Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 01/10/2018 - 19/10/2018, 14/01/2019-18/01/2019, 07/03/2019-08/03/2019, 20/05/2019-22/05/2019

Medical Practitioner’s name: Dr Nishanth NAIR

GMC reference number: 6156848

Primary medical qualification: MB BCh 2007 University of Wales

Type of case
New - Misconduct

Outcome on impairment
Impaired

Summary of outcome
Conditions, 12 months.
Review hearing directed
Immediate order imposed

Tribunal:

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<tr>
<td>Legally Qualified Chair</td>
<td>Mr Paul Moulder</td>
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<tr>
<td>Lay Tribunal Member:</td>
<td>Mr Geoffrey Brighton</td>
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<td>Medical Tribunal Member:</td>
<td>Dr Joanne Topping</td>
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<tr>
<td>Tribunal Clerk:</td>
<td>Mr John Poole 1-19 October 2018</td>
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<td>Ms Angela Carney 14-18 January 2019</td>
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<td>7-8 March 2019, 20-22 May 2019</td>
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Attendance and Representation:

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<td>Medical Practitioner:</td>
<td>Present and represented</td>
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<td>Medical Practitioner’s Representative:</td>
<td>Mr Kevin McCartney, Counsel, instructed by Hempsons</td>
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<tr>
<td>GMC Representative:</td>
<td>Ms Chloe Hudson, Counsel</td>
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Attendance of Press / Public
In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly in private.
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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 - 08/03/2019

Background

1. Dr Nair qualified in 2007 from the University of Cardiff Medical School. Prior to the
events which are the subject of this hearing, he worked in a series of short, medium and
long term locum posts having decided to leave his specialist training rotation in 2014.

2. The allegations that have led to this hearing stem from consultations held by Dr Nair

3. The consultations with Patients A and B occurred at the Ambulatory Care Unit in
Wexham Park Hospital, part of the Frimley Health NHS Foundation Truth (‘the Trust’). The
consultation with Patient C occurred at the Acute Care Unit in the Gloucestershire Royal
Hospital. It is alleged that aspects of the examinations conducted by Dr Nair on each
patient were not clinically indicated and were sexually motivated.

The Outcome of Applications Made during the Facts Stage

4. The Tribunal granted an application made by Mr McCartney, Counsel on behalf of
Dr Nair, for 9 October 2018 to be a non-sitting day. This application was heard in
private and the tribunal’s decision is included at Annex A.

5. The Tribunal granted an application made by Ms Hudson on behalf of the GMC,
in accordance with Rule 34(13) of the General Medical Council (Fitness to Practise
Rules) 2004 as amended (‘the Rules’), for a witness to give evidence via video link. The
Tribunal’s full decision on the application is included at Annex B.

6. The Tribunal refused an application made by Mr McCartney for a direction that
Patient C give oral evidence in chief in accordance with Rule 34(11)(c) of the Rules. The
Tribunal’s full decision on the application is included at Annex C.

7. The Tribunal granted an application made by Mr Hudson, under Rule 17(6) of the
Rules, for part of the allegation to be amended. The Tribunal’s decision is included at
Annex D.

8. At the conclusion of the GMC’s case, Mr McCartney made an application under
Rule 17(2)g of the Rules with regard to parts of the allegation. The Tribunal’s full
determination on this application is included at Annex E.
9. The Tribunal granted an application made by Mr McCartney, pursuant to Rule 34(13), that a witness give evidence via video link. The Tribunal’s decision is included at Annex F.

10. The Tribunal granted an application made by Mr McCartney for an un-redacted witness statement to be admitted into evidence for an expert witness to be examined on. The Tribunal’s decision is included at Annex G.

**The Allegation and the Doctor’s Response**

11. The Allegation made against Dr Nair is as follows:

1. On 9 June 2015, you consulted with Patient A and you:
   a. unclipped Patient A’s bra;  
      **To be determined**
   b. lifted Patient A’s:
      i. top;  
      **To be determined**
      ii. bra;  
      **To be determined**
   c. lowered Patient A’s jeans and underwear to her pubic bone;  
      **To be determined**
   d. attempted to pull Patient A’s trousers down further;  
      **To be determined**
   e. failed to:
      i. afford Patient A the opportunity to move her own clothing as set out in paragraphs 1a – 1d;  
      **To be determined**
      ii. obtain Patient A’s consent to move her clothing as set out in paragraphs 1a – 1d;  
      **To be determined**
   f. carried out:
      i. an assessment of Patient A’s thigh circumference;  
      **Admitted and found proved**
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ii. an examination of Patient A’s femoral pulses;
Admitted and found proved

iii. a breast examination of Patient A;
To be determined

g. failed to:

i. offered Patient A a chaperone;
To be determined

ii. offer appropriate covering material for Patient A’s buttocks or thighs during your examination of her legs for deep vein thrombosis;
To be determined

iii. adequately communicate with Patient A the detail of the examination/s you intended to perform.
To be determined

2. On 29 May 2015, you consulted with Patient B and you:

a. lifted up Patient B’s:

i. top;
Deleted following Rule 17(2)g application

ii. bra;
To be determined

b. unfastened Patient B’s bra;
To be determined

c. lowered Patient B’s trousers to the top of her groin;
Deleted following Rule 17(2)g application

d. carried out an assessment of Patient B’s thigh circumference;
Admitted and found proved

e. failed to:

i. afford Patient B the opportunity to move her own clothing as set out in paragraphs 2a–2c;
Deleted following Rule 17(2)g application in relation to 2a(i) & 2c

i. afford Patient B the opportunity to move her own clothing as set out in paragraphs 2a(ii) and 2b
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To be determined in relation to 2a(ii) & 2b

ii. obtain Patient B’s consent to move her clothing as set out in paragraphs 2a—2c;
Deleted following Rule 17(2)g application in relation to 2a(i) & 2c

To be determined in relation to 2a(ii) & 2b

i. obtain Patient B’s consent to move her clothing as set out in paragraphs 2a(ii) and 2 b;

To be determined in relation to 2a(ii) & 2b

iii. obtain Patient B’s consent for a:

1. respiratory examination;
Deleted following Rule 17(2)g application

2. examination of Patient B’s femoral pulses;
Deleted following Rule 17(2)g application

3. examination of Patient B’s legs;
Deleted following Rule 17(2)g application

To be determined

iv. indicate to Patient B that she could cover her breasts when you had completed the respiratory examination;

To be determined

v. offer Patient B a chaperone;
Deleted following Rule 17(2)g application

vi. failed to adequately communicate with Patient B the detail of the examination/s you intended to perform.
To be determined

3. At around 07:00 on 10 March 2016 you consulted with Patient C and you:

a. opened Patient C’s pyjama top exposing her breasts;
To be determined

b. failed to:

i. obtain Patient C’s consent before opening her pyjama top;
To be determined

ii. afford Patient C the opportunity to open her pyjama top;
To be determined
iii. offered Patient C a blanket to cover her breasts;

To be determined

c. touched Patient C’s breasts one at a time as though massaging them;

To be determined

d. failed to stop touching Patient C’s breasts when she indicated she wanted you to stop;

To be determined

e. pulled Patient C’s:

i. pyjama bottoms down to her knees;

To be determined

ii. knickers down to her knees;

To be determined

f. failed to:

i. obtain Patient C’s consent before pulling down her:

1. her pyjama bottoms;

To be determined

2. knickers;

To be determined

ii. afford Patient C the opportunity to pull down her own:

1. pyjama bottoms;

To be determined

2. knickers;

To be determined

iii. offer Patient C a chaperone;

To be determined

g. touched Patient C’s groin areas;

To be determined

h. asked Patient C to turn over and you:

i. touched Patient C’s bottom;

To be determined
ii. put your fingers close to Patient C’s anus;  
**To be determined**

iii. put your fingers approximately 2cm away from Patient C’s vagina;  
**To be determined**

i. failed to:
   
i. obtain Patient C’s consent for the examination set out at paragraph 3h;  
**To be determined**

ii. document the reasons why carried out a:
   
1. breast examination on Patient C;  
**To be determined**

2. groin examination on Patient C;  
**To be determined**

iii. adequately communicate with Patient C the details of the examination/s you intended to perform.  
**Added pursuant to Rule 17(6)**
**To be determined**

k. adequately communicate with Patient C the details of the examination/s you intended to perform.  
**Deleted pursuant to Rule 17(6)**

4. Your actions at 1(f), 2(d), 3(c), 3(g) and 3(h) were not clinically indicated.  
**To be determined**

5. Your actions at paragraphs 1 to 4 were sexually motivated.  
**To be determined**

**The Admitted Facts**

12. At the outset of these proceedings, through his representative, Mr McCartney, Dr Nair made admissions to some sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these sub-paragraphs of the Allegation as admitted and found proved.

**The Facts to be Determined**
13. In light of Dr Nair’s response to the Allegation made against him, the Tribunal is required to determine the remaining sub-paragraphs and paragraphs of the Allegation. It must determine whether aspects of Dr Nair examinations were clinically indicated and if they were sexually motivated.

**Factual Witness Evidence**

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

- Patient A, in person
- Patient B, in person
- Patient C, in person
- Ms D, Complex Case Lead, via video link. Ms D was the Complex Case Lead at the Trust at the time of the events and was involved in the investigation of the complaints made by Patient A and B
- Ms E, Ward Sister, Gloucestershire Royal Hospital, in person. Ms E was on duty at the time of the events involving Patient C
- Ms F, Ward Sister, Gloucestershire Royal Hospital, in person. Ms F was on duty at the time of the events involving Patient C
- Ms G, Health Care Assistant, Gloucestershire Royal Hospital in person. Ms G was on duty at the time of the incident involving Patient C

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

- Ms H, friend of Patient A
- Ms I; Head of Patient Involvement for the Trust at the time of complaints made by Patient A and Patient B and involved in the management of those complaints;
- Dr J, Responsible Officer and Medical Director at the Trust at the time of the events;
- Ms K, GMC Paralegal.

16. Dr Nair provided his own witness statement and also gave oral evidence at the hearing. In addition, the Tribunal received evidence on behalf of Dr Nair, from Dr L, via video-link.

**Expert Witness Evidence**

17. The Tribunal also received evidence from two expert witnesses, Dr M and Professor N.

18. Dr M was instructed on behalf of the GMC and provided a report dated 7 September 2016 regarding Patients A and B. He provided a report regarding Patient C on 22 October 2017, as well as supplemental opinions to his reports in July and August 2018.
19. Professor N was instructed on behalf of Dr Nair and provided a report dated 13 September 2018.

20. In addition, both experts provided joint reports dated 7 October 2018 and 15 October 2018.

**Documentary Evidence**

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

- Email complaint from Patient A to Wexham Park Hospital, dated June 2015
- Telephone note between Patient A and Ms D, dated June 2015
- Police witness statement of Patient A, dated June 2015
- Police interview with Dr Nair regarding Patient A, dated June 2015
- Medical records relating to Patient A
- Email complaint from Patient B to Ms I, dated June 2015
- Handwritten notes of a telephone conversation between Patient B and Ms I
- Police witness statement of Patient B, dated May 2016
- Medical records relating to Patient B
- Police witness statement of Patient C, dated March 2016
- Police witness statement of Ms E, dated March 2016
- Police witness statement of Ms G, dated March 2016
- Police interview with Dr Nair regarding Patient C, dated March 2016
- Medical records relating to Patient C

**The Tribunal’s Approach**

22. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Nair does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

**The Tribunal’s Analysis of the Evidence and Findings**

**The Allegation**

23. 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.

**Paragraphs of the Allegation relating to Patient A**

24. Patient A was a 24 year old female who was referred by her GP to the ACU to rule out the possibility of a pulmonary embolism (PE). She presented to her General Practitioner (GP) with a several day history of chest pain. In her previous history she had been treated for tuberculosis. Patient A arrived on ACU in the morning of 9 June 2015. She was initially seen by a nurse who carried out an Electrocardiogram (ECG),
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and took bloods. Patient A was then sent for a chest x-ray. Patient A reported that she was wearing a black poncho, skinny jeans and a loose fitted top. Patient A was seen by Dr Nair.

25. The Tribunal noted that Patient A was referred by her GP to the Ambulatory Care Unit (ACU) to rule out the possibility of a pulmonary embolism (PE). The Tribunal found that it was significant that Patient A maintained that she did not know the purpose of her visit to the hospital. She stated that up until she was asked some questions at the hearing about clots she had no idea that this was why she had been referred to the ACU. This was despite having conversations with her GP, the nurse who conducted the assessment, the fact that she had a D Dimer test and on her own account had a discussion with Dr Nair at the end of the consultation.

26. The Tribunal accepted that this was significant for the following reasons. First, it affected the confidence of the Tribunal that Patient A was able to accurately assess what occurred in relation to the consultation with Dr Nair, her GP and with the nurse. Secondly, Patient A’s understanding of the reason for attending hospital was limited. Thirdly, Patient A’s understanding as to why her chest and legs were examined in the manner undertaken by Dr Nair, was affected as she believed that she was being assessed for Tuberculosis (TB).

27. The GMC invited the Tribunal to find that Patient A was a compelling witness, in that, her demeanour was measured, consistent and detailed. She was not prone to exaggeration or embellishment and when robustly challenged she was clear that she had not misinterpreted or misunderstood Dr Nair’s actions.

28. The Tribunal was referred to the transcript where Patient A responded to a series of questions about how she would have viewed the consultation if she had understood why the examination was necessary. It was clear that this would have altered her perception of the examination, although she maintained that she wouldn’t have wanted her ‘boobs’ exposed or to ‘nearly’ have her vagina exposed.

29. The Tribunal accepted that Patient A’s perception of the examination and therefore her concerns would have been exacerbated by inadequacies in Dr Nair’s communication.

30. Patient A was cross examined in private session on day two of her evidence about whether

‘some XXX that had happened to you in the past and you thought that that might – the examination by Dr Nair and your concerns, might have triggered anxiety about that in your mind’.

Patient A firmly rejected such a suggestion and the GMC submitted that the Tribunal should accept her evidence.
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31. The Tribunal noted that Ms D was asked about the conversation she had with Patient A on 15 June 2015 about XXX. Ms D was questioned about whether that raised in her mind the possibility that Patient A might not be able to judge things objectively. The GMC invited the Tribunal to disregard the notion that anything in the Patient’s past negatively influenced her evidence or undermined her credibility.

32. Having heard Patient A give evidence and respond to cross-examination on these issues, the Tribunal found her to be a credible witness as to the facts of what occurred. It bore in mind her lack of awareness of the nature of the examination that was to be undertaken, set against her experience of previous consultations arising from her TB. It bore in mind that the decision as to the motivations of Dr Nair was in any event a matter for its own assessment.

Dr Nair

33. Dr Nair gave oral evidence before the Tribunal. He accepted that, in relation to Patient A (and Patient B) he could not recall the detail of the examinations. During his oral evidence Dr Nair stated that he couldn’t remember some of the events, but described to the Tribunal what was his usual practice. He denied any sexual motivation to his actions. The Tribunal had, in addition, the record of his police interview in relation to two of the three patients.

34. The Tribunal noted that Dr Nair had attended voluntary interviews with the Police in relation to Patients A, B and C. It was Dr J’s evidence that Dr Nair engaged with the Trust’s investigations. Dr Nair provided a witness statement and gave oral evidence. The GMC suggested that Dr Nair was evasive and the Tribunal noted that Dr Nair was deeply upset at this criticism. The Tribunal noted Dr Nair’s consistent approach to questioning and his emotional reaction to the suggestions made of his conduct and his complete rejection of it. The Tribunal was mindful of the fact that if someone says ‘I can’t remember’ it does not mean that they are not a credible witness.

35. The Tribunal found Dr Nair to be a credible witness, who was prepared to make concessions appropriately, and did not seek to embellish his account. He maintained a definite denial of the sexual motivation allegations. His evidence suffered to a degree from the fact that he could not remember the detail of some of the examinations, although the Tribunal bore in mind that reasons for this could include both lapse of time and number of consultations undertaken.

36. The Tribunal closely considered the medical notes, which in broad terms support the diagnoses that Dr Nair says he made. The Tribunal found this to be evidence in support of Dr Nair’s case that his actions were clinically indicated. However, it was recognised by Dr M and Professor N, that Dr Nair having made the correct diagnosis did not preclude sexual motivation. The Tribunal was aware that this was a matter that it would have to assess from all the evidence.

37. The Tribunal noted that there have been no previous disciplinary findings against Dr Nair and it has accepted the application of good character in relation to propensity
and credibility. The Tribunal took account of the positive testimonials in support of Dr Nair.

**Paragraph 1a**

38. The Tribunal noted Patient A’s email dated 12 June 2015 in which she stated:

’ve undone [sic] my bra and exposed my chest without warning or permission.’

39. The Tribunal also noted the transcript, written retrospectively (from the handwritten notes taken during a telephone conversation on 15 June 2015 by Ms D), which states that Patient A reported:

’ve undid my bra’.

40. The Tribunal further noted Patient A’s police statement dated 16 June 2015 in which she reported:

’ve while I was in this position the doctor unclipped my bra fastening’

41. In her oral evidence Patient A stated:

’ve He was listening to my chest from my back he just undone my bra without warning... He just unclipped it without asking... if he had asked, then it wouldn’t have been such a shock when he did it.’

42. The Tribunal noted in the transcript of Dr Nair’s police interview dated 29 June 2015, he relied upon what was his usual practice was rather than reporting the events. In his oral evidence Dr Nair stated:

’Q    I just want to go back to the question that I asked you, which was in respect of the fact that you unclipped the bra. Twice during that answer that you gave, you said, ‘I might have helped unclip the bra.’ You do not address this in your witness statement. Did you, in your evidence, unclip this patient’s bra?
A     I cannot recall exactly. Sometimes the patients do it, sometimes I ask them, sometimes I help. So it is possible, yes.’

43. The Tribunal noted that Ms D reported that when she called Patient A to discuss the complaint she was very upset and distressed with her encounter with Dr Nair

44. Taking all the evidence into account, including Patient A’s clear recollection set against the doctor’s lack of specific recall, the Tribunal was satisfied, on the balance of probabilities that, Dr Nair did unclip Patient A’s bra. Accordingly, the Tribunal found paragraph 1a, proved.
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Paragraph 1b(i)

45. The Tribunal noted Patient A’s police statement dated 16 June 2015, in which she stated:

‘...He asked me to sit on the bed properly and adjusted the bed. He asked me to sit forwards which I did and he placed the stethoscope up my top and onto my back. I lent forward and took deep breaths as I was asked. While I was in this position the doctor unclipped my bra fastening. He then pushed his hand on my shoulder so I was lying on the bed. The push on my shoulder was not forceful. As though guiding me back.

.. The Dr then grabbed my top and my bra and lifted them both up to my neck. This left both my breasts exposed.’

46. The Tribunal noted Patient A’s emails to Wexham Park Complaints dated 12 June 2015, in which she stated:

‘... While I was sat up on the bed and he was listening to my chest from the back he just undone [sic] my bra without warning or even asking...’

‘... the thing that got me the most is how he undone[sic] my bra and exposed my chest without warning or permission

47. The Tribunal took account of the witness statement of Ms H:

‘....this phone call happened so long ago now I can’t recall the exact details of our conversation. I remember she said something along the lines of the doctor had got her breasts out...’

48. The Tribunal noted Dr Nair’s police interview when he told the Police what his usual practice was:

‘...and in some instances "I’m going to lift this top—I’m going to lift your top up to listen to it.” I don’t think I am that explicit and say "I’m going to lift your bra and now your breasts are going to be exposed. I don’t. That’s not usually what I say – It’s not my usual practice to say that in that much detail

... There would be no point where I would have sort of forcedly [sic] done it’

... "... I think that maybe while I was sort of focussing on the examination maybe I went into [some] sort of robotic mode and didn’t ..., you know, communicate - I think communication was the - Maybe I didn’t sort of explicitly say--”

49. The Tribunal took into account Dr Nair’s oral evidence:
Dr Nair’s account was that he could not clearly recall the actual examination of Patient A. He said that he:

’could not remember 100 per cent” and “but I did not think it was – in my mind, I did not feel that it was that exposed; I did not appreciate it at the time. To me, it did not even – it is not even a thing that occurred to me at all.’ …

50. The Tribunal accepted Patient A’s evidence which was consistent from her original complaint, through to her discussions with the Trust. The Tribunal noted that Dr Nair described his usual practice and the need to lift up the patient’s top in order to carry out the chest examination. It also took into account the doctor’s admission that he could not fully recall this examination. Having weighed the evidence the Tribunal was satisfied that, on the balance of probabilities, Dr Nair lifted Patient A’s top. Accordingly, the Tribunal found paragraph 1b(i), proved.

**Paragraph 1b(ii)**

51. The Tribunal noted Patient A’s evidence from her original complaint that Dr Nair unclipped her bra then listened to her chest through her back. Dr Nair then guided Patient A back and lifted her top and bra. Patient A stated that Dr Nair asked her to breathe deeply as he listened and then undid her bra strap. The Tribunal noted that Dr Nair stated he had no recollection of lifting Patient A’s bra but made it clear that the reason why he moved the bra was so that he could listen properly to the patient’s heart sounds.

52. The Tribunal accepted Patient A’s evidence which was consistent. It considered that it was a significant event for Patient A. The Tribunal also noted Dr M’s opinion that ‘...there is a degree of disorder of the garments which then must be replaced.’ The Tribunal was satisfied on the balance of probabilities, that it was more likely than not, that Dr Nair lifted Patient A’s bra. Accordingly, the Tribunal found paragraph 1b(ii), proved.

**Paragraph 1c**

53. The Tribunal noted that Patient A was wearing ‘Jeggings’ which are a combination of leggings and jeans and she described them as tight fitting.

54. The Tribunal noted Patient A’s email complaint to the Trust dated 10 June 2015, in which she stated:
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‘.. I covered myself and he tried to pull down my trousers again without asking.’

55. The Tribunal noted Patient A’s witness statement in which she states:

‘I recall Dr Nair then hooked his fingers into the side of my elasticated jeans at my waist and then pulled them down with my underwear to my pubic line, exposing my whole pubic region. I was really embarrassed as my pubic hair was exposed. I was laid on the bed at this point.’

56. The Tribunal also noted the telephone note made by Ms D of her conversation with Patient A, which states:

‘He pulled my trousers down and said he needed to check. Patient A said that her underwear was coming down with her trousers which caused her to feel uncomfortable.’

57. The Tribunal further noted Patient A’s Police statement which states:

‘..the Dr returned to the bedside and tucked his fingers in the waist band of my jeans and pulled them down along with my underwear’

58. The Tribunal noted the transcript of Dr Nair’s police interview:

‘GM  So the very top of the pubic area
NN  Yes

GM  So it may be that some pubic hair may be exposed?
NN  Yes sometimes

...  
GM  Did you remove this ladies trousers for her or assist in taking them down?
NN  I don’t. I don’t. I’ve definitely not undone her undergarments. That is –

GM  Just answer the question.
NN  Yes, so trousers, I don’t know. So it just depends on what they are wearing. So when I am measuring the legs, so some people, they can lift their trousers at the bottom end.

...  
Some people are wearing tight clothing; they can’t do that. Sometimes it becomes necessary to lower it down to be able to see any sort of superficial veins to measure it. So sometimes it does become necessary. Sometimes they just stand up and they just lower it down and I just sort of measure it. But undergarments wouldn’t have to come off’

59. The Tribunal noted Dr Nair’s oral evidence:
'Q Because what you in fact did was take your fingers, put them inside her jeggings and pulled them down didn’t you, without any warning?
A The lowering of trousers or jeggings as she says, in most instances I would have asked the patient to do it as Patient B [sic] recalls. I would have said something to the patient ‘I need to examine your legs, I am going to examine your legs’ is what would be my normal practice. I can’t recall what I did exactly in this instance but I hope I would have said something before examining the patient.

Q Do you accept that you did that, that you pulled down her trousers?
A Yes, sometimes I assist the patient or sometimes I tell the patient can I examine your legs and I indicate that as part of that, lower the trousers. I say could you lower your trousers for me. That is what Patient B [sic] recalls and that is what I recognise.’

60. The Tribunal noted that in cross examination Dr Nair stated that he could not remember, but that in Dr Nair’s witness statement he stated:

‘I would have needed her to lower her trousers or take them off, or lift them up, if they were loose enough to lift above the knee

and his

‘usual practice is to tell patients that I need to examine the pulses in their groin before carrying out …. I may have helped…”

61. The Tribunal found that Patient A’s oral evidence was consistent with her witness and police statements. The Tribunal also noted that Dr Nair needed access to the area and that he acknowledged that he could not remember the patient but accepted that he may have helped her in order to carry out the examination. The Tribunal was satisfied that on the balance of probabilities, it was more likely than not that Dr Nair lowered Patient A’s trousers jeans and underwear to her pubic bone. Accordingly, the Tribunal found paragraph 1c, proved.

Paragraph 1d

62. The Tribunal noted Patient A’s email complaint dated 10 June 2015:

‘He tried to pull my trousers down without warning or asking. Saying he needed to feel the pulse in my groin and measure my legs from the front and back.’

63. The Tribunal noted Patient A’s Police statement in which she stated: ‘the doctor tried to pull my jeans down further, I said would you like me to take them off?’

64. The Tribunal noted Patient A’s witness statement:
20. After feeling around my groin area, Dr Nair hooked his fingers into my jeans and underwear again and started to pull on them – as he did this he said words to the effect of "I just need to measure your legs". I could feel my underwear moving further down. I panicked that if he pulled them down any further, my vagina would be exposed.

21. As he was starting to pull down my jeans and underwear. I stopped him and asked “Do you want me to pull them down?” He stopped pulling them down and took his hands from my jeans. I Sat up slightly to pull my underwear back into place and I pulled my pants down to my shin. I then lay back down . I cannot recall if he said anything during this time.’

65. The Tribunal also noted the telephone note made by Ms D of her conversation with Patient A, which states:

‘He pulled my trousers down and said he needed to check and Patient A said that her underwear was coming down with her trousers which caused her to feel uncomfortable.’

66. The Tribunal noted Patient A’s Police statement dated 16 June 2015:

‘The doctor returned to the bedside and hooked his fingers in the waist band of my jeans and pulled them down along with my underwear. Only after he had pulled them down to my pubic bone did he say to me 'I need to check your groin. My pubic hair was exposed. He began feeling either side of my groin for 10/20 seconds either side. He was prodding between my pubic bone and my thigh. I was in shock. The Dr tried to pull my jeans down further. I said to him ‘Do you want me to take them off?’’

67. In Patient A’s witness statement dated 8 May 2017 she stated:

‘I recall Dr Nair then hooked his fingers into the side of my elasticated jeans at my waist and pulled them down with my underwear to my pubic line, exposing my whole pubic region. I was really embarrassed as my pubic hair was exposed.’

68. In her oral evidence Patient A stated:

Q: But you took them down, not him. You have told us you took them down?
A: Yes, because he was pulling them down, so I said, "Would you like me to pull them down?"

69. In Dr Nair’s police statement he stated:

‘GM Would you have done it? Would you have removed – Not removed, lowered her trousers for her without asking her permission?

NN That is unlikely...’
70. The Tribunal accepted Patient A’s evidence, having found her to be a clear and cogent witness. Furthermore, Dr Nair needed access to the area, Dr Nair acknowledged that he could not remember, but said it was a possibility that he may have helped Patient A in order to carry out the examination. The Tribunal was satisfied, on the balance of probabilities, that it was more likely than not that Dr Nair attempted to pull Patient A’s trousers down further. Accordingly, the Tribunal found paragraph 1d, proved.

**Paragraph 1e(i)**

71. The Tribunal noted paragraph 5f of the GMC’s guidance on ‘Intimate examinations and chaperones’:

> '5 Before conducting an intimate examination, you should:
> ...
> f give the patient privacy to undress and dress, and keep them covered as much as possible to maintain their dignity; do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help.’

72. Dr M stated in his oral evidence:

> 'If a woman’s underwear is to be touched then it requires separate consent.’

73. The Tribunal noted Patient A’s email complaint:

> 'While I was sat up on the bed and he was listening to my chest from my back and he just undone [sic] my bra without warning or even asking told me lay back and then fully exposed my chest. At this point I felt VERY uncomfortable I just wanted to cover myself...
> After that had happened and I covered myself he tried to pull down my trousers again without warning or asking.’

74. The Tribunal noted Dr Nair’s Police interview in which he stated:

> ‘GM Would you have done it? Would you have removed – Not removed, lowered her trousers for her without asking her permission?
>  
>  
> NN That is unlikely... I would have said “I need to feel your groin pulses” and then I would have lowered it down after saying that.’

75. The Tribunal noted that Dr Nair asked Patient A whether he could examine her chest and informed her that he needed to feel the pulse in her groin. The Tribunal considered that to some degree Dr Nair had explained that he was going to carry out an examination.
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76. The Tribunal noted that Patient A stated that he did not ask her to unclip her bra or ask her to pull her jeans down. The Tribunal noted that Dr Nair needed access to the areas he intended to examine. Dr Nair acknowledged that he assumed that the patient was aware of what he was going to do in order to examine her.

77. The Tribunal considered that Dr Nair should have offered Patient A the opportunity to remove or move her clothing. The Tribunal accepted the evidence of Dr M on this matter and this was clearly the case from the Intimate Examinations Guidance. The Tribunal considered that Dr Nair did not specifically offer Patient A that opportunity, although he did say some words about examining her chest and groin.

78. It was Dr Nair’s position was that sometimes he does explain about moving clothing but he could not specifically remember on this occasion. Dr Nair said that he could not remember the patient but said it was a possibility that he may have helped Patient A in order to carry out the examination.

79. The Tribunal was satisfied on the balance of probabilities, that it is more likely than not, that Dr Nair failed to afford Patient A the opportunity to move her own clothing as set out in paragraphs 1a – 1d. Accordingly, the Tribunal found paragraph 1e(i), proved.

Paragraph 1e(ii)

80. The Tribunal noted the GMC’s guidance on ’Intimate examinations and chaperones’:

’S Before conducting an intimate examination, you should:

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

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

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

81. The Tribunal noted Patient A’s witness statement in which she described that Dr Nair moved her clothing in order to examine her breasts and groin area.

82. The Tribunal considered that Dr Nair had a duty to obtain express consent from Patient A to move her clothing. The Tribunal next considered whether Dr Nair had implied consent as he had asked to listen to Patient A’s chest and informed her that he needed to take the pulse in her groin.
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83. The Tribunal was of the opinion that Dr Nair should have obtained express consent when he moved Patient A’s clothing. The Tribunal took account of evidence of Patient A that Dr Nair did not obtain express consent before moving her clothing at paragraphs 1a-1d.

84. Tribunal found no evidence of Patient A’s consent and her accounts were consistent in her email complaint and subsequent statements.

85. Although the Tribunal accepted that Dr Nair asked Patient A if he could listen to her chest, examine her groin area and measure her legs, to which she agreed, it was of the opinion that Dr Nair should have asked Patient A for permission each time an item of clothing was moved.

86. The Tribunal was satisfied, on the balance of probabilities that. Dr Nair did not expressly ask Patient A for her permission to remove any of her clothing and it determined that he did not implicitly have permission to move any of her clothing. The Tribunal was satisfied that Dr Nair failed to obtain Patient A’s consent to move her clothing as set out in paragraphs 1a – 1d. Accordingly, the Tribunal found paragraph 1e(ii), proved.

Paragraph 1f(iii)

87. The Tribunal noted Patient A’s email complaint dated 10 June 2015.

‘He then went on to listen to my chest and then started to grope my breasts saying he needed to check them again without asking for my consent.’

88. The Tribunal also noted the telephone note of the conversation with Patient A made by Ms D, which states:

‘He felt my boobs and said he needed to check them…..’

89. The Tribunal noted Patient A’s Police witness statement, dated 08 May 2017:

‘He listened either side of my chest with the stethoscope and then put his hand on my left breast. Only after his hand was on my breast did he say, ‘I'M JUST GOING TO CHECK YOUR BREAST.’ He first used his right hand then both pressing around with his fingertips as though examining them. He then did the same with the other breast.’

... Dr Nair then felt my breast; I think he touched my left breast first. I recall his stethoscope was around his neck. He felt my breast with his right hand I think. He used his fingertips and touched my breasts in a pressing motion; he did not wear gloves at any time during the examination. After pressing around on my left breast, he moved to my right breasts and did the same thing there. He didn’t touch the nipple; it was more the tissue of the breast. He said words to the effect of "I'm just checking to see if there are any lumps."”
90. The Tribunal noted Patient A’s oral evidence:

Q: In your police statement, what you said there was, he said, "I’m just going to check your breast"?
A: Yes

Q: Do you think that you might have made a mistake and it was he said, "I’m just going to check your chest"?
A: No.

Q: It would be an easy mistake to make though, wouldn’t it, breast/chest?
A: No, because he was touching my breasts. He said he needed to check them for lumps.

Q: ...how clear are you that that happened?
A: Hundred per cent clear.

A: He was using his fingertips and moving around the breast.

Q: When you say "around the breast" – sorry to be so specific but it is important – when you say "around the breast", so not the breast tissue itself but on the chest wall surrounding the breast on each side?
A: No, the actual – my actual breasts.

Q: Do you think it is something that you could possibly be wrong about, that it was pressing on the chest rather than pressing on the breast tissue itself?
A: No. Obviously, my chest is a completely different area than my breast.

Q: I mean it might be pretty close, Patient A, it might have been pressed pretty close. Do you think that might be the purpose of the examination, a chest examination rather than a breast examination?
A: No, it was definitely my breast.

...He was using his fingertips and moving around the breast - no my actual breasts...

91. The Tribunal noted that in her email complaint Patient A used the term ‘grope’ to describe the examination, but later clarified that she meant it was touching and pressing.

92. The Tribunal considered the account in Patient A’s witness statement was more of a description of a chest examination. Patient A was clear that Dr Nair did not touch her nipples.

93. The Tribunal noted Patient A’s presenting condition and there was no indication to undertake a breast examination but there was an indication to examine the chest
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wall. The Tribunal accepted that an examination of the chest was clinically indicated. It also accepted Professor N’s opinion that some breast tissue would have been pressed.

94. The Tribunal noted that Patient A subsequently presented with breast pain and had a breast examination with her GP to exclude lumps. The Tribunal reminded itself that Patient A had little appreciation of the reasons for the examinations undertaken by Dr Nair, as above.

95. The Tribunal also noted that Patient A stated that Dr Nair said to her during his examination that he was going to examine her ‘breast for lumps’. However, The Tribunal considered that Patient A’s description of the ‘breast/chest’ examination was not consistent throughout her statements. In all the circumstances, the Tribunal was not satisfied on balance that Dr Nair had said these words. The Tribunal noted that Dr Nair diagnosed musculoskeletal pain/costochondritis and a chest examination for this examination would have been necessary in order to diagnose this condition.

96. The Tribunal took account of Professor N’s oral evidence:

‘It is because I took the view that, as I tried to explain earlier in my answers to questions, there was a misinterpretation of breast examination. If you wish to auscultate the chest or the heart, you have to move the breast out of the way in order to access the heart sounds properly using your stethoscope. Similarly, if you wish to try and elicit local tenderness in the bones or the muscles which make up the thoracic wall, the chest wall, then it is, I am afraid, unavoidable that you will feel through the breasts or move them aside. This is not a breast examination.’

97. Given Dr Nair’s diagnosis and Patient A’s description of the examination, the Tribunal found it more likely than not, that the examination he undertook was consistent with a chest examination and not a breast examination. Therefore, the Tribunal was not satisfied, on the balance of probabilities, that Dr Nair carried out a breast examination of Patient A. Accordingly, the Tribunal found paragraph 1f(iii), not proved.

Paragraph 1g(i)

98. The Tribunal noted the GMC’s guidance on ‘Intimate examinations and chaperones’:

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

5 Before conducting an intimate examination, you should:
8 When you carry out an intimate examination, you should offer the patient the option of having an impartial observer (a chaperone) present wherever possible. This applies whether or not you are the same gender as the patient.

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

a be sensitive and respect the patient’s dignity and confidentiality

b reassure the patient if they show signs of distress or discomfort

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

d stay for the whole examination and be able to see what the doctor is doing, if practical

e be prepared to raise concerns if they are concerned about the doctor’s behaviour or actions.’

11 If either you or the patient does not want the examination to go ahead without a chaperone present, or if either of you is uncomfortable with the choice of chaperone, you may offer to delay the examination to a later date when a suitable chaperone will be available, as long as the delay would not adversely affect the patient’s health.

12 If you don’t want to go ahead without a chaperone present but the patient has said no to having one, you must explain clearly why you want a chaperone present. Ultimately the patient’s clinical needs must take precedence. You may wish to consider referring the patient to a colleague who would be willing to examine them without a chaperone, as long as a delay would not adversely affect the patient’s health.

13 You should record any discussion about chaperones and the outcome in the patient’s medical record. If a chaperone is present, you should record that fact and make a note of their identity. If the patient does not want a chaperone, you should record that the offer was made and declined.’

99. The Tribunal noted in his police interview Dr Nair stated that he did not consider this to be an intimate examination therefore did not offer a chaperone. He said that at no point he did not specifically examine Patient A’s breast, although he conceded that he did touch around the breasts.
100. The Tribunal found that in examining Patient A’s chest it was necessary for Dr Nair to touch the breasts to an extent. Also, Dr Nair knew that he was going to examine her groin.

101. The Tribunal concluded that the examination of the chest and groin area falls within the description of an intimate examination in that the guidance states:

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

102. The Tribunal noted that the experts say that in view of what took place Dr Nair should have had a chaperone.

103. The Tribunal considered that as indicated in the Guidance above, the offer of a chaperone is to be regarded from the patient’s point of view. The Tribunal considered that there were several triggers at which a reasonable body of doctors may have considered offering a chaperone. On this occasion, in particular the way in which Dr Nair undertook his examination of Patient A’s chest, causing her breasts to be fully exposed, the Tribunal considered that Dr Nair had a duty to offer a chaperone.

104. The Tribunal considered that Dr Nair did not take into account, that although he was undertaking a chest examination, he would have come in close proximity to Patient A’s breast and that he would be undertaking an examination of her groin. Dr Nair failed to treat Patient A as an individual nor did he respect her privacy.

105. The Tribunal having heard from Patient A the Tribunal was able to gauge the discomfort and embarrassment she experienced the Tribunal was satisfied that Dr Nair should have foreseen this and therefore the need for a chaperone.

106. Therefore, taking the evidence as a whole, the Tribunal was satisfied that Dr Nair had a duty to offer a chaperone but failed to do so. Accordingly, the Tribunal found paragraph 1g(i) proved.

**Paragraph 1g(ii)**

107. The Tribunal noted that the experts agreed that not offering appropriate covering material for Patient A’s buttocks or thighs during Dr Nair’s examination of her legs for deep vein thrombosis was a failing.

108. The Tribunal noted paragraph 25 of Patient A’s witness statement:

‘25. Dr Nair measured the back of my upper legs; my jeans were still down at my shin level. Dr Nair then said that he had finished and that I could get dressed.’
109. The Tribunal noted that Dr Nair did not dispute that he failed to offer covering material to Patient A. Both experts felt this was a failing. Dr M thought the failing was ‘seriously below’ and Professor N ‘below’ the standard.

110. Dr Nair gave an explanation that he simply had not noticed the nature of her underwear and accepted that he should have offered some cover. The Tribunal noted that Patient A was lying on her front with her buttock exposed. Taking the evidence as a whole, the Tribunal found paragraph 1g(ii) proved.

Paragraph 1g(iii)

111. The Tribunal noted that Dr Nair asked Patient A if he could examine her back and chest. He told her that he needed to take her femoral pulse in her groin area and that he needed to measure her legs. He said that he had explained the X-ray to her but she was not really listening.

112. Both experts stated that, if proven, Dr Nair’s performance would have been seriously below the standard expected.

113. The Tribunal found that it was unclear what the ‘detail of the examination’ referred to and therefore what the doctor had failed to ‘adequately communicate.’ The Tribunal was of the opinion that Dr Nair’s failure in communication related to the removal of the clothing rather than the examinations themselves.

114. The Tribunal was satisfied that Dr Nair gave a broad outline of the examination(s) he was about to undertake. There was clearly some communication between Dr Nair and Patient A.

115. The Tribunal was not satisfied, on the balance of probabilities, that the GMC has proven that Dr Nair failed to adequately communicate with Patient A the detail of the examination/s he intended to perform. Accordingly, the Tribunal found 1g(iii), not proved.

Paragraph 4 in relation to paragraph 1f(i)

116. The Tribunal noted that paragraph 4 alleges that Dr Nair’s actions were not clinically indicated in relation to paragraph 1f.

117. The Tribunal understood the ‘actions’ referred to in paragraph 4 as not being clinically indicated meant carrying out an assessment of the thigh circumference.

118. The Tribunal noted that Dr Nair admitted that he carried out an assessment of Patient A’s thigh circumference. The Tribunal noted that Patient A was lying on her front when he undertook this assessment.
119. Dr M stated that he would expect there to be a measurement up from the knee and a circumference of the thigh and the same in the other direction when measuring the calves. He conceded that if the doctor were being extra careful he would measure the circumference of the leg from the front and visually inspect the front and the back. He accepted that the issue raised some very fine margins and he would not criticise a doctor for looking at the entire leg. Professor N expressed the following robust view:

‘I think if you focus on deep venous thrombosis below the knee to the exclusion of any other problem then one is almost going to be negligent. When one is approaching such a patient, one needs to look at the whole lower limb rather than just below the knee.’

Q Just pause there for a second. (Pause) Carry on, Professor N, please.

A If you do not do a comprehensive examination, all those upper extremity conditions will be missed and of course they may be there in addition to a blood clot below the knee.’

120. The Tribunal accepted that Patient A could not recollect having her calf examined however, the Tribunal noted the medical records which stated this examination had occurred.

121. The Tribunal noted Dr M found it ‘inexplicable’ why Dr Nair asked Patient A to lie on her front in order to measure her thigh circumference. Professor N stated that he had no explanation as to why Dr Nair repeated the measurements with Patient A ‘turned over’.

122. The Tribunal noted that Dr M had no criticism of the clinical basis upon which Patient A was examined, with the exception of how the thighs were examined for Deep Vein Thrombosis (DVT). Whilst he believed that an examination of the thighs was unnecessary as there should be enough information on the calves, he accepted that some doctors do check the thigh circumference.

123. Had Dr Nair failed to undertake an assessment of the calf then an examination of the thigh on its own would have been necessary. The experts agreed that some doctors would also assess the thigh. Furthermore, the experts were not critical of a doctor with a lack of experience, such as Dr Nair doing so.

124. The Tribunal noted that the experts agreed that an assessment of patient A’s thigh was appropriate. However, they both described a method of assessment which did not require the patient to lie on her front and could not see Dr Nair’s rationale for doing so.

125. The Tribunal noted that Dr Nair stated the reason he asked Patient A to lie on her stomach was purely for observational purposes. It noted in his Police interview Dr Nair gave a detailed explanation of measuring Patient A’s legs. In oral evidence he stated:
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‘Q Once you say, in your usual practice, you would do the calf measurement, would that be first?
A Yes I would measure the calves first and measure the thighs too.

Q If the calf measurement is normal why is it necessary to go on and do the thigh measurement?
A I tend to do both because from my understanding it was necessary to do both. At the time it was to compare the difference.

Q But if you have measured the calves and they are normal, there is no redness of the calves, there is no swelling of the calves, there are no dilated veins in the lower leg, there would be no reason would there to go on and examine the patient’s thighs?
A It was my understanding that it was both that needed to be measured.

Q So it is a possibility that you have asked this patient to lie on her stomach.
A Mm.

Q Your reason for doing that is to make sure there is no redness to the thighs.
A Yes to visualise the... To have a look at the entire leg, swelling, redness, there is no abnormality. Sometimes you get phlebitis which is a vein that has thrombosed and can give you redness. It can extend to become DVT.

Q Does that just show itself at the back of the thigh?
A Yes it can do as a sort of dilated vein, so it can be inflamed.’

126. The Tribunal noted Dr M’s oral evidence:

‘Q I phrase the question deliberately in a different way, which is: do you accept that as Professor N maintains they are significant factors for the tribunal to consider?
A Yes, I think if somebody does something in an automatic manner on the three patients before them it is of relevance, yes.

A She described in that telephone call the following day a physical examination that is very similar to Patient A, almost that it is identical, yes, and therefore I suspect this is Dr Nair’s routine, okay, this appears to be Dr Nair’s routine, I accept that point.’

127. Whilst the Tribunal noted that the experts agreed it would not be their own practice for Patient A to have been lying on her front, the Tribunal also noted that Dr M accepted that:
"I suspect this is Dr Nair’s routine, okay, this appears to be Dr Nair’s routine, I accept that point”.

128. From the expert evidence and having heard Dr Nair give evidence, the Tribunal concluded that it was not satisfied that it had not been clinically indicated for Dr Nair to assess Patient A’s thigh, and also that the GMC’s expert accepted that the doctor was following through what he regarded as a normal practice, in assessing the back of the thigh. Accordingly, the Tribunal found paragraph 4 in relation to paragraph 1f(i), not proved.

**Paragraph 4 in relation to paragraph 1f(ii)**

129. The Tribunal accepted Dr Nair’s explanation that he had previously made an incorrect diagnosis in a patient with an aortic dissection. Following this experience, Dr Nair had adopted a practise of performing an assessment of the femoral pulses to exclude a diagnosis of aortic dissection. This could be considered clinically indicated in a patient presenting with chest pains.

130. The Tribunal noted paragraph 4.26 of Dr M’s report which states:

‘It is very thorough of Dr Nair to consider aortic dissection in a patient suffering from chest pain, and it is appropriate if such a concern is raised in the mind of a clinician that femoral pulses are palpated…’

131. Since both experts felt that such a cautious approach was understandable, the Tribunal could not be satisfied that it was not clinically indicated to carry out an examination of Patient A’s femoral pulses. Accordingly, the Tribunal found paragraph 4 in relation to paragraph 1f(ii), not proved.

**Paragraph 4 in relation to paragraph 1f(iii)**

132. As the Tribunal found paragraph 1f(iii) not proved paragraph 4 falls in relation to this paragraph.

**Paragraph 5 – Sexually-motivated conduct**

**General approach of Tribunal**

133. Mr McCartney submitted that before it was safe for the Tribunal to reach a conclusion on sexual motivation it should rule out any other alternative explanation for Dr Nair’s behaviour. He submitted that, in relation to Patients A and B, there was insufficient evidence from which a sexual motivation as a state of mind could be proved. In respect of Patient C, he submitted that factually her account should not be preferred to Dr Nair’s account. If the doctor’s account was or might be true, no sexual motivation could be inferred.
134. The GMC submitted that Dr Nair’s actions had been sexually motivated. Ms Hudson submitted that alternative explanations for his behaviour could be safely discounted. She submitted that the doctor’s actions towards Patient A were ‘inconceivable’ for a legitimate motive; his examination of Patient B had been unnecessary, in light of the information already in his possession from other tests; she invited the Tribunal to find Patient C’s account to be correct and pointed to the conduct alleged as indicating a sexual motivation. She submitted that the allegations made by each patient did have distinguishing features. However there were common themes: the gender of Patients A, B and C, the similarity of their ages, the proximity of their ages to Dr Nair, the exposure of the breasts, the potentially unnecessarily elaborate examinations and the turning onto their stomachs or away from Dr Nair. These were not isolated incidents; the common themes were telling. Ms Hudson submitted that the Tribunal should consider each patient separately however, and only if having found sexual motivation proved in respect of one patient, to go on to consider this in relation to another patient.

135. The Tribunal had been referred to Soni v GMC [2015] EWHC 364. In that case, the Court had held that it was not open to a Tribunal to draw an inference as to the doctor’s dishonesty. The Court said it had not been possible, on the evidence provided, for the Tribunal to have discounted other practical explanations for what had occurred on the facts, in the alternative to inferring how the doctor had acted and hence that he had been dishonest.

136. The Tribunal reminded itself of the judgment of the High Court in Basson v GMC [2018] EWHC 505:

"A sexual motive means that the conduct was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship." (paragraph 14)

"In civil proceedings that fact, the state of the man’s mind, is to be proved in the usual way by the necessary body of evidence on the balance of probabilities.....However, the state of a person’s mind is not something that can be proved by direct observation. It can only be proved by inference or deduction from the surrounding evidence” (paragraph 17)

137. The Tribunal was satisfied that this was not a case of the doctor pursuing a future sexual relationship. Therefore, the allegation had to be that the doctor was pursuing sexual gratification by his actions.

138. The Tribunal bore in mind that the burden of proving sexual motivation lay with the GMC, but that determining that state of the doctor’s mind in acting as he had was a matter of inference, rather than direct evidence. In its view, an inference amounted to a reasonable conclusion, drawn from the surrounding facts found by way of evidence. The Tribunal also had regard to the matter of the doctor’s previous good character and the testimonials and evidence provided about his character.
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139. Accordingly, the Tribunal approached the issue of sexual motivation on the basis that it should only draw such an inference if it was satisfied that this was a correct inference, on the balance of probabilities, having considered the evidence. In considering the evidence, it was necessary to consider alternative explanations for the doctor’s actions and whether these could be discounted. In particular it may be relevant whether the doctor’s actions had been in the course of an examination that had been clinically indicated. If clinically indicated, the manner in which the doctor conducted the examination would be relevant.

140. Mr McCartney identified a number of potential explanations for Dr Nair’s behaviour which included an automaton approach, a poorly or clumsily conducted examination, poor communication, overly methodical, following a routine pattern, diagnosis by exclusion, as the alternative to sexual motivation.

141. The Tribunal also bore in mind the agreement of the parties on the question of ‘cross-admissibility’ of the issue of sexual motivation. As had been agreed by the parties, the Tribunal considered that, to a limited extent, it could consider its finding on the issue of sexual motivation, as in the case of each patient, either in favour of the doctor, or against him (referred to as ‘cross admissibility’) when considering Dr Nair’s motive in relation to another patient in the allegation.

Paragraph 5 in relation to paragraph 1a

142. The Tribunal found that Dr Nair unclipped Patient A’s bra. The Tribunal noted that Dr Nair asked permission to examine Patient A’s chest. Drawing on the available evidence before it, the tribunal found it more likely that the correct inference to be drawn from Dr Nair’s behaviour towards patient A was one of indifference or lack of respect for the patient’s dignity rather than of sexual motivation.

143. In the absence of any particularly cogent evidence the Tribunal did not find any remarkable features in the sex or age of the patients. Since the examination, which had not been found to be ‘not clinically indicated’, necessitated removal of Patient A’s clothing, the Tribunal considered with care whether there were features of the examination which in particular suggested sexual gratification and not just an insensitive and clumsy approach. Dr Nair’s approach towards removal of items of clothing was not consistent, and, for example, he immediately ceased attempting to lower Patient A’s trousers when she asked if he wanted her to do it. It noted that his lack of adequate interaction with patient A was consistent with his approach to other patients. The Tribunal saw no sufficient evidence of tangible sexual gratification, and as stated, the examination had required that Patient A’s clothing be removed to an extent.

144. On each occasion the Tribunal found Dr Nair removed clothing without seeking permission and gave reasons for removal after the fact, rather than before. Furthermore, he failed to understand that consent for an examination did not give implied consent for removal of clothing. This required separate explicit consent and the offer of a chaperone.
145. The Tribunal found an absence of sufficient evidence which might lead to a positive inference of sexual motivation. There was also evidence from Patient A that the doctor had not particularly engaged her in conversation and explanation. The Tribunal was of the opinion that in unclipping Patient A’s bra, Dr Nair’s conduct was consistent with a motive of and demonstrated poor communication and an insensitive approach. The Tribunal did not find that this was evidence on which a reasonable inference of sexual motivation could be drawn.

146. Accordingly, the Tribunal found Paragraph 5 in relation to paragraph 1a, not proved.

Paragraph 5 in relation to paragraph 1b(i)

147. The Tribunal found that Dr Nair lifted Patient A’s top. The Tribunal noted that Dr Nair asked permission to examine Patient A’s chest. The Tribunal was of the opinion that in lifting Patient A’s top Dr Nair demonstrated poor communication and an insensitive approach. Noting that this step had been clinically necessary, and upon a similar consideration of the circumstances as above in relation to 1a, the Tribunal did not find that there was sufficient positive evidence that the doctor was obtaining sexual gratification from this step which was necessary for the examination. The explanation of poor communication and an insensitive approach could not be ruled out as unlikely. The Tribunal was not satisfied that in doing so Dr Nair’s actions were sexually motivated, as it could not draw a reasonable inference as to sexual motivation. Accordingly, the Tribunal found Paragraph 5 in relation to paragraph 1b(i), not proved.

Paragraph 5 in relation to paragraph 1b(ii)

148. The Tribunal found that Dr Nair lifted Patient A’s bra. The Tribunal noted that it is recognised by the experts that it was not a failing to fully expose the chest if carrying out a through cardiovascular examination. The Tribunal accepted Dr Nair’s explanation that when carrying out examinations he does so automatically, without much thought to his actions or the patient. Noting that the exposure of Patient A’s chest had been clinically necessary, and upon a similar consideration of the circumstances as above in relation to 1a, the Tribunal did not find that there was sufficient positive evidence that the doctor was obtaining sexual gratification from this step which was necessary for the examination. The explanation of poor communication and an insensitive approach could not be ruled out as unlikely. As above, the Tribunal was not satisfied that in doing so Dr Nair’s actions were sexually motivated as it could not draw a reasonable inference as to sexual motivation. Accordingly, the Tribunal found Paragraph 5 in relation to paragraph 1b(ii), not proved.

Paragraph 5 in relation to paragraphs 1c and 1d

149. The Tribunal was of the opinion that lowering Patient A’ jeans and underwear to her pubic bone and pulling her jeans down further Dr Nair actions demonstrated poor communication and an insensitive approach, with little or no thought for Patient A’s
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dignity. Noting that lowering the patient’s jeans and underwear to a degree had been clinically necessary, there was no sufficient evidence positively inferring sexual motivation and the explanation of poor communication and an insensitive approach could not be ruled out as unlikely. For the same reasons and upon a similar consideration of the circumstances as given in relation to paragraph 1(a) above, the Tribunal was not satisfied that Dr Nair’s actions were sexually motivated as it could not draw a reasonable inference as to sexual motivation. Accordingly, the Tribunal found Paragraph 5 in relation to paragraphs 1c and 1d, not proved.

Paragraph 5 in relation to paragraphs 1e(i) and 1e(ii)

150. The Tribunal determined that in failing to afford Patient A the opportunity to move her own clothing and in failing to obtain consent to move Patient A’s clothing for her, Dr Nair’s apparent motivation was equally consistent poor communication and an insensitive approach, with Dr Nair displaying little or no thought for Patient A’s dignity. Noting that moving Patient A’s clothing had been clinically necessary, the Tribunal, as above, did not find that there was sufficient evidence that the doctor was obtaining sexual gratification from this step which was necessary for the examination. The explanation of poor communication and an insensitive approach could not be ruled out as unlikely. For the same reasons and upon a similar consideration of the circumstances as given in relation to paragraph 1(a) above, the Tribunal was not satisfied that Dr Nair’s actions were sexually motivated as it could not draw a reasonable inference as to sexual motivation. Accordingly, the Tribunal found Paragraph 5 in relation to paragraphs 1e(i) and 1e(ii) not proved.

Paragraph 5 in relation to paragraphs 1f(i) and 1f(ii)

151. The Tribunal found that Dr Nair carried out an assessment of Patient A’s thigh circumferences and her femoral pulse, that these were appropriate examinations, and that Dr M had accepted that Dr Nair was following his usual practice in examining Patient A’s thigh. It accepted the evidence that Dr Nair was operating according to what was termed ‘diagnosis by exclusion’.

152. Again, upon a similar consideration of the circumstances in relation to paragraph 1a the Tribunal noted an insufficiency of evidence which might lead to a positive inference of sexual motivation. There was also evidence from Patient A that the doctor had not particularly engaged her in conversation and explanation. The Tribunal was of the view that in carrying out an assessment of Patient A’s femoral pulse Dr Nair’s conduct was potentially consistent with poor communication and an insensitive approach. The Tribunal concluded that, in carrying out an assessment of Patient A’s thigh circumference, with her lying on her front, was consistent with poor technique and a disregard for patient dignity. However, the Tribunal considered that on the evidence provided that it could not draw a reasonable inference as to sexual motivation.

153. Accordingly, the Tribunal found Paragraph 5 in relation to 1f(i) and 1f(ii) not proved.
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**Paragraph 5 in relation to paragraph 1f(iii)**

154. The Tribunal found that Dr Nair did not carry out a breast examination of Patient A. Accordingly, paragraph 5 in relation to paragraph 1f(ii) falls and is therefore found not proved.

**Paragraph 5 in relation to paragraph 1g(i)**

155. The Tribunal found that Dr Nair failed to offer a chaperone to Patient A. The Tribunal was noted Dr Nair’s explanation that he did not consider the examination of Patient A to be an intimate examination. Whilst the Tribunal did not find this to be a correct view, it accepted that Dr Nair had genuinely held that view. The Tribunal had accepted that the examination had been clinically indicated. The Tribunal found that there was an alternative explanation to sexual motivation, namely that Dr Nair undertook the examination of Patient A with poor communication and without consideration for the maintenance of Patient A’s dignity. It was clearly a poorly conducted examination. Upon a similar consideration of the circumstances as in relation to paragraph 1a the Tribunal noted that there was not sufficient evidence positively inferring sexual motivation. The explanation of poor communication and an insensitive approach could not be ruled out as unlikely. In addition, the Tribunal was not satisfied that in doing so Dr Nair’s actions were sexually motivated as it could not draw a reasonable inference as to sexual motivation. Accordingly, the Tribunal found Paragraph 5 in relation to 1g(i) not proved.

**Paragraph 5 in relation to paragraph 1g(ii)**

156. The Tribunal found that Dr Nair failed to offer appropriate covering material to Patient A. The Tribunal found that there was an alternative explanation to sexual motivation, namely that Dr Nair undertook the examination of Patient A with poor communication and without consideration of the maintenance of Patient A’s dignity. The Tribunal concluded that the explanation of poor communication could not be ruled out as unlikely. It also displayed a particular lack of empathy for Patient A and a lack of respect for her dignity. Upon a similar consideration of the circumstances in relation to paragraph 1a, the Tribunal was not satisfied that in doing so Dr Nair’s actions were sexually motivated as it could not draw a reasonable inference as to sexual motivation. Accordingly, the Tribunal found Paragraph 5 in relation to paragraph 1g(ii) not proved.

**Paragraph 5 in relation to paragraph 1g(iii)**

157. The Tribunal found that Dr Nair did not fail to adequately communicate with Patient A the detail/s of the examination he intended to perform. Accordingly, paragraph 5 in relation to paragraph 1g(iii) falls and is therefore found not proved.

158. Therefore, the Tribunal found paragraph 5 in relation to paragraph 1 not proved.
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159. As had been agreed by the parties, in their submissions, the Tribunal considered that, to this limited extent, it could consider its findings on the issue of sexual motivation, as in the case of each other patient, either in favour of the doctor, or against him (referred to as ‘cross admissibility’). The Tribunal therefore took this into account in its further deliberations.

Paragraphs of the Allegation relating to Patient B

160. Patient B was a 25 year old female who was employed in a non-clinical capacity at Wexham Park hospital. She had been experiencing pain and swelling in her legs which had been investigated by her GP. As part of the investigations a D Dimer blood test was undertaken. The D Dimer blood test was elevated and therefore Patient B was contacted by her GP and asked to attend at A&E to exclude Deep Vein Thrombosis. She attended the A&E department around 8.30am on 25 May 2015, was seen by a nurse and was then referred to the ACU. She had an ultrasound and was then seen by Dr Nair. Patient B raised her concerns around four weeks after the events.

161. The Tribunal found Patient B to be a credible witness who was unwavering in her evidence relating to the exposure of her breasts during the examination. However, in relation to examination of her legs Patient B was less clear in her recollection of events and she agreed that contemporaneous notes were likely to be correct.

162. Dr Nair gave evidence in relation to Patient B but conceded that he could not remember the detail of the consultation and examination. He gave evidence of what was his usual practice in the circumstances. He denied any sexual motivation to his actions. The Tribunal’s assessment of Dr Nair’s credibility is set out above.

163. The Tribunal noted that Dr Nair undertook a cardiovascular and respiratory examination as well an examination of the patient’s legs for DVT. Dr Nair had no specific recollection of this particular examination and precisely how it was conducted. Further, Dr Nair accepted that Patient B may not have understood the detail of the examination and that his communication could have been better.
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Paragraph 2a(ii) and 2b

164. The Tribunal has noted the email from Patient B to Ms I dated 22 June 2015, which states:

'I want to raise a concern I had about my visit to the Ambulatory Care Unit on Friday 29 May...he wanted to listen to my chest and got me to lift up my top. He then lifted my bra up, but at no point explained that he was going to do that...When he listened to my back he undid my bra, again without telling me what he was going to do.’

165. The Tribunal noted that the email dated 22 June 2015 also contains handwritten notes made by Ms I:

'- Lifted top up
  - Lifted up bra- exposed breasts- didn’t ask – didn’t touch them.
  - Undid bra without asking...

166. The Tribunal has noted Patient B’s witness statement:

‘17. Without saying anything Dr Nair lifted up my top and bra and listened to my chest through his stethoscope for about 30 seconds, during which time both my breasts were fully exposed. Dr Nair did not touch my breasts or examine them in any way.

18. Dr Nair did not ask me to remove any clothing and did not offer a chaperone. Dr Nair did not wear gloves at any time during the examination.

19. After having listened to my chest, Dr Nair asked me to turn around. Because of how I was perched on the bed, I twisted my torso so that Dr Nair could access my back. Dr Nair did not request that I pull my bra or top back down; I just did this straight away.’

167. The Tribunal noted Patient B’s Police statement dated 8 May 2016:

‘Dr Nair did not inform me of what examinations he was due to embark upon and without a word he lifted my top and bra off of my chest where he then applied the stethoscope to listen. He did not undo my bra and lifted it up leaving my breasts exposed. He did not touch my breasts or examine them in any way.’

168. The Tribunal noted that under cross examination Patient B maintained her position that that Dr Nair had unfastened her bra.

169. The Tribunal noted Dr Nair’s oral evidence:

‘Q This patient also has given evidence to the Tribunal that when you listened to her chest you undid her bra.'
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A Mm.

Q Do you remember that?
A No.

Q If you did do that, as she says, she hadn’t asked you to do it had she?
A She didn’t ask me, no.

Q You ought to have given her the opportunity to do that herself if she is right?
A Yes.

Q If you did it you ought to have asked her first before you went in and unclipped her bra?
A Yes.’

170. The Tribunal noted that Dr Nair does not recall the examination on Patient B. In his witness statement he stated ‘I accept that I may have helped Patient B to remove her top and bra in order to enable me to carry out the examination.’

171. The Tribunal accepted Patient B’s evidence. It noted that Dr Nair in his witness statement stated that it was possible but he could not remember Patient B. The Tribunal is satisfied, on the balance of probabilities that, Dr Nair lifted up Patient B’s bra and unfastened Patient B’s bra. Accordingly, the Tribunal found paragraphs 2a(ii) and 2b proved.

Paragraph 2e(i) in relation to paragraphs 2a(ii) and 2b

172. The Tribunal noted paragraph 5f of the GMC’s guidance ‘Intimate examinations and chaperones’:

‘5. Before conducting an intimate examination, you should:
...

f. give the patient privacy to undress and dress, and keep them covered as much as possible to maintain their dignity; do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help.’

173. The Tribunal noted Dr M’s oral evidence:

‘If a woman’s underwear is to be touched then it requires separate consent.’

174. The Tribunal noted that Dr Nair has no recollection of the consultation and relied upon his usual practise. He conceded in cross examination that he ought to have asked Patient B to move her own clothing and acknowledged that he had a duty to afford her this opportunity.
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175.  The Tribunal accepted Patient B’s evidence as given in her statement. The Tribunal was satisfied, on the balance of probabilities that, Dr Nair failed to afford Patient B the opportunity to move her own clothing. Accordingly, the Tribunal found paragraph 2(e)(i) in relation to 2a(ii) and 2b proved.

Paragraph 2e(ii)

176.  The Tribunal noted paragraph 5f of the GMC’s guidance *Intimate examinations and chaperones*:

‘5. Before conducting an intimate examination, you should:

*f give the patient privacy to undress and dress, and keep them covered as much as possible to maintain their dignity; do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help.*’

177.  The Tribunal has noted Patient B’s witness statement:

‘19. After having listened to my chest, Dr Nair asked me to turn around. Because of how I was perched on the bed, I twisted my torso so that Dr Nair could access my back. Dr Nair did not request that I pull my bra or top back down; I just did this straight away.’

178.  The Tribunal noted that Dr Nair had no clear recollection of Patient B and gave evidence as to what his usual practice would be.

179.  The Tribunal accepted Patient B’s evidence which was consistent in all of her statements. It is clear from Patient B’s evidence that Dr Nair did not tell her that he would be moving her clothing in order to carry out the examination.

180.  The Tribunal was of the opinion that Dr Nair should have obtained express consent when he moved Patient B’s clothing. The Tribunal took account of evidence of Patient B that Dr Nair did not obtain express consent before moving her clothing.

181.  The Tribunal was satisfied, on the balance of probabilities, that Dr Nair did not expressly ask Patient B for her permission to remove any of her clothing and it determined that he did not implicitly have permission to move any of her clothing. The Tribunal was satisfied that Dr Nair failed to obtain Patient B’s consent to move her clothing. Accordingly, the Tribunal found paragraph 2e(ii) in relation to 2a(ii) and 2b proved.

Paragraph 2e (iv)

182.  The Tribunal has noted paragraph 19 of Patient B’s witness statement:
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‘19. After having listened to my chest, Dr Nair asked me to turn around. Because of how I was perched on the bed, I twisted my torso so that Dr Nair could access my back. Dr Nair did not request that I pull my bra or top back down; I just did this straight away.’

183. The Tribunal noted however, Patient B’s oral evidence under cross examination:

‘Q He then went around to the back and you pulled your top down?
A Yes.

Q Essentially you covered yourself as soon as you could?
A Yes.

Q As soon as he moved away from your chest, presumably you just did that instinctively immediately?
A Yes.’

184. The Tribunal determined that Dr Nair was under a duty to protect Patient B’s dignity once the examination had finished. However, on the facts, Patient B agreed that of her own volition she had covered herself as soon as she had been able to.

185. The Tribunal was not satisfied, on the balance of probabilities that, Dr Nair failed to indicate to Patient B that she could cover her breasts when he had completed the respiratory examination. Accordingly, the Tribunal found paragraph 2e(iv) not proved.

Paragraph 2e(vi)

186. The Tribunal noted Patient B’s witness statement in which she stated

‘He did not say anything about the examination he was going to conduct and why.’

However, having accepted that the notes of her conversation with Ms I were more likely to be correct, Patient B conceded that she:

"Q – you accepted that some explanation must have been given, bearing in mind what you said to her; is that fair?
A Yes, that is fair’

187. Further, in cross examination, Patient B accepted the following:

[In response to the note ‘He got me to lift up my top’] –

‘Q ”Which is it; did he lift your top up or did you do it?
A I cannot remember, to be honest. I would have thought that the account I gave to Ms I would be most accurate as it was nearer the time.’
188. The Tribunal noted under cross examination Dr M stated:

'Q Would you be critical if Dr Nair, having told the patient that he was going to do the examination to feel for the pulse in the groin, did not thereafter explain the medical reason for feeling the pulse in the groin?

A No.'

189. The Tribunal noted that it was Dr Nair’s evidence that he explained that he wanted to examine Patient B’s chest and that he explained what he was doing whilst checking her femoral pulse. Further, the Tribunal noted that Patient B had no complaint at all about the examination of her legs.

190. The Tribunal was not clear from the paragraph in the allegation what ‘the detail of the examination/s’ meant, in other words, did it mean what he was going to do or why he was going to do it. The Tribunal was of the opinion that Dr Nair’s failure in communication related to the moving of Patient B’s clothing rather than the examination(s) itself.

191. The Tribunal found that there was evidence of some communication to some elements of the examination and Patient B conceded when cross examined that Dr Nair must have offered some explanation. Also it was Dr M’s evidence that he was not critical of the explanation given by Dr Nair.

192. The Tribunal was not satisfied on the balance of probabilities that the GMC has proven that Dr Nair failed to adequately communicate with Patient B the detail of the examination/s he intended to perform. Accordingly, the Tribunal found 2e(vi) not proved.

**Paragraph 4 in relation to paragraph 2d**

193. The Tribunal noted that Dr Nair admitted that he carried out an assessment of Patient A’s thigh circumference.

194. The Tribunal noted paragraph 5.9 and 5.10 of Dr M’s report:

'5.9 It can be argued that there was no reason for Dr Nair to examine the femoral pulses of Patient B given that he had already been presented with the Doppler scan which showed that there was no evidence of Deep Vein Thrombosis.

5.10 However, for similar reasons I mention above there may be clinicians who feel that in a DVT clinic other reasons for swelling of a leg should be sought, and this could include examination of the femoral pulses. Therefore I do not feel that
Dr Nair’s examination of the femoral pulses per se fell below the standard of care required of a doctor practising medicine in the UK.’

195. The Tribunal noted that there had been documentation of leg swelling in Patient B’s GP notes and the hospital admission notes.

196. The Tribunal noted the ultrasound report, the clinical history states:

‘Patient has left leg swollen’.

197. The Tribunal noted Patient B’s medical notes which stated:

‘left calf swelling for 2/7’

198. The Tribunal also noted that under cross examination Patient B stated that she had more pain in her leg rather than swelling.

199. The Tribunal noted the notes made by Ms I on Patient B’s email complaint dated 22 June 2015, which state:

‘asked to turn over – why?’

200. The Tribunal noted that Patient B does not mention being asked to turn over in her witness statement or in her police statement.

201. The Tribunal also noted that Dr M’s previous evidence, in relation to Patient A, where he accepted that

‘I suspect this is Dr Nair’s routine, okay, this appears to be Dr Nair’s routine, I accept that point’.

202. In view of the presentation of Patient B and the expert evidence the Tribunal could not exclude the appropriateness of a closer examination. Therefore, on the balance of probabilities, the Tribunal was not satisfied that the GMC had proved that Dr Nair’s assessment of Patient B’s thigh circumference was not clinically indicated. Accordingly, the Tribunal found paragraph 4 in relation to paragraph 2d not proved.

**Paragraph 5 in relation to paragraph 2**

203. As it had in relation to the allegations concerning Patient A, the Tribunal reminded itself of the judgment of the High Court in Basson v GMC [2018] EWHC 505 and Soni v GMC 2015 EWHC 364 as set out above. The Tribunal therefore It followed the same approach as outlined in relation to paragraph 5 in relation to paragraph 1 above.
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204. The Tribunal also took into account its findings, on the agreed basis of ‘cross admissibility’ regarding the doctor’s motivation concerning other patients in the Allegation.

205. The Tribunal noted that Patient B was wearing a loose crew neck tee shirt, and a pair of navy cropped tapered trousers which were front fastened with a zip and a button.

Paragraph 5 in relation to paragraphs 2a(ii) and 2b

206. The Tribunal concluded there was an alternative explanation to Dr Nair lifting up and unfastening Patient B’s bra, other than sexual motivation, in that, he was demonstrating poor communication and an insensitive approach. There was also evidence from Patient B that the doctor had not particularly engaged her in conversation and explanation. The Tribunal was of the opinion that in lifting up and unfastening Patient B’s bra Dr Nair’s conduct was consistent with his demonstrated poor communication and an insensitive approach. For similar reasons to its assessment in relation to paragraph 1a given above, the Tribunal noted the absence of sufficient evidence which might lead to a positive inference of sexual motivation as it could not draw a reasonable inference as to sexual motivation.

207. Accordingly, the Tribunal found paragraph 5 in relation to paragraphs 2a(ii) and 2b not proved.

Paragraph 5 in relation to paragraph 2d

208. The Tribunal considered whether there was an alternative explanation for Dr Nair’s assessment Patient B’s thigh circumference, other than sexual motivation. Having found that Dr Nair’s assessment of Patient B’s thigh circumference was clinically indicated, the Tribunal determined that Dr Nair’s actions were consistent with his automatic approach to the examination and an example of his poor communication and insensitive approach toward Patient B. For similar reasons to its assessment in relation to paragraph 1a given above, the Tribunal noted the absence of sufficient evidence which might lead to a positive inference of sexual motivation as it could not draw a reasonable inference as to sexual motivation.

209. The Tribunal was not satisfied, on the balance of probabilities that, the GMC has proven that Dr Nair’s actions were sexually motivated. Accordingly, the Tribunal found paragraph 5 in relation to paragraph 2d not proved.

Paragraph 5 in relation to paragraph 2e(i)

210. The Tribunal considered whether there was an alternative explanation for Dr Nair failing to afford Patient B the opportunity to move her own clothing. The Tribunal determined that Dr Nair undertook the examination of Patient B automatically but clearly without due consideration to the maintenance of Patient B’s dignity. It was a poorly conducted examination.
211. The Tribunal determined that Dr Nair’s actions was an example of his automatic approach to the examination, his poor communication and insensitive approach toward Patient B. For the same reasons as given above, in relation to the other parts of paragraph 2, the Tribunal was not satisfied, on the balance of probabilities, that the GMC has proven that Dr Nair’s actions were sexually motivated as it could not draw a reasonable inference as to sexual motivation. Accordingly, the Tribunal found paragraph 5 in relation to paragraph 2e(i) not proved.

**Paragraph 5 in relation to paragraphs 2e(iv) and 2e(vi)**

212. As the Tribunal found paragraph 2e(iv) not proved paragraph 5 falls in relation to paragraphs 2e(iv) and 2e(vi).

213. The Tribunal was not satisfied, on the balance of probabilities that, that the GMC had proved that Dr Nair’s actions were sexually motivated in relation to his actions at paragraph 2.

214. Therefore paragraph 5 as it applied to paragraph 2 was found not proved.

**Paragraphs of the Allegation relating to Patient C**

215. Patient C was an 18 year old female who attended the A&E department of Gloucester Royal Infirmary on the evening of 9 March 2016, following a deliberate drug overdose. Patient C had a history of anxiety and depression. It was deemed appropriate to admit her to the ACU due to ECG abnormalities in the early hours of 10 March 2016. Dr Nair was the SHO covering the ACU. According to the medical notes Dr Nair clerked Patient C at 2.07am. At 2.30am Patient C was seen by a nurse who noted repeat ECG done on arrival. A second observation 03.10 am records Patient C ‘shaking her right leg’.

216. Dr Nair’s medical note is timed at 7.00am but it was agreed that the examination took place earlier.

217. The Tribunal noted that Patient C made a complaint between 6.15 am and 7.00am. Patient C raised a concern with Health Care Assistant, Ms G about Dr Nair. Ms G escalated the complaint to Ms F who at the time was the Ward Sister. Ms G informed Ms E a second sister working that evening. Sisters F and E discussed the case with Patient C and following escalation to the Clinical Site Manager, Sister F contacted the Police.

218. On 10 March 2016 Patient C provided a statement to the police. On 24 June 2016 Patient C provided a statement to the GMC. The Tribunal found that Patient C in giving oral evidence appeared to want to assist the Tribunal.

219. According to the medical records Patient C was seen and examined by two further doctors at the hospital; Dr L, the Ward Consultant and a neurologist. She was
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also seen by the mental health liaison nurse prior to discharge. Significantly, Patient C
did not have any recollection of these examinations, which were clearly recorded in her hospital notes.

220. The Tribunal also noted that in her GMC witness statement Patient C appeared to recall that the first time she had seen Dr Nair on 10 March 2016 had been when he had performed the examination of which she later complained. However, this was demonstrably incorrect, which she later accepted.

221. A question was raised as to whether Patient C had had a copy of her police witness statement 10 March 2016 with her during the interview when she gave her GMC witness statement. Initially Patient C stated that she had been provided with the police statement by the GMC but it was established that she could not have received it from the GMC. Patient C then told the Tribunal that she may have received it electronically but could not confirm from whom she had received it.

222. The Tribunal found that Patient C was not necessarily consistent in some of her recollections, an example being that, she could not recollect having been seen by two other healthcare professionals. At times, Patient C appeared to be unconcerned when discrepancies in her evidence were highlighted. At other times, she accepted, of her own volition, when there were mistakes in her statements. Patient C admitted that her recollection of the chronology of events was not good.

223. The Tribunal was not satisfied with Patient C’s explanation regarding the lack of detail about the examination in her police statement. Patient C told the Tribunal that she only gave the salient facts during the police interview and intimated that the police interviewer may not have written down all of the details. The Tribunal was also mindful that Patient C was given information of what other witnesses had said and was cautious that her evidence to the police may have been influenced by this.

224. The Tribunal noted that Patient C had undergone a traumatic family situation which resulted in a deliberate overdose, was examined by a number of healthcare professionals and would have been sleep deprived having likely to have been awake for over 24 hours at the time of the events. The Tribunal noted that at admission and prior to discharge Patient C was not showing any adverse signs during her mental health assessments.

225. The Tribunal considered that Patient C did not appear to be vexatious or exhibit any signs of malice towards Dr Nair. The Tribunal was also mindful of the passage of time since these events. However, the Tribunal noted that these factors reduced the reliability of some of Patient C’s evidence but did not go so far as to render it all unreliable.

226. The Tribunal took account of the cumulative picture described about Patient C. The Tribunal noted the differing accounts given by Patient C. It noted that Patient C’s evidence, in relation to the most serious accusation, is inconsistent with other witnesses. The Tribunal looked at Patient C’s evidence cumulatively against the
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background, that she had been admitted following an overdose as a result of a family argument.

227. The Tribunal received a copy of a telephone note of a conversation between Patient C and the GMC dated 10 October 2018, which states:

"Notes –
Patient C wished to make some clarifications in respect of her GMC statement, dated 24 June 2017, and police statement dated 10 March 2016. Patient C stated that in her police statement she states that she rang the Help button because she wanted to tell someone, but that no-one came for a little while. Patient C stated that she remembers that when she went out to find someone. She said that she remembered walking up to the nurse.

Patient C stated that her police statement was fresh and probably accurate about that, but she remembers going up to nurse. Patient C stated that in her police statement she did not really say anything about Dr N feeling her arms – she just talked about what she had felt was inappropriate, but when she gave her GMC statement she talked about it all.

Patient C stated that she remembered saying when giving her statement that she could not be sure of the order of events. She stated that she remembered the key parts. She stated that she cannot remember whether she was on front on back at the point, but remembers the key points.

Patient C stated that straight after the incident she wanted reassurance everything was okay, but now on reflection knows what happened was wrong. Patient C stated that she did not want to seem like a drama queen at the time.

Patient C stated that in her police statement she stated that Dr N had forced open her legs, but that she had not included that in her GMC statement. Patient C stated that she said in her GMC statement that Dr N had touched her around her leg/groin area and that was how she remembered it."

228. In her oral evidence Patient C stated:

'Q Do you still maintain then that, apart from that and in addition to that, he massaged your neck and asked you if you liked it?
A Around the back of my neck. That is not my back; that is the back of my neck.

Q Neck or back. Do you still say that he massaged your neck and asked you if you liked it?
A Yes.

Q Can you just take your time and go to the GMC statement and tell me where you refer to that in the GMC statement?
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A Having reads it over yesterday I don’t think I did in that part.

Q Why is that?
A Obviously I did not remember it and it does say something like “What does that feel like?” Paragraph 15 it says - bear with me just two seconds.

Q Let us go to paragraph 16.

“After this, Dr Nair moved over to my left arm. I cannot recall exactly how he reached my left arm. I think he reached over me. He did the same thing with my left arm, but applied more pressure. I thought he was doing this purposely as that is where I felt more of the numbing sensation. Every now and then he would say something like ‘what does that feel like?’ and ‘does it feel numb there?’”

A Yes.

Q You are not complaining about that, are you?
A Well, when I say “What does that feel like?” it is the same as saying whatever - what did I write on the statement?

Q “He asked me if I liked it”.
A Yes, so, that is the maintaining.

Q Your evidence is those are the same?
A Yes, it is just a different way of wording.

Q Let us look at that. “What does this feel like?” Would you agree that that is a perfectly proper question for somebody who is trying to test whether you are numb or whether or not you have lost any sensory feeling?
A Yes and perhaps it should have been worded differently, but, this was said when he was massaging my breasts and my neck.

Q This was said when he was massaging your breasts and your neck?
A Yes.”

229. Dr Nair gave evidence in relation to Patient C and explained the sensory examination that he had carried out. He said he had asked Patient C if she wanted him to repeat the sensory examination because he felt she thought he had not sufficiently examined her. He denied the allegations that he had either exposed Patient C’s breasts, pulled down her pyjama bottoms, pulled down her knickers, touched her bottom, near her anus and near her vagina. He denied any sexual motivation to his actions. His evidence was therefore in direct conflict with Patient C’s evidence. The Tribunal’s assessment of Dr Nair’s credibility is set out above.

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230. The Tribunal noted Patient C’s police statement:

‘As I lay on my back, without warning, the doctor ripped open my pyjama top exposing my naked breasts. The doctor wasn’t wearing any gloves. He then began to touch my breasts, one at a time it was [sic] if he was massaging them.’

231. In her GMC witness statement Patient C stated:

‘18. Dr Nair, then, without saying anything moved towards my chest and “unpopped” the buttons on my pyjama top. I had no clothing or bra on underneath my top. I cannot recall if Dr Nair popped open all of the buttons or just a few. He touched my breast, I cannot recall if he touched my left or right breast first but it definitely felt different to how he touched my arms; it did not feel right. This was more like a massage and deeper pressure. He was working his way around my breasts in a massage sort of way. I cannot be sure whether he used one hand or both hands. He did not explain why he was doing this and did not ask if I wanted anyone in the cubicle with me. At some point whilst he was touching my breast, he asked me whether I wanted him to stop, I said “yes please”, he said words to the effect of “are you sure?” and carried on. I then asked him to stop and he did stop…’

232. The Tribunal noted that Patient C gave varying accounts the degree to which her top was opened.

233. It was Dr Nair’s account was that he carried out the neurological examination over Patient C’s clothing then later stated that he asked whether he could examine her abdomen but that her chest remained covered. Both agree that Patient C’s abdomen was exposed.

234. The Tribunal noted Ms G stated that she put her head through the curtain and said that she saw Patient C sitting up with her pyjama top on, as she says it was her practice to check on patients who had been admitted for an overdose. However, it is unknown at what time this occurred and Ms G could not recall. The Tribunal noted that there were difficulties with some of the timings offered by Ms G, but she stuck to her recollection of what she had seen.

235. It was Dr Nair’s evidence that Ms G came into the cubicle. Ms G stated that she looked around the curtain and when she did so she saw both Dr Nair and Patient C. Patient C was sat up in bed and Patient C looked at her.

236. In contrast to this Patient C’s evidence was that nobody else came into the bay or put their head around the curtain.

237. The Tribunal was told by a number of witnesses and accepted, that Patient C’s bed was situated in a four bedded bay on the ward near the nurse’s station. Taking account of Ms G’s evidence, the Tribunal considered that it raised a question of whether
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it was probable that Dr Nair would undertake the breast examination in the manner described by Patient C knowing that at any time anyone could have put their head around the curtain rather than if an examination took place in a room with the door closed.

238. The Tribunal found a direct conflict between Ms G, Dr Nair and Patient C’s evidence. It preferred the account of both Ms G and Dr Nair as to Ms G’s entry to the cubicle. This tended to undermine the credibility of Patient C’s recollections. The Tribunal accepted evidence given by both Ms G and Dr Nair that Ms G looked into the cubicle at some point.

239. The Tribunal noted that Dr Nair undertook a neurological examination but the notes were written up at 7.00am after the event. The Tribunal heard from other witnesses that medical notes sometimes were not available for a doctor to write them contemporaneously. This evidence supported Dr Nair’s account.

240. The Tribunal found that Patient C’s recollection that Dr Nair moved her pyjama top was consistent with his explanation of performing a sensory abdominal examination. However, Dr Nair had denied having opened Patient C’s top thereby exposing her breasts.

241. The Tribunal considered the evidence and its assessment of the credibility of the witnesses, including its assessment of the evidence of Patient C, as above. In light of the conflict and its assessment of the witnesses’ credibility it could not accept Patient C’s account. The Tribunal was not satisfied, on the balance of probabilities, that it was more likely than not, that Dr Nair opened Patient C’s pyjama top exposing her breasts. Accordingly, the Tribunal found paragraph 3a not proved.

Paragraphs 3b, 3c and 3d

242. As the Tribunal found paragraph 3a not proved it follows that Dr Nair could not have failed to obtain Patient C’s consent before opening her pyjama top, afford Patient C the opportunity to open her pyjama top, offer Patient C a blanket to cover her breasts. Based on its findings, the Tribunal was not satisfied that Dr Nair touched Patient C’s breasts one at a time as though massaging them or fail to stop touching Patient C’s breasts when she indicated she wanted him to stop. Accordingly, the Tribunal found paragraphs 3b, 3c and 3d not proved.

Paragraphs 3e(i) and 3e(ii)

243. The Tribunal had found that Patient C’s recollection that Dr Nair moved her pyjama top was consistent with his explanation of performing a sensory abdominal examination. It noted that Dr Nair then went on to conduct a neurological examination of Patient C’s lower limbs.

244. Dr Nair stated that he did not remove any of Patient C’s clothing nor did he ask her to remove any of her clothing.
245. The Tribunal noted Patient C’s police statement:

'without warning he pulled my pyjama bottoms down to about my knees... He then asked me to turn over so that I was lying on my stomach. My pyjama bottoms were still around my knees along with my pants'.

246. In Ms E’s police witness statement she reported that Patient C said:

'he touched my boobs and removed my pants and trousers’
.... Did not say exactly where she had been touched. However I then asked if she had been touched sexually, to which she replied 'yes'.

247. In Ms G’s police statement she stated:

'I went over to the cubicle to carry out observations on her whilst I was doing this Patient C said "That doctor pulled my knickers down really roughly, he put his finger inside me and said "does that feel nice". She said this to me a couple of times.’

248. In her oral evidence Patient C stated:

'..., Well, I would have no reason to make this up. I have got no, you know, as it said, I just said I felt uncomfortable. I never wanted to get anyone in trouble or anything like that until after when I realised how wrong it was and that I had been taken advantage of. So, you know - and I think if I don’t say something then what’s it to stop it happening to someone else. It could have been worse with someone else.'

249. The Tribunal was concerned that apparently it had been Ms E who had first mentioned the matter of the touching being ‘sexual’.

250. The Tribunal further noted that Patient C had said in her statement that Dr Nair had asked her 'Does that feel nice’ and in oral evidence had said that this was the equivalent of being asked 'what does that feel like?’. The Tribunal concluded that this was at best a possible illustration of the misinterpretation of events by Patient C. It considered that this affected the weight that it could give to Patient C’s evidence.

251. However, the Tribunal found that Patient C had been consistent about the fact that her pyjama bottoms had been lowered by Dr Nair. She had also given the same account to both Ms G and Ms E at the time. Given the consistencies in Patient C’s accounts to Ms G, Ms E and the police, the Tribunal concluded it was more likely than not that, on the balance of probabilities that, Dr Nair pulled Patient C’s pyjama bottoms down to her knees. Accordingly, the Tribunal found paragraph 3e(i) proved.

252. The Tribunal also considered that it was possible that Patient C’s underwear may have been dislodged to a degree, but did not consider it was likely that this was to her
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knees. The Tribunal was concerned at the various inconsistencies in her evidence. Therefore, the Tribunal was not satisfied, on the balance of probabilities, that Dr Nair pulled Patient C’s knickers down to her knees. Accordingly, the Tribunal found paragraph 3e(ii) not proved.

Paragraph 3f(i)1

253. The Tribunal noted the GMC’s Guidance ‘Intimate examinations and chaperones’, which states:

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

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

…

5 Before conducting an intimate examination, you should:

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

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

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

…

f give the patient privacy to undress and dress, and keep them covered as much as possible to maintain their dignity; do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help.’

254. The Tribunal considered that Dr Nair had a duty of care to obtain Patient C’s consent before moving any of her clothing.

255. Having accepted Patient C’s evidence ‘without warning he pulled my pyjama bottoms down to about my knees’ and having found it proved, the Tribunal was satisfied, on the balance of probabilities that, it was more likely than not that Dr Nair failed to obtain Patient C’s consent before pulling down her pyjama bottoms. The Tribunal was also satisfied that as Dr Nair without warning’ pulled down Patient C’s pyjama bottoms, it was more likely than not that he failed to afford Patient C the
opportunity to pull down her own pyjama bottoms. Accordingly, the Tribunal found paragraphs 3f(i)1 proved.

**Paragraph 3f(ii)1**

256. The Tribunal had found that Dr Nair had pulled down Patient C’s pyjama bottoms without her consent. In addition to seeking her consent, the Tribunal was satisfied that Dr Nair should have offered Patient C the opportunity to pull down her bottoms. Accordingly, the Tribunal found paragraphs 3f(ii)1 proved.

**Paragraphs 3f(i)2 and 3f(ii)2**

257. The Tribunal having found paragraph 3e(ii) not proved, that Dr Nair pulled Patient C’s knickers down to her knees, paragraphs 3f(i)2 and 3f(ii)2 fall. Accordingly, the Tribunal found paragraphs 3f(i)2 and 3f(ii)2 not proved.

**Paragraph 3f(iii)**

258. The Tribunal noted Patient C’s evidence that Dr Nair failed to offer her a chaperone.

259. It was Dr Nair’s evidence that he did not consider the examination to be an intimate one and therefore did not offer a chaperone.

260. The Tribunal noted the GMC’s Guidance ‘Intimate examinations and chaperones’, as listed above.

261. The Tribunal is of the opinion that the examination of the chest and groin area falls within the description of an intimate examination in that the guidance states:

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

262. The Tribunal noted that the experts agree that Dr Nair should have offered a chaperone to Patient C.

263. In oral evidence Dr M described in detail how a sensory neurological examination would be undertaken. This entailed touching the skin up to at least mid-thigh although he described this as being done by elevating the patient’s pyjama legs rather than lowering them. Dr Nair acknowledged that he opened Patient C’s pyjama top to expose her abdomen. Both of these factors lead the Tribunal to believe that a chaperone should have been offered.
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264. The examination was clearly embarrassing for Patient C. The Tribunal considered that a reasonable body of doctors would have offered a chaperone.

265. Therefore, the Tribunal was satisfied that Dr Nair had a duty to offer a chaperone but failed to do so. Accordingly, the Tribunal found paragraph 3f(iii) proved.

Paragaphs 3g, 3h(i) 3h(ii) and 3h(iii)

266. In her police statement dated 10 March 2018, Patient C stated

‘He then started touching my bum…but I wouldn’t say it was in a sexual way. He then asked me to open my legs wider which I did a bit but he then got his hands in between my legs and forced them open. He then put his fingers very close to my anus and then a bit further down towards my vagina, maybe about 2cm away’

267. In her GMC witness statement dated 24 June 2017, Patient C stated:

‘20. I cannot be certain, but I think this was when Dr Nair, without saying anything, pulled down my pyjama bottoms and my underwear to around mid-thigh. I recall being extremely embarrassed as I was menstruating at the time. Dr Nair pushed my legs open slightly; I recall my legs being as open as far as my underwear would allow. I cannot be certain which way I was facing, because at some point during this time, Dr Nair asked me to turn over. I do think that I was lay facing up, towards the ceiling, when he pulled my pants and underwear down; exposing my genital area.

...23. I could feel Dr Nair put his hand through my legs from the back of my legs and touch around my groin area around whether [sic] the knicker line would be. In a statement which I provided to the police, I stated that Dr Nair touched my bum. I did not mention this to the Paralegal who took my statement, however, on reflection, I am sure Dr Nair did touch my bum. I was bare as he had pulled down my underwear and pants. I do not know how long he touched the area – it felt like a long time but that is probably because I felt so uncomfortable.’

268. As has been set out above, The Tribunal found significant inconsistencies in Patient C’s evidence. It also bore in mind the evidence given by the other witnesses, including Ms G, and the circumstances of the positioning of the cubicle in the ward, when considering whether it was likely that Dr Nair had conducted the examination in the manner described by Patient C.

269. The Tribunal reminded itself of Ms G’s account of her initial conversation with Patient C in her police statement:

‘I went over to the cubicle to carry out observations on her whilst I was doing this Patient C said “That doctor pulled my knickers down really roughly, he put
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his finger inside me and said “does that feel nice”. She said this to me a couple of times.’

270. The Tribunal noted that, when challenged, Patient C had accepted Dr Nair may have asked her ‘What does that feel like?’ but did not appear to regard this as substantially different.

271. The Tribunal had found that it was unlikely in the circumstances of the examination that Dr Nair had turned over Patient C or had pulled her knickers down. It also noted the doubt and change of account that Patient C had exhibited in relation to the question whether Dr Nair had touched her bottom, over the course of preparing her witness statement for the GMC.

272. Dr Nair’s evidence was in direct contrast to this, in so far as he said he had conducted only a neurological examination. Given the Tribunal found Patient C’s accounts to be inconsistent with regard to what took place after the lowering of her pyjama bottoms, the Tribunal could not be satisfied, on the balance of probabilities, that it was more likely than not that Dr Nair touched Patient C’s groin area, bottom, and put his fingers close to Patient C’s anus and vagina. Accordingly, the Tribunal found paragraphs 3g, 3h(i) 3h(ii) and 3h(iii) not proved.

Paragraph 3i(i)

273. The Tribunal found that Dr Nair had not touched Patient C’s bottom, or that he had put his fingers close to her anus or approximately 2cm away from Patient C’s vagina. Therefore paragraph 3i(i) falls. Accordingly, the Tribunal found paragraph 3i(i) not proved.

Paragraph 3i(ii)1

274. The Tribunal found that Dr Nair did not carry out a breast examination on Patient C. Therefore paragraph 3i(ii)1 falls. Accordingly, the Tribunal found paragraph 3i(ii)1 not proved.

Paragraph 3i(ii)2

275. The Tribunal found that Dr Nair did not carry out a groin examination on Patient C. Therefore paragraph 3i(ii)2 falls. Accordingly, the Tribunal found paragraph 3i(ii)2 not proved.

Paragraph 3i(iii)

276. The Tribunal noted Patient C’s GMC witness statement in which she stated that she had told Dr Nair about the numbness in her limbs. The Tribunal also noted that Dr Nair said that he tested the power in Patient C’s limbs, which Patient C could not recall.
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277. The Tribunal further noted that Patient C had no recollection of having been
examined by Dr L, the Consultant on call or the Consultant neurologist. The Tribunal
noted that in her oral evidence Patient C was still unsure of what a neurological
examination was. However, Patient C was complaining of leg twitching and numbness
all over her body. The Tribunal found it likely that Patient C may not have had a full
understanding what a neurological examination entailed.

278. It was Dr M’s opinion that there was adequate communication with regard to the
examination but possibly not enough communication with regard to the removal of
clothing.

279. The Tribunal was of the opinion that Dr Nair had a duty to explain what
examination he was about to undertake. The Tribunal accepted that Dr Nair explained
that he would examine parts of Patient C’s body. It was of the opinion that most
doctors would not give a ‘running commentary’ of how they would perform that
examination.

280. The Tribunal found that it was unclear what the ‘detail of the examination’
referred to in the paragraph and therefore what the doctor had failed to ‘adequately
communicate.’

281. Whilst the Tribunal found proved that Dr Nair had pulled down Patient C’s
pyjama bottoms, it considered this to have been a separate matter with regards to
adequate communication. The Tribunal was of the opinion that Dr Nair’s failure in
communication related to the removal of the clothing rather than the examination(s)
itsel. The Tribunal was satisfied that the extent of Dr Nair’s explanation was to give an
outline the examination to Patient C. The Tribunal had also already dealt with the issue
of failure to obtain consent, in the paragraphs above, and it considered that this
paragraph had to relate to other explanations.

282. The Tribunal was not satisfied, on the balance of probabilities that Dr Nair, failed
to adequately communicate with Patient C the details of the examination/s he intended
to perform. Accordingly, the Tribunal found paragraph 3(iii) not proved

Paragraph 4 in relation to paragraphs 3c, 3g and 3h

283. The Tribunal found that Dr Nair did not touch Patient C’s breasts one at a time
as though massaging them nor did he touch patient C’s groin area or bottom or put his
fingers close to her anus or vagina. Therefore, the issue of these actions being clinically
indicated did not arise and the Tribunal could not make any finding that Dr Nair had
been guilty of any failure. Accordingly, the Tribunal found paragraph 4 in relation to
paragraphs 3c, 3g and 3h not proved.

Paragraph 5 in relation to paragraph 3
284. The Tribunal then went on to consider paragraph 5, as it applied to those parts of paragraph 3 that had been found proved: paragraphs 3e(i), 3f(i)1 and 3f(ii)1, since the remainder of paragraph 3 had not been found proved.

285. As it had in relation to the allegations concerning Patient A, the Tribunal reminded itself of the judgment of the High Court in Basson v GMC [2018] EWHC 505 and Soni v GMC 2015 EWHC 364 as set out above. The Tribunal therefore followed the same approach as outlined in relation to paragraph 5 in relation to paragraph 1 and 2 above.

286. It bore in mind that the burden of proving sexual motivation lay with the GMC, but that determining that state of the doctor’s mind in acting as he had was a matter of inference, rather than direct evidence.

287. Mr McCartney had identified a number of potential explanations for Dr Nair’s behaviour which included an automaton approach, poorly or clumsy conducted examination, poor communication, overly methodical, following a routine pattern, diagnosis by exclusion and sexual motivation.

288. The Tribunal also took into account its findings, on the agreed basis of ‘cross admissibility’ regarding the doctor’s motivation concerning other patients in the Allegation.

289. In summary the Tribunal had to consider whether Dr Nair had been sexually motivated in relation to its findings in paragraphs 3e(i), 3f(i)1 and 3f(ii)1 that he had pulled Patient C’s pyjama bottoms to her knees, failed to obtain her consent before doing so, and failed to offer Patient C the opportunity to do so herself. These were the factual particulars that it had found proved.

290. As before, the Tribunal had found the examination that had been carried out had been clinically indicated. In this case, Patient C had indicated that Dr Nair had said inappropriate words as in ‘Do you like it?’ However, on cross examination she had accepted that the words may have been ‘What does that feel like?’, which were appropriate words in the context of the examination. There was also evidence from Patient C that the doctor had not particularly engaged her in conversation and explanation. The Tribunal concluded that in pulling down Patient C’s pyjama bottoms, without first asking for her consent or giving Patient C the opportunity to do so, Dr Nair’s conduct was consistent with his demonstrated poor communication and an insensitive approach (if not more likely) It concluded that there was an absence of sufficient evidence which might lead to a positive inference of sexual motivation as it could not draw a reasonable inference as to sexual motivation.

291. Accordingly, the Tribunal found that paragraph 5 in relation to paragraphs 3e(i), 3f(i)1 and 3f(ii)1 was not proved.

292. Therefore paragraph 5 as applied to paragraph 3 was found not proved.
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Paragraph 5 as it applied to paragraph 4

293. The Tribunal had not found paragraph 4 proved and therefore it could not find paragraph 5 proved in relation to paragraph 4, since there had been no finding of actions which were not clinically indicated.

The Tribunal’s Overall Determination on the Facts

294. The Allegation made against Dr Nair is as follows:

1. On 9 June 2015, you consulted with Patient A and you:
   a. unclipped Patient A’s bra;  
      **Found Proved**
   b. lifted Patient A’s:
      i. top;  
      **Found Proved**
      ii. bra;  
      **Found Proved**
   c. lowered Patient A’s jeans and underwear to her pubic bone;  
      **Found Proved**
   d. attempted to pull Patient A’s trousers down further;  
      **Found Proved**
   e. failed to:
      i. afford Patient A the opportunity to move her own clothing as set out in paragraphs 1a – 1d;  
      **Found Proved**
      ii. obtain Patient A’s consent to move her clothing as set out in paragraphs 1a – 1d;  
      **Found Proved**
   f. carried out:
      i. an assessment of Patient A’s thigh circumference;  
      **Admitted and found proved**
      ii. an examination of Patient A’s femoral pulses;  
      **Admitted and found proved**
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iii. a breast examination of Patient A;

**Found Not Proved**

g. failed to:

i. offered Patient A a chaperone;

**Found Proved**

ii. offer appropriate covering material for Patient A’s buttocks or thighs during your examination of her legs for deep vein thrombosis;

**Found Proved**

iii. adequately communicate with Patient A the detail of the examination/s you intended to perform.

**Found Not Proved**

2. On 29 May 2015, you consulted with Patient B and you:

a. lifted up Patient B’s:

i. top;

**Deleted following Rule 17(2)g application**

ii. bra;

**Found Proved**

b. unfastened Patient B’s bra;

**Found Proved**

c. lowered Patient B’s trousers to the top of her groin;

**Deleted following Rule 17(2)g application**

d. carried out an assessment of Patient B’s thigh circumference;

**Admitted and found proved**

e. failed to:

i. afford Patient B the opportunity to move her own clothing as set out in paragraphs 2a–2c;

**Deleted following Rule 17(2)g application in relation to 2a(i) & 2c**

i. afford Patient B the opportunity to move her own clothing as set out in paragraphs 2a(ii) and 2b

**Found Proved in relation to 2a(ii) & 2b**
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ii. obtain Patient B’s consent to move her clothing as set out in paragraphs 2a–2e;
Delete following Rule 17(2)g application in relation to 2a(i) & 2c

ii. obtain Patient B’s consent to move her clothing as set out in paragraphs 2a(ii) and 2b;
Found Proved in relation to 2a(ii) & 2b

iii. obtain Patient B’s consent for a:

1. respiratory examination;
Delete following Rule 17(2)g application

2. examination of Patient B’s femoral pulses;
Delete following Rule 17(2)g application

3. examination of Patient B’s legs;
Delete following Rule 17(2)g application

iv. indicate to Patient B that she could cover her breasts when you had completed the respiratory examination;
Found Not Proved

v. offer Patient B a chaperone;
Delete following Rule 17(2)g application

vi. failed to adequately communicate with Patient B the detail of the examination/s you intended to perform.
Found Not Proved

3. At around 07:00 on 10 March 2016 you consulted with Patient C and you:

a. opened Patient C’s pyjama top exposing her breasts;
Found Not Proved

b. failed to:

i. obtain Patient C’s consent before opening her pyjama top;
Found Not Proved

ii. afford Patient C the opportunity to open her pyjama top;
Found Not Proved
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iii. offered Patient C a blanket to cover her breasts;
    *Found Not Proved*

c. touched Patient C’s breasts one at a time as though massaging them;
    *Found Not Proved*

d. failed to stop touching Patient C’s breasts when she indicated she wanted you to stop;
    *Found Not Proved*

e. pulled Patient C’s:
    i. pyjama bottoms down to her knees;
    *Found Proved*

    ii. knickers down to her knees;
    *Found Not Proved*

f. failed to:
    i. obtain Patient C’s consent before pulling down her:
        1. her pyjama bottoms;
        *Found Proved*
        2. knickers;
        *Found Not Proved*

    ii. afford Patient C the opportunity to pull down her own:
        1. pyjama bottoms;
        *Found Proved*
        2. knickers;
        *Found Not Proved*

    iii. offer Patient C a chaperone;
    *Found Proved*

g. touched Patient C’s groin areas;
    *Found Not Proved*

h. asked Patient C to turn over and you:
    i. touched Patient C’s bottom;
    *Found Not Proved*
ii. put your fingers close to Patient C’s anus;  
**Found Not Proved**

iii. put your fingers approximately 2cm away from Patient C’s vagina;  
**Found Not Proved**

i. failed to:

i. obtain Patient C’s consent for the examination set out at paragraph 3h;  
**Found Not Proved**

ii. document the reasons why carried out a:

1. breast examination on Patient C;  
**Found Not Proved**

2. groin examination on Patient C;  
**Found Not Proved**

iii. adequately communicate with Patient C the details of the examination/s you intended to perform.  
**Added pursuant to Rule 17(6)**  
**Found Not Proved**

k. adequately communicate with Patient C the details of the examination/s you intended to perform.  
**Deleted pursuant to Rule 17(6)**

4. Your actions at 1(f), 2(d), 3(c), 3(g) and 3(h) were not clinically indicated.  
**Found Not Proved in relation to paragraphs 1(f), 2(d), 3(c), 3(g) and 3(h)**

5. Your actions at paragraphs 1 to 4 were sexually motivated.  
**Found Not Proved in relation to paragraphs 1-4**

**Determination on Impairment - 21/05/2019**

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

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence as follows.

3. Dr Nair provided his own reflective statement and gave oral evidence at the impairment stage of the hearing.

4. The Tribunal also received the following certificates and documents from Dr Nair:

- MDU Online - Medical Ethics and Law- 09 December 2015
- Oxford University Hospitals NHS Trust - Medico-legal Skills Defendable Practice 16 July 2018
- Clinic for Boundaries Studies - Maintaining Professional Boundaries – 10 December 2018
- LearnPac - Chaperone for Health and Social Care - Level 2 Online Course – 19 March 2019
- BMJ Learning- Understanding consent- 17 April 2019
- The Global Health Network - Introduction to informed consent- 17 April 2019
- BMJ Learning- Communication skills - 18 April 2019
- LearnPac - Consent Training Level 2 Online CPD Course - 25 April 2019
- Learn Pac - Dignity, Privacy & Respect Level 2 Online CPD Course - 25 April 2019
- Royal College of Physicians - Emotional Intelligence- 26 April 2019
- Royal College of Physicians - Communication skills - London - 29 April 2019
- Person-Centred Care 8 May 2019
- Patient/relative feedback
- Colleague feedback
- Consultant supervision - SLE mini-CEX – 17 May 2019
- Reflections and Remediation document

Ms Hudson’s Submissions

5. On behalf of the GMC, Ms Hudson referred the Tribunal to its over-arching objective and the importance of doctors following GMC guidance. Ms Hudson stated that the GMC’s position is that the facts found proved are a sufficient departure from Good Medical Practice so as to amount to misconduct. Ms Hudson referred the Tribunal to page 1 of the GMC’s guidance, Good Medical Practice (the GMP), which states:

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'**The duties of a doctor registered with the General Medical Council**

*Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.*

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Knowledge, skills and performance

- Make the care of your patient your first concern.
- Provide a good standard of practice and care.
  - Keep your professional knowledge and skills up to date.
  - Recognise and work within the limits of your competence.

Safety and quality

- Take prompt action if you think that patient safety, dignity or comfort is being compromised.
- Protect and promote the health of patients and the public.

Communication, partnership and teamwork

- Treat patients as individuals and respect their dignity.
  - Treat patients politely and considerately.
  - Respect patients’ right to confidentiality.

- Work in partnership with patients.
  - Listen to, and respond to, their concerns and preferences.
  - Give patients the information they want or need in a way they can understand.
  - Respect patients’ right to reach decisions with you about their treatment and care.’

6. Ms Hudson also drew the Tribunal’s attention to paragraphs 1, 2, 46 and 47 of the GMP, which state:

‘1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues…’

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

46. You must be polite and considerate.

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

7. Ms Hudson submitted that Dr Nair did not follow this guidance by failing to treat patients as individuals and to respect their dignity and privacy. She referred the Tribunal to its determination on facts. She reminded the Tribunal that by the time Dr Nair saw Patient C, some 8 and 9 months had elapsed since he had seen Patients A
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and B and had had discussions with Dr J and been on a number of courses. She stated that there was an obvious impact on each of these patients and this amounted to serious misconduct.

8. In relation to chaperoning Ms Hudson referred the Tribunal to paragraph 11 of the GMP, which states:

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

9. Ms Hudson referred the Tribunal to its determination on facts and reminded it of the evidence of Dr M, the GMC’s expert witness, and of his report. He found that lifting and unclipping Patient A’s bra fell seriously below the standard expected. Patient A also had her buttocks exposed. Ms Hudson reminded the Tribunal that it found a reasonable body of doctors would have offered a chaperone and in failing to do so this amounted to serious misconduct. She stated that both experts agreed that Patient C should have been offered a chaperone. She reminded the Tribunal that Dr Nair did not make admissions to this allegation at the outset. Ms Hudson stated that Dr Nair had not learned about chaperoning by the time he saw Patient C despite the advice given to him by Dr J.

10. In relation to consent Ms Hudson referred the Tribunal to paragraph 17 of the GMP which states:

   '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.’

11. Ms Hudson reminded the Tribunal that that these allegations related to three patients who were not offered the opportunity to move their own clothing. She referred the Tribunal to Dr M’s report stating that he found Dr Nair’s actions fell seriously below the standard expected.

12. Ms Hudson submitted that there were many examples of Dr Nair failing to follow the guidance in GMP. She stated that patients should be able to expect to see doctors who are up to date with the guidance. Ms Hudson submitted that the facts found proved amounted to misconduct.

13. In relation to impairment, Ms Hudson referred the Tribunal to the cases of Cheatle v GMC [2009] EWHC 645 (Admin) and GMC v Meadows [2006] EWCA Civ 1390. She submitted that the Tribunal will have to consider Dr Nair’s wide ranging failures to follow the guidance in Good Medical Practice and the repeated nature of those failings. She submitted that these are very serious breaches of the standards to be expected of doctors and were not isolated failings.

Mr McCartney’s submissions
14. Mr McCartney referred the Tribunal to paragraph 22 of the judgement Cheatle v GMC [2009] EWHC 645 (Admin), which states:

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

15. Mr McCartney stated that what was uncontroversial was Dr Nair’s desire to ‘get it right’ clinically, against a background of a previous misdiagnosis, and this resulted in Dr Nair not paying enough regard to the patients.

16. Mr McCartney stated in relation to consent, Dr Nair can now see how his actions had made the patients feel quite uncomfortable and how obtaining consent to examination does not equate to consent to move a patient’s clothing. He said it was Dr Nair’s understanding that consent for the examination had been given which led him to believe that it was also consent to move the patient’s clothing.

17. In relation to Patient A, whilst the Tribunal had found Dr Nair had not conducted a breast examination, he conceded that her breasts were exposed and a chaperone should have been obtained. Mr McCartney stated that Dr Nair’s thinking at the time was that he was undertaking a chest examination which was not an intimate examination requiring a chaperone. He now accepts that this did not preclude the need for a chaperone. Mr McCartney submitted that the issues arising with regard to Patient C were quite distinct and there was a conflict of evidence as to what had occurred in her examination. He stated that the majority of allegations in relation to Patient C were not found proved and therefore the Tribunal should not be too critical.

18. Mr McCartney stated that the two areas found proved in relation to Patient C were the moving of clothing and the failure to offer a chaperone. He reminded the Tribunal that there was ultimate agreement between the two experts that a chaperone was required but it was the defence expert who stated that a chaperone should have been obtained as Patient C was vulnerable, having taken an overdose.

19. In relation to the breaches of GMP Mr McCartney stated that not every breach leads to misconduct. In response to the GMC’s submission that maintaining confidence in the profession required a finding of misconduct he referred the Tribunal to R (ota Remedy UK Ltd) v GMC [2010] EWHC1245 (Admin) in relation to the issue of motivation, which states:
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‘Accordingly, action taken in good faith and for legitimate reasons, however inefficient or ill-judged is not capable of constituting misconduct... merely because it might damage the reputation of the profession’

20. He stated that Dr Nair’s motivation had been positive and his motives were well intentioned but misjudged. On this basis according to *Remedy* there should not be a finding of misconduct on the basis of maintaining public confidence in the profession.

21. Mr McCartney stated that the Tribunal may find that all, none or some of the matters found proved amount to serious misconduct. Mr McCartney stated that Dr Nair has accepted the changes that needed to be made to his practice and referred the Tribunal to his reflective statement. Mr McCartney reminded the Tribunal that the issue of impairment requires consideration of Dr Nair’s practice today and whether or not he has taken remedial action. He submitted that Dr Nair had remediated and it had undoubtedly been successful. He asked the Tribunal to accept the documentary evidence put forward, including Dr Nair’s reflective statement, his previously unblemished record and his oral evidence to demonstrate that he has gained full insight and has taken appropriate remedial action.

22. Mr McCartney submitted that Dr Nair had thought about how the patient feels, and how conducting his examination and communicating in a different way, would enhance his clinical care of patients. Mr McCartney submitted that Dr Nair’s conduct is remediable and has been remediated and therefore the Tribunal may find that his fitness to practise is not impaired as matters stand today.

The Relevant Legal Principles

23. The Tribunal has taken account of the evidence placed before it, as well as the submissions of the representatives, and its findings made at the facts stage. The Tribunal reminded itself that there is no burden or standard of proof at this stage and that in reaching its decision on impairment the Tribunal should exercise its own judgement.

24. The Tribunal was mindful that the purpose of these proceedings is not to punish a doctor for past misconduct, but that its over-arching role is the protection of the public, which includes:

- protecting the safety and well-being of the public,
- maintaining public confidence in the medical profession, and
- upholding proper professional standards and conduct for members of the profession.

25. The Tribunal adopted a two-stage process in considering impairment by misconduct. First, it considered whether the facts as found proved amounted to misconduct which was serious. Second, it then considered whether the doctor’s fitness to practise is currently impaired by reason of any serious misconduct found. The Tribunal also took into account the doctor’s history and matters since any misconduct had occurred.
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26. Regarding misconduct, the Tribunal has considered the following authorities.

- *in Roylance vs GMC (2) [2000]1AC 311* it was said that misconduct is a word of
general effect involving some act or omission which falls short of what would be
proper in the circumstances. The standard of propriety may often be found by
reference to the rules and standards ordinarily required to be followed by a
medical practitioner in the particular circumstances.

- *in GMC v Meadows [2006] EWCA Civ 1390*, serious professional misconduct was
described as conduct which would be regarded as ‘deplorable’ by fellow
practitioners.

- *in R (Remedy UK Ltd) v GMC [2010] EWHC1245 (Admin)* it was said that the
conduct must be sufficiently serious that it can be properly described as
misconduct going to fitness to practise.


27. In considering current impairment, the Tribunal looked forward to determine
whether the doctor is currently fit to practise without restriction. It also took into
account the doctor’s conduct at the time of the events in question, and any relevant
factors since then, such as whether the misconduct was remediable, had been
remedied, any evidence of insight and the risk of repetition.

The Tribunal’s Determination on Impairment

Misconduct

28. The Tribunal took account of page 1 of the GMC’s guidance in GMP and also
paragraphs 1, 2, 46 and 47, as cited above. It also took account of the GMC’s guidance
‘Intimate examinations and chaperones’, as cited above.

29. The Tribunal accepted Mr McCartney’s submission that Dr Nair had undertaken
the examinations of Patients A, B and C ‘in good faith’ and with good intention. This
was relevant to whether a finding of misconduct was necessary for the purposes of
maintaining confidence in the profession (*Remedy*). However, in its view this did not
affect its consideration of the manner in which Dr Nair undertook the examinations of
Patients A, B and C. The Tribunal still had to consider whether Dr Nair had engaged in
misconduct in the way in which he had carried out these examinations. It was clear that
the examinations had caused embarrassment and distress to Patients A, B and C.

30. The Tribunal considered that Dr Nair had made serious omissions in maintaining
patient dignity by moving items of clothing without consent and by failing to offer
appropriate covering material for Patient A’s buttocks or thighs and failing to offer a
chaperone to Patients A, B and C.
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Patient A

Paragraphs 1a and 1b(ii)

31. The Tribunal found proved that on 9 June 2015, Dr Nair consulted with Patient A and he lifted Patient A’s bra and he unclipped Patient A’s bra.

32. The Tribunal noted that Dr M, instructed by the GMC was of the opinion that Dr Nair’s actions in lifting Patient A’s bra were seriously below the standard expected of a reasonably competent doctor (‘the standard’) and Professor N, instructed by Dr Nair, was of the opinion that Dr Nair’s actions were below but not seriously below. It noted that both experts agreed that Dr Nair’s actions in in unclipping Patient A’s bra were seriously below the standard.

33. The Tribunal reminded itself of paragraph 3 and 5 f of the GMC’s guidance ‘Intimate examinations and chaperones’ which states:

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

5f. give the patient privacy to undress and dress, and keep them covered as much as possible to maintain their dignity; do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help.’

34. The Tribunal reminded itself it that Patient A was able to remove her own poncho prior to the examination and would have been perfectly capable of unclipping her own bra.

35. The Tribunal preferred Dr M’s opinion in relation to Dr Nair lifting Patient A’s bra and accepted both experts’ opinion in relation to Dr Nair unclipping Patient A’s bra. The Tribunal considered that Dr Nair’s actions were serious misconduct, in that they involved the moving and unclipping of a patient’s undergarment. This had been likely to and did cause the patient embarrassment and distress contrary to the principles set out above. The Tribunal was therefore satisfied that in moving Patient A’s bra and unclipping her bra, Dr Nair breached the GMC’s guidance to an extent which amounted to misconduct.

Paragraph 1b(i)

36. The Tribunal found proved that on 9 June 2015, Dr Nair consulted with Patient A and he lifted Patient A’s top.
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37. The Tribunal noted the experts agreed that that Dr Nair’s actions in lifting Patient A’s top were below the standard but not seriously below. The Tribunal accepted in the course of his examination of Patient A Dr Nair would have had to move her top, an outer garment.

The Tribunal accepted the experts’ opinions and found that Dr Nair’s actions did not amount to misconduct.

Paragraphs 1c and 1d

38. The Tribunal found proved that on 9 June 2015, Dr Nair consulted with Patient A and he lowered Patient A’s jeans and underwear to her pubic bone and attempted to pull her trousers down further.

39. The Tribunal noted that Dr M considered that Dr Nair’s actions of lowering Patient A’s jeans and underwear to her pubic area were seriously below the standard required. Professor N considered Dr Nair’s actions were below the standard. Professor N believed that whilst he would not undertake this action himself unless given express permission by the patient, a doctor might find himself examining in this way as part of a routine, albeit inappropriately, and not seriously below the standard.

40. The Tribunal noted that both experts agreed that Dr Nair’s actions in attempting to pull Patient A’s trousers down further were seriously below the standard.

41. As noted previously, Patient A was capable of moving her own clothing. The Tribunal preferred Dr M’s opinion that that Dr Nair’s actions in lowering Patient A’s jeans and underwear to her pubic bone were seriously below the standard. The lowering of the jeans and potential for exposing Patient A’s vagina had caused her embarrassment and distress and this was a serious failing.

42. The Tribunal accepted both experts’ opinions that Dr Nair’s actions in attempting to pull Patient A’s trousers down further were seriously below the standard. Dr Nair breached the GMC’s guidance in relation to intimate examinations. The Tribunal was satisfied that this amounted to misconduct.

Paragraphs 1e(i) and 1e(ii)

43. The Tribunal found proved that on 9 June 2015, Dr Nair consulted with Patient A and he failed to afford Patient A the opportunity to move her own clothing and failed to obtain Patient A’s consent to move her clothing as set out in paragraphs 2a(ii) and 2b.

44. The Tribunal noted that both experts agreed that patients should be requested to remove their own clothing, and that a failure to do so was below the required standard. Further, the experts considered that Dr Nair, in failing to afford Patient A the opportunity to move her own clothing, his actions were seriously below the standard. Both experts agreed that the failure to obtain consent to move Patient A’s clothing was seriously below the standard.
45. The Tribunal accepted the experts’ opinion that Dr Nair’s actions in failing to afford Patient A the opportunity to move her own clothing and failing to obtain her consent to move her clothing were seriously below the standard. Dr Nair’s failure to ask Patient A to move her own clothing or to obtain her consent to his actions had resulted in embarrassment and distress for Patient A. The Tribunal determined that this amounted to misconduct.

Paragraphs 1f(i) and 1f(ii)

46. The Tribunal found proved that on 9 June 2015, Dr Nair consulted with Patient A and he carried out an assessment of Patient A’s thigh circumference and her femoral pulses.

47. The Tribunal noted that both experts were not overly critical of Dr Nair’s assessment of Patient A’s thigh circumference and her femoral pulses. On the basis that the experts did not criticise Dr Nair’s actions, the Tribunal was satisfied that this element of the examination did not amount to misconduct.

Paragraph 1g(i)

48. The Tribunal found proved that on 9 June 2015, Dr Nair consulted with Patient A and he failed to offer Patient A a chaperone.

49. The Tribunal found that both experts agreed that, if Dr Nair unclipped and lifted Patient A’s bra and lowered her jeans and underwear to her pubic bone leading to exposure of her pubic hair, then a chaperone should have been offered. The experts agreed that a failure to offer a chaperone was seriously below the standard.

50. The Tribunal accepted the experts’ opinions. It noted that Dr Nair’s failure resulted in distress and embarrassment for Patient A and determined that his actions in failing to offer Patient A a chaperone were seriously below the standard and amounted to misconduct.

Paragraph 1g(ii)

51. The Tribunal found proved that on 9 June 2015, Dr Nair consulted with Patient A and he failed to offer appropriate covering material for Patient A’s buttocks or thighs during his examination of her legs for deep vein thrombosis.

52. The Tribunal noted it was Dr M’s opinion that if Patient A was examined lying on her front with her buttock exposed, then a failure to offer covering material would be seriously below the standard. It was Professor N’s opinion that such a failure would be below the standard.

53. The Tribunal found that Patient A was lying on her front when she was examined. It also noted that Patient A was wearing ‘thong’ type underwear which would
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have been obvious to Dr Nair when he examined her. It had led to exposure of the patient’s buttocks resulting in embarrassment and distress to her. The Tribunal preferred Dr M’s evidence that Dr Nair’s actions in failing to offer covering material was seriously below the standard and amounted to misconduct.

Patient B

Paragraph 2a(ii) and 2b

54. The Tribunal found proved that on 29 May 2015, Dr Nair consulted with Patient B and he lifted up Patient B’s bra and unfastened her bra.

55. The Tribunal noted that both experts considered Dr Nair’s action in lifting up Patient B’s bra to be seriously below the standard. In relation to unfastening Patient B’s bra, Dr M considered this was seriously below the standard and Professor N considered this would be below the standard.

56. The Tribunal accepted the experts’ opinions in relation to Dr Nair lifting up Patient B’s bra and preferred the opinion of Dr M in relation to Dr Nair unfastening Patient B’s bra. The lifting and unfastening of Patient B’s bra had been of concern to her and caused her distress. The Tribunal was satisfied that Dr Nair’s actions in lifting up and unfastening Patient B’s bra was seriously below the standard and amounted to misconduct.

Paragraph 2d

57. The Tribunal found proved that on 29 May 2015, Dr Nair consulted with Patient B and he carried out an assessment of Patient B’s thigh circumference.

58. The Tribunal noted that both experts agreed there could be have been a clinical reason for Dr Nair carrying out an assessment of Patient B’s thigh circumference. The Tribunal accepted the experts’ opinion and was satisfied that this element of the examination did not amount to misconduct.

Paragraph 2e(i)

59. The Tribunal found proved that on 29 May 2015, Dr Nair consulted with Patient B and failed to afford Patient B the opportunity to move her own clothing as set out in paragraphs 2a(ii) and 2b.

60. The Tribunal noted that both experts considered Dr Nair’s actions in failing to afford Patient B the opportunity to move her own clothing, by him lifting her bra was seriously below the standard.

61. The Tribunal found that Dr Nair’s action in failing to afford Patient B the opportunity to move her own clothing before he lifted and unfastened her bra was
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seriously below the standard. The failure had caused Patient B embarrassment and distress. It was satisfied that Dr Nair’s actions amounted to misconduct.

Paragraph 2e(ii)

62. The Tribunal found proved that on 29 May 2015, Dr Nair consulted with Patient B and failed to obtain Patient B’s consent to move her clothing as set out in paragraphs 2a(ii) and 2b.

63. The Tribunal noted that both experts agreed that a failure to obtain consent for the removal of clothing was seriously below the standard.

64. The Tribunal accepted the experts’ opinions. The failure to obtain consent resulted in Dr Nair acting without the patient having an awareness of what he was about to do, resulting in embarrassment and distress. The Tribunal was satisfied that this was seriously below the standard and amounted to misconduct.

Patient C

Paragraph 3e(i)

65. The Tribunal found proved that on 10 March 2016 Dr Nair consulted with Patient C and he pulled Patient C’s pyjama bottoms down to her knees.

66. The Tribunal noted that both experts agreed that Dr Nair’s actions in pulling Patient C’s pyjama bottoms down to her knees (if found proved) were seriously below the standard.

67. The Tribunal accepted the experts’ opinions. Dr Nair’s actions in pulling Patient C’s pyjama bottoms down to her knees caused the patient embarrassment and distress. This was seriously below the standard and amounted to misconduct.

Paragraph 3f(i)(1)

68. The Tribunal found proved that on 10 March 2016 Dr Nair consulted with Patient C and he failed to obtain Patient C’s consent before pulling down her pyjama bottoms.

69. The Tribunal noted that both experts agreed that Dr Nair’s actions in failing to obtain Patient C’s consent before pulling down her pyjama bottoms were seriously below the standard.

70. The Tribunal accepted the experts’ opinions. The failure to obtain consent resulted in Dr Nair acting without the patient having an awareness of what he was about to do, resulting in embarrassment and distress. The Tribunal was satisfied that this was seriously below the standard and amounted to misconduct.

Paragraph 3f(ii)(1)
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71. The Tribunal found proved that on 10 March 2016 Dr Nair consulted with Patient C and he failed to afford Patient C the opportunity to pull down her own pyjama bottoms.

72. The Tribunal noted that both experts agreed that Dr Nair’s actions in failing to afford Patient C the opportunity to pull down her own pyjama bottoms were seriously below the standard.

73. The Tribunal accepted the experts’ opinion. The failure to afford Patient C the opportunity to pull down her own pyjama bottoms caused the patient embarrassment and distress. The Tribunal was satisfied that this was seriously below the standard and amounted to misconduct.

Paragraph 3f(iii)

74. The Tribunal found proved that on 10 March 2016 Dr Nair consulted with Patient C and he failed to offer Patient C a chaperone.

75. The Tribunal accepted the experts’ opinions. It noted that his failure resulted in distress and embarrassment for Patient C and determined that Dr Nair’s actions in failing to offer Patient C a chaperone were seriously below the standard and amounted to misconduct.

76. The Tribunal has concluded that Dr Nair’s conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

Impairment

77. The Tribunal having found some of the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct Dr Nair’s fitness to practise is currently impaired.

78. The Tribunal had found that Dr Nair had engaged in misconduct in relation to Patients A, B and C in a number of respects. The misconduct included moving the patients’ clothing in intimate areas, failing to gain consent or allowing them to move clothing themselves and failing to offer them a chaperone. This resulted in their experiencing embarrassment and distress. In the Tribunal’s view these actions represented serious breaches of Good Medical Practice and had resulted in harm being caused to the patients and therefore breaches of fundamental tenets of the profession.

79. In considering the question of Dr Nair’s current impairment the Tribunal therefore considered whether this misconduct was potentially remediable, whether Dr Nair had taken sufficient and effective steps to remediate the misconduct, his degree of insight and whether it could be said that he was unlikely to repeat the misconduct in the future.
80. The Tribunal had found that Dr Nair’s actions had displayed a rather insensitive and inconsiderate approach to the patients’ dignity and feelings. The Tribunal noted Dr Nair’s reflective statement, provided to this Tribunal in May 2019:

‘I was focussed on not making mistakes and getting diagnosis right that I feel that I have put the patient experience on the back bench.

... Having read the determination and finding of facts I have had to come to terms with the reality that my practice at the time was inadequate.’

81. The Tribunal determined that this realisation on the part of Dr Nair indicated that he was capable of developing insight. It also accepted that he had taken some steps towards remediating his misconduct. He had engaged in learning and directed Continuing Professional Development courses over a period and had produced a reflective statement.

82. The Tribunal noted that following the complaint of Patient A in June 2015 Dr Nair had engaged with Dr J, Consultant Surgeon and responsible Officer, Frimley Health NHS Foundation Trust and had suggested at that time that he was going to undertake appropriate remediation.

83. The Tribunal noted the letter dated 25 April 2016 from Dr J, which states:

‘.. We discussed his communication skills and he accepted that although he thought he had explained to the patient his actions in examining her, she had clearly not understood him hence her feeling uncomfortable when he undid her bra to listen to her heart and examined her pulses. That discussion included asking the patient if she understood, and gaining the patient’s permission to perform the examination and we also discussed the vital importance of having a chaperone both for the patient’s safety and the doctor’s protection.’

84. It also noted paragraph 12 of Dr J’s GMC witness statement which states:

‘12. I recall that having interviewed Dr Nair I pointed out to him that it was apparent that he wasn’t communicating as well as he thought he was with his patients and I suggested to him that he a) take time to reflect on this and b) take actions to improve his examination technique and his communication skills. I suggested to Dr Nair that he should check his patients’ understanding of what he had just communicated to them as his own perception of their level of understanding might be incorrect.’

85. In March 2016, however, in his consultation with Patient C, Dr Nair failed again to act appropriately and the Tribunal had found that he had committed further misconduct in regard to this examination. The Tribunal concluded that Dr Nair had not sufficiently learnt from his past mistakes to avoid committing further misconduct on this occasion. Dr Nair’s evidence to the Tribunal had been that he had not considered that the patient had required a chaperone and had not offered one. It noted that despite
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Dr J’s advice on the use of a chaperone and his recommendation for Dr Nair to improve his communication skills, Dr Nair had nevertheless failed to develop a sufficient understanding of the needs of the patients.

86. The Tribunal noted Dr Nair’s reflective statement which demonstrated that it was only after hearing the patients give evidence to the Tribunal that he fully understood the effect of his actions on them and he then reflected further on his practice as a doctor. Dr Nair undertook a ‘Clinic for Boundaries Studies’ course in December 2018, as a result of which he has engaged in further reflection on his practice.

87. Dr Nair has undertaken further courses in March and April 2019 on such topics as consent, communication and respecting dignity and privacy. He has undertaken a chaperone course in March 2019 and as a result stated he has fully considered the guidance on chaperones.

88. Dr Nair gave evidence to the Tribunal about his recent employment and the opportunities he has had to put his learning into practice. The Tribunal found that he had only limited opportunities to put into practice his recent reflections and learning. He was able to give limited examples as to how he has been able to put his learning into practice and to begin the process of embedding it.

89. Considering his past misconduct and the steps that Dr Nair has taken to remediate it, the Tribunal considered that he has engaged in a process of developing remediation that is still ongoing today. His insight, learning and reflection on that learning still require further opportunity to be tested in practice. Many of the courses he had undertaken had been within recent months. In the past Dr Nair had had advice on taking steps to remediate his misconduct but had not at that time gone on to sufficiently embed his learning to develop his practice and avoid similar errors.

90. The Tribunal concluded that whilst it accepts that Dr Nair is engaging in genuine attempts at remediation and has developed insight into his past behaviours, it was not satisfied that he has fully completed the process of developing his learning and embedding his insight and incorporating it into his daily clinical practice. The Tribunal would wish to see concrete examples and explanations of how he would enforce his learning in practise and avoid the risk of further similar errors.

91. Therefore the Tribunal could not be satisfied on the evidence before it that there is no longer a risk that Dr Nair might repeat his misconduct in the future. In its view he is still currently in the process of embedding his remediation and reflection into practice. Therefore the Tribunal concluded that since it cannot be satisfied that there is presently no risk of repetition, Dr Nair’s fitness to practice is impaired by reason of his misconduct.
Determination on Sanction - 22/05/2019

1. Having determined that Dr Nair’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 what action, if any, it should take with regard to Dr Nair’s registration.

The Evidence

2. The Tribunal has taken into account the background to the case and the evidence received during the earlier stages of the hearing where relevant to reaching a decision on what action, if any, it should take with regard to Dr Nair’s registration.

Ms Hudson’s Submissions

3. On behalf of the GMC, Ms Hudson submitted that the GMC’s position is that the appropriate and proportionate sanction is one of conditions. Ms Hudson referred the Tribunal to the Sanctions Guidance (February 2018) (the SG). In relation to the public confidence aspect of the case Ms Hudson referred the Tribunal to paragraphs 14 and 17 in of the SG which states:

’14. The main reason for imposing sanctions is to protect the public. This is the statutory overarching objective, which includes to:

a protect and promote the health, safety and wellbeing of the public

b promote and maintain public confidence in the medical profession

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

17. Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients’ trust in them and the public’s trust in the profession (see paragraph 65 of Good medical practice). Although the tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.’

4. In relation to the issue as to whether conditions might be appropriate Ms Hudson referred the Tribunal to the following paragraphs in of the SG which state:

’79. Similar to undertakings, conditions restrict a doctor’s practice or require them to do something. But conditions are imposed on, rather than agreed with, the doctor for up to three years. The conditions can be renewed for a further three-year period each time they are reviewed.
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80. In many cases, the purpose of conditions is to help the doctor to deal with their health issues and/or remedy any deficiencies in their practice or knowledge of English, while protecting the public. In such circumstances, conditions might include requirements to work under supervision.

81. Conditions might be most appropriate in cases:

a  ...

b involving issues around the doctor’s performance

c where there is evidence of shortcomings in a specific area or areas of the doctor’s practice

d where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision.

82. Conditions are likely to be workable where:

a the doctor has insight

b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings

c the tribunal is satisfied the doctor will comply with them

d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.’

5. Ms Hudson submitted that she did not seek to advance any particular conditions on behalf of the GMC. She said that particular conditions was a matter for the Tribunal as was the period for which the conditions should be imposed.

6. Mr Hudson submitted that the Tribunal had identified an aggravating feature of the case in its impairment determination in the fact that there had been a repetition of the mistakes by Dr Nair despite earlier advice, learning and reflection.

Mr McCartney’s submissions

7. On behalf of Dr Nair, Mr McCartney submitted that conditions would be the appropriate sanction in this case. In relation to the examination of Patient C, Mr McCartney reminded the Tribunal that there had been some change in Dr M’s position on chaperoning in the course of giving evidence. Professor N had taken a stricter view. He further submitted that Dr Nair’s current position with regard to chaperoning has developed and he now has a much broader view in relation to circumstances when a chaperone should be present. Dr Nair now understands that the requirement is not restricted purely to intimate examinations. Mr McCartney requested the Tribunal accept that Dr Nair has now firmly embedded his knowledge as to the necessity for and the use of chaperones.

8. Mr McCartney referred the Tribunal to Dr Nair’s attendance on the extensive course ‘Clinic for Boundaries Studies’. He reminded the Tribunal of its observation in its determination that Dr Nair has been unable to put into practice his learning and reflection. He submitted that as Dr Nair understood matters, the Tribunal was looking for further
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evidence to allay any fears of repetition of his misconduct and to ensure he has evidence to demonstrate his errors have not been repeated. Mr McCartney told the Tribunal that Dr Nair is currently working for a locum agency, Pro Medical. He said that it is Dr Nair’s intention to remain with this agency for the next year and his long term goal is to seek an ST3 training post in respiratory medicine having previously worked in acute medicine.

9. Mr McCartney told the Tribunal that Dr Nair’s interim order was revoked on 3 May 2019 in light of the Tribunal’s findings on fact announced in March 2019. He told the Tribunal that due to the allegation of sexual misconduct at the time, a central condition of the interim order had been a chaperoning condition. This allegation of sexual misconduct had been announced as not proved in March 2019. He told the Tribunal that that due to this condition Dr Nair had found it very difficult to gain employment. Mr McCartney submitted that in light of the facts found proved a chaperoning condition was no longer necessary. He submitted that Dr Nair’s inability to provide evidence of putting his learning into practice, which was a concern of the Tribunal, was explained to a large degree by Dr Nair’s difficulty in gaining employment.

10. Mr McCartney told the Tribunal that as soon as the interim conditions had been revoked Dr Nair was able to gain employment at Maidstone and Tunbridge Wells Hospital. He referred the Tribunal to the Consultant Supervision document and the patient feedback forms Dr Nair provided at the impairment stage. He submitted that these provided some evidence of Dr Nair’s improved communication and patient handling skills.

11. Mr McCartney stated that if the Tribunal is minded to impose conditions, a condition could be devised for Dr Nair to obtain a monthly report from his clinical supervisor from any locum placements he undertakes. Every three months he should discuss those reports with his Responsible Officer at Pro Medical. Mr McCartney told the Tribunal that depending on the sanction imposed, the Compliance Manager at Pro Medical has confirmed that the Responsible Officer should support Dr Nair while he is employed by the agency.

12. Mr McCartney stated that, depending on the length of the sanction imposed, Dr Nair could undergo monthly assessments with his clinical supervisor. If conditions were imposed for 12 months a reviewing Tribunal would have 12 reports to consider. He said that in addition, Dr Nair’s Responsible Officer would be able to provide a report to the reviewing Tribunal. Mr McCartney submitted that the suggested conditions would serve to both address the concerns raised by the Tribunal in its determination and also allow Dr Nair to focus on and develop the areas requiring remediation. He submitted that there was no longer a justification for imposing a general chaperoning condition. He said this would be counterproductive, in light of the Tribunal’s requirement that he embed his learning. He said that such a condition would make it extremely difficult for Dr Nair to demonstrate embedding his learning and reflection in his practice.

13. Mr McCartney submitted that a condition imposing a minimum period in relation to locum work would restrict Dr Nair’s ability to gain employment. He submitted and Dr Nair confirmed that in the past he has rarely undertaken ‘one-off’ locum shifts. He has usually worked in locum posts of not less than a week. Mr McCartney confirmed that the Interim Orders Tribunal did not impose such a restriction.
14. Mr McCartney reminded the Tribunal that prior to his misconduct Dr Nair had had a previously unblemished career. Since the misconduct occurred he submitted there had been no repetition of his misconduct. Mr McCartney submitted that the question of risk based on the Tribunal’s findings appears to be limited to Dr Nair not having the opportunity to demonstrate his learning and reflection.

The Tribunal’s Determination

15. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken account of the SG. It has borne in mind that the purpose of the sanctions is not to be punitive, but to protect patients and the wider public interest, although they may have a punitive effect.

16. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Nair’s interests with the public interest. The public interest includes, amongst other things, the protection of patients, the maintenance of public confidence in the profession, and the declaring and upholding of proper standards of conduct and behaviour.

17. The Tribunal has already given a detailed determination on impairment and it has taken those matters into account during its deliberations on sanction.

Aggravating Factors

18. The Tribunal considered the following to be aggravating factors:

- Dr Nair’s misconduct was repeated despite being given advice by Dr J
- Dr Nair was late in developing insight into his misconduct (Dr Nair’s insight began to develop firstly after hearing the impact it had on witnesses and secondly following the Tribunal’s determination on facts).

Mitigating Factors

19. The Tribunal considered the following to be mitigating factors:

- Dr Nair’s previous unblemished career
- Dr Nair has undertaken a number of courses to remediate his misconduct
- Dr Nair has demonstrated developing insight
- Dr Nair is a relatively junior doctor.

The Tribunal’s Decision

No Action
20. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Nair’s case, the Tribunal first considered whether to conclude the case by taking no action.

21. The Tribunal considered that there were in this case no exceptional circumstances which might justify taking no action against a Dr Nair’s registration. The Tribunal determined that in view of the Tribunal’s findings on impairment, it would be neither sufficient, proportionate nor in the public interest, to conclude this case by taking no action.

Conditions

22. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Nair’s registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

23. The Tribunal has borne in mind paragraphs 52a, 52b and 52c of the SG which state:

'52. A doctor is likely to lack insight if they:

a. refuse to apologise or accept their mistakes

b. promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing

c. do not demonstrate the timely development of insight

d...'f

24. The Tribunal had noted in its determination on impairment that Dr Nair had been given advice by Dr J to improve his patient communication skills and the importance of having a chaperone. However, in March 2016, in his consultation with Patient C, Dr Nair had failed again to act appropriately committing further misconduct in regard to this examination.

25. The Tribunal however, accepted that over recent months Dr Nair had taken significant steps to remediate his misconduct. Since the hearing in October 2018 he had attended relevant courses and undertaken relevant training. In particular, he had attended the extensive ‘Clinic for Boundary Studies’ course in December 2018.

26. In addition Dr Nair had provided the Tribunal with a considered and detailed reflection document. He had also undertaken a chaperoning course and considered and reflected on ‘The Model Chaperone Framework’. The Tribunal accepted that this demonstrated he had engaged in considerable re-evaluation of his actions. The Tribunal’s concern was that whilst he had gained insight into his misconduct he had had
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little opportunity to demonstrate the embedding of his learning and reflection into practice.

27. The Tribunal was satisfied as a result that Dr Nair has developing insight. It was further of the view that a period of supervision was likely to be the most appropriate way of addressing its findings of impairment. In view of the steps that Dr Nair had taken so far, the Tribunal was of the view that Dr Nair is likely to comply with conditions and that he has the potential to respond positively to remediation and supervision. Therefore, the Tribunal concluded that it was appropriate to impose conditions on Dr Nair’s registration.

28. Dr Nair had told the Tribunal that he does not seek locum position of less than a week and had rarely undertaken any, for reasons of convenience. The Tribunal was concerned that, since he still requires to be supervised and has yet to fully embed his learning, sort periods of locum work of less than one week would render conditions unworkable in practice. In light of the fact that Dr Nair does not actively seek the same and having balanced his interests with the risks identified, the Tribunal determined to restrict his locum work to periods of not less than five working days.

29. The Tribunal determined that conditional registration for a period of 12 months, with a review, to be the appropriate and proportionate sanction in this case. The Tribunal is of the opinion that 12 months will enable Dr Nair to fully remediate his misconduct and to provide sufficient evidence to the reviewing Tribunal that he has embedded his learning and reflection into his clinical practice. The conditions are as follows:

1. He must personally ensure the GMC is notified of the following information within seven calendar days of the date these conditions become effective:

   a The details of his current post, including:
      i his job title
      ii his job location
      iii his responsible officer (or their nominated deputy)

   b the contact details of his employer and any contracting body, including his direct line manager

   c any organisation where he has practising privileges and/or admitting rights

   d any training programmes he is in
2. He must personally ensure the GMC is notified:
   
a. of any post he accepts, before starting it

   b. that all relevant people have been notified of his conditions, in accordance with condition 12.

   c. if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings

   d. if any of his posts, practising privileges, or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination

   e. if he applies for a post outside the UK.

3. He must allow the GMC to exchange information with any person involved in monitoring his compliance with his conditions.

4. a. He must have a workplace reporter appointed by his responsible officer (or their nominated deputy).

   b. He must not work until:

      i. his responsible officer (or their nominated deputy) has appointed his workplace reporter

      ii. he has personally ensured that the GMC has been notified of the name and contact details of his workplace reporter.

5. a. He must design a Personal Development Plan (PDP), with specific aims to address the deficiencies in the following areas of his practice:

   • Communication with patients
   • Appropriate use of chaperones
   • Clinical examination for Thromboembolic Diseases

   b. His PDP must be approved by his responsible officer (or their nominated deputy).

   c. He must give the GMC a copy of his approved PDP within three months of these substantive conditions becoming effective.
d  He must give the GMC a copy of his approved PDP on request.

e  He must meet with his responsible officer (or their nominated deputy), as required, to discuss his achievements against the aims of his PDP.

6. He must get the approval of the GMC before working in a non-NHS post or setting.

7. a  He must be supervised in all of his posts by a clinical supervisor, as defined in the *Glossary for undertakings and conditions*. His clinical supervisor(s) must be appointed by his responsible officer (or their nominated deputy).

   b  He must not work until:

      i  his responsible officer (or their nominated deputy) has appointed his clinical supervisor and approved his supervision arrangements

      ii he has personally ensured that the GMC has been notified of the name and contact details of his clinical supervisor(s) and his supervision arrangements.

8. a  He must meet with his clinical supervisor(s), in person, at least once a fortnight for a case-based discussion unless his post is only one week’s duration in which case he must provide evidence of some form of workplace based assessment.

    b  He must provide evidence of these meetings with his clinical supervisor(s).

9.  He must not work in any locum post or fixed term contract of less than five working days’ duration.

10. a  He must keep a log in every case where he has consulted with a patient where a chaperone has been present. This log must detail the reasons for the use of the chaperone and be signed by that chaperone.

    b  He must give the GMC a copy of this log on request.

11. He must have a mentor who is approved by his responsible officer (or their nominated deputy).

12. He must personally ensure the following persons are notified of the conditions listed at 1 to 11:
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a his responsible officer (or their nominated deputy)

b the responsible officer of the following organisations:

i his place(s) of work, and any prospective place of work (at the time of application)

ii all of his contracting bodies and any prospective contracting body (prior to entering a contract)

iii any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application)

iv any locum agency or out of hours service he is registered with

v if any of the organisations listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within that organisation. If he is unable to identify that person, he must contact the GMC for advice before working for that organisation.

c his immediate line manager and senior clinician (where there is one) at his place of work, at least 24 hours before starting work (for current and new posts, including locum posts).

30. The Tribunal determined to direct a review of Dr Nair’s case. A review hearing will convene shortly before the end of the period of conditional registration, unless an early review is sought. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Nair to demonstrate how he has fully remediated his misconduct. It therefore may assist the reviewing Tribunal if Dr Nair provided in advance of its hearing:

- Copy of his chaperone log
- Evidence of meetings with his clinical supervisor(s)
- Update on his Personal Development Plan
- A report from his Responsible Officer
- Evidence of Continuing Professional Development
- Any relevant Patient/Colleague feedback

31. Dr Nair will also be able to provide any other information that he considers will assist.

32. The Tribunal has directed to impose conditions on Dr Nair’s registration for a period of 12 months. The MPTS will send Dr Nair a letter informing him of his right of appeal and when the direction and the new sanction will come into effect.
Determination on Immediate Order - 22/05/2019

1. Having determined to impose conditions on Dr Nair’s registration, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Ms Hudson referred the Tribunal to the paragraph 172 of the Sanctions Guidance (February 2018) (the SG), which states:

‘172. The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.’

3. Ms Hudson submitted that in light of the Tribunal’s finding on impairment and given Dr Nair’s developing insight and need to remediate, an immediate order of conditions was necessary. She stated, given that the Tribunal considered that Dr Nair requires to remediate his misconduct, that should start immediately. She reminded the Tribunal that were Dr Nair to appeal there would be no order in place as the interim order had been revoked.

4. On behalf of Dr Nair, Mr McCartney submitted that the substantive conditions imposed are unworkable. He referred the Tribunal to paragraph 172 of the SG, and stated that the test is the same test as the Interim Order Tribunal. He reminded the Tribunal that the Interim Order Tribunal revoked its order as Dr Nair’s misconduct did not meet the criteria of protecting the public or otherwise in the public interest. He stated that since the Interim Order was revoked this Tribunal has received Dr Nair’s evidence in relation to his remediation. He submitted that the Interim Orders Tribunal did not have before it the evidence of remediation that Dr Nair has undertaken. Mr McCartney submitted that the test is not met and therefore an immediate order is not necessary. He stated that it would be unfair for an immediate order to be made.

The Tribunal’s Determination

5. The Tribunal reminded its self of paragraphs 78 and 91 of its impairment determination which state:

‘78. The Tribunal had found that Dr Nair had engaged in misconduct in relation to Patients A, B and C in a number of respects. The misconduct included
moving the patients’ clothing in intimate areas, failing to gain consent or allowing them to move clothing themselves and failing to offer them a chaperone. This resulted in their experiencing embarrassment and distress. In the Tribunal’s view these actions represented serious breaches of Good Medical Practice and had resulted in harm being caused to the patients and therefore breaches of fundamental tenets of the profession.

91. Therefore the Tribunal could not be satisfied on the evidence before it that there is no longer a risk that Dr Nair might repeat his misconduct in the future. In its view he is still currently in the process of embedding his remediation and reflection into practice. Therefore the Tribunal concluded that since it cannot be satisfied that there is presently no risk of repetition, Dr Nair’s fitness to practice is impaired by reason of his misconduct.’

6. The Tribunal also reminded itself of paragraph 24 in its sanction determination, which states:

‘7. The Tribunal had noted in its determination on impairment that Dr Nair had been given advice by Dr J to improve his patient communication skills and the importance of having a chaperone. However, in March 2016, in his consultation with Patient C, Dr Nair had failed again to act appropriately committing further misconduct in regard to this examination.’

8. The Tribunal noted paragraph 21 and 22 of the SG, which state:

‘21. However, once the tribunal has determined that a certain sanction is necessary to protect the public (and is therefore the minimum action required to do so), that sanction must be imposed, even where this may lead to difficulties for a doctor. This is necessary to fulfil the statutory overarching objective to protect the public.

22. The doctor may have had an interim order to restrict or remove their registration while the GMC investigated the concerns. However, the tribunal should not give undue weight to whether a doctor has had an interim order and how long the order was in place. This is because an interim orders tribunal makes no findings of fact, and its test for considering whether to impose an interim order is entirely different from the criteria that medical practitioners tribunals use when considering an appropriate sanction on a doctor’s practice.’

9. Having considered the submissions, and in the light of all the circumstances of the case, the Tribunal is satisfied that it had identified in its determination on impairment, a risk of harm to patients that persisted whilst Dr Nair’s fitness to practise remains impaired. This is a risk to patients were Dr Nair to be allowed to practise unrestricted. The Tribunal is satisfied that it is necessary for the protection of members of the public and in the public interest for Dr Nair’s registration to be subject to immediate conditions. The conditions are as follows:
1. He must personally ensure the GMC is notified of the following information within seven calendar days of the date these conditions become effective:
   
   a. The details of his current post, including:
      
      i. his job title
      
      ii. his job location
      
      iii. his responsible officer (or their nominated deputy)
   
   b. the contact details of his employer and any contracting body, including his direct line manager
   
   c. any organisation where he has practising privileges and/or admitting rights
   
   d. any training programmes he is in
   
   e. of the contact details of any locum agency or out of hours service he is registered with

2. He must personally ensure the GMC is notified:
   
   a. of any post he accepts, before starting it
   
   b. that all relevant people have been notified of his conditions, in accordance with condition 12.
   
   c. if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings
   
   d. if any of his posts, practising privileges, or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination
   
   e. if he applies for a post outside the UK.

3. He must allow the GMC to exchange information with any person involved in monitoring his compliance with his conditions.

4. a. He must have a workplace reporter appointed by his responsible officer (or their nominated deputy).
b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his workplace reporter

ii he has personally ensured that the GMC has been notified of the name and contact details of his workplace reporter.

5. a He must design a Personal Development Plan (PDP), with specific aims to address the deficiencies in the following areas of his practice:

- Communication with patients
- Appropriate use of chaperones
- Clinical examination for Thromboembolic Diseases

b His PDP must be approved by his responsible officer (or their nominated deputy).

c He must give the GMC a copy of his approved PDP within three months of these substantive conditions becoming effective.

d He must give the GMC a copy of his approved PDP on request.

e He must meet with his responsible officer (or their nominated deputy), as required, to discuss his achievements against the aims of his PDP.

6. He must get the approval of the GMC before working in a non-NHS post or setting.

7. a He must be supervised in all of his posts by a clinical supervisor, as defined in the *Glossary for undertakings and conditions*. His clinical supervisor(s) must be appointed by his responsible officer (or their nominated deputy).

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his clinical supervisor and approved his supervision arrangements

ii he has personally ensured that the GMC has been notified of the name and contact details of his clinical supervisor(s) and his supervision arrangements.

8. a He must meet with his clinical supervisor(s), in person, at least once a fortnight for a case-based discussion unless his post is
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only one week’s duration in which case he must provide evidence of some form of workplace based assessment.

b. He must provide evidence of these meetings with his clinical supervisor(s).

9. He must not work in any locum post or fixed term contract of less than five working days’ duration.

10. a He must keep a log in every case where he has consulted with a patient where a chaperone has been present. This log must detail the reasons for the use of the chaperone and be signed by that chaperone.

b He must give the GMC a copy of this log on request.

11. He must have a mentor who is approved by his responsible officer (or their nominated deputy).

12. He must personally ensure the following persons are notified of the conditions listed at 1 to 11.

a his responsible officer (or their nominated deputy)

b the responsible officer of the following organisations:

i his place(s) of work, and any prospective place of work (at the time of application)

ii all of his contracting bodies and any prospective contracting body (prior to entering a contract)

iii any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application)

iv any locum agency or out of hours service he is registered with

v if any of the organisations listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within that organisation. If he is unable to identify that person, he must contact the GMC for advice before working for that organisation.

c his immediate line manager and senior clinician (where there is one) at his place of work, at least 24 hours before starting work (for current and new posts, including locum posts).
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10. This means that Dr Nair’s registration will be subject to the above conditions from today. The substantive direction, as already announced, will take effect 28 days from today, 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.

Confirmed
Date 22 May 2019

Mr Paul Moulder, Chair
Application for 9 October 2018 to be a non-sitting day

1. Mr McCartney, Counsel, on behalf of Dr Nair, made an application for 9 October 2018 to be a non-sitting day. The Tribunal determined to hear this application in private as it related to a personal and professional matter of Mr McCartney.

2. Mr McCartney informed the Tribunal that he had XXX. He told the Tribunal that he had made enquiries as to whether the date could be changed but, unfortunately, his available dates could not be accommodated.

3. Mr McCartney added that that he had requested if XXX could be held in Manchester but that this too could not be accommodated. Mr McCartney apologised for the inconvenience to the Tribunal and the GMC, and submitted that it was an unusual set of circumstances.

4. On behalf of the GMC, Ms Hudson, Counsel, informed the Tribunal that the GMC had three witnesses scheduled for 9 October 2018. She told the Tribunal that enquiries had been made as to whether any of these witnesses could be moved. Ms Hudson added that it was hoped these witness could be moved as they were professional witnesses.

The Tribunal’s decision

5. The Tribunal was provided with the proposed witness timetable to help it in its consideration of Mr McCartney’s application. Based on the indication from the parties following receipt of further disclosure that the issues in the case had narrowed, it was apparent that a requested hiatus in the timetable could be adequately managed.

6. However, the Tribunal accepted that the circumstances were out of Mr McCartney’s control and it noted that he had taken all reasonable steps to attempt to change the date, time and location of XXX. Given this, the Tribunal considered that it would be fair and reasonable to grant Mr McCartney’s application.

7. Accordingly, the Tribunal has determined that 9 October 2018 will be a non-sitting day.
Application to receive evidence by video link

1. On behalf of the GMC, Ms Hudson made an application pursuant to Rule 34(13) of the Rules, for a witness, Ms D, to give evidence via video link.

2. Ms Hudson explained that Ms D was currently giving evidence in another case at the Crown Court. Ms Hudson added that travel arrangements for Ms D would not have been possible for her to give evidence in person, due to where she lives in the country.

3. Ms Hudson submitted that it would be more convenient for Ms D to give her evidence via video link and that the Tribunal would still be able to assess her demeanour despite her not being in the hearing room. Ms Hudson added that a video link would save time, costs, and progress the hearing.

4. Mr McCartney, on behalf of Dr Nair, did not oppose the application.

The Tribunal’s Decision

5. The Tribunal had regard to Rule 34(13) and (14) of the Rules and considered the submissions made by Ms Hudson. It noted that this application was not opposed by Mr McCartney.

6. The Tribunal accepted Ms Hudson’s submissions and agreed that, given the circumstances, it would be appropriate for Ms D to give her evidence via video link. The Tribunal was satisfied that a video link was an expeditious way in which to receive Ms D’s evidence and it was satisfied that it is fair and in the interests of justice to allow this application.
Application that Patient C give oral evidence in chief

Submissions on behalf of Dr Nair

1. Mr McCartney made an application that the Tribunal direct that Patient C give oral evidence in chief in accordance with Rule 34(11)(c). He provided the Tribunal with a skeleton argument and made oral submissions. Mr McCartney submitted that the Rules envisaged such circumstances when it would be appropriate for a witness to give oral evidence in chief.

2. Mr McCartney submitted this was the fair and proper course in light of the particular factors that arise in relation to Patient C’s evidence. Mr McCartney detailed these factors as being the medical evidence concerning Patient C; different accounts provided regarding the examination conducted by Dr Nair and issues with Patient C’s GMC witness statement.

3. Mr McCartney submitted that the medical records reveal that Patient C has on occasions ‘XXX.’ He added that the records disclose that Patient C has described previously feeling let down by healthcare professionals and has expressed a belief that there is a ‘XXX.’

4. Mr McCartney submitted that Patient C has provided a number of differing accounts regarding the examination conducted by Dr Nair. He submitted that her credibility will be central to the Tribunal’s assessment of her allegations, and that in such circumstances, the fairest course is for her to give oral evidence in chief so that her credibility can be assessed during the entirety of her evidence. Mr McCartney made an analogy to the criminal jurisdiction, in which the jury are able to assess a witness’ credibility by watching a pre-recorded interview, when the interviewer is bound by the code of conduct applicable to interviews given under the Achieving Best Evidence procedure.

5. Mr McCartney explained that the difficulty in allowing the witness to adopt her witness statement is that the Tribunal are unable to fully assess the witness, as they do not know how, and in what manner, questions were asked to elicit the contents of the witness statements.

6. In summary, Mr McCartney submitted that:

   a) it is unclear which account the witness is being asked to adopt;
   b) it is unclear to what extent any changes to her witness statement are as a result of the manner in which it was taken, or information that was provided to her;
   c) it would appear that she has been informed of the content of statements taken from other witnesses;
   d) unused material disclosed that she made enquires with regard to conditions on Dr Nair’s practice and other complaints.
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7. After the Tribunal had retired to consider its decision, Mr McCartney applied to make further submissions based on an attendance note dated 10/10/2018 and timed at 12:10pm. This had been taken by the GMC solicitor in the case and detailed comments made by Patient C following review of her GMC witness statement and exhibit. A copy of this attendance note was provided to the Tribunal. Mr McCartney submitted that the contents further support his application that the witness should give oral evidence in chief.

GMC submissions

8. Ms Hudson also provided the Tribunal with a skeleton argument and made oral submissions. She submitted that there was no justifiable reason why the Tribunal should not receive Patient C’s witness statement as evidence-in-chief. Ms Hudson submitted that Rule 34(11) was clear that a signed witness statement must be received as evidence-in-chief.

9. Ms Hudson added that all the points raised by Mr McCartney go to the weight to be attached to Patient C’s evidence and any inconsistencies in the evidence could be explored in cross examination.

10. Ms Hudson further added that the hearing was already overrunning and that it would be unfair and disproportionate to subject Patient C to protracted questioning. Ms Hudson urged the Tribunal to consider that the factors raised by Mr McCartney are actually points that can be dealt with by cross examination. She invited the Tribunal to reject the application and submitted that it could do so without their being any prejudice to Dr Nair’s case.

11. With regard to the attendance note submitted referred to in paragraph 7 above, Ms Hudson submitted that this reflected no more than a witness attending a hearing and reading material not viewed for some months and seeking to provide clarification on certain points. This was similar to what had occurred with other witnesses and was a common occurrence. It could easily be dealt with by the asking of questions to clarify the points recorded within the attendance note.

The Tribunal’s decision

12. The Tribunal carefully considered the skeleton arguments and submissions made by parties. It bore in mind that the key consideration was fairness to both parties and that this was more important than timetabling matters.

13. The Tribunal also had regard to Rule 34(11) of the Rules which states:

‘(11) A Committee or Tribunal must receive into evidence a signed witness statement containing a statement of truth as the evidence-in-chief of the witness concerned, unless—
(a) the parties have agreed;
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(b) a Case Manager has directed; or
(c) the Committee or Tribunal decides, upon the application of a party or of its
own motion, that the witness concerned, including the practitioner, is to give
evidence-in-chief by way of oral evidence;’

14. The Tribunal considered the points raised by Mr McCartney as set out in paragraph 6 a-d above.

15. With regard to a); 'it is unclear which account the witness is being asked to adopt’. The Tribunal did not accept this submission. The Tribunal considered that it was clear that Patient C would be asked to adopt her GMC witness statement and would be subject to appropriate questioning on any variation in her account.

16. With regard to b); 'it is unclear to what extent any changes to her witness statement are as a result of the manner in which it was taken, or information that was provided to her’. The Tribunal considered that the points raised in this submission could be clarified in cross examination, which would be the fair course to adopt as any changes could be explored with Patient C.

17. With regard to c); 'it would appear that she has been informed of the content of statements taken from other witnesses'. The Tribunal again considered that the points raised in this submission could be dealt with in cross examination and that this would be the fair course of action as the issues could be explored with the witness.

18. With regard to d); 'unused material disclosed that she made enquires with regard to conditions on Dr Nair's practice and other complaints.’ The Tribunal did not accept the relevance of this submission as conditions placed on a doctor are a matter of public record. Moreover, as before, it would be open to the defence to ask questions of the witness concerning these matters.

19. Having considered the attendance note referred to above, the Tribunal considered that it had been appropriately disclosed to the defence and that it provided material on which the witness could be further questioned by both parties for the reasons set out above.

20. The Tribunal considered that it would be able to assess Patient C’s credibility by hearing her questioned by the parties and by considering her GMC witness statement and other statements made by the witness, including the attendance note put into evidence.

21. Accordingly, the Tribunal determined to refuse Mr McCartney’s application for Patient C to give oral evidence in chief.
Application to amend the allegation

1. Ms Hudson made an application to amend the allegation in accordance with Rule 17(6) of the Rules. She submitted that Paragraph 3(k) of the allegation was a typographical error and should be Paragraph 3(i)(iii).

2. Mr McCartney did not object to the proposed amendment.

The Tribunal’s decision

3. The Tribunal considered that the reading of Paragraph 3(k) of the allegation did appear to be a typographical error. It determined that it was appropriate to accede to the application to amend the paragraph as recommended made by Ms Hudson. The Tribunal considered that the amendment could be made fairly and without injustice to either party.
Application under Rule 17(2)(g)

Submissions on behalf of Dr Nair

1. Following the conclusion of the GMC’s case, Mr McCartney made submissions under Rule 17(2)g, which provides that:

"the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld"

2. Mr McCartney invited the Tribunal to consider various allegations in relation to Patient B and an agreed summary of the oral evidence (‘the agreed summary’) given by the witnesses who appeared before the Tribunal. The agreed summary had been settled between counsel for the GMC and for the doctor.

3. In relation to paragraph 2a(i), Mr McCartney submitted that, as set out in the agreed summary, Patient B had accepted that she had lifted up her own top. Mr McCartney submitted therefore that there cannot be any basis to proceed in relation to paragraph 2a(i).

4. In relation to paragraph 2c, Mr McCartney submitted that, as set out in the agreed summary, Patient B had accepted that she had taken down her trousers and that Dr Nair would have asked her to do it. In re-examination she had said that she could not remember if it was Dr Nair or her that had taken down the trousers.

5. Mr McCartney submitted that, taking the GMC’s case at its highest, the evidence was that Patient B could not remember what had happened, alternatively that it had been herself who had removed her trousers. Accordingly, there was no reliable evidence that it was more probable than not that Dr Nair had pulled down Patient B’s trousers.

6. In relation to paragraph 2e(i), Mr McCartney submitted it followed that there was no case to go forward concerning a failure to afford Patient B an opportunity to remove her own clothing, in relation to the lifting up of her top (paragraph 2a(i)) and the lowering of her trousers (paragraph 2c).

7. Similarly, in relation to paragraph 2e(ii), he submitted that Patient B clearly did consent to examination because she lifted the top herself. In relation to the removal of her trousers, he submitted that it could not be said that it was more probable than not that here had been a failure. Therefore, he submitted that the Tribunal could not find this paragraph proved.
8. In relation to paragraph 2e(iii), Mr McCartney submitted that Patient B accepted in her evidence and as detailed in the agreed summary, that she had provided consent for a respiratory examination and examination of her legs. With regard to the examination of Patient B’s femoral pulses, he submitted that there was no positive evidence that Dr Nair did not obtain consent before the examination took place.

9. In relation to paragraph 2e(iv), Mr McCartney submitted that Patient B stated in her evidence, as was summarised in the agreed summary, that she had immediately pulled her top down to cover her chest following the chest examination. Mr McCartney submitted that on any sensible view, there was no opportunity for Dr Nair to say to Patient B that she could cover her breasts. As such, Mr McCartney submitted that this could not, therefore, be a failure and could not be found proved as an allegation.

10. In relation to paragraph 2e(v), Mr McCartney submitted that Dr M was clear that he would not regard it as a failing if a chaperone was not present for a chest examination.

11. In relation to paragraph 2e(vi), Mr McCartney submitted that Patient B accepted in her evidence as summarised in the agreed summary, that she knew she was being examined for DVT and PE and accepted that Dr Nair did explain that he was going to do a chest examination from the back. Mr McCartney reminded the Tribunal of Dr M’s evidence that, in any event, he would not regard it as a failing if Dr Nair did not explain the medical reason for the examinations.

12. Mr McCartney then invited the Tribunal to consider paragraph 5 as it pertains to Patient B. In so doing, he invited the Tribunal to consider the case of Soni v General Medical Council [2015] EWHC 364 (Admin) (‘Soni’), and in particular paragraph 61 which states:

‘The crucial question, therefore, is whether on a fair view of the evidence as a whole it was open to the Panel to infer that Mr Soni had deliberately withheld from the Trust sums of money which he had received from the five private patients, and which he knew he should pay to the Trust, and was deliberately dishonest. In my judgment, it was not. Although this was not a criminal charge against Mr Soni, and the GMC only needed to prove its paragraph on the balance of probabilities and not to the higher criminal standard, the principle must nonetheless apply that before an inference could properly be drawn, the Panel had to be able safely to exclude, as less than probable, other possible explanations for Mr Soni’s conduct.’

13. Mr McCartney reminded the Tribunal that Patient B herself did not allege that there was any sexual motivation and had volunteered this information to police. Mr McCartney invited the Tribunal to consider the allegations that remain following its considerations, and then see what is left and what inference can be drawn as regards considering sexual motivation.

GMC submissions
Ms Hudson submitted that in respect of paragraph 2a(i), the Tribunal had the evidence of Patient B, both orally and in various documents and in statements provided, the agreed summary, and its notes as to what she had said under cross examination. Ms Hudson submitted that it was a question on the evidence for the Tribunal, and that while the point is not conceded by the GMC, she had noted what Patient B had said under cross examination. Ms Hudson made a similar submission in respect of paragraph 2c.

In relation to paragraphs 2e(i) and 2e(ii), Ms Hudson submitted that it was for the Tribunal to assess the evidence.

With regard to 2e(iii), Ms Hudson submitted that Patient C was consenting only to a properly conducted respiratory examination and that this case involved the unfastening of her bra and lifting up of the bra without warning. Ms Hudson submitted that there were many unusual features in this examination. With regard to the examination of the femoral pulses, Ms Hudson similarly submitted Patient B could only consent to a medical examination properly conducted.

In relation to paragraph 2e(iv), Ms Hudson submitted that Dr Nair should have been in a position to indicate to Patient B that she could cover her breasts before she pulled down her top.

In relation to paragraph 2e(v), Ms Hudson submitted that Patient B’s breasts were exposed and that this could therefore be considered an intimate examination for which Dr Nair should have offered a chaperone.

In relation to paragraph 2e(vi), Ms Hudson submitted that Patient B was left distressed and decided to complain following the examinations, made a police statement and described matters as a ‘breach of trust’. Ms Hudson submitted that this supported the charge that Dr Nair failed to adequately communicate to Patient B the detail of the examinations.

In relation to paragraph 5 as it relates to the allegations at paragraph 2, Ms Hudson submitted that it was not necessary for Patient B to believe there was sexual motivation for there to be sexual motivation present. Ms Hudson submitted that what was important was the motivation of Dr Nair. She submitted that there was ample evidence from which the Tribunal can make an inference of sexual motivation.

The Tribunal’s Approach

In reaching its decision the Tribunal heard and accepted the advice of the Legally Qualified Chair, who advised it to adopt the approach set out in the case of R v Galbraith [1981] 1 WLR 1039. The Tribunal acknowledged that whilst this was an authority arising in the criminal jurisdiction, it noted that this an accepted test in regulatory cases. Accordingly, the Tribunal distinguished between its approach to the evidence at this stage of the proceedings and its approach at the end of the fact finding.
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stage. It bore in mind that its role at this stage is not to make findings of fact but to
determine whether the evidence heard in the GMC’s case, taken at its highest, is such
that the Tribunal could properly find an alleged fact proved on the balance of
probabilities. The Tribunal bore in mind that if it finds that there is sufficient evidence
for the hearing to proceed on a particular allegation, it will have to decide in the light of
all the evidence before it at the end of the fact finding stage, whether that allegation
has in fact been found proved or not.

22. The Tribunal also considered the case of Soni as referred to by Mr McCartney. In
addition it had regard to the case of Basson v General Medical Council [2018] EWHC505
(Admin) (‘Basson’), and in particular the following extract as referred to by the Legally
Qualified Chair:

‘In Edgington v Fitzmaurice (1885) 29 Ch D 459, Bowen LJ famously said that
the state of a man’s mind is as much a fact as the state of his digestion.
Therefore, in civil proceedings that fact, the state of the man’s mind, is to be
proved in the usual way by the necessary body of evidence on the balance of
probabilities. An appellate challenge to a finding of fact is always highly
demanding. However, the state of a person’s mind is not something that can be
proved by direct observation. It can only be proved by
inference or deduction from the surrounding evidence.’

The Tribunal’s Decision

23. The Tribunal first considered paragraph 2a(i). The Tribunal noted that the GMC’s
case relied heavily on the recollection of Patient B. The Tribunal noted discrepancies
within her written evidence. Under cross examination Patient B accepted that the email
complaint to Ms I was more contemporaneous than her other statements and was likely
to be the more accurate. Within this, Patient B accepted that she had lifted her own
top. The Tribunal considered that on the evidence it had before it, this paragraph could
not be proved on the balance of probabilities. As such the application succeeds in
relation to this allegation.

24. In respect of paragraph 2c, the Tribunal bore in mind that Patient B had stated
in her oral evidence that it was more likely that she had lowered her own trousers. The
Tribunal considered that on the evidence before it, this paragraph could not be proved
on the balance of probabilities. As such the application succeeds in relation to this
allegation.

25. For the reasons outlined above, the Tribunal considered that paragraph 2e(i)
could not be proved in so far it relates to paragraphs 2a(i) and 2c. Therefore, the
application succeeds in relation to 2e(i) in relation to 2a(i) and 2c. It followed that the
application in relation to 2e(ii) as it relates to 2a(i) and 2c, also succeeds for the same
reasons.

26. The Tribunal then considered the application in relation to paragraph 2e(iii). The
Tribunal noted that Patient B accepted in her evidence that she consented to the
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respiratory examination and the examination of her legs, paragraphs 2e(iii)(1) & 2e(iii)(3) respectively. With regard to paragraph 2e(iii)(2), the Tribunal noted that Patient B had stated in her evidence that she had lowered her trousers. The Tribunal considered that, as such, there was an anticipation of an examination in that area and that this action was only really consistent with Patient B having given at least implied consent. The Tribunal therefore determined that the application succeeds in relation to the entirety of paragraph 2e(iii).

27. In respect of paragraph 2e(iv), the Tribunal considered Patient B’s oral evidence in which she stated she immediately pulled her top down following the chest examination. The Tribunal noted in both Patient B’s GMC and Police witness statements, she stated that Dr Nair, having listened to her chest, asked her to turn around but did not request her to pull her bra back up and that she just did this straight away. The Tribunal considered the chronology of the examination and the evidence it had received. As the evidence stood, the Tribunal considered it was open to it to make a finding that Dr Nair could have provided an indication to Patient B that she could have covered her breasts before being asked to turn around. As such, the Tribunal considered that taking this evidence at its highest, this paragraph of the Allegation could be found proved. Accordingly the application is refused in relation to paragraph 2e(iv).

28. In respect of paragraph 2e(v), the Tribunal considered that in order to find a failure to offer a chaperone it would be necessary to first find that there had been an obligation on Dr Nair to offer Patient B a chaperone. The Tribunal had regard to the evidence of the GMC’s expert Dr M, the GMC Guidance on Intimate examinations and chaperones 2013 and Good Medical Practice 2013 edition ("GMP").

29. Dr M had stated that although not common practice, he accepted some teaching hospitals did train doctors to examine patients in this way without the presence of a chaperone. He also stated that the GMC guidance on chaperones was not entirely clear. Dr M stated that, in the circumstances, he was not critical of Dr Nair’s failure to offer a chaperone.

30. Having considered this evidence, the Tribunal considered that, taking the evidence from the GMC at its highest, it could not make a finding that Dr Nair had been obliged to offer a chaperone. Accordingly it acceded to the application in relation to paragraph 2e(v).

31. The Tribunal then considered the application in respect of paragraph 2e(vi). The Tribunal considered that the paragraph alleging a failure to adequately communicate the details of examination in its broadest aspect could embrace matters going beyond merely giving the medical reasons for an examination. It considered that it was possible to find a difference between explaining the medical reasons for an examination and explaining the details of what the examination entailed. The Tribunal noted Dr M’s evidence that it would not be a failure to not communicate the medical reasons. It also noted Patient B’s evidence of having left the examination in a tearful state, of making a complaint and that she had said that she might have asked for a chaperone had she
known what was going to take place. Accordingly, the Tribunal concluded that there was a case to answer that Dr Nair had failed to adequately communicate the details of the examinations to Patient B. As such the application is refused in relation to paragraph 2e(vi).

32. The Tribunal has therefore determined that there has not been sufficient evidence adduced on which it would be possible to find the following paragraphs of the Allegation proved:

- 2a(i), 2c, 2e(i) in relation to 2a(i) & 2c, 2e(ii) in relation to 2a(i) & 2c, 2e(iii) & 2e(v)

33. The Tribunal next considered paragraph 5 in relation to the remaining parts of Paragraph 2 which are:

- 2a(ii), 2b, 2d, 2e(i) in relation to 2a(ii) & 2b, 2e(ii) in relation to 2a(ii) & 2b, 2e(iv) & 2e(vi).

34. In accordance with Basson, the Tribunal considered that it had to make an appropriate inference on the evidence as to the doctor’s motivation. The Tribunal accepted the GMC’s submission that in considering the question of sexual motivation, it should focus on an inference as to the motives of the doctor. Whilst it would take into account the perceptions of the patient, this was not a determining factor.

35. The Tribunal noted Dr M’s evidence questioning the need for a respiratory examination and a lack of a valid reason for the methodology of the examination of Patient B’s thigh. In addition, it noted the allegation included the exposure of Patient B’s breast area and Patient B having been upset by the examination. The Tribunal considered that taken at its highest, this could be evidence leading to an inference of a sexual motivation.

36. The Tribunal considered the test in Soni, that in order to give rise to a particular inference it must be able to find that other possible alternative explanations had been less probable. The Tribunal considered that there were other possible inferences to be drawn, for example that Dr Nair had been over meticulous in his approach, or that he had been guilty of a ‘clumsy’ technique, or that he had adopted a ‘automaton’ approach. The Tribunal considered that it was possible on the evidence to find that these alternatives were less probable and accordingly that it was possible that the finding of an inference of sexual motivation could be made.

37. Accordingly, the application was refused in relation to paragraph 5 so far as it related to the remaining parts in paragraph 2 of the Allegation.
Application to receive evidence by video link

1. On behalf of Dr Nair, Mr McCartney made an application pursuant to Rule 34(13) of the Rules, for a witness, Dr L, to give evidence via video link.

2. Mr McCartney made the application on the basis of Dr L’s clinical commitments and personal circumstances in that she was in the process of moving house. Mr McCartney also added that she was located in Gloucestershire.

3. Ms Hudson, on behalf of the GMC, did not oppose the application.

The Tribunal’s Decision

4. The Tribunal had regard to Rule 34(13) and (14) of the Rules and considered the submissions made by Mr McCartney. It noted that this application was not opposed.

5. The Tribunal accepted Mr McCartney’s submissions and agreed that, given the circumstances, it would be appropriate, fair and in the interests of justice to allow this application.
Admissibility application

1. Mr McCartney made an application that previous redactions to the witness statement of Dr J, be un-redacted in parts, so that questions could be put to Professor N in relation to this material, and so that the Tribunal could see the information that was before Professor N when he formulated his report and the opinions therein.

2. Ms Hudson opposed the application on the basis that it would amount to the back door re-introduction of hearsay evidence which should not be before the Tribunal.

Tribunal decision

3. As a professional Tribunal, the Tribunal considered it was able to turn its mind away from being influenced by evidence which does not have sufficient weight. It appreciated that the unredacted material is hearsay evidence and considered that it was a matter for the Tribunal to determine the question of sexual motivation.

4. The evidence of the expert was important evidence and the Tribunal was of the view that it should have a complete picture. Accordingly, for the purposes of knowing what Professor N was considering when he formulated his report, the Tribunal agreed to Mr McCartney’s application.