditional registration was not sufficient to address the seriousness of the misconduct found proved.

Suspension

545. The Tribunal then went on to consider whether a period of suspension would be appropriate.

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

547. The Tribunal noted paragraphs 92 and 93 of the SG:

> *"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…"*

548. The Tribunal was of the view that Mr Dixon's misconduct was so serious that action needed be taken to protect members of the public, maintain public confidence in the profession and uphold and maintain proper professional standards. It also considered that there was acknowledgement of fault, although the Tribunal did note that there was a risk of repetition as Mr Dixon's insight was developing and his remediation was incomplete.

549. The Tribunal also considered paragraphs 97a and b of the SG:

> *"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.*
>
> *b In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining…"*

550. The Tribunal considered that there had been a serious departure from GMP and that a sanction lower than suspension would not be sufficient to protect the public. The Tribunal

reminded itself that Mr Dixon breached a number of paragraphs of GMP; he breached the 2008 consent guidelines and failed to obtain informed consent in that he did not adequately advise Patients A, G, F and J, of the risks involved in their respective procedures and he carried out procedures on Patients F and G which they were not expecting and had not adequately consented to. The Tribunal had previously determined that this conduct could be remediated. The Tribunal considered that erasure was not in the public interest in these circumstances. This was particularly so given Mr Dixon's considerable skills as a surgeon.

551. Mr Dixon had demonstrated willingness and the potential for remediation and/or retraining and had very recently taken steps to arrange mentoring. The Tribunal had evidence, in the form of the testimonials, that Mr Dixon was committed to learning and had sought to improve his skills throughout his career. The Tribunal considered that the evidence demonstrated that Mr Dixon was able and willing to remediate his failings and it had no reason to doubt that he was not sincere in this regard.

552. The Tribunal considered that a period of suspension was the appropriate and proportionate sanction in this case and would satisfy the overarching objective.

Erasure

553. Whilst the Tribunal considered a period of suspension was appropriate to satisfy the overarching objective, it went on to consider the sanction of erasure. The Tribunal had regard to the SG in which it set out factors being present which may indicate that erasure was the appropriate sanction.

> *"109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.*
>
> *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…"*

554. The Tribunal considered that whilst there was a serious departure from the principles set out in GMP, it has already set out that the misconduct could be remediated. It did not consider that Mr Dixon demonstrated a deliberate or reckless disregard the departure from

the principles set out in GMP. The Tribunal was of the view that Mr Dixon did consider that he was acting in his patient's best interests and had never deliberately or recklessly sought to do anything other than achieve the best outcome with his surgery.

555. The Tribunal was satisfied that none of the other factors in the SG suggesting erasure was the appropriate sanction were present in this case. Having balanced all the circumstances of this case, the Tribunal was of the view that Mr Dixon's misconduct was not fundamentally incompatible with continued registration. The Tribunal considered that to erase Mr Dixon's name from the register would be disproportionate, that erasure was not the least restrictive sanction to protect the public interest, and erasure would deprive the public of a skilled surgeon in circumstances where there was a willingness to remediate.

Length of Suspension

556. Having determined that a period of suspension was the appropriate and proportionate sanction, the Tribunal went on to determine the length of the suspension. In doing so, it had regard to paragraph 100 of SG which states:

> *'100 The following factors will be relevant when determining the length of suspension:*
>
> *a the risk to patient safety/public protection*
>
> *b the seriousness of the findings and any mitigating or aggravating factors…*
>
> *c ensuring the doctor has adequate time to remediate.'*

557. The Tribunal determined that a suspension for a period of 6 months would the appropriate and proportionate length. This period would allow Mr Dixon sufficient time to develop further insight into his actions and remediate his misconduct. This period of suspension would also address the public interest in this case by declaring and upholding proper standards of behaviour for the profession and by sending a signal to Mr Dixon, the wider profession and the public about conduct which is regarded as unbefitting a registered doctor. The Tribunal considered that a longer period of suspension would be unduly punitive, especially taking into account the period that Mr Dixon had already been the subject of fitness to practise proceedings.

Review

558. The Tribunal considered whether to direct a review hearing. It bore in mind the guidance at paragraph 164 of the SG which advises that:

> *"164 In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. However, in most cases where a period of suspension is imposed… the tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions... A review hearing is therefore likely to be necessary, so that the tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):*
>
> *a they fully appreciate the gravity of the offence*
>
> *b they have not reoffended*
>
> *c they have maintained their skills and knowledge*
>
> *d patients will not be placed at risk by resumption of practice or by the imposition of conditional registration."*

559. The Tribunal determined to direct a review of Mr Dixon's case to be convened shortly before the end of the period of suspension. The Tribunal considered that a review hearing was necessary for a review Tribunal to be satisfied that Mr Dixon had addressed the matters as set out in paragraph 164 of the SG. In particular, that he had fully remediated his misconduct, developed his insight, and would not pose a risk of repetition of the misconduct.

Determination on Immediate Order - 18/07/2024

560. Having determined to suspend Mr Dixon's registration, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Mr Dixon's registration should be subject to an immediate order.

Submissions

561. On behalf of the GMC, Ms Fairley referred the Tribunal to the relevant paragraphs of the SG when considering an immediate order. She submitted that an immediate order was necessary given the serious matters which led to the substantive direction being made. She said an immediate order was necessary to protect public confidence in the profession. She said that when considering the balancing exercise between Mr Dixon's interests and the

public interest, Mr Dixon was not currently practising and therefore there was no significant detriment to Mr Dixon if an immediate order was made.

562. On behalf of Mr Dixon, Mr Basu said that an immediate order of suspension was not contested. He confirmed that there was an interim order of conditions which would need to be revoked.

The Tribunal's Determination

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

> *"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.*
>
> *…*
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect."*

564. The Tribunal has determined that, given the nature of the findings, it was necessary for the protection of members of the public and is otherwise in the public interest to impose an immediate order of suspension on Mr Dixon's registration. It also took into account that as Mr

Dixon was not currently practising there would be no significant detriment to Mr Dixon and in any event that his interests were outweighed by the public interest.

565. This means that Mr Dixon's registration will be suspended from today. 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.

566. There interim order of conditions currently imposed on Mr Dixon's registration is revoked with immediate effect.

567. That concludes this case.

ANNEX A – 15/09/2023

Application to admit of hearsay evidence

568. At the outset of the hearing, Ms Chloe Fairley, Counsel, on behalf of the GMC, made an application to admit the hearsay evidence of Patient G, pursuant to Rule 34 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules').

Submissions on behalf of the GMC

569. Ms Fairley provided a written submission. She submitted that this application was in relation to the witness statement of Patient G, undated, and a supplementary witness statement, dated 30 September 2023, with supporting exhibits.

570. Ms Fairley submitted that this application is made pursuant to Rule 34 and that in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) at [45], the High Court set out the relevant factors to be considered in determining whether it is fair in all the circumstances to admit hearsay evidence:

> *"1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.*
>
> *1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.*
>
> *1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.*
>
> *1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the*

evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability."

571. Ms Fairley submitted that the witness statement of Patient G can be fairly admitted as hearsay evidence in all the circumstances of the case. She said that there is good reason for the absence of Patient G as a witness as Patient G has suffered a significant deterioration in her mental and physical health following the treatment provided by Mr Dixon. Ms Fairley said that this included a diagnosis of Post Traumatic Stress disorder ('PTSD'), and that the process of giving evidence and reliving the events is likely to affect this. She said that as a result of this, Patient G feels unable to attend to give evidence.

572. Ms Fairley submitted that the witness statement of Patient G is not the sole and decisive evidence in relation to the allegations in respect of this patient. She said that the evidence in Patient G's witness statement is supported by a significant number of contemporaneous medical records. The Tribunal will be able to test the reliability of the evidence contained in Patient G's witness statement by considering whether it is consistent with the medical records.

573. Ms Fairley submitted that the defence will not have the opportunity to cross-examine Patient G in the event the witness statement is admitted as hearsay. However, the Tribunal can reflect this when considering what weight, if any, they can give to that account once all of the evidence has been heard, including any evidence the defence may choose to provide in relation to those allegations.

Submissions on behalf of Dr Dixon

574. Mr Dijen Basu KC, on behalf of Dr Dixon, submitted that in Patient G's witness statement, undated, but which looks to be written in around 2020, she stated that she understood that her evidence could be used for the purposes of a hearing before an MPT and confirmed that she was willing to attend any such hearing to give evidence if asked to do so. Mr Basu said that something since then has changed. He said the Tribunal have been confidently told Patient G has been diagnosed with PTSD. He said that in Patient G's medical records there are two references to PTSD, where her GP was told by Patient G herself that she has PTSD. Mr Basu said that PTSD is not a simple condition, that there are criteria involved in diagnosing it and that the Tribunal would need to see evidence of such a diagnosis is to be relied upon. Mr Basu said that Patient G cannot even tell the Tribunal when she was diagnosed with PTSD, he said that she suggested it was shortly after a consultation in 2016, but that this was years before she gave the witness statements.

575. Mr Basu submitted that it is important when someone's career is on the line that there is an Article 6 compliant hearing. He invited the Tribunal to be cautious about accepting an invitation to allow evidence to be given by way of a written statement that cannot be challenged at all by the doctor. He said that there is no lack of sympathy for Patient G. He invited the Tribunal to consider the question of a video link, where arrangements could be made in which Patient G would not see Dr Dixon. He submitted that if Patient G could not attend remotely, it would be anticipated that the GMC would have an appropriately qualified expert who would be able to give evidence about the psychological or psychiatric state of a particular witness to assist the Tribunal with making a decision like this.

576. Mr Basu submitted that this was not a question of either the whole statement goes in entirely or none of it goes in, rather, the question is how much of it needs to be challenged. He said that there was one Allegation where Patient G's evidence is sole and decisive where she could say what she was told, what she knew and understood.

577. Mr Basu said that Dr Dixon will say there was informed consent after a detailed discussion; after which Patient G was satisfied; and, that he gave her the opportunity to go away and think about it and coming back another day. Mr Basu said that there is a dispute on the evidence. He said that it is for Patient G to tell the Tribunal what she was told about these matters.

578. Mr Basu said that if Patient G were to give evidence via video link, the matters she is concerned about can be alleviated and she would not see Dr Dixon. He said that talking about these matters will of course be distressing, as they are for those who give evidence and in attempted murder trials, or those who give evidence in cases where sexual offences have been committed against them. He said that these things are terribly difficult to talk about but that the Courts and lawyers are very experienced in dealing with this. Mr Basu submitted that Patient G's evidence can be given by way of video link as there is no medical evidence being provided to suggest this cannot be done.

579. In respect of paragraph 24 of the Allegation, Mr Basu submitted that Dr Dixon undertook full and proper engagement with Patient G's aftercare, and that he is a sympathetic surgeon who takes care of his patients. He said that Dr Dixon is not someone who would refer to someone as being 'very emotional' in a derogatory way. Mr Basu submitted that Dr Dixon was asked by the nurse what was wrong with this patient, then, in a sympathetic way, Dr Dixon said she is very emotional. Mr Basu said that Patient G was in a lot of pain at the time and in great distress. He said the Tribunal will hear that Patient G's pain was magnified by her psychological state and by her emotional state. He said that this is well understood to be something that makes pain and one's experience of pain worse.

Tribunal's decision

580. The Tribunal had regard to Rule 34 of the Rules, which provide:

"(1) The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law."

581. The Tribunal considered each of the allegations against Dr Dixon in respect of Patient G:

20. On 24 February 2015 you consulted with Patient G and you failed to:

a. take into account Patient G's family history, including her younger sister's history of pre-cancerous polyp;
b. arrange a colonoscopy;
c. arrange a proctogram.

21. On 16 December 2015 you performed a stapled trans-anal rectal resection ('Patient G's Procedure') which was not clinically indicated in that you failed to:

a. adequately investigate her presenting symptoms;
b. trial non-surgical interventions;
c. perform a less invasive procedure.

22. You failed to obtain Patient G's informed consent for Patient G's Procedure in that you did not explain:

a. the expected benefits of Patient G's Procedure;
b. non-surgical treatment options;
c. the risks associated with Patient G's Procedure.

23. (in the alternative to paragraph 22) you failed to record taking the steps outlined at paragraph 22.

24. Your post-operative care of Patient G was inappropriate in that you:

a. failed to adequately engage in Patient G's aftercare;
b. stated that Patient G was being 'very emotional', or words to that effect, when she was re-admitted on or around 20 December 2015.

582. When considering whether it was fair to admit Patient G's witness statement in respect of paragraphs 20a-c and 21a-c of the Allegation, the Tribunal noted that Patient G's hearsay evidence was not the sole and/or decisive evidence that it would need to rely on to determine the facts. It noted that medical records could be provided which would assist the Tribunal in its decision making.

583. The Tribunal was satisfied that it would not therefore be unfair to Dr Dixon for the hearsay witness statement of Patient G to be admitted in respect of paragraphs 20a-c and 21a-c.

584. In respect of paragraphs 22a-c, the Tribunal considering that these paragraphs were about the recollections of what Patient G said happened, contested by Dr Dixon. These matters would not necessarily have been recorded in the medical record and Patient G's account was the sole and decisive factor in supporting the allegation.

585. The Tribunal considered that hearsay evidence could be balanced against that of a doctor's sworn evidence, and that it would be a matter of weight to be applied.
It was of the view however, that if an allegation could only be proven based on hearsay evidence, where the allegation is contested, and the hearsay evidence is not tested under cross examination, then there is inherent unfairness to the doctor.

586. The Tribunal was satisfied therefore that it would be unfair to Dr Dixon if Patient G's hearsay evidence was admitted in respect of paragraphs 22a-c of the Allegation.

587. In respect of paragraph 23 of the Allegation, the Tribunal considered that this allegation alleges a failure to record, which can either be substantiated or not by looking at the medical records.

588. In relation to paragraph 24a of the Allegation, which involved an alleged failure to adequately engage in Patient G's aftercare, the Tribunal noted that Patient G's hearsay evidence was not the sole and/or decisive evidence that it would need to rely on to determine the facts. It noted that medical records could be provided which would assist the Tribunal in its decision making.

589. In respect of paragraph 24b of the Allegation, the Tribunal considered that whilst it was submitted by Mr Basu that Dr Dixon will not be disputing he said that which is set out, the context of what was said will be contested. The Tribunal considered that this allegation would be balancing the contested, untested, hearsay evidence of Patient G against Dr Dixon's sworn evidence.

590. For the same reasons as it has set out in respect of paragraphs 22a-c, the Tribunal was satisfied that it would be unfair to Dr Dixon for the hearsay evidence of Patient G to be admitted in respect of paragraph 24b.

591. The Tribunal recognised that giving evidence before proceeding such as these can be very stressful and it is not unsympathetic. It noted however, that it has not been provided with any detailed medical evidence as to her medical condition and/or diagnosis.

592. The Tribunal noted that in Patient G's statement, there is no reference to any objection to reasonable adjustments or any information that these have been explored with Patient G.

593. The Tribunal considered that potential reasonable adjustments could be made such as providing her evidence via video link, Dr Dixon not being seen by Patient G on camera, and/or a list of agreed questions provided to her in advance of her evidence.

594. The Tribunal had before it no evidence as to why reasonable adjustments or special measure which could be put in place would not work.

595. The Tribunal determined to exclude the hearsay evidence in respect of 22a-c and 24b as it cannot be tested in cross examination and is the sole and decisive evidence in respect of those allegations. However, the GMC should be given the opportunity to explore with Patient G the possibility of special measures / reasonable adjustments which could be put in place in order for her to give her best possible evidence and for her to overcome the difficulties she is encountering in giving evidence.

ANNEX B – 15/09/2023

Tribunal Directions

596. In respect defence document disclosures, the Tribunal made the following direction:

1. By 9:00 AM on 19 September 2023, the defence will file and serve on the GMC the witness statement of Dr Dixon regarding Patient F, together with a core bundle of documents;
2. By 9:00 AM on 20 September 2023, the defence will file and serve on the GMC the witness statement of Dr Dixon regarding Patient B, together with the core bundle of documents;
3. By 9:00 AM on 27 September 2023, the defence will file and serve on the GMC the witness statement of Dr Dixon in relation to the Performance Assessment.
4. By 9:00 AM on 29 September 2023, the defence will file and serve on the GMC Professor M's report relating to Patients' A, B, F, J, D & G.
5. By 9:00 AM on 3 October 2023, the defence will file and serve on the GMC the witness statement of Dr Dixon relating to Patients' D, G and J, together with the core bundle of documents.

ANNEX C – 26/10/2023

Application to Amend the Allegation

597. On Day 23 of the hearing, Ms Chloe Fairley, Counsel, on behalf of the GMC, made an application to amend the Allegation pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules').

598. Ms Fairley proposed the following amendments to paragraphs 4a, 5, 6, 8b and c, 22a, b and c, 23 and 24b of the Allegation, and to withdraw those allegations in respect of Patient D, allegations 12-15:

Patient A

4. On 18 November 2011 you performed a laparoscopic sub-total colectomy on Patient A ('Patient A's Second Procedure') and you failed to:

   a. ensure that a CT scan was undertaken to exclude other causes of her symptoms ~~ensure that a transit study had been undertaken to confirm your diagnosis of slow transit constipation ensure that a CT scan~~;

   ...

5. Before performing thea ~~a revision rectopexy~~ revision surgery on Patient A in December 2013 you failed to:

Patient B

6. On or around 20 ~~22~~ March 2012 you performed a rectal examination on Patient B:

…

8. On 15 July 2016 you performed ~~a revision~~ a hindgut resection and ~~revision of Patient B's~~ LVMR ('Patient B's Procedure') and you failed to:

…

b. obtain informed consent in that you:

~~i. rushed through the information contained on the consent form when discussing it with Patient B;~~

~~ii. did not allow Patient B to ask any questions;~~

~~iii. did not advise Patient B that a very poor result was possible;~~

iv. had previously only told Patient B that you would perform a surgical resection;

v. did not discuss the risks associated with Patient B's Procedure;

vi. did not make a legible copy of the consent form;

vii. obtained consent on the day of Patient B's Procedure;

c. (in the alternative to paragraph ~~8biii and~~ 8bv), record taking the steps at paragraph ~~8biii and~~ 8bv.

~~Patient D~~

~~12. On 15 May 2013 you consulted with Patient D and you communicated inappropriately with Patient D in that you:~~

~~a. continuously interrupted Patient D as he tried to answer questions;~~

~~b. asked Patient D's wife 'don't you feel like strangling [Patient D]?', or words to that effect.~~

~~13. On 6 March 2014 you performed a rectopexy procedure on Patient D ('Patient D's Procedure') and you failed to:~~

~~a. obtain informed consent in that you:~~

~~i. did not advise Patient D of:~~

~~1. other treatment options;~~

~~2. the expected benefits of Patient D's Procedure;~~

~~3. the risks associated with Patient D's Procedure;~~

~~ii. rushed through the information contained on the consent form when discussing it with Patient D;~~

~~iii. did not allow Patient D to ask any questions;~~

~~iv. obtained consent on the day of Patient D's Procedure;~~

~~b. (in the alternative to paragraph 13ai) record taking the steps at paragraph 13ai.~~

~~14. On 24 April 2014 you consulted with Patient D and you:~~

~~a. were dismissive when Patient D complained about ongoing pain, advising that 'everything had gone well', or words to that effect;~~

~~b. ignored Patient D when he advised that the physical examination you were performing on him caused him pain.~~

~~15. On 21 October 2014, you consulted with Patient D and you dismissed Patient D's complaint that he was having difficulties defecating, advising that 'you're getting better then', or words to that effect.~~

Patient G

22. You failed to record obtaining Patient G's informed consent for Patient G's Procedure in that you did not record explaining:

~~a. the expected benefits of Patient G's Procedure;~~

~~b. non-surgical treatment options; To be determined~~

~~c. the risks associated with Patient G's Procedure.~~

~~23. (in the alternative to paragraph 22) you failed to record taking the steps outlined at paragraph 22.~~

24. Your post-operative care of Patient G was inappropriate in that you:

a. failed to adequately engage in Patient G's aftercare~~;~~.

~~b. stated that Patient G was being 'very emotional', or words to that effect, when she was re-admitted on or around 20 December 2015~~.

Submissions on behalf of the GMC

599. In summary, Ms Fairley submitted that the proposed amendment to paragraphs 4a and the stem of 5 do not materially affect the substance of those allegations and both are made following an opportunity for the GMC expert to consider the defence documents. She submitted that the essential element of paragraph 4a is that the procedure was performed without appropriate investigations having been undertaken by Mr Dixon. She submitted that the proposed amendment of paragraph 4a does not therefore materially affect the substance of that allegation and provides greater clarity about what investigations were alleged to be required following the expert's review.

600. In respect of the proposed amendment to the stem of paragraph 5, Ms Fairley submitted that the allegation should read 'before performing the revision surgery'. She submitted that Mr Dixon undertook the surgical procedure without carrying out a full investigation or discussing the case with colleagues from other disciplines. She said that the amendment reflects that a simple revision rectopexy was not undertaken, rather that it was bespoke surgery as described in Mr Dixon's witness statement. She submitted that the amendment was fair and caused no injustice.

601. In respect of the stem of paragraph 6 of the Allegation, Ms Fairley submitted that in the documentation it appears that the date on which Patient B saw Mr Dixon was on 20 March 2012. She submitted that when considering whether the amendment can be made without any unfairness, the substance of the allegation was that a rectal examination was performed, which does not appear to be in dispute, and in the absence of a chaperone. She said that there is no unfairness in amending that date as the substance of the allegation would be unaffected.

602. in respect of paragraph 8, Ms Fairley submitted that there was a suggestion from the defence that the allegation should include a hind gut resection and the revision LVMR, as that was the procedure performed. She said that the GMC acknowledged that is correct and that was the basis on which the defence had been proceeding and the basis on which Mr Basu cross examined the patient. She submitted therefore that this amendment could be made with no unfairness to the defence. Ms Fairley also submitted that the GMC would like to withdraw paragraph 8biii of the Allegations given the provision of further defence documentation.

603. Ms Fairley made an application to withdraw paragraphs 12 to 15 of the Allegation (save 13b), those in respect of Patient D. She said that Patient D cannot now attend to give evidence due to his health. She said that the GMC acknowledge that the majority of these allegations relating to Patient D relied upon his witness statement evidence which cannot now be challenged. In respect of paragraph 13b, Ms Fairley submitted that the reasoning is slightly different as this relates to an alleged failure in record keeping. She submitted whilst the GMC consider there is enough evidence to support this allegation, it has taken the view that when considered in isolation, the GMC do not consider it would amount to a serious breach of Good Medical Practice and therefore, it does not seek to proceed with the charge and applies for it to be withdrawn.

604. In respect of Patient G, Ms Fairley proposed an amendment to reflect the Tribunal's determination on the hearsay application at paragraph 22.

605. Following Ms Fairley's submission, and a question from the Tribunal in respect of the proposed amendments, Ms Fairley made a further submission in relation to paragraph 8c, which is an allegation in the alternative to be amended reflect that it relates solely to 8bv and not 8biii, should the Tribunal accept the application to withdraw 8biii.

Submissions on behalf of Mr Dixon

606. In summary, Mr Basu made no objections to the proposed amendments to the Allegation. He submitted however hat the GMC should 'nail their colours to the mast' as they have had the medical records for some time and that the defence need to know with clarity the particulars of the allegation against Mr Dixon.

Tribunal's decision

607. The Tribunal noted that the application to amend the Allegation was not contested in any substantial way by Mr Basu. However, it considered carefully the overarching objective and whether it was fair to allow the amendments. In particular, the Tribunal bore in mind its role to protect patients and the public. It determined that all the proposed amendments to the Allegation in respect of paragraphs 4a, 5, 6, 8b and c, 22 and 24 of the Allegation could be made without injustice to all parties and provided greater clarity.

608. The Tribunal accepted the application to re-word paragraph 22 which effectively substituted the alternative charge at paragraph 23 and amounted to an application to withdraw the original paragraph 22 of the Allegation. The Tribunal considered that this was appropriate and fair given the determination it had made in relation to the hearsay

application in relation to Patient G. The allegation was made in the alternative and the Tribunal did not consider that this amounted to an under prosecution.

609. In respect of withdrawing the allegations in respect of Patient D, the Tribunal was mindful that whilst the GMC had made an application for the withdrawal of these allegations, it had a duty to protect the public where there was a case to answer. It bore in mind that it had to consider the allegations carefully before allowing the GMC to withdraw any allegation.

610. The Tribunal was of the view that it would be wholly inappropriate to take any steps to compel Patient D to attend to give evidence, given the reason for his absence was due to ill health. It was not advanced before the Tribunal that it should allow the statement to be admitted as hearsay evidence. In any event, the Tribunal considered that without any further detail this would be unfair to Mr Dixon given the extent of the challenge to the evidence and that it was the sole and decisive evidence relating to those allegations as it relied on the recollection of Patient D. It considered that the allegations which relied on Patient D's oral evidence could not be challenged in cross-examination and that it was therefore in the interests of justice and fairness that those allegations be withdrawn.

611. The Tribunal considered that 13b related to the alleged failure to record and did not rely on the evidence of Patient D, rather it relied on the medical records. It bore in mind the expert report of Colonel L in which he opined in respect of Patient A:

> *"5. Did Mr Dixon adequately discuss the procedure(s) with Patient [A]?*
>
> *I consider Mr Dixon's preoperative discussions with the patient to have been reasonable, and based on his clinic note from 15 May 2013 and the consent form, I consider that consent for the procedure was reasonable. The signing of the form on the day of surgery falls below the standard expected; however, in light of the documented preoperative discussion, I consider this failure to meet standard to be minor…"*

612. The Tribunal considered that even if it were to find that there was a failure to record, it would be unlikely to amount to a finding of serious misconduct either on its own, or cumulatively. The Tribunal therefore determined therefore that the entirety of that alleged in respect of Patient D, be withdrawn.