Neutral Citation Number: [2023] EWHC 2984 (Admin)

Case No: CO/2319/2023

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30 November 2023

Before :

MICHAEL FORD KC
SITTING AS A DEPUTY HIGH COURT JUDGE

- -

Between :

DR KAMRAN ALI	**Claimant**
- and –	
THE GENERAL MEDICAL COUNCIL	**Defendant**

Gudrun Young KC (instructed by **Weightmans LLP**) for the **Claimant**
Jenni Richards KC (instructed by **GMC Legal Department**) for the **Defendant**

Hearing date: 2 November 2023

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APPROVED JUDGMENT

Michael Ford KC, sitting as a Deputy High Court Judge

Introduction

1. This is an appeal brought by Dr Kamran Ali against a decision of the Medical Practitioners Tribunal (the "Tribunal") dated 15 May 2023, in which the Tribunal determined that some of the allegations against Dr Ali were proven, including that some of his actions towards a patient, referred to as "Patient C", were sexually motivated. That decision led to further determinations by the Tribunal that his fitness to practise was impaired by reason of misconduct and that his name should be erased from the medical register. The appeal is brought under s.40 of the Medical Act 1983 ("MA 1983").

2. The Respondent to the appeal is the General Medical Council (the "GMC"), a body corporate whose functions and powers are set out in the MA 1983. Under s.40 MA 1983 the appeal is against the direction for erasure. The focus of this appeal, however, has been on the Tribunal's Determination on the Facts dated 15 May 2023 (the "Determination") and which led to the subsequent decision that his name should be erased from the Medical Register.

3. The Appellant was represented by Ms Young KC and the Respondent by Ms Richards KC. Both presented helpful written and oral submissions, for which I am very grateful.

Background

4. Dr Ali obtained his GMC registration in December 2008, having already qualified and practised as a junior doctor in Pakistan. He eventually decided to train as a General Practitioner. On 3 August 2016 he joined the Hollies Surgery in Benfleet (the "Surgery"), a practice with six partners, as an ST3 GP trainee/registrar. His Educational Supervisor was Dr Whitear. It was while he was working at the Surgery that the allegations against him arose.

5. The allegations concerned Dr Ali's consultations with four female patients, referred to as Patients A, B, C and D, during the period 15 September to November 2016. The full allegations are set out in the Tribunal's Determination on the Facts and I do not repeat them here.

6. The allegations in relation to Patient A were of inappropriate hand holding, examining her legs without explanation and placing her hands around her calves during a consultation on 16 September 2016. Dr Ali admitted he had examined her calves. The allegations included that his actions were not clinically indicated and were sexually motivated.

7. Those relating to Patient B were that he had asked to examine her vagina and had stared at her at a consultation on 7 October 2016. It was also alleged that these actions were not clinically indicated and were sexually motivated.

8. The allegations in relation to Patient D concerned a consultation on 17 November 2016. It was alleged that at this consultation Dr Ali performed a vaginal examination without a chaperone or wearing gloves and failed to make adequate records. Dr Ali

admitted each of these allegations. It was not alleged that they were not clinically indicated or were sexually motivated.

9. It was the allegations relating to Patient C which were central to the Tribunal's Determination and which were central to this appeal. They concerned a consultation on 10 November 2016. They were listed at §§5-7 of the Determination and Dr Ali made admissions to some, which were consequently found proved under rule 17(2)(e) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 (the "2004 Rules") as the Tribunal explained at §8.

10. Adopting the lettering used by the Tribunal, the allegations relating to Patient C were that Dr Ali had: 5(a) inappropriately placed his hand on Patient C's hand while taking her blood; 5(b) lifted her top without permission; 5(c) lifted her shorts, exposing the lower part of her buttocks without explanation or warning; 5(d) stroked Patient C's buttocks; 5(e) told Patient C he needed to examine her vulva without explanation; 5(f) began to pull down Patient C's shorts without permission; 5(g) used two fingers to open Patient C's labia (admitted by Dr Ali and found proved); 5(h) examined Patient Cs genitals (admitted by Dr Ali and found proved); 5(i) failed to offer her a chaperone (admitted and found proved), obtain her express consent to an intimate examination, give her privacy to dress/undress, wear gloves while undertaking an examination of her genitalia (admitted and found proved) or wash his hands after doing so; 5(l) failed to make an adequate record of the consultation in that he did not record he had performed an intimate examination or whether she had consented to it (both of which were admitted and found proved); 5(k) asked Patient C for her personal contact details because he had said he needed to arrange a mortgage or something similar; and 5(l) requested Patient C's e-mail address.

11. It was further alleged that allegations 5(a)-(i) were not clinically indicated and were sexually motivated (§6(a), §6(b)) and that allegations 5(j)-(l) were sexually motivated (§7). As set out above, Dr Ali admitted allegations 5(g) and 5(h); some elements of (i), as recorded above; and allegation 5(j). The other allegations fell to be determined by the Tribunal. Dr Ali denied any sexual motivation.

12. Criminal charges were brought against Dr Ali and both he and Patient C were interviewed by the police. He was acquitted of those charges in 2018 following a Crown Court trial.

The Determination

13. The hearing before the Tribunal took place between 14 November and 1 December 2022. The Tribunal then heard submissions between 7-8 March 2023 and delivered its Determination on 15 May 2023. The Tribunal comprised a legally qualified chair and two other members, including a medical tribunal member and a lay member. Dr Ali was represented then as now by Ms Young KC. The GMC was represented by Ms Laura Barbour.

14. The hearing heard much oral evidence over many days. Patients A, B and C gave evidence and there was a witness statement from Patient C. Dr Ali also provided a detailed written witness statement (and a supplementary statement). Both he and patient C gave oral evidence and were cross-examined.

15. As noted by the Tribunal at §§13-15, there was expert evidence before it, including a joint statement of the two experts. The documentary evidence relevant to the allegations relating to Patient C is summarised by the Tribunal at §16. It included text messages she had exchanged with her then boyfriend just after the consultation with Dr Ali, a transcript of her interview with the police on 27 November 2016, her police statement, and evidence she had given at the Crown Court. The documentary evidence also included Dr Ali's interview by the police, his training records and the medical records of Patient C, including the entry Dr Ali had made on the day of the consultation.

16. **The Chair's Direction**. After hearing submissions on 8 March 2023, Mr Hoskins, the legally qualified member, gave the Tribunal a direction on the law. He reminded the Tribunal that the burden of proof was on the GMC and the standard of proof was the balance of probabilities, but explaining by reference to authorities such as Lord Nicholls' judgment in ***Re H (Minors)*** [1996] AC 563 that the more serious an allegation, the less likely it is that the event occurred and hence the stronger the evidence that should be required to support it. He also cited Lord Nicholls' familiar dictum in ***Re H***, which is also relied upon by Ms Young KC in this appeal, at at 586F-H:

> "Built into the preponderance of the probability standard is a generous degree of flexibility in respect of the seriousness of the allegation.
>
> Although the result is much the same, this does not mean that where a serious allegation is in issue the standard of proof required is higher. It means only that the inherent probability or improbability of an event is itself a matter to be taken into account when weighing the probabilities and deciding whether the even, on balance, the event occurred. The more improbable the event, the stronger must be the evidence that it did occur before, on the balance of probability, its occurrence will be established."

The Chair warned that as a result the Tribunal must regard evidence of serious allegations with care.

17. The Chair went on to give the Tribunal guidance on cross-admissibility, saying that each allegation was to be considered separately but that if the Tribunal was satisfied that separate allegations were proved and they showed a tendency to behave in a sexually motivated way, it might take those into account in relation to a different patient, though it was not required to do so. He gave guidance on the approach to the evidence, based on two authorities which are relevant to this appeal and which I consider further below: ***R (Dutta) v General Medical Council*** [2020] EWHC 1974 (Admin) and ***R (Khan) v General Medical Council*** [2021] EWHC 374 (Admin).

18. The direction reminded the Tribunal of the fallibility of human memory and how it can become distorted or blurred by the passage of time; how honest and confident witnesses may nonetheless be unreliable, making it important to test their evidence against the known facts and any contemporary documents; and the dangers, emphasised in ***Dutta***, of relying on "demeanour" as a guide to the reliability of a witness. Drawing on ***Dutta***, the direction explained how it would be an:

> "error of principle for any tribunal to begin its consideration of disputed factual evidence by embarking at the outset of its deliberations upon some

> general assessment of the credibility of the various witnesses from whom it has heard"

19. The Chair referred to the definition of sexual motivation given in ***Basson v General Medical Council*** [2018] EWHC 505 (Admin). As it connotes a mental state, he explained it could only be proved by inference, and the Tribunal would want to examine Dr Ai's conduct in light of all the circumstances, including what actually happened, whether or not it was clinically justified, and what was recorded. At the conclusion of the direction, the Chair repeated that Dr Ali need not prove anything and referred to his good character as both supporting his credibility and making it less likely that he acted out of sexual motivation.

20. **The Written Determination**. After setting out the brief background, the allegations against Dr Ali, the admitted facts and the evidence before it, in the written Determination the Tribunal gave itself a rather more succinct self-direction at §§17-21 than the one given by the Chair, but it again referred to the burden and standard of proof, the guidance in ***Dutta***, and Dr Ali's good character. It also summarised the approach on cross-admissibility in relation to sexual motivation at §22.

21. The structure of the Determination was then to consider each allegation in relation to each patient separately. The Tribunal adopted a common form of analysis, consistent with how the allegations were framed. First, the Tribunal considered whether the actions took place - what are usually referred to as the primary facts. Second, in light of those findings it then decided whether the actions were clinically indicated and/or were sexually motivated.

22. I need say little about Patients A, B and D, save to highlight some points that were relevant to arguments raised in the appeal. The Tribunal found it not proved that the actions relating to Patient B were not clinically indicated or sexually motivated. Patient D did not give evidence, the acts relating to her were admitted, but there was no allegation that the actions relating to her were not clinically indicated or were sexually motivated.

23. There were similar allegations of inappropriate hand holding in relation to both Patients A and C. The evidence was that Dr Ali took a pulse by resting his hand on top of the patient's hand. The joint expert statement stated that if he was taking Patient A's pulse, this was entirely appropriate: Determination §28. The expert evidence was that this was a "slightly unusual" but "perfectly valid" way to take a pulse so long as Dr Ali's fingers were on the radial pulse: §§35-36. Dr Ali gave evidence about his method of taking a pulse: §32. In light of the expert evidence, Patient A's concession in cross-examination that she could not exclude the possibility Dr Ali was taking her pulse, Dr Ali's evidence that he had been taking a pulse, and the fact that the medical notes included a pulse measurement, the Tribunal found the allegation of inappropriate hand holding relating to Patient A unproven: §37. Having found two of the allegations against Patient A not proven, and the third, admitted action of examining her calves as clinically indicated, the Tribunal decided the GMC had failed to prove any sexual motivation on the part of Dr Ali in relation to her: §§55-6.

24. One of the allegations against Patient B was that Dr Ali "stared" at her during the

consultation. The Tribunal decided that it was a matter of subjective perception whether Dr Ali looked or stared at her, leading it to decide this allegation was proven: see §§62-66. In the event, however, the Tribunal found it was unproven that this matter was not clinically indicated, owing in particular to the "highly subjective" nature of the allegation and the risk of misinterpretation of Dr Ali's conduct (§77). Having regard to its findings that all Dr Ali's actions relating to Patient B were clinically indicated, the Tribunal decided it was not proved that Dr Ali's actions were sexually motivated: §§79-82.

25. This brings me to Patient C. She attended the appointment on 10 November 2016 wearing gym clothes. She had made the appointment because she had spots on her face, white coating on her tongue and a wish to obtain a prescription for drugs to control anxiety: Determination, §83. There was a more or less contemporaneous text message she sent to her then boyfriend immediately after the consultation, much of which was set out in §84 of Tribunal's Determination. It stated, referring to the consultation she had just had:

> "That weren't right/Went in for spots/And he went do you get them anywhere else o went no....He went can you lay on your front...Was checking my back and bum.. He then asked me to turn over.. And was like to you get any down there and looked at my canyon [*this word is agreed to be a phone-induced misprint for "fanny"*] and touch it/Not right/Fanny*/How weird is that
>
> [*After a response from her boyfriend*]
>
> I know. I was like, no there is nothing down there he went can I look. Then he started actually pulling my shorts down, like completely down/It's gets worse/He when asked for my personal and work email. As he wants me to do his mortgage. And told me I was a very important person [emoji]/I feel violated [emoji]/His not my doctor Iv never seen him before
> ....
> I'm defo leaving the practice/Why did he have to look at my Fanny and bum../Why would I get acne there"

26. The Tribunal referred to Patient C's explanation that she did not report the matter immediately because she did not want to believe she had been sexually assaulted §85, and Dr Ali's evidence about what he recollected of the consultation: §§86-7. It set out the clinical record completed by Dr Ali shortly after the consultation, which recorded an examination showing facial acne, a diagnosis of acne and a treatment plan; referred to Patient B's anxiety for which citalopram was prescribed; recorded her blood pressure at 122/78; and also prescribed adapalene for the acne and nystatin for the white tongue. The notes did not record a vaginal examination or a pulse measurement.

27. The Tribunal then dealt with the allegations about what had in fact taken place during the consultation with Patient C. These are subject to specific challenge under the grounds of appeal, so at this stage I only summarise the conclusions. The Tribunal held that allegation 5(a), of inappropriate hand holding was proven, saying at §94:

> "Patient C's account in relation to this issue has been consistent from a very early point after the consultation. The clinical record does not suggest that a pulse measurement was taken, although the record shows that blood pressure was recorded. The Tribunal considered it unlikely that Dr Ali would forget to

> enter a fundamental routine measurement of this type if indeed he had taken Patient C's pulse manually. The Tribunal accepted the evidence of patient C and finds that Dr Ali was not taking her pulse when he held her hand in the way she described. He was holding her hand inappropriately."

28. Allegation 5(b), of lifting Patient C's top without permission, was found not proven because, in essence, the Tribunal decided that Patient C knew the purpose of her lying on the couch was so that Dr Ali could examine her back: §§96-7. As for allegation 5(c), the Tribunal decided "on the balance of probabilities, it was more likely than not that Dr Ali had lifted Patient C's shorts, exposing the lower part of her buttocks without explanation or warning" (§104).

29. It found allegation 5(d) not proven because, although it considered it more likely than not that stroking had occurred, the evidence of Patient C was that the stroking was not on her buttocks (as alleged) but of the top of her thigh: see §§106-108.

30. The Tribunal concluded that allegation 5(e), that Dr Ali said he needed to examine Patient C's vulva "without explanation" was not proven, principally because in her police interview Patient C had said that Dr Ali had given *an* explanation of why he needed to do such an examination - that he needed to check if she got "acne down there": see §§109, 113.

31. The Tribunal also found allegation 5(f) proven, that Dr Ali pulled down Patient C's shorts without permission. At §120 it stated:

> "The Tribunal accepted Patient C's oral evidence, which was strongly supported by the text message she had sent immediately after the consultation and consistent with the account she gave to the police soon after the examination. Dr Ali had no recollection of the event. It was satisfied, on the balance of probabilities, it was more likely than not that Dr Ali had begun to pull down Patient C's shorts without permission."

32. Of the other allegations that were not admitted, the Tribunal determined that Dr Ali had failed to obtain express consent to conduct an intimate examination (5(i)ii), had failed to give Patient C privacy to dress or undress (5(i)iii), had failed to wash his hands after examining her genitalia (5(i)v): see §§122-134. Finally in the section dealing with primary facts, it decided that Dr Ali had asked for Patient C's personal details in order to arrange a mortgage and had asked for her personal e-mail address, so that allegations 5(k) and (l) were proved: see its reasons at §§135-142.

33. Next the Tribunal turned to whether the admitted actions or those it had found proven were clinically indicated. The answer to this question was driven by a combination of (i) the admitted or proven facts about what had happened and (ii) the joint views of the experts. For example, under allegation 5(a), the Tribunal determined that Dr Ali inappropriately placed his hand on A's hand while taking her blood pressure and was not taking her pulse: see §94. The expert evidence was that there was no clinical reason to hold her hand without taking her pulse, leading to the inevitable conclusion that doing so while taking her blood pressure was not clinically indicated: §§145-6. Similarly, the Tribunal decided that the admitted actions of opening Patient C's labia (allegation 5(g)) and examining her genitals (allegation 5(h)) were not clinically indicated because of its factual finding that Patient C did not complain of symptoms

in this area coupled with the view of the experts that, in the absence of such complaints, the actions were not clinically indicated: see §§149-150. However, it reached a different conclusion about Dr Ali's lifting of Patient C's shorts without explanation because of evidence that she had a rash at the top of her thighs: §147.

34. In the last section of its Determination dealing with Patient C the Tribunal considered whether Dr Ali's actions were sexually motivated. The structure of its analysis was as follows.

35. First, the Tribunal identified the main features of the consultation based on the primary facts it had determined, saying at §152:

> "The main features of the consultation itself were inappropriate hand-holding; the attempted pulling down of Patient C's shorts in preparation for an examination of Patient C's genitalia when there was no complaint of symptoms in that area; no careful discussion of why such an examination might be required; an examination which included touching and opening of labia' and a number of failings which were clearly inconsistent with a properly conducted, professional examination."

36. Next, the Tribunal considered that these features "viewed in the round" indicated that a sexual motive was operating, for the reasons it gave at §153. The Tribunal then addressed the submission from Ms Young KC that Dr A's lack of experience, incompetence, unfortunate manner or other failings might provide an alternative explanation for his conduct. For this purpose it had regard to the evidence of Dr Whitear, Dr Ali's trainer and mentor at the Surgery, the experts' views on his career history and competence, and the evidence of Dr Khokar, with whom Dr Ali worked for about four years at Southend Hospital. Although the Tribunal concluded that Dr Ali found the practice of medicine to be "challenging", it stated at §163:

> "However, the Tribunal considered that a number of the allegations which it found proved could not realistically be attributed to deficiencies in training or lack of knowledge or inexperience when confronted with a patient with more than one complaint".

It went on to give a list of those features, including the conduct of an intimate examination without any "measured conversation" about why it was necessary and Patient C's "expressed reservations and denial of symptoms in that area".

37. The Tribunal next considered and rejected Ms Young's submission that it was "inherently unlikely" a new trainee such as Dr Ali would behave in the way alleged: §164. It reminded itself that the burden of proof was on the GMC but not Dr Ali, and that he was a man of good character (§165). Its ultimate conclusion, however, was that it was proved on the balance of probability that allegations 5(a), 5(f), 5(g), 5(h) and 5(i) were sexually motivated: §166 (there is a typo in §166 referring to 5(l) instead of 5(i)).

38. Finally, the Tribunal addressed the charge that allegations 5(j), 5(k) and 5(l) were sexually motivated. Dr Ali admitted not recording that he had performed an intimate examination or that Patient C had given consent to it (allegation 5(j)). Based on the expert evidence of Dr Caudell, the Tribunal considered that the failure to record the

examination was a "significant omission, particularly in view of the persistence with which Dr Ali had pursued the need for an intimate examination despite Patient C's obvious reluctance" (§169). It concluded that failure, and the failure to make any notes about consent, "arose from a desire to conceal what had in fact occurred and, in this sense, was part of the sexual motivation operating during the consultation": see §169. Lastly, it concluded it was "difficult to envisage any proper reason" for seeking Patient C's personal contact details, holding that on the balance of probabilities Dr Ali's motivation was sexual (§171).

39. **The Later Determinations** Following its finding in the Determination, the Tribunal subsequently decided, in a determination dated 17 May 2023, that Dr Ali's fitness to practise was impaired by reason of misconduct. Following the consideration of further evidence and submissions, in a determination dated 18 May 2023 it decided that the appropriate sanction was that Dr Ali's name be erased from the Medical Register.

The Legal Framework and Principles

40. The overarching objective of the GMC is the protection of the public: see s. 1(1A). Its committees include the Medical Practitioners Tribunal Service (the "MPTS") and the Medical Practitioners Tribunal ("MPT"): see s.1(3) MA 1983. The procedure governing fitness to practise involves an investigation stage and then reference to the MPT: see s.35D. The reasons for which fitness to practise is regarded as impaired include misconduct: s.35D(2)(a).

41. The functions of an MPT are set out in s.35D. It states so far as is material:

> "(1) Where an allegation against a person is referred under section 35C(5)(b) above to the MPTS—
> (a) the MPTS must arrange for the allegation to be considered by a Medical Practitioners Tribunal, and
> (b) a Fitness to Practise Panel, subsections (2) and (3) below shall apply.
>
> (2) Where the Medical Practitioners Tribunal find that the person's fitness to practise is impaired they may, if they think fit—
> (a) except in a health case or language case , direct that the person's name shall be erased from the register;
> (b) direct that his registration in the register shall be suspended (that is to say, shall not have effect) during such period not exceeding twelve months as may be specified in the direction; or
> (c) direct that his registration shall be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with such requirements so specified as the Tribunal think fit to impose for the protection of members of the public or in his interests."

42. The relevant rules governing the MPT when it hears matters under s.35D are set out in Part 4 of the 2004 Rules. By rule 17(2)(j) the MPT gives reasons for its findings of fact.

43. Where an MPT directs that a person's name shall be erased from the register under s.35D(2), the MPTS must inform the person concerned of his right to appeal under s.40 MA 1983. It is s.40 which provides for the right of appeal against a decision of erasure. In England and Wales the appeal is brought to the High Court: see s.40(4)(5). The powers on appeal are set out in s.40(7):

> "(7) On an appeal under this section from a Medical Practitioners Tribunal , the court may—
> (a) dismiss the appeal;
> (b) allow the appeal and quash the direction or variation appealed against;
> (c) substitute for the direction or variation appealed against any other direction or variation which could have been given or made by [a Medical Practitioners Tribunal][14] ; or
> (d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court,
> and may make such order as to costs (or, in Scotland, expenses) as it thinks fit."

The GMC may appear as a respondent on an appeal: see s.40(9). It has a more restricted right of appeal in s.40A.

44. An appeal under s.40 is governed by rule 52.21(3) of the Civil Procedure Rules ("CPR"), by which the Court will allow an appeal where the decision of the lower court was "(a) wrong; or (b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court". The appeal court may draw inferences of fact which it considers justified on the evidence: CPR rule 25(4). An appeal under s.40 of the MA 1983 is by way of a re-hearing, as stated in CPR Practice Direction 52D, §19.

45. There was no disagreement about the relevant principles to be applied on this appeal. It is common ground that the burden of proof was on the GMC and the standard of proof is the balance of probabilities. Although the appeal under s.40 is a rehearing and is not limited to a review, appropriate respect should be given to the decision of the MPT. The degree of deference depends on the circumstances and must not be more than is warranted by the circumstances: see Lord Millett in ***Ghosh v GMC*** [2001] 1 WLR 1915 at §34, cited along with other guidance by the Court of Appeal in ***Sastry v General Medical Council*** [2021] 1 WLR 5029 at §103. See, similarly, ***Bhatt v GMC*** [2011] EWHC 783 (Admin), to which Ms Young KC referred me, and in which Langstaff J, after reviewing the case law, summarised the principles in the following terms (§9):

> "9. I accept and adopt the approach outlined in these authorities, in particular that although the court will correct errors of fact or approach:
> i) it will give appropriate weight to the fact that the Panel is a specialist tribunal, whose understanding of what the medical profession expects of its members in matters of medical practice deserves respect;
> ii) that the tribunal has had the advantage of hearing the evidence from live witnesses;
> iii) the court should accordingly be slow to interfere with the decisions on matters of fact taken by the first instance body;
> iv) findings of primary fact, particularly if founded upon an assessment of the credibility of witnesses, are close to being unassailable, and must be shown with reasonable certainty to be wrong if they are to be departed from;
> v) but that where what is concerned is a matter of judgement and evaluation of evidence which relates to police practice, or other areas outside the immediate focus of interest and professional experience of the FTPP, the

> court will moderate the degree of deference it will be prepared to accord, and will be more willing to conclude that an error has, or may have been, made, such that a conclusion to which the Panel has come is or may be "wrong" or procedurally unfair."

46. Both counsel referred me to ***Dutta v GMC***, in which Warby J (as he then was) distilled the principles from a number of authorities, referred to by him at §19, which apply where there is a challenge to the fact-finding stage of a decision of the MPT. He summarised the principles in the following terms (case references omitted):

> "21. Bearing that in mind, the points of most importance for the purpose of this case can be summarised as follows:
> (1) The appeal is not a re-hearing in the sense that the appeal court starts afresh, without regard to what has gone before, or (save in exceptional circumstances) that it re-hears the evidence that was before the Tribunal. "Re-hearing" is an elastic notion, but generally indicates a more intensive process than a review…. The test is not the "Wednesbury" test.
> (2) That said, the appellant has the burden of showing that the Tribunal's decision is wrong or unjust…The Court will have regard to the decision of the lower court and give it "the weight that it deserves...
> (3) A court asked to interfere with findings of fact made by a lower court or Tribunal may only do so in limited circumstances. Although this Court has the same documents as the Tribunal, the oral evidence is before this Court in the form of transcripts, rather than live evidence. The appeal Court must bear in mind the advantages which the Tribunal has of hearing and seeing the witnesses, and should be slow to interfere….
> (4) Where there is no question of a misdirection, an appellate court should not come to a different conclusion from the tribunal of fact unless it is satisfied that any advantage enjoyed by the lower court or tribunal by reason of seeing and hearing the witnesses could not be sufficient to explain or justify its conclusions….
> (5) In this context, the test for deciding whether a finding of fact is against the evidence is whether that finding exceeds the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible….
> (6) The appeal Court should only draw an inference which differs from that of the Tribunal, or interfere with a finding of secondary fact, if there are objective grounds to justify this….
> (7) But the appeal Court will not defer to the judgment of the tribunal of fact more than is warranted by the circumstances; it may be satisfied that the tribunal has not taken proper advantage of the benefits it has, either because reasons given are not satisfactory, or because it unmistakably so appears from the evidence…Another way of putting the matter is that the appeal Court may interfere if the finding of fact is "so out of tune with the evidence properly read as to be unreasonable"...

47. Applying those principles, Warby J allowed an appeal in ***Dutta*** because the tribunal had committed three fundamental errors, summarised at §38. First, it had begun with an assessment of the credibility of the uncorroborated evidence of a witness about events which took place ten years' earlier, rather than starting with the contemporaneous documents (see §42). Second, it had based that assessment largely, if not exclusively on demeanour. In relation to both of these points, at §39 Warby J referred to cases, such as ***Gestmin SGPS SA v Credit Suisse*** [2013] EWHC 3650

(Comm), in which Legatt J (as he then was) emphasised the fallibility of memory, the danger of assuming that a confident witness is telling the truth and said that the best approach is to base factual findings on inferences drawn from documentary evidence and known or probable facts.

48. Third, Warby J considered the tribunal's approach to the documents demonstrated a mistaken approach to the burden of proof. Instead of assessing the evidence in the round, including the contemporary documents, the tribunal had asked itself whether the contemporary documents "precluded" the theory it had proposed based on the credibility of a witness: see the tribunal finding at §31, set out in §30 of Warby J's judgment, and his reasons at §43.

49. The judgment in ***Khan*** is another illustration of a tribunal going wrong and not applying the principles in ***Dutta*** because it started its analysis with a general conclusion that one of the witnesses against the doctor, Miss C, was credible and genuine, based on her demeanour - despite an admission that she had lied in employment tribunal proceedings - and only then went on to consider the specific allegations she had made: see §§107-8. The effect of this initial global assessment of credibility was that the tribunal's findings on the specific allegations were a foregone conclusion: §§116-9.

50. But these authorities and principles must not be read as suggesting that oral evidence is not relevant. Ms Richards KC referred me to the judgment of Morris J in ***Byrne v General Medical Council*** [2021] EWHC 2237 (Admin) in which he, too, summarised the principles from the many authorities to which he had earlier referred at §10, including ***Dutta***, ***Khan***, ***Gupta v General Medical Council*** [2002] 1 WLR 1691 (citing ***Thomas v Thomas***]1947] AC 484), ***Southall v General Medical Council*** [2010] EWCA Civ 407 ***McGraddie v McGraddie*** [2013] UKSC 58 and ***Henderson v Foxworth*** [2014] UKSC 41. Ms Young KC did not dispute these principles. Morris J stated (most case references again omitted):

> "(**1) The approach of the Court on appeal to a finding of fact, and in particular a finding of primary fact.**
>
> 11. The issue is as to the circumstances in which an appeal court will interfere with findings of fact made by the court or decision maker below. This is an issue which has been the subject of detailed judicial analysis in a substantial number of authorities and where the formulation of the test to be applied has not been uniform; the differences between formulations are fine. I do not propose to go over this ground again in detail, but rather seek to synthesise the principles and to draw together from these authorities a number of propositions.
> 12. First, the degree of deference shown to the court below will differ depending on the nature of the issue below; namely whether the issue is one of primary fact, of secondary fact, or rather an evaluative judgment of many factors…. The present case concerns findings of primary fact: did the events described by the Patient A happen?
> 13. Secondly, the governing principle remains that set out in *Gupta* §10 referring to *Thomas v Thomas*. The starting point is that the appeal court will be very slow to interfere with findings of primary fact of the court below. The reasons for this are that the court below has had the advantage of having seen

and heard the witnesses, and more generally has total familiarity with the evidence in the case. A further reason for this approach is the trial judge's more general expertise in making determinations of fact... I accept that the most recent Supreme Court cases interpreting *Thomas v Thomas* (namely *McGraddie* and *Henderson v Foxworth)* are relevant. Even though they were cases of "review" rather than "rehearing", there is little distinction between the two types of cases for present purposes (see paragraph 16 below).

14. Thirdly, in exceptional circumstances, the appeal court will interfere with findings of primary fact below. (However the reference to "virtually unassailable" in *Southall* at §47 is not to be read as meaning "practically impossible", for the reasons given in *Dutta* at §22.)

15. Fourthly, the circumstances in which the appeal court will interfere with primary findings of fact have been formulated in a number of different ways, as follows:

- where " *any advantage enjoyed by the trial judge by reason of having seen and heard the witnesses could not be* sufficient *to explain or justify the trial judge's conclusions...;*

- findings " *sufficiently out of the tune with the evidence to indicate with reasonable certainty that the evidence had been misread* "*…;*

- findings " *plainly wrong or so out of tune with the evidence properly read as to be unreasonable*" …;

- where there is " *no evidence to support a ... finding of fact or the trial judge's finding was* one *which no reasonable judge could have reached"….*

In my judgment, the distinction between these last two formulations is a fine one. To the extent that there is a difference, I will adopt, in the Appellant's favour, the former. In fact, as will appears from my analysis below, I have concluded that, even on that approach, I should not interfere with most of the Tribunal's primary findings of fact….

…..

(2) The credibility of witnesses and corroborating evidence

17. First, the credibility of witnesses must take account of the unreliability of memory and should be considered and tested by reference to objective facts, and in particular as shown in contemporaneous documents. Where possible, factual findings should be based on objective facts as shown by contemporaneous documents: *Dutta* §§39 to 42….

18. Secondly, nevertheless, in assessing the reliability and credibility of witnesses, whilst there are different schools of thought, I consider that, if relevant, demeanour might in an appropriate case be a significant factor and the lower court is best placed to assess demeanour: Despite the doubts expressed in *Dutta* §42 and *Khan* §110, the balance of authority supports this view: *Gupta* §18 and *Southall* at §59.

19. Thirdly, corroborating documentary evidence is not always required or indeed available. There may not be much or any such documentary evidence. In a case where the evidence consists of conflicting oral accounts, the court may properly place substantial reliance upon the oral evidence of the complainant (in preference to that of the defendant/appellant)…There is no rule that corroboration of a patient complainant's evidence is required…..

20. Fourthly, in a case where the complainant provides an oral account, and there is a flat denial from the other person concerned, and little or no

> independent evidence, it is commonplace for there to be inconsistency and confusion in some of the detail. Nevertheless the task of the court below is to consider whether the core allegations are true…."

51. At §22 Morris J referred to his earlier judgment in ***O v Secretary of State for Education*** [2014] EWHC 22 (Admin), summarising the principles to be applied where allegations against a person, or the consequences for them, are particularly serious as follows:

> "(1) There is only one civil standard of proof in all civil cases, and that is proof that the fact in issue more probably occurred than not.
>
> (2) There is no heightened civil standard of proof in particular classes of case. In particular, it is not correct that the more serious the nature of the allegation made, the higher the standard of proof required.
>
> (3) The inherent probability or improbability of an event is a matter which can be taken into account when weighing the probabilities and in deciding whether the event occurred. Where an event is inherently improbable, it may take better evidence to persuade the judge that it has happened. This goes to the quality of evidence.
>
> (4) However it does not follow, as a rule of law, that the more serious the allegation, the less likely it is to have occurred. So whilst the court may take account of inherent probabilities, there is no logical or necessary connection between seriousness and probability. Thus, it is not the case that "the more serious the allegation the more cogent the evidence need to prove it".

The reference to the "inherent probability" of an event echoes the speech of Lord Nicholls in ***Re H***, to which I have referred above.

52. ***Byrne*** also provides a convenient summary at §§23-6 of the duty of an MPT to give reasons, on which again there was no disagreement. The general purpose of the duty is to enable the losing party to know why he or she has lost and to allow him or her to consider an appeal: §24. Where there is a dispute of fact, to be resolved on the credibility of witnesses, it may be sufficient to say that the evidence of one witness was preferred: §26(1). There is no requirement to make a general comparative assessment of the credibility of witnesses and, if this is undertaken without reference to the specific allegations, it may give rise to the very problem which arose in ***Dutta*** and ***Khan***: §26(2).

53. As for an appeal based on a reasons challenge, Morris J summarised the position by reference to ***English v Emery Reimbold v Strick*** [2002] 1 WLR 2409:

> "27. Finally, an appeal court will not allow an appeal on grounds of inadequacy of reasons, unless, even with the benefit of knowledge of the evidence and submissions made below, it is not possible for the appeal court to understand why the judge below had reached the decision it did reach. It is appropriate for the appeal court to look at the underlying material before the judge to seek to understand the judge's reasoning and to "identify reasons for the judge's conclusions which cogently justify" the judge's decision, even if the judge did not himself clearly identify all those reasons: see *English v*

Emery Reimbold §§89 and 118."

The Grounds of Appeal: Overview

54. The grounds of appeal are as follows:

> "The decision of the [Tribunal] finding the Appellant to have acted towards a patient for reasons of sexual motivation, and consequently to find his fitness to practise impaired and to erase his registration were:
> 1. wrong, and
> 2. unjust, in that they relied on partial and inadequate reasoning, and
> 3. because they erred in the proper application of the burden of proof."

The grounds, accordingly, are only directed to the findings that Dr Ali's conduct towards Patient C were sexually motivated (there was no such finding in relation to any other of the patient witnesses), though the arguments covered a wider terrain and raised objections to particular findings of fact as well as to the Tribunal's general approach.

55. Ms Young's overarching submission was that the Tribunal committed precisely the errors which arose in ***Dutta*** and ***Khan***: it approached the evidence of Patient C on the basis that she was credible overall - illustrated, for example, by its reference at §89 to her being "adamant" Dr Ali's fingers were not on her wrist when he took her pulse - meaning that it treated her as telling the truth unless there was other evidence to disprove her. The effect of this approach in practical terms, she submitted, was to reverse the burden of proof.

56. In support of that overarching submission, under Ground (1) Ms Young drew attention to factors she said the Tribunal ignored, including that Patient C's belief she had been sexually assaulted must have influenced her recollection of the detail. She submitted that the Tribunal gave insufficient acknowledgement to the fallibility of memory and ignored the danger of supposing a confident witness is telling the truth. In addition, she made challenges to certain specific findings of primary fact made by the Tribunal, which I address below. She also submitted that when it came to the findings of sexual motivation, instead of starting from the premise that it should be slow to find Dr Ali committed the actions alleged against him by Patient C, and that it should only find he did if there was clear evidence over and above Patient C's subjective perception, the Tribunal placed improper reliance on Patient C's subjective perceptions and gave only a passing regard to the "inherent unlikelihood" that a trainee in the position of Dr Ali would act in the way alleged.

57. As for ground (2), she submitted that the Tribunal had failed in its duty to give reasons, in particular because it had not given reasons why they rejected Dr Ali's account that he had not engaged in sexually motivated behaviour and had not adequately explained why it reached different conclusions on "hand holding" in respect of Patient A and Patient C. Ground (3) was not dealt with separately but was effectively wrapped on in the approach to ground (1).

58. For the GMC, Ms Richards submitted that there was no complaint about the Tribunal's self-direction. The Tribunal's core primary factual findings here were not matters open to misinterpretation or matters of subjective perception - for example, the findings that Dr Ali undertook a vaginal examination of a vulnerable young

woman, presenting with complaints of acne on her face and anxiety but who did not complain of symptoms in that area, without a chaperone or gloves or recording the examination - but findings of primary facts about what did or did not happen. The Tribunal did not approach Patient C's evidence globally and commit the errors which arose in ***Dutta*** and ***Khan***. Rather, it made careful findings of primary fact about what happened, based on an appropriate assessment of the evidence, including the contemporaneous or roughly contemporaneous documents. Nor, when it came to the findings of sexual motivation, was the Tribunal swayed by Patient C's subjective perception. On the contrary - it examined the factual features of the consultation, considered these could not be explained by Dr Ali's shortcomings, and addressed whether it was inherently unlikely he did what was alleged, reminding itself of his good character. It gave sufficient reasons for its findings for Dr Ali to know why he lost.

59. My starting points in considering the grounds of appeal are the principles set out in ***Dutta*** at §21 and amplified in ***Byrne*** at §§12-20 and 22. It is rightly not submitted here that the Tribunal misdirected itself on the law. In my judgement, both the self-direction given by the Chair at the hearing and the Tribunal's written self-direction were fully in accordance with the legal principles.

60. As a consequence, I should be slow to interfere with findings of primary fact because the Tribunal had the advantage of hearing and seeing the witnesses, as well as having greater familiarity with the evidence over a hearing which lasted many days. While I accept that findings of primary fact are not "virtually unassailable" for the reasons given by Warby J in ***Dutta*** at §22, the circumstances in which an appeal court can interfere with those findings are restricted, as illustrated by the various formulations summarised in ***Byrne*** at §§14-15, such as a finding must be based on no evidence or "plainly wrong or so out of tune with the evidence as to be unreasonable" (see §50 above). That was the formulation also adopted in ***Dutta*** at §21(7).

61. In addition, when it comes to drawing inferences from those primary facts, I should only draw an inference, or make a finding of secondary fact, which is different from the Tribunal if there are objective grounds to justify this: ***Dutta*** §21(6).

62. In approaching the grounds of appeal, I shall deal first with the specific findings of primary fact challenged by Ms Young KC. I will then consider her fundamental submission that the Tribunal committed the same sort of error as arose in ***Dutta*** or ***Khan***. It seems to me that a proper consideration of the overarching submission requires examining first the Tribunal's approach to specific findings which are challenged.

Ground 1

63. In support of her submission that the Tribunal's general approach was to give undue prominence to the subjective perception of the patients, Ms Young KC drew attention to how the Tribunal approached aspects of the evidence of Patients A and B, saying its treatment of their evidence reflected and demonstrated its generally wrong approach.

64. When it came to Patient A the Tribunal found the allegation of inappropriate hand holding was not proven: see §§28-35. In reaching its conclusion, the Tribunal referred

to what she had said at the police interview five months later, examined the clinical record made at the time (which recorded a pulse measurement), and considered the views of the experts. I do not consider the Tribunal's approach shows it was giving undue or improper weight to Patient A's subjective perceptions or her oral evidence, and nor does it reasoning display the sort of error identified in ***Dutta*** and ***Khan***, of starting with a general assessment of the credibility of Patient A. On the contrary, the Tribunal examined all the evidence, and gave "significant weight" in Dr Ali's favour to the fact that the contemporaneous clinical record included a pulse measurement (§36).

65. As regards Patient B, Ms Young submitted that the finding the Tribunal found about "staring" is illustrative of the Tribunal's general approach, of giving too much weight to the patients' subjective perception. But its conclusion at §64, based on Patient B's subject perception that Dr Ali was "staring", must be read in context. The Tribunal thought that the allegation itself was of an action which largely turned on the patient's subjective perception. It was well aware of the danger of relying on such subject perceptions and the problem of misinterpretation of Dr Ali's actions because, in rejecting the allegations that his actions were not clinically indicated, it said at §77:

> "The Tribunal were of the view that Dr Ali would need to look carefully at Patient B during this consultation and that this could easily be misinterpreted. It was concerned, as were the experts, about the highly subjective nature of this allegation, and in particular the potential for an awkward personal mannerism to be found as a significant criticism."

In my view, the Tribunal's approach demonstrates that it was cautious about relying on matters which could be open to subjective interpretation. More fundamentally, I do not consider that the approach it took with regard to Patient B and this single, specific matter provide any real support for an argument that the Tribunal's *general* approach was to start from the perspective that the complaints of the patients, or those of Patient C in particular, were credible or to be believed.

66. I turn, then, to the findings in relation to Patient C which are challenged, or are not challenged, under ground (1). Before I examine these, it should be noted that the Tribunal prefaced its discussion of the findings of fact on each allegation with a general account of the background, summarised at §§25-26 above, in which it cited two key contemporary documents: the text message sent by Patient C minutes after the consultation (§84) and the clinical record (§87). What it did not do was begin with a general assessment of the credibility or general demeanour of Patient C (or of Dr Ali).

67. **Allegation 5(a)**. The Tribunal found that Dr Ali placed his hand inappropriately on Patient C's hand while taking her blood pressure. In reaching that finding it had regard to Patient C's oral evidence (in which she was "adamant" that Dr Ali's hands were "nowhere near" her wrist), her police interview, her Crown Court evidence, Dr Ali's evidence and, especially, the absence of a pulse measurement in the clinical records: see §89-95.

68. Ms Young KC contended the finding of primary fact was wrong and the Tribunal improperly placed too much weight on Patient C being "adamant". She drew attention

to the Tribunal's different findings with regard to the similar charge involving Patient A, saying that the Tribunal paid insufficient regard to whether Patient C may also have misinterpreted Dr Ali's actions when he was taking her blood pressure. She pointed out, too, that Dr Ali's failure to record a pulse management was consistent with his not recording other matters, such as the tongue inspection.

69. There were significant differences between the evidence in relation to Patient A and Patient C, not restricted to Patient C being "adamant" in her evidence. Patient C did not make a similar concession as did Patient A in cross-examination (§89). In addition, Patient C had given a similar account to the police in her police interview on 27 November 2016, shortly after the consultation (§90), and there was no record of a pulse measurement in the clinical records of her consultation (§94). The Tribunal had regard to the possibility that the absence of a record was attributable to poor record keeping but rejected it (§§93-4).

70. I do not consider the Tribunal's conclusion was based on any general assessment of Patient C's credibility or that it gave improper weight to her oral testimony. It merely considered her oral evidence as part of the evidence in the round, including the contemporaneous (or more or less contemporaneous) records and documents. It did not, in my view, commit an error of the sort identified in ***Dutta*** or ***Khan***: neither case suggests an MPT should ignore oral testimony and ***Byrne*** confirms at §19 that it may properly place "substantial reliance" on oral evidence in the absence of corroboration. The Tribunal's approach to the allegation against Patient A shows it was acutely aware of the possibility of an action of pulse-taking being misinterpreted. Nor do I consider its finding of primary fact in relation to Patient C on this allegation was plainly wrong or so out of tune with the evidence as to be unreasonable. In my judgement it does not come close to the threshold where an appeal court could interfere with it, regardless of which of the various formulations in ***Byrne*** at §15 is applied. I am reinforced in that view because the Tribunal's assessment that Dr Ali would not have failed to record a fundamental, routine measure such as pulse measurement is an area in which it has some expertise.

71. **Allegation 5(b)**. The Tribunal found not proved the allegation that Dr Ali lifted Patient C's top to reveal her back without permission, principally because Patient C accepted Dr Ali had asked to examine her back, so that she effectively consented to lifting her top: §§96-7. In her oral submissions, Ms Young KC argued this was a further illustration of giving prominence to Patient C's subjective perceptions. I do not accept that. The Tribunal found the allegation not proven because Patient C was clear that the purpose of her lying on her back was to inspect her back, which necessarily required lifting her top (§97). Her subjective understanding was, therefore, relevant to the decision whether or not she had in reality consented to Dr Ali's actions. I do not consider the treatment of this allegation provides any sufficient basis for viewing the Tribunal as committing the kind of errors which arose in ***Dutta*** and ***Khan***.

72. **Allegation 5(c)**. Based on the oral testimony and the statement Patient C had made in her police interview, the Tribunal decided that Dr Ali had lifted Patient C's shorts without explanation or warning, exposing the lower part of her buttocks (§§99-105). Ms Young submitted, once again, that this displayed a wrong focus on Patient C's subjective views because the only difference between this allegation and allegation

5(b) was that Patient C saw nothing wrong with her top being lifted, whereas she did when it came to her shorts. Alternatively, she said the Tribunal's findings about 5(b) and 5(c) were inconsistent.

73. The Tribunal's analysis of the evidence showed that Patient C effectively gave permission to her top being lifted, whereas it found Dr Ali gave no warning he would lift her shorts (§104). Patient C's evidence was that she had a heat rash at the top of her thigh and there was no explanation before Dr Ali lifted her shorts; Dr Ali's account was that he would have asked her first before lifting her clothing, though he had no specific recollection of the incident (§§99-102). There is no inconsistency between the two findings on these allegations: Patient C could have consented to her back being examined given the finding that Dr Ali has asked to examine her back, but there to have been no explanation or warning before he lifted her shorts. There is no sufficient basis for me interfering with the primary facts found in relation to 5(c) in light of the principles set out in the authorities. The Tribunal based its conclusion in part on the police interview of Patient C shortly afterwards, it did not start with any presumption that Patient C was credible, and its conclusion was expressly based on the balance of probabilities (§104). I do not consider this finding of primary fact was plainly wrong or so out of tune with the evidence as to be unreasonable.

74. **Allegation 5(d)**. It was submitted that, in finding Dr Ali "stroked" Patient C's thighs, the Tribunal displayed the same erroneous approach. Patient C said that he had stroked the top of her thigh, whereas the evidence of Dr Ali was that he might have palpated the rash he noticed there. The Tribunal found this allegation not proven because of the evidence of Patience C that, even on her account, the "stroking" did not involve her buttocks: §§106-8. In that light, it did not go on to consider whether this action was clinically indicated nor whether it was sexually motivated. (The joint expert report noted the subjective nature of this allegation but said that palpating with the pulps of the fingers might be part of a valid clinical examination of the skin, but their interpretation of "stroking" would not be).

75. The Tribunal did not base its conclusion solely on Patient C being "adamant" that Dr Ali had stroked her, probably three times. It also examined what she had said at police interview, which was consistent with her oral evidence. It is a matter of speculation how the Tribunal would have gone on to address this allegation if it were found to be proven: it might, for example, have adopted a similar approach as it did in relation to the allegation made by Patient B that Dr Ali had "stared" at her (where it found not proven the allegation that his action was not clinically indicated); and the Tribunal did not refer to this matter when it came to assessing whether Dr Ali's actions were sexually motivated. But, so far as the primary factual finding is concerned, in my view, the Tribunal's approach was consistent with the principles in ***Dutta*** and ***Byrne*** and did not give improper prominence to Patient C's subjective perceptions. In light of what Patient C had said at the police interview, I do not consider the Tribunal's finding that stroking had occurred on the balance of probabilities can be said to be plainly wrong or so out of tune with the evidence so as to be unreasonable.

76. **Allegation 5(e)**. No criticism was made of the Tribunal's approach to this allegation, that Dr Ali said he needed to examine Patient C's vulva without explanation, dealt with by the Tribunal at §§109-114. The allegation involved a clear dispute of fact because Dr Ali's evidence was that Patient C had said words to the effect that she got

"excessive sweating and itching down there" at the consultation, whereas Patient C's account was that she had said the opposite, that "I don't get it down there".

77. It is instructive that the Tribunal did not start from the premise that Patient C was a credible witness and only find otherwise if there were evidence to undermine her. Rather, it examined carefully what she had said at police interview, Dr Ali's account, and her contemporary text message, in which she told her boyfriend she had said to Dr Ali "no there is nothing down there", before deciding that it preferred her account in light of the text message (§§109-112). In the event, however, this allegation was not proved because the Tribunal accepted on Patient C's account that Dr Ali had given *an* explanation, along the lines of needing to check if she got acne down there (§113).

78. **Allegation 5(f)**. Ms Young KC accepted the Tribunal was entitled to find that Dr Ali pulled down Patient C's shorts without permission, which was the basis of this allegation. Once more, the Tribunal did not reach that conclusion based on a global assessment of Patient C's credibility or demeanour but instead examined the oral testimony, Patient C's police interview and the text message in which Patient C had said "Then he started actually pulling my shorts like completely down" (§§115-121).

79. **Allegations 5(g)(h)(i)**. Dr Ali had admitted several of these matters, all of which related to his examination of Patient C's genitals. He admitted that he had opened her labia and had conducted an intimate examination without offering her a chaperone, without wearing gloves and without making an adequate record of the examination. However, it was in issue whether Patient C had consented to the intimate examination (allegation 5(i)ii)).

80. In its findings on allegation 5(e) the Tribunal had earlier rejected Dr Ali's account and decided it preferred Patient C's account, supported as it was by the contemporary text messages, that she had not complained of itching or sweating "down there": see above §§76-7. Echoing those findings, at §123 the Tribunal said it was satisfied she had told him she did not get acne in the area he was proposing to examine and had made clear she was reluctant to undergo an examination. The Tribunal decided, in the circumstances, that this was not effective consent (§123).

81. Ms Young criticised the Tribunal for discounting Dr Ali's evidence that Patient C had complained to him of symptoms and for not referring to Patient C's medical history which showed she had experienced problems in the past with matters such as vaginal thrush. But, as part of the duty to give reasons, a tribunal is not required to refer to every submission or all the evidence before it. The Tribunal paid careful attention to Dr Ali's evidence that Patient C had complained to him of "sweating and itching down there" and gave sufficient reasons for its decision on allegations 5(e) and 5(i)ii for Dr Ali to know why it did not accept his account and found against him. I do not consider its finding comes close to one with which an appeal court could properly interfere in light of the various formulations in ***Byrne***. Once more I am reinforced in that view because the Tribunal's assessment of whether or not Patient C gave genuine consent to the examination is an area in which the Tribunal has specialist expertise. But, even ignoring that factor, I do not consider its finding was plainly wrong, so out of tune with the evidence properly read as to be unreasonable, or demonstrates a general misplaced approach to the evidence of the sort identified in ***Dutta*** and ***Khan***.

82. The second allegation on which Ms Young KC focussed was allegation 5(i)v, that Dr Ali failed to wash his hands after examining Patient C's genitalia. She made a detailed attack on the Tribunal's findings at §§130-4, pointing out that there were in fact two sinks in the room and submitting that the Tribunal should only have rejected Dr Ali's account, that he had washed his hands at a different sink from the one referred to by Patient C, if there were compelling evidence to the contrary.

83. The Tribunal referred to the photographs showing two sinks in the room, which I was also shown. They showed one sink integrated in a unit close to Dr Ali's desk and another close to the side of the couch on which Patient C was examined (where Dr Ali said he washed his hands). The Claimant's oral evidence was that Dr Ali went straight to his desk after the examination without washing his hands (§130). Her evidence was consistent with her police interview, to which the Tribunal referred at §130, in which she had said he did not wash his hands and went back to sit at his desk, and with her evidence in cross-examination, referred to by the Tribunal at §131.

84. The Tribunal carefully considered the possibility that Dr Ali had in fact washed his hands at the sink by the couch, but rejected it on the basis that (i) Patient C's evidence had been consistent from an early stage and (ii) if Dr Ali had washed his hands at the sink close to the couch, Patient C would have heard it. I do not accept that the Tribunal should only have rejected Dr Ali's case if there were compelling evidence to undermine it, which does not accord with the principles in the authorities: see ***Byrne*** at §§17-20. In agreement with the Tribunal, I do not see any inconsistency in Patient C's account. But in any event the Tribunal made the primary finding "on the balance of probabilities" (§133) and I consider it is not a finding with which, in accordance with the various formulations in the authorities summarised by Morris J in ***Byrne*** at §14, I could interfere.

85. **Allegations 5(k)(l)**. These two allegations related to Dr Ali asking Patient C for her contact details in order to arrange a mortgage and asking for her personal e-mail address. The Tribunal examined Patient C's contemporary text messages, in which she had said Dr Ali had asked for her personal and work e-mail (§135), her police interview, and the evidence of both her and Dr Ali: §§135-142. In accepting her evidence and finding the allegations proven, it placed weight on the text message and her police interview: §141.

86. Ms Young made two criticisms of this finding. First, the charges were in fact duplicated. Second, the Tribunal made no reference to the fact that Dr Ali had not contacted Patient C in the two weeks following the consultation or the inherent unlikelihood of a doctor using a personal e-mail to contact a patient when he already had, e.g., her telephone number on the medical records.

87. I do not accept these submissions. As to the first, the allegations involved two distinct actions and it seems Dr Ali accepted he had asked for an e-mail address but denied insisting on a personal address (§138). As for the second, the Tribunal gave sufficient reasons for its findings, and carefully examined Dr Ali's account that there had been a misunderstanding (§139). It relied on the contemporary documents to support its finding of primary fact, fully consistent with ***Dutta*** and ***Byrne***. It gave adequate reasons for its decision and, in my judgement, it was not required to refer to the fact

that Dr Ali had not contacted Patient C (or speculate on why he had not). That he had not done so is not sufficient to show its finding of fact was plainly wrong or so out of tune with the evidence properly understood as to be unreasonable.

88. **The findings of primary fact: stepping back**. I return to Ms Young's overarching submission, that the Tribunal's general approach to its primary findings of fact was that Patient C must be right unless there was some evidence which demonstrated she was wrong, "tantamount to reversing the burden of proof": see Appellant's skeleton, §67.

89. I do not consider that is a fair or reasonable interpretation of what the Tribunal did when it came to the primary findings of fact. At times, as I understood it, Ms Young's submission came close to saying that *unless* there was clear objective evidence beyond the oral testimony of a patient, the doctor's evidence or explanations had to be accepted. I do not consider that is consistent with how the burden and standard of proof operates, nor with the principles in ***Dutta*** and ***Byrne***. Nor, in my judgement, was the Tribunal required to consider that Patient C's recollection "must" have been influenced by her belief that she had been sexually assaulted or had been affected by discussions with others, as submitted in her skeleton, both of which are little more than assertions. The Tribunal was well aware of the fallibility of human memory, as it directed itself at §18.

90. Having directed itself at the outset in accordance with the burden of proof and the guidance in ***Dutta***, in my judgement the Tribunal properly applied those principles when it made its findings of primary fact. In each case, it examined carefully the relevant evidence, without starting with an assumption or presumption that a witness was credible or telling the truth and without simply accepting or giving undue weight to Patient C's subjective interpretation. Its approach reflected caution in placing undue reliance on the demeanour of a witness, just as it had directed itself at §18, and correctly paying careful attention to the contemporary documents where they were available, examining them and the evidence for consistencies and inconsistencies. At times it paid regard to the oral testimony of a witness, but there is no dispute that is permissible: see ***Byrne*** at §19. Its approach was, I consider, fully in accordance with the principles set out in ***Dutta*** and ***Byrne***; it did not commit the kind of general error of approach which arose in ***Dutta*** and ***Khan***; and the specific individual findings of primary fact which were subject to challenge were neither plainly wrong nor so out of tune with the evidence properly read as to be unreasonable.

91. **The challenge to the findings of sexual motivation**. I have set out above how the Tribunal dealt with the question of sexual motivation following its findings of primary fact: see §§34-38. As an additional argument under ground (1). Ms Young KC submitted that the Tribunal's decision was wrong on this aspect of its decision. Her overarching submission was that the Tribunal reached its conclusions of sexual motivation based on Patient C's perception of what had occurred, *before* considering whether there was an alternative explanation for the events based on Dr Ali being a struggling and incompetent trainee. She supplemented that submission with specific examples, some of which were based on criticisms of the primary findings of fact and which I have addressed above.

92. In support of her overarching submission, Ms Young focussed on §153 of the

Determination, where she said the Tribunal found as a fact, based on its primary findings, that there was a sexual motivation operating in relation to allegations 5(a)-(i) before it considered whether the actions could be explained by Dr Ali's inexperience, incompetence or unfortunate manner.

93. I do not consider that is a fair reading of the Tribunal's approach to sexual motivation. At §153 it only said that the main features of the consultation it had identified at §154, set out above at §35, "indicated" that a sexual motive was operating. But before it made any definitive finding on that matter it considered and addressed three matters.

94. First, it considered in detail the submission made on behalf of Dr Ali, and the relevant evidence to support it, that these events (or Patient C's "perceptions" about them) could be explained by his inexperience, incompetence or unfortunate manner, concluding they could not: §§154-163. It accepted Dr Ali found the practice of medicine "challenging" but did not consider his lack of knowledge or experience was an adequate explanation for the events: see §163, cited above at §36. Second, the Tribunal also considered and rejected the submission that it was "inherently unlikely" that Dr Ali would behave in the way alleged: §164. Third, it reminded itself that he was a man of good character and took into account other relevant evidence: §165.

95. It was only after "taking all this into account" that, at §166, the Tribunal decided that sexual motivation was proven in relation to the allegations. In other words, it only made its finding of sexual motivation after considering these three matters. Accordingly, I reject the submission that it had prejudged matters or that in essence it reversed the burden of proof. Nor do I consider the Tribunal erred in its overall approach, of first making findings of primary fact and then dealing with the question of sexual motivation, including the potential explanations based on incompetence put forward by Dr Ali. That approach is consistent with the authorities. Unless and until there is a prior determination of what in fact happened – for example, whether Patient C had complained to Dr Ali of sweating and itching "down there" as he alleged – it is hard to see how an MPT could properly or practically consider if those actions were sexually motivated or if there was an alternative explanation for them.

96. As for the specific criticisms made of the Tribunal at §73 of Ms Young's skeleton argument, most of these have been dealt with above in relation to the challenges to primary fact and so I only deal with them briefly below (and adopting the same lettering as in the skeleton argument):

    a. I do not consider the findings in relation to Patients A and B demonstrate a flawed approach to the evidence in general or of Patient C, as I have explained above (see §§67-70). For the reasons set out above, I consider the Tribunal's primary finding that Dr Ali inappropriately held Patient C's hand is not one with which an appeal court can properly interfere because it was not plainly wrong or so out of tune with the evidence read properly as to be unreasonable.

    b. I do not consider the Tribunal had "insufficient regard" to evidence that Dr Ali was an incompetent and struggling trainee, as argued by Ms Young QC - quite the contrary. I consider it paid careful attention to that matter and there is no objective reason for interfering with its conclusions.

c. For the reasons given at §§79-81, I consider the primary finding that Patient C did not complain of symptoms in the area before Dr Ali examined her genitalia cannot be said to be one with which I could properly interfere in light of the principles in the authorities. The Tribunal was well aware that Dr Ali denied sexual motivation and considered in detail his evidence to the effect that Patient C had complained of symptoms in that area (Determination §§109-112). It was not required to refer to all the evidence; its finding of primary fact, supported as it was by a contemporary text message, cannot be said to be plainly wrong or so out of tune with the evidence to be unreasonable.

d. The Tribunal did not approach Patient C's evidence by assuming that she was right unless she could be demonstrated to be wrong, either in relation to specific allegations or in general: see §§88-90 above. Both the direction of the Chair and the Tribunal's own direction reminded it of the fallibility of memory and the danger of relying on demeanour.

e. Nor do I accept that the Tribunal only paid a "passing regard" to the inherent unlikelihood that Dr Ali would sexually abuse a vulnerable patient. It properly considered that matter at §164.

f. The Tribunal's findings that Patient C consented to the back examination but not to having her shorts pulled down were not, in my view, inconsistent: see §73. Moreover, it is not correct that the "stroking" was "entirely clinically indicated". The Tribunal made no finding on this matter (see §§106-8) and the view of the joint experts was that "stroking" was not clinically indicated.

g. The Tribunal did not fail to give "proper regard" to Dr Ali's evidence. In relation to each specific finding of primary fact, and its decisions on sexual motivation, it gave sufficient reasons why it disbelieved Dr Ali's evidence or found against. Had it made any global assessment of his credibility or lack of credibility, it might have fallen into the very trap in which the MPT fell into in ***Dutta***.

97. For completeness, I should add that I can detect no error of approach in the Tribunal's findings that the failure to record the intimate examination, and the request for Patient C's personal details were sexual motivated: see §§167-173. I can see no objective grounds for departing from the findings and inference of the Tribunal: see ***Dutta*** at §21(6).

98. For all these reasons, I consider the Tribunal did not fall into the same errors as the MPTs in ***Dutta*** or ***Khan*** when it came to the findings on sexual motivation. On the contrary, it followed and applied the guidance in ***Dutta*** and its approach was fully consistent with ***Byrne***. According to Warby J in ***Dutta*** at §21(6), an appeal court should draw an inference which differs from that found by the MPT, or interfere with a finding of secondary fact, if there are "objective grounds to justify this". I do not consider there are any such objective grounds.

Ground 2

99. Ground (2) is a reasons challenge. I have summarised the relevant principles at §§52-

3 above, and they are not in dispute. The issue was given little attention in oral submissions but the argument was clearly set out in Ms Young KC's skeleton at §§75-79. As Morris J explained in ***Byrne***, on disputes of fact the adequacy of reasons will vary and there is a danger in giving a general assessment of the credibility of a witness, as shown by ***Dutta***. It is clear from ***Byrne*** and the citation from ***Southall v General Medical Council*** [2020] EWCA Civ 407, per Leveson LJ at §§55-6, that reasons need not be extensive. In particular, an MPT is not required to address all the evidence or every submission made to it.

100. I do not accept the characterisation in the Appellant's skeleton argument that the majority of the case depended not so much on whether the Appellant did certain things but on why he did them. In some important instances, the primary facts *were* in dispute, leading to the detailed findings in the Determination at §§89-142; examples are whether Dr Ali pulled down Patient C's shorts without permission, whether he obtained express consent for an intimate examination and whether he washed his hands afterwards.

101. In each case, in my judgement, the Tribunal gave full and adequate reasons for why it decided as it did on the primary facts, sufficient for Dr Ali to know why it rejected his account and found against him. In addition, when it came to the evaluative question of whether his actions were sexually motivated, it went far beyond providing brief reasons to show why they rejected his account, illustrated by the rejection of the submission on his behalf that his conduct could be explained by his inexperience, incompetence or unfortunate manner: see Determination at §§154-166. The reasons are sufficient in each case for the Appellant to know why he lost on it and to allow him properly to consider an appeal.

102. Second, the Tribunal gave full and adequate reasons why it reached different conclusions on the allegation of hand holding with regard to Patient A and Patient C. In each case, it referred to the relevant evidence and explained why it found the allegation not proven in the case of Patient A but proved in the case of Patient C: see above at §§68-70. The reasons are more than sufficient to meet the standard of adequacy of reasons in relation to disputed matters of fact.

Ground 3

103. The final ground is that the Tribunal erred in the proper application of the burden of proof. In the event, this ground was not dealt with separately in the Appellant's skeleton argument or in the oral submissions but was wrapped up with the submissions on ground (1). For the reasons I have given in relation to that ground, I consider the Tribunal properly directed itself in accordance with, and correctly applied, the burden of proof.

Conclusion

104. For the reasons set out above, my conclusion is that none of the grounds of appeal is upheld. The Determination of the Tribunal was not wrong or unjust and nor did it err in the application of the burden of proof. The consequence is that the appeal is dismissed under s.40(7) of the MA 1983.