

PUBLIC RECORD**Dates:** 12/05/2025 - 30/05/2025

16/06/2025-06/08/2025

Doctor: Dr Anthony DIXON**GMC reference number:** 2805726**Primary medical qualification:** MB BS 1983 University of London

Type of case	Outcome on facts	Outcome on impairment
New – Misconduct	Facts relevant to impairment found proved	Impaired
Review – Misconduct		Impaired

Summary of outcome

Erasure

Tribunal:

Legally Qualified Chair	Miss Samantha Gray
Lay Tribunal Member:	Mr Amit Jinabhai
Registrant Tribunal Member:	Dr Sarah Woodford

Tribunal Clerk:	Ms Fiona Johnston 12/05/25-30/05/25 & 07/07/2025 – 06/08/2025 Ms Ciara Fogarty 16/05/25 -04/07/2025
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Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Dijen Basu, KC, instructed by Clyde & CO

GMC Representative:	Ms Chloe Fairley, Counsel
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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 in public.

Overarching Objective

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

Determination on Facts - 16/07/2025

Background

1. Mr Dixon's last appointment was as a Consultant Colorectal Surgeon at Frenchay Hospital, appointed in May 1996. Mr Dixon obtained his MBBS in 1983, and he became a fellow of the Royal College of Surgeons (Edinburgh) in 1987. He was awarded FRCS Eng ad eundem in 2012. Mr Dixon was an Honorary Reader in Colorectal and Pelvic Floor Surgery at the University of Bristol. He was a member of council for his subspecialty professional association (ACPGBI) 2008-16 and was founder and elected inaugural Chairman of the Pelvic Floor Society from 2013 to 2016.
2. The matters which have led to the Allegation can be summarised that, between 2007 and 2017, Mr Dixon failed to provide adequate care to three patients.
3. It is also alleged that between 2018 and 2020, as part of a review by Spire Healthcare (Spire) into patients treated by Mr Dixon at Spire, Mr Dixon disclosed medical records for seven patients through his legal representatives which he created after his involvement in their care had ended and which contained false information.

4. It is also alleged that, between 2018 and 2024, in the course of civil proceedings initiated against him by former patients, Mr Dixon allowed documents to be disclosed to the patients' solicitors which he created after his involvement in the patients' care had ended and which contained false information.
5. It is further alleged that on or before 2 October 2023, in the course of a GMC investigation, Mr Dixon allowed documents to be disclosed to the GMC which he created after his involvement in the patient's care had ended and which would give the false impression that the notes were contemporaneous.
6. It is alleged that Mr Dixon's actions were dishonest.

The Outcome of Applications Made during the Facts Stage

7. On day 1 of the hearing, Ms Fairley, on behalf of the GMC, made an application pursuant to Rule 17(6) of the Rules to withdraw paragraphs 1 a and b of the Allegation and also to amend an error in the dates in paragraph 13 of the Allegation. Mr Basu made no objections to the application. The Tribunal determined to grant the application on the basis that Mr Dixon and his legal team had no objection to the same and that the amendments could be made without injustice or prejudice.
8. On day 1, Mr Basu, representing Mr Dixon, also made an application under Rule 34(1) of the Rules. He addressed the Tribunal on the admissibility of a comment made by Patient I in his witness statement and contained in the main hearing bundle and invited the Tribunal to exclude it. He submitted that it had no relevance to the allegation. He also submitted that Mr Dixon denied that this comment was made.
9. Ms Fairley objected to the application; she submitted that the witness gives evidence about the consultation on the 8 November 2005 and makes reference to this phrase. She submitted that what was said may well be in dispute. However, it is part of his recollection and therefore relevant for the Tribunal to consider.
10. The Tribunal considered that the phrase referred to by Patient I may be linked to the context of the allegations and therefore may be fair and relevant to the proceedings. Accordingly, the Tribunal refused Mr Basu's application and admitted the comment made by Patient I. However, the Tribunal noted that should the phrase become a key part of evidence

during the hearing it would deal with it appropriately and sensitively in the interest of all parties.

The Allegation and the Doctor's Response

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

Patient A

1. ~~On 22 June 2007, you performed a stapled trans anal rectal resection procedure on Patient A:~~
 - a. ~~which was not clinically indicated;~~
 - b. ~~without adequately considering non-operative treatments.~~

Patient B

2. Before performing a laparoscopic ventral mesh rectopexy ('LVMR') procedure on Patient B on 20 June 2014 you failed to:
 - a. consider non-operative treatments; **To be determined**
 - b. carry out all necessary tests and investigations; **To be determined**
 - c. involve other specialists in your assessment and treatment plan, including a dietician. **To be determined**
3. On 14 April 2017 you performed a re-look laparotomy on Patient B for postoperative complications following an anterior resection and loop ileostomy procedure you performed on Patient B on 8 April 2017, but failed to adequately explain the complications to Patient B. **To be determined**

Patient C

4. On 24 February 2017, you performed an LVMR on Patient C which was not clinically indicated. **To be determined**

Patient D

5. Before performing an LVMR and sacrohysteropexy on Patient D on 21 April 2017 ('Patient D's Procedure') you failed to:
 - a. allow sufficient time to trial non-operative treatment; **To be determined**
 - b. arrange for Patient D to be assessed by the following specialists in order for them to consider non-operative treatments:
 - i. a gastroenterologist with an interest in abdominal pain / an IBS specialist; **To be determined**
 - ii. an anorectal physiologist; **To be determined**
 - c. obtain informed consent in that you:
 - i. placed too great an emphasis on anatomical correction of a proctographic image; **To be determined**
 - ii. did not inform Patient D that:
 1. the functional outcome might not be what they would hope for/expect; **To be determined**
 2. Patient D's Procedure involved risk of a number of potentially serious complications. **To be determined**

Probity concerns: Spire Review Patient concerns

6. Between approximately 5 March 2018 and 19 October 2020, you were contacted by Spire Healthcare ('Spire') as part of a review ('the Spire Review'), who requested that you provide them with records for patients you had treated at Spire. **To be determined**

Patients E-K

7. On 17 March 2020 and on or around 4 November 2020 you allowed to be disclosed to Spire, through your legal representatives, medical records for Patients E-K, as described in Schedule 1 ('the Spire Records'):
 - a. which you created/allowed to be created after your involvement in the care of Patients E-K had ended; **To be determined**

- b. that included one or more false references to you:
 - i. obtaining consent before procedures; **To be determined**
 - ii. giving additional information to one or more of Patients E-K before the procedures; **To be determined**
 - iii. providing further detail as to your decision making before carrying out a procedure; **To be determined**
 - c. and you failed to ensure that Spire were aware that the Spire Records had been created after your involvement in Patients' E-K care had ended. **To be determined**
8. At the time of your actions as described at paragraph 7, you knew:
- a. the Spire Review was looking into:
 - i. whether you had obtained consent for the procedures carried out on Patients E-K; **To be determined**
 - ii. the information provided to Patients E-K before any proposed procedure; **To be determined**
 - iii. your decision-making regarding the choice of procedures for Patients E-K; **To be determined**
 - iv. the occurrence and management of complications; **To be determined**
 - b. the Spire Records had been created after your involvement in the care of Patients E-K had ended; **To be determined**
 - c. the Spire Records included one or more false references to you:
 - i. obtaining consent before procedures; **To be determined**
 - ii. giving additional information to one or more of Patients E-K before the procedures; **To be determined**
 - iii. providing further detail as to your decision making before carrying out a procedure; **To be determined**

- d. your actions would give the false impression that the Spire Records were contemporaneous. **To be determined**
- 9. Your actions as set out at paragraph 7 were dishonest by reason of paragraph 8. **To be determined**

Probity concerns: Other Patients

Patient L

- 10. Between March 2018 and March 2020, in the course of civil proceedings initiated against you by Patient L in relation to a procedure you had performed on her in November 2009, you allowed to be disclosed to Patient L's solicitors a handwritten record dated 22 October 2009, as described in Schedule 2 ('the 22 October Record'):
 - a. which you created after your involvement in Patient L's care had ended; **To be determined**
 - b. which contained false information as set out in Schedule 2; **To be determined**
 - c. and you failed to ensure that Patient L's solicitors were aware that the 22 October Record had been created after your involvement in Patient L's care had ended. **To be determined**
- 11. At the time of your actions as described at paragraph 10 you knew:
 - a. the 22 October Record had been created after your involvement in Patient L's care had ended; **To be determined**
 - b. the 22 October Record contained false information as set out in Schedule 2; **To be determined**
 - c. the 22 October Record had not been provided contemporaneously to Spire; **To be determined**
 - d. your actions would give the false impression that the 22 October Record was contemporaneous. **To be determined**
- 12. Your actions at paragraph 10 were dishonest by reason of paragraph 11. **To be determined**

Patient M

13. In 2021, in the course of civil proceedings initiated against you by Patient M in relation to procedures you had performed on her between 2009 and 2011, you allowed to be disclosed to Patient M's solicitors, letters as described in Schedule 3, addressed to Patient M's GP ('the Patient M Letters'):
- a. which you created/allowed to be created after your involvement in Patient M's care had ended; **To be determined**
 - b. which included false reference to:
 - i. you explaining Patient M's condition to Patient M and her husband; **To be determined**
 - ii. discussion of risks of the proposed treatment plan; **To be determined**
 - iii. Patient M being pleased with the outcome of her treatment; **To be determined**
 - iv. you directing Patient M to additional information about the proposed treatment; **To be determined**
 - v. you advising Patient M to 'come straight back' if she developed any complications; **To be determined**
 - vi. Patient M's functional and Quality of Life scores; **To be determined**
 - c. and you failed to ensure that Patient M's solicitors were aware that the Patient M Letters had been created after your involvement in Patient M's care had ended. **To be determined**
14. At the time of your actions as described at paragraph 13, you knew:
- a. the Patient M Letters had been created after your involvement in Patient M's care had ended; **To be determined**
 - b. the Patient M Letters included false reference to:

- i. you explaining Patient M's condition to Patient M and her husband; **To be determined**
 - ii. discussion of risks of the proposed treatment plan; **To be determined**
 - iii. Patient M being pleased with the outcome of her treatment; **To be determined**
 - iv. you directing Patient M to additional information about the proposed treatment; **To be determined**
 - v. you advising Patient M to 'come straight back' if she developed any complications; **To be determined**
 - vi. Patient M's functional and Quality of Life scores; **To be determined**
- c. the version of the Patient M Letters you allowed to be disclosed were not the letters sent contemporaneously to Patient M's GP; **To be determined**
 - d. your actions would give the false impression that the Patient M Letters were contemporaneous. **To be determined**
15. Your actions as set out at paragraph 13 were dishonest by reason of paragraph 14. **To be determined**

Patient N

16. In around May 2022 in the course of civil proceedings initiated against you by Patient N in relation to procedures you had performed on him in March 2012, you allowed to be disclosed to Patient N's solicitors handwritten notes and letters ('the Patient N Records'):
- a. which you created/allowed to be created after your involvement in Patient N's care had ended; **To be determined**
 - b. which contained false reference to:
 - i. you telling Patient N that he had a rectal prolapse; **To be determined**
 - ii. discussion of alternatives to the LVMR procedure; **To be determined**

- iii. an appointment two weeks' post-surgery that did not take place; **To be determined**
 - iv. Patient N saying he felt much better after surgery; **To be determined**
 - v. Patient N's sphincter contraction being good after surgery; **To be determined**
- c. and you failed to ensure that Patient N's solicitors were aware that the Patient N Records had been created after your involvement in Patient N's care had ended. **To be determined**
17. At the time of your actions as described at paragraph 16, you knew:
- a. the Patient N Records had been created after your involvement in Patient N's care had ended; **To be determined**
 - b. the Patient N Records contained false reference to:
 - i. you telling Patient N that he had a rectal prolapse; **To be determined**
 - ii. discussion of alternative to the LVMR procedure; **To be determined**
 - iii. an appointment two weeks' post-surgery that did not take place; **To be determined**
 - iv. Patient N saying he felt much better after surgery; **To be determined**
 - v. Patient N's sphincter contraction being good after surgery; **To be determined**
 - c. the Patient N records had not been provided contemporaneously to Spire; **To be determined**
 - d. the letters within the Patient N Records had not been provided contemporaneously to Patient N's GP; **To be determined**
 - e. your actions would give the false impression that the Patient N Records were contemporaneous. **To be determined**

18. Your actions at paragraph 16 were dishonest by reason of paragraph 17. **To be determined**

Patient O

19. In around July 2022 in the course of civil proceedings initiated against you by Patient O in relation to procedures you had performed on her on 19 February 2010, you allowed to be disclosed to Patient O's solicitors a letter dated 21 February 2010 and addressed to Patient O's GP ('the 21 February Letter'):

- a. which you created/allowed to be created after your involvement in Patient O's care had ended; **To be determined**
- b. and you failed to ensure that Patient O's solicitors were aware that the 21 February Letter had been created after your involvement in Patient O's care had ended. **To be determined**

20. At the time of your actions as described at paragraph 19, you knew:

- a. the 21 February letter had been created after your involvement in Patient O's care had ended; **To be determined**
- b. the 21 February Letter had not been provided contemporaneously to Patient O's GP **To be determined**
- c. your actions would give the false impression that the 21 February Letter was contemporaneous. **To be determined**

21. Your actions as set out at paragraph 19 were dishonest by reason of paragraph 20. **To be determined**

Patient P

22. In around April 2022 in the course of civil proceedings initiated against you by Patient P in relation to procedures you had performed on her on 26 June 2010, you allowed to be disclosed to Patient P's solicitors a letter dated 30 June 2010 and addressed to Patient P's GP ('the 30 June Letter'):

- a. which you created/allowed to be created after your involvement in Patient P's care had ended; **To be determined**

- b. and you failed to ensure that Patient P's solicitors were aware that the 30 June Letter had been created after your involvement in Patient P's care had ended.

To be determined

23. At the time of your actions as described at paragraph 22, you knew:

- a. the 30 June Letter had been created after your involvement in Patient P's care had ended; **To be determined**
- b. the 30 June Letter had not been provided contemporaneously to Patient P's GP; **To be determined**
- c. your actions would give the false impression that the 30 June Letter was contemporaneous. **To be determined**

24. Your actions as set out at paragraph 22 were dishonest by reason of paragraph 23. **To be determined**

Patient Q

25. On or before around 2 October 2023, during a GMC investigation into your fitness to practise, you allowed to be disclosed to the GMC handwritten records for consultations with Patient Q in February 2017 and April 2017 ('the Patient Q notes'):

- a. which you created/allowed to be created after your involvement in Patient Q's care had ended; **To be determined**
- b. and you failed to ensure that the GMC were aware that the Patient Q notes had been created after your involvement in Patient Q's care had ended. **To be determined**

26. At the time of your actions as described at paragraph 25, you knew:

- a. the Patient Q notes had been created after your involvement in Patient Q's care had ended; **To be determined**
- b. your actions would give the false impression that the Patient Q notes were contemporaneous. **To be determined**

27. Your actions as set out at paragraph 25 were dishonest by reason of paragraph 26. **To be determined**

Patient R

28. On around 13/14 May 2024, in the course of civil proceedings initiated against you by Patient R in relation to a procedure you had performed on her in June 2010, you allowed to be disclosed to Patient R's solicitors a handwritten record dated 11 June 2010 and timed at 1830 hours ('the 1830 Note'):

- a. which you created after your involvement in Patient R's care had ended; **To be determined**
- b. and you failed to ensure that Patient R's solicitors were aware that the 1830 Note had been created after your involvement in Patient R's had care ended. **To be determined**

29. At the time of your actions as described at paragraph 28 you knew:

- a. the 1830 Note had been created after your involvement in Patient R's care had ended; **To be determined**
- b. your actions would give the false impression that the 1830 Note was contemporaneous. **To be determined**

30. Your actions as set out at paragraph 28 were dishonest by reason of paragraph 29. **To be determined**

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

Witness Evidence

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

- Patient B, in person. Patient B provided a witness statement, dated 11 January 2023;
- Patient N, via MS Teams. Patient N provided a witness statement, dated 29 January 2025
- Patient D in person. Patient D provided a witness statement, dated 21 February 2023;
- Patient M, in person. Patient M provided a witness statement, dated 15 March 2025;
- Patient L, via MS Teams. Patient L provided a witness statement, dated 24 January 2025;

- Patient I, via MS teams. Patient I provided a witness statement, dated 16 January 2025;

Expert Evidence

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

Documentary Evidence

14. The Tribunal had regard to the documentary evidence provided by both parties. This evidence included, but was not limited to: witness statements and attached exhibits; medical records; various emails; and correspondence.

On behalf of Mr Dixon

15. Mr Dixon provided oral evidence to the Tribunal; he also provided two witness statements dated 28 April 2025 (amended 9 May 2025) and 2 May 2025.

The Tribunal's Approach

16. At this stage in the proceedings and in accordance with Rule 17(2)(j) the Tribunal is required to deliberate to make its findings on the facts alleged. In making a determination on the facts the Tribunal considered the legal advice provided to it by the Legally Qualified Chair, together with the case law it was referred to by Mr Basu in his closing submissions in relation to the evidence of witnesses, including expert witnesses.

17. In particular, the Tribunal noted that it should have regard to the whole of the evidence and form its own judgement about the witnesses (including the Registrant), and which evidence is reliable, and which is not. The veracity of a witness' evidence should not be assessed exclusively on their demeanour when giving evidence but should be tested by reference to objective facts proved independently in their evidence, in particular by reference to the documents in the case. The Tribunal should make a rounded assessment of a witness's reliability, rather than approaching their reliability in respect of each charge in isolation from the others. Furthermore, the Tribunal was reminded that it is open to them not to rule out the whole of a witness's evidence based on credibility as credibility can be divisible.

18. The Tribunal also noted that the matters to which the witnesses and the Registrant were being referred occurred some time ago and the Tribunal should take into account the extent to which the passage of time may have affected a witness's memory and that it is possible that memories, being fluid, are changeable when they are retrieved and/or discussed.

19. The Tribunal were advised that where there may be inconsistencies in the evidence as between different witnesses and their assessment of this factor will be influenced by their conclusions as to the facts of this case. The Tribunal must form a view of what happened based on all the evidence they have heard including any inconsistencies which it may identify and what effect they may have on a witness's truthfulness.

20. The Tribunal noted that part of the Allegation relates to dishonesty. It recognised that in order to determine whether or not such parts of the Allegation had been proved, it should apply the two-limbed test set out in the matter of *Ivey v Genting Casinos*.

21. First, the Tribunal must ascertain (subjectively) the state of the Mr Dixon's knowledge or belief as to the facts. The reasonableness of the belief is a matter of evidence going to whether he genuinely held the belief, but it is not a requirement that the belief must be reasonable. Secondly, the Tribunal must then consider whether the conduct was dishonest by the (objective) standards of ordinary decent people. There is no requirement that Mr Dixon must appreciate that what he has done was, by those standards, dishonest.

22. The Tribunal noted that when applying the *Ivey* test the objective standards of ordinary decent people must involve the expectation that registered professionals will have at least some regard to the professional standards under which they are required to operate, pursuant to a system of regulation that is designed to protect the public.

23. In reaching its decision on facts, the Tribunal has borne in mind the GMC's statutory overarching objective:

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

The Tribunal's Analysis of the Evidence and Findings

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

Patient B

25. The Tribunal noted that throughout his evidence Patient B was articulate and his evidence was clear and consistent. The Tribunal also considered Patient B's evidence to be fair. It noted that he conceded on a number of occasions that his recollections could be different and/or he accepted that Mr Dixon may have explained some matters to him but may have used different language, for example sleeving as opposed to prolapsing. The Tribunal considered that these concessions were understandable due to the passage of time and had no bearing on the overall veracity of Patient B's evidence. He specifically recalled that Mr Dixon and he had discussed that, because of Patient B's XXX background, he asked many questions and wanted to have a mechanical understanding of his symptoms and possible treatments. This corresponded with Mr Dixon's recollection of Patient B and his eagerness to understand his situation and options.

26. In respect of Mr Dixon's evidence in relation to Patient B, the Tribunal noted some discrepancies in his evidence, both documentary and oral, which would suggest that his recollection of his interactions with Patient B may not be entirely clear. In particular, the Tribunal was referred to Mr Dixon's handwritten note of a consultation which took place on 15 May 2014 which noted that Patient B was XXX but also a "Biker". However, when this was put to Patient B in cross examination, he clearly stated that in 2014 he was not a biker. He stated that he only started riding a motorbike after being off work. When it was put to him that Mr Dixon meant a cyclist rather than a motorcyclist, Patient B responded by stating that in 2014 he "*was neither... I have a cycling top on, but I'm not a cyclist. I now ride a motorbike, yes, but I never used to*". The Tribunal further noted that in cross examination it was Mr Dixon's evidence that he recalled Patient B saying he was a biker and "*he came to see me in the appointments with his leathers on... When I knew him later, he took up cycling*". The Tribunal noted that this was both inconsistent with the questions put to Patient B in cross examination, when it was suggested that he was a cyclist in 2014, and with Patient B's clear evidence on the matter. When Mr Dixon was challenged about this own recollection, he suggested that it was Patient B's evidence in this regard which was incorrect.

27. The Tribunal noted that it was troubled by Mr Dixon's evidence in this regard. It had no reason to doubt Patient B's evidence relating to his hobbies. His interests were personal to him and therefore it was more likely than not that Patient B's recollections as to whether he was ever a cyclist and when he started to ride his motorbike were correct. Furthermore, the Tribunal noted these matters were not specifically relevant to matters giving rise to the Allegation and therefore considered that it was unlikely that Patient B would fabricate his responses to these particular questions. However, it appeared that Mr Dixon was not willing to consider that his recollection may be incorrect, which would be understandable considering the relevant consultation occurred some 11 years prior. His position was simply that Patient B's evidence on this point was incorrect.

Paragraph 2a

28. The Tribunal noted that it was accepted by Patient B that he had a longstanding history of bowel dysfunction, including symptoms suggestive of obstructed defaecation, prolapsing haemorrhoids, and other functional issues. He also accepted that prior to the surgical consultation with Mr Dixon on 15 May 2014, he had already trialled various conservative treatments, including dietary modifications and laxatives. Patient B also stated that he had researched Mr Dixon and specifically requested to be privately referred to him, having reached the limit of tolerance with the status quo of his situation. The Tribunal noted that both Mr S and Professor T, in their joint report, suggested that Patient B was "*desperate*" and both experts considered that Patient B presented with a complex history. Indeed, Patient B, in cross examination, stated that he was "*desperate for help from anyone*" and was considering whether having a stoma would ease his symptoms.

29. The Tribunal heard from two expert witnesses: Mr S, instructed on behalf of the GMC, and Professor T, instructed on behalf of Mr Dixon. The Tribunal took into account the views of each expert on the matter. It noted that Mr S was of the firm view that prior to elective surgery all non-operative options should be exhausted before surgery took place. However, it was also cognisant of Professor T's opinion that in his experience "...many patients, frustrated by a long history of intrusive symptoms, are eager to pursue what they may perceive as a "quick fix"". The Tribunal noted that Patient B had stated that his symptoms had a significant impact on his life and that he wanted a resolution. The Tribunal further noted that in cross-examination Mr S had accepted that Professor T's opinion on the matter was within the spectrum of acceptable practice for a surgeon of Mr Dixon's standing. Mr S accepted that his own practice may represent the more conservative end of that spectrum, whereas Mr Dixon's practice was likely to sit at the opposite end of that spectrum.

30. The Tribunal noted that both experts agreed that Patient B presented with two distinct issues, first irritable bowel syndrome (IBS) and secondly obstructive defecation with features of high grade rectal prolapse and third-degree haemorrhoids. The Tribunal accepted the evidence of the experts that each of these issues would require different approaches. The Tribunal also noted that Patient B's referral letter from his general practitioner (GP) on 26 February 2014 requested both "*further advice on management of his bowel symptoms as well as treatment of his haemorrhoids*".

31. The Tribunal heard from Mr S whose opinion was that non operative treatments such as dietary manipulation, biofeedback/toilet training and psychological interventions should be considered. However, the Tribunal were mindful of Patient B's evidence that he had tried different diets and laxatives, and these had not improved his intrusive symptoms.

32. The Tribunal noted that it was Mr Dixon's evidence that his usual practice would be to dictate letters to a patient's GP to summarise findings and options discussed with the patient during the consultation with the patient present. It considered Mr Dixon's letter to the GP dated 16 May 2014 reflected his view that the patient's symptoms were unlikely to be explained solely by IBS. In that correspondence, Mr Dixon also notes that dietary changes had been attempted without significant improvement.

33. Mr Dixon's evidence throughout the proceedings was that the option of biofeedback was not usually funded by private insurance companies and his handwritten notes of the consultation with Patient B on 15 May 2014 suggested he had considered this option. The Tribunal also noted that it was Professor T's opinion that where a patient presents with a demonstrable anatomical abnormality, such as Patient B's, non-surgical treatments are usually more successful following surgical correction. Professor T also suggested that a patient may be better focused to proceed with offers of psychological support following the correction of the anatomical abnormality.

34. The Tribunal considered that whilst Patient B did not recollect discussing non-surgical matters with Mr Dixon he did state that he did have some discussions with him at the first consultation and recalled a diagram being drawn by Mr Dixon to assist with the explanation of the possible causes of his pain and symptoms. However, the Tribunal noted that Patient B did not recognise the drawing put to him as being the diagram drawn at the consultation as he believed it was a different sketch as "*the sketch drawn was illegible by the time it was finished*".

35. The Tribunal noted that Mr Dixon's decision to proceed with LVMR surgery was not made in isolation but in the context of a protracted and complex clinical history in which other interventions had already been trialled. The Tribunal concluded that it is important to consider the clinical decision in the context of the overall management pathway, rather than in isolation.

36. While the Tribunal acknowledged that input from a dietitian or other specialists can be helpful, in this case, the patient had already explored dietary approaches without success. The Tribunal also noted that Professor T's opinion that biofeedback and psychological interventions maybe more successful following surgery.

37. Based on the information available, the Tribunal concluded that Mr Dixon did give due thought and clinical attention to non-operative management. He made a reasonable, evidence-based decision in line with accepted practice, albeit at the less conservative end of the acceptable spectrum, and that his management was both justified and proportionate in the context of the patient's symptoms, condition and preferences. The Tribunal therefore finds paragraph 2(a) of the Allegation not proved.

Paragraph 2b

38. In considering this paragraph of the Allegation, the Tribunal reviewed the clinical records, expert reports, and oral evidence provided during the hearing. The focus was whether Mr Dixon failed to carry out all necessary tests and investigations prior to performing an LVMR procedure on Patient B.

39. The Tribunal considered the opinions of each of the experts in respect of the allegation. Mr S was of the opinion that further pre-operative investigations should have been conducted, including functional assessments (such as a defecating proctogram (DPG) and anorectal physiology) to correlate with Mr Dixon's anatomical findings following an examination under anaesthetic (EUA) and laparoscopy. He stated that in complex patients like Patient B "*every opportunity should be taken to get more information to get an accurate picture of the patient and consider all options before embarking on operative treatment.*" He concluded that Mr Dixon's approach fell seriously below the standard expected

40. The Tribunal considered that Professor T agreed that most surgeons would not rely upon an EUA and laparoscopy alone but offered a more nuanced view. The Tribunal noted in his report the following:

"7.13 Most surgeons, when faced with a complex patient such as B, would wish to have full assessment of pelvic floor prior to undertaking surgery. This is a helpful baseline against which future investigations can be compared which is useful if interventions prove to be unsuccessful. Mr AD did discuss the option of anorectal physiology studies and proctography with B but advised that they were not available privately and there would be a long wait as an NHS patient. The decision was not to pursue these and although providing a helpful baseline, in my opinion, the results of these tests would not have altered decision-making.

7.15 In my opinion, it would have been sensible for Mr AD to have arranged proctography and anorectal physiology tests and, in the absence of other tests, this would have fallen below an acceptable standard of care. However, in this case, the impact of omitting these investigations was mitigated by undertaking EUA and laparoscopy, which provided valuable information. Omitting these tests was not reckless or unsafe practice as diagnosis was confirmed on EUA and laparoscopy and these are recognised as useful means of assessing patients with complex pelvic floor conditions. In my opinion, Mr AD's choice of investigations did not fall below the standard expected of a reasonably competent consultant colorectal surgeon, but reflected a pragmatic approach to managing a patient with complex presentation such as B."

41. The Tribunal noted that Professor T acknowledged in his evidence that while he personally would have conducted further investigations including proctography and anorectal physiology he did not criticise Mr Dixon for choosing not to do so. Professor T accepted that, in retrospect, the decision-making might have been different, but still considered Mr Dixon's actions to fall within the spectrum of acceptable professional practice, albeit at the extreme end.

42. The Tribunal noted that Patient B was described as an intelligent and health literate individual who had already explored conservative management options, including dietary changes. He stated in his evidence "*I actually researched him as an individual which is why I asked my GP to go and see him. I was fully aware that he was chairman of the pelvic floor society which gave me trust in his ability and his decision making*". He also commented that "*I*

recall him saying that as an [XXX] I was particularly problematic because I had to have everything explained to me, I needed to understand it”.

43. The Tribunal considered that the evidence suggested Mr Dixon had an informed discussion with Patient B, including discussion of the risks and benefits of surgery. The Tribunal accepted that while some practitioners, including Mr S, would have opted for further testing or delayed surgical intervention, others, like Mr Dixon, may reasonably proceed on clinical grounds when confident in their assessment and supported by the patient’s request for definitive intervention.

44. The Tribunal was also mindful of the inherent subjectivity involved in certain assessments such as an EUA. While the Tribunal accepted that further objective investigations could have been beneficial and might have informed a different course of treatment, it did not find that the failure to carry them out necessarily amounted to a failure to perform “*all necessary tests*,” particularly in light of the expert consensus that Mr Dixon’s practice, though at one end of the spectrum, was still within the bounds of reasonable clinical judgment. Therefore, the Tribunal found paragraph 2(b) of the Allegation not proved.

Paragraph 2c

45. In considering this paragraph of the allegation, the Tribunal reviewed the clinical notes, expert reports, and oral evidence provided by both parties. The central issue was whether Mr Dixon should have involved other specialists, such as a dietitian or gastroenterologist, prior to proceeding with LVMR surgery on Patient B.

46. The Tribunal noted that Patient B, a relatively young male, presented with significant internal rectal prolapse, a diagnosis confirmed by both the GMC’s expert, Mr S, and the registrant’s expert, Professor T. There was agreement that the patient’s symptoms were intrusive and likely attributable to the prolapse.

47. The Tribunal noted that Mr S’s opinion was that Mr Dixon should have referred Patient B to a dietitian prior to surgery. He stated in his oral evidence that he would also expect to see a gastroenterologist and a psychologist involved. He maintained that a gastroenterologist has a skill set in the management of IBS and functional bowel disease that surgeons do not. He also maintained that referral to a dietitian should have occurred pre-operatively to ensure all conservative options were fully explored. Mr S regarded this as good

clinical practice and felt that Mr Dixon's failure to pursue this course was seriously below expected standards.

48. In contrast, the Tribunal considered that Professor T gave compelling evidence. In his oral evidence he stated that the involvement of other specialists would not have improved symptoms attributed to a rectal prolapse. He was of the opinion that Patient B was well informed, and it was his experience that individuals who are deeply troubled by their symptoms would invest significant time to seek out a solution. The Tribunal noted Professor T's report in relation to specialists noted at paragraph 7.19:

"7.19 In general, non-surgical treatments such as biofeedback and pelvic physiotherapy are more successful following surgical correction of high-grade prolapse. B had already received advice on conservative treatment and was aware of dietary impact on bowel function. In my opinion, it was reasonable to discuss the option of surgical treatment of the new diagnosis of high grade internal rectal prolapse without further conservative management or dietetic input and this was an acceptable standard of care that did not fall below the standard of a reasonably competent consultant colorectal surgeon."

49. The Tribunal considered Professor T's evidence, that in light of the confirmed anatomical abnormality, it was reasonable to proceed directly to surgical management. He explained that some symptoms, particularly obstructive defaecation, would not have been improved by dietary intervention, and that attempts at conservative management could reasonably follow anatomical correction. He described Mr Dixon's approach as falling within the acceptable spectrum of clinical practice, even if on the more proactive end.

50. The Tribunal accepted that there are differing schools of thought in colorectal surgical practice. Mr S advocated a structured, multi-specialist work-up prior to surgery, whereas Professor T emphasised that surgical correction can itself help distinguish symptoms attributable to structural abnormalities from those due to functional causes. The Tribunal noted that post-operative referral to a dietician was in fact made by Mr Dixon. Additionally, Patient B was described as health literate and had made significant efforts to alter his diet prior to surgery, supporting the view that further professional dietary input at that stage may not have been successful.

51. Moreover, the Tribunal accepted that Patient B was experiencing persistent and distressing symptoms and had clearly communicated a desire for resolution. The treating clinician's decision to proceed surgically reflected this context.

52. Taking the evidence as a whole, and having weighed the views of both experts, the Tribunal preferred the evidence of Professor T. The Tribunal found that while the involvement of other specialists may have been appropriate in some cases, the Tribunal did not find that the failure to do so in this instance amounted to a failure to meet the standard expected of a reasonably competent practitioner. Mr Dixon's actions remained within the spectrum of acceptable professional judgment. Therefore, the Tribunal found paragraph 2(c) of the Allegation not proved.

Paragraph 3

53. The Tribunal considered whether Mr Dixon adequately explained to Patient B the nature of the complications that led to the re-look laparotomy on 14 April 2017.

54. The Tribunal considered that the evidence confirmed that Patient B experienced a postoperative ileus complicated by a mechanical small bowel obstruction as a result of the congested small bowel slipping under the mobilised colon, which required surgical intervention. During the re-look laparotomy, this "internal hernia" was corrected and the small bowel decompressed. There was no evidence of a major haemorrhage during the procedure.

55. The Tribunal heard from both expert witnesses Mr S and Professor T who agreed that there is a professional duty to adequately explain significant surgical complications to a patient. They further agreed that while the '*gold standard*' is to provide a written follow-up letter, a thorough oral explanation may suffice, and that the oral explanation should be addressed in a series of discussions with both the patient and their family. The experts agreed that the key element was that a patient should come away from the situation with a clear understanding of what had occurred.

56. In this case, the Tribunal considered that the contemporaneous records were limited. It noted that the Spire operative notes dated 14 April 2017 state that at the end of the operation a venous sample was taken at 13:09. In his witness statement Mr Dixon stated he reviewed Patient B in the recovery room between 13:30 and 14:30, prior to transfer to the ward. The Tribunal noted that in his oral evidence Mr Dixon stated that he first informed

Patient B of the findings of the surgery and the complications arising during the surgery in the recovery room, and that Patient B had had a “*very careful anaesthetic ... and would come around quickly and was compos mentis*”. He stated that it was his recollection that Patient B was “*taking part in the conversation*”.

57. However, the Tribunal heard the compelling opinion given by Professor T, that a surgeon should be mindful that, due to the effects of an anaesthetic, it was unlikely that any patient would be able to recall anything that was said to them in the recovery room post-surgery. It was also mindful of Patient B’s oral evidence relating to his first conversation with Mr Dixon post-surgery where he stated “*I do recall once beingliterally coming too, having a conversation with him and I only, literally, had just come through from the anaesthetic and not remembering anything.... I’d literally just woken up...if It’s when I have just come out of theatre...I do remember a conversation but I don’t remember anything*”.

58. The Tribunal noted that in his witness statement Mr Dixon stated that he had reviewed Patient B again post-surgery on the ward at 19.00 hours. At this time Mr Dixon stated that he had explained the findings of the surgery to Patient B, his mother and his wife. However, in his own evidence Patient B stated that he could not recall this but “*to be fair I wasn’t in a good state....after that second surgery I don’t remember having anything explained to me at all...I know he discussed it with my family but I don’t recall him discussing it with me.*”

59. The Tribunal considered that Patient B gave clear and credible evidence that he did not fully understand what had happened to him. It was apparent to the Tribunal that he believed, up until the time of giving evidence in this hearing, that he had suffered a major internal bleed. The Tribunal considered that this was understandable if Patient B and his family had not received the relevant information from Mr Dixon or had not understood what they had been told. The Tribunal noted that Patient B and his family would have been aware of and, likely, seen that Patient B had three units of blood administered post-surgery, two running concurrently. It is likely that they would have also read the discharge documentation which, copied to Patient B, erroneously referred to Patient B having “*post op bleeding*” in the “*Complications Related to Procedure*” section referencing the LVMR operation. Patient B was clear that Mr Dixon had explained to him that a “*nick*” in his bowel had occurred during the re-look laparotomy. However, it was apparent to the Tribunal that until it was explained to him, during the course of the hearing, that this was not unusual in such a procedure. Patient B was told that the hole had been used to surgically relieve some of the symptoms and repaired without complication. Patient B had understood this to be the cause of an internal

bleed. In his oral evidence he stated, “as far as I knew I was bleeding to death”. The Tribunal noted a genuine relief from the Patient during cross-examination when what occurred during the surgery was explained to him.

60. The Tribunal noted that it was Mr Dixon’s evidence that he had used diagrams to explain to Patient B what had occurred during the re-look surgery, and these were provided by Mr Dixon to the Tribunal. However, the Tribunal noted that it was Patient B’s evidence that he had not seen these before and if he had, he “would have asked for a copy of them”. The Tribunal also noted Mr Dixon’s oral evidence where he stated that he would not always write post-operative notes in a Patient’s hospital records and would only usually do so when something had not gone to plan. However, the Tribunal noted that no such notes had been left by Mr Dixon in the hospital notes nor were the diagrams referring to the re-look surgery. The Tribunal further noted that Professor T, when asked by the Tribunal whether he would expect to see such diagrams in a patient’s hospital notes he responded with a categorical “Yes”.

61. The Tribunal was also mindful of Mr Dixon’s oral evidence during which he recalled that during his post-operative conversations with Patient B he “...had to keep him mentally robust, he felt lousy... he was asking about his bloods”. The Tribunal considered that where a surgeon had recognised that a patient required motivation post-surgery and was feeling unwell, it was, in line with Professor T’s opinion that surgeons should be cognisant about a patient’s ability to digest information post-surgery. It would be reasonable to assume that the patient may not be properly processing all information provided to them whilst feeling this way.

62. The Tribunal considered the failure to include the diagrams drawn by Mr Dixon in the hospital notes was a significant missed opportunity to support Patient B’s understanding of the procedure and complications that had occurred. Similarly, both experts referred to, in their evidence, a follow-up letter from Mr Dixon to Patient B’s GP dated 19 June 2017 which they had both had the benefit of reviewing but had not been available to the Tribunal. Each expert stated to the Tribunal that this letter could have been utilised by Mr Dixon to further clarify matters, however, it in itself was misleading as it only referred to Patient B’s complications being caused by a protracted ileus rather than a mechanical blockage and did not correct the discharge summary in reference to post operative bleeding or why the blood transfusions were necessary. The Tribunal considered that this too was a missed opportunity to reinforce an oral explanation and provide the patient with something to discuss with his GP or family.

63. In respect of the agreed position of the experts with regard to the nature of the complications experienced by Patient B, the Tribunal noted that Mr Dixon did not agree with them that the complication was best described as a mechanical obstruction of the bowel and maintained that it was an ileus causing the issues. In his oral evidence Mr Dixon stated that he didn't "*want to criticise the experts... I was the operating surgeon, only I can say what the problem was... they only say that because on the diagram I wrote obstruction. It was a secondary, not the main problem*". However, the Tribunal noted the explanations provided by Professor T, in particular, where he stated that he could not "...recall if the ileostomy stopped completely... even if partial, there would have been lots of fluid... effectively a complete obstruction..." .

64. In considering all of the evidence available to it as a whole the Tribunal considered it more likely than not that various conversations took place post-surgery with Patient B and his family members. However, it was apparent to the Tribunal that no clear, comprehensive explanation of the actual complication was ever fully understood by Patient B. This is supported by his mistaken belief, which persisted long after discharge, that he had nearly '*bled to death*'.

65. The Tribunal noted that in his witness statement Mr Dixon acknowledged that "*it was my normal practice to dictate a GP letter after each surgical intervention particularly following a problematical post operative recovery as happened with Patient B and copy it to the patient. I accept that, in this instance, I failed to meet my own high standards and no letter was produced.*"

66. Taking all of the above into account, the Tribunal concluded that, although some attempt was made to communicate with Patient B, Mr Dixon failed to adequately explain the nature of the complication. The explanation, if given, was either too early in the patient's postoperative recovery, not in accessible language, or not reinforced in writing. Therefore, the Tribunal found paragraph 3 of the Allegation proved.

Patient C

Paragraph 4

67. The Tribunal considered whether or not the LVMR performed by Mr Dixon on 24 February 2017 on Patient C was clinically indicated at the time of the procedure.

68. The Tribunal had regard to the evidence of both expert witnesses Mr S and Professor T. The Tribunal noted that, both experts agreed that in the presence of a high grade internal rectal prolapse with symptoms which could be attributed to this, LVMR was a clinically indicated procedure. The issue was whether it was indicated in this particular patient, at that time, given her complex presentation.

69. The Tribunal noted that Patient C was a highly vulnerable individual with a complex medical history spanning over a decade, primarily centred around chronic pelvic pain and bowel dysfunction. These conditions contributed to depressive episodes and coping mechanisms which was causing her harm. She was referred to Dr U in 2016 in his role as a pelvic pain specialist and he subsequently, in December 2016 referred Patient C to Mr Dixon informing him that Patient C had a sensitised pain system, and her symptoms were significantly worse when constipated.

70. The Tribunal noted that in an outpatient appointment on the 5 January 2017, Mr Dixon diagnosed obstructive defecation syndrome (ODS) and pelvic pain secondary to high grade internal rectal prolapse. In a letter to Patient C's GP Mr Dixon acknowledged the challenges presented by the longevity of Patient C's problems and that her expectations of surgical intervention were reasonable given she was at the end of her tether in terms of the intrusiveness of her symptoms and the effects they were having on her quality of life.

71. Mr S expressed concern that while the prolapse might have been present, the decision to proceed with surgery was hasty and not appropriate for this particular patient, due to her background of complex psychological and functional issues. He questioned whether the risks had been properly weighed and whether less invasive options had been exhausted.

72. In contrast, Professor T accepted that, although the case was complex, there was a reasonable clinical basis for proceeding with the LVMR surgery. He acknowledged the presence of prolapse, the patient's ongoing symptoms, and her history of poor response to conservative treatment. He accepted that Mr Dixon's decision to offer surgery fell within the range of acceptable clinical judgment and was clinically indicated given the circumstances.

73. The Tribunal also took into account that at the time of referral in December 2016, Mr Dixon had access to a referral letter from Dr U, and relied primarily on this, along with the history from the patient.

74. The Tribunal noted Mr Dixon's witness statement, in particular the following:

"I specifically remember the consultation and the discussions that I had with [Patient C and her husband], including the history that they put forward, [the husband's] surgical opinions (XXX...), their interpersonal interactions, [Patient C's] persona and the length of the consultation. I also remember my concerns regarding her husband's management of the situation, which I pointed out to him as being inappropriate, and his failure to comply with Dr. [U's] and my suggestions that he desist from subjecting his wife to daily rectal examinations and phosphate enemas. My recollection is that [Patient C] made and voiced her own decisions and that we enjoyed a very good rapport."

75. The Tribunal noted that Mr Dixon acknowledged awareness of certain elements (opioid use, distress, some aspects of learned behaviour), but it is not clear from the evidence precisely when he became aware of the full extent of Patient C's psychosocial background, including the previous decisions of other surgeons not to operate.

76. The Tribunal took into account the evidence of Professor T and, in particular, his opinion that a prolapsed bowel, as an anatomical abnormality, could only be corrected with surgery. Therefore it was not unusual for a surgeon to first seek to correct the anatomy in order to alleviate the symptoms caused by the prolapse and then ascertain what residual symptoms may remain as a result of co-existing conditions and thereafter treat them appropriately.

77. The Tribunal noted the evidence provided to it that Patient C experienced highly sensitised pain and Mr S's evidence that this was a reason for not undertaking surgery in this particular patient. However, the Tribunal also took into account that Patient C had, at the relevant time, recently coped well following XXX surgery and also sought to book herself in for the LVMR procedure whilst recovering from XXX. Accordingly, it did not appear to the Tribunal that it was unreasonable to conclude that Patient C was content to proceed with the procedure and could withstand surgical pain where the potential benefits may override the pain associated with surgical procedures.

78. The Tribunal considered that the evidence suggests Mr Dixon acted in good faith, based on the clinical signs, history available at the time, and an examination confirming a prolapse. While there were concerns about the potential limited benefit due to the

behavioural factors and ongoing external interference (e.g. repeated enemas and physical manipulation by her husband), the Tribunal accepted that Mr Dixon planned for post-operative psychological and medical support and was hopeful that by correcting the anatomical issue the patient and her husband might be more receptive of psychological intervention thereafter.

79. The Tribunal acknowledged that Patient C may have been desperate for intervention and that there may have been psychosocial influences at play. However, desperation alone does not invalidate a clinical indication — what matters is whether, at the material time, a competent clinician could reasonably conclude that surgery was appropriate.

80. On the evidence presented, the Tribunal found that both experts accepted that LVMR surgery was clinically indicated in principle, and that Mr Dixon's decision fell within the spectrum of reasonable medical practice. The Tribunal was not satisfied that the GMC had discharged the burden of proof to establish that LVMR surgery was not clinically indicated in this specific case.

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

Patient D

Paragraph 5a

82. The Tribunal considered whether Mr Dixon failed to allow sufficient time for non-operative treatments before performing a LVMR and sacrohysteropexy on Patient D in April 2017.

83. In considering this allegation the Tribunal noted that Patient D's evidence was consistent and balanced, however, it did also take into account that Patient D had confirmed that she had been involved in social media groups relating to LVMR procedures and had given media interviews in relation to the procedure and Mr Dixon. Accordingly, it bore in mind that Patient D had, in the years since the first consultations with Mr Dixon spoken about her experiences on a number of occasions and that this may have, understandably, affected her recollections. Patient D was candid in accepting areas where she could not recall specifics and acknowledged she had not received all the letters or communications said to have been sent.

84. The Tribunal noted that Patient D had stated to the Tribunal that she had been engaged and proactive in seeking treatment. The Tribunal noted that her evidence was that she agreed to proceed with a DPG following her first consultation, and thereafter, when a prolapse had been identified, Patient D had contacted Mr Dixon's office and booked herself in for the LVMR surgery within eight days of her second consultation after discussing the proposed treatment with her husband.

85. The Tribunal noted that Patient D was a XXX woman with a history of pelvic floor dysfunction, including urinary symptoms, and presented with symptoms including faecal urgency, with near incontinence with exercise, abdominal pain, and incomplete bowel evacuation. At her consultation with Mr Dixon on 21 February 2017, she reported high-impact symptoms and significant disruption to daily life. On 10 March 2017, Patient D underwent a DPG. Patient D then met with Mr Dixon again on the 16 March 2017 where he explained that the DPG recorded a grade 3/4 internal rectal prolapse and that this was probably the cause of her symptoms.

86. The Tribunal noted that it was Mr Dixon's evidence that he considered the patient had several problems, included IBS, possible biliary pain and also bowel and pelvic floor symptoms. He indicated that these latter symptoms were indicative of an underlying longstanding problem, rather than a recent acute onset problem. Although only six weeks had passed since an episode of acute pain, the broader clinical picture and history, included a 2015 colonoscopy and an earlier referral and procedure by a gynaecologist pointed to chronic pelvic floor dysfunction.

87. The Tribunal examined the question of whether sufficient time had been allowed to explore non-operative treatment and considered the expert evidence provided by Mr S and Professor T. Mr S was of the view that more time should have been taken to exhaust conservative options, and he criticised the relatively short interval between the initial consultation and the surgery. However, Professor T offered a different view. He noted that whilst there can be an overlap of symptoms in IBS and rectal prolapse, conservative or non-surgical options would be primarily aimed at managing IBS. He further noted that pelvic floor physiotherapy would not have corrected the prolapse and could reasonably be offered post-operatively, once the underlying anatomical issue had been corrected. The Tribunal had particular regard to the following in his report:

"7.8 In my opinion, offering surgery 5 weeks after the last clinic appointment did not fall below the standard expected of a reasonably competent consultant colorectal

surgeon. Following MDT review, there does not appear to be a role for non-operative treatment of the rectal prolapse which was treated in isolation to D's IBS. MDT advice is that biofeedback is unlikely to work in view of the degree of prolapse, but the physiologists would be happy to see after surgery. A parallel is seen in musculoskeletal treatments. Conservative treatment such as physiotherapy is helpful for many conditions but if there is marked anatomical abnormality, eg a divided tendon or broken bone, it should be repaired before physiotherapy can be expected to restore function."

88. The Tribunal accepted that non-operative treatments including dietary modification, antispasmodic medication, physiotherapy, or biofeedback therapy, might be regarded as the first step in managing pelvic floor symptoms. However, the Tribunal also accepted that conservative treatment is not always appropriate or effective, particularly in cases of significant anatomical prolapse.

89. The Tribunal was mindful that in his oral evidence Mr Dixon stated he was one of the leaders in a randomised controlled trial and was keen to recruit to the study. He referred to notes in his witness statement that at a multidisciplinary team (MDT) meeting held on 28 March 2017 he asked about the suitability of biofeedback in this trial in relation to Patient D prior to surgery. It was Mr Dixon's evidence that two gastrointestinal physiologists sitting on the MDT were of the opinion that Patient D was not suitable for the trial due to the extent of the prolapse and severity of her symptoms.

90. While the Tribunal recognised that more detailed documentation and direction around conservative treatment options to the GP could have strengthened the record, it did not find that the absence of a prolonged trial of non-operative measures rendered the decision to operate inappropriate or premature. Given the severity of prolapse, the impact on her quality of life, and the expert evidence that surgery was a clinically reasonable course, the Tribunal concluded that Mr Dixon's approach fell within the spectrum of acceptable medical practice, albeit at the opposite end of the spectrum to that of Mr S.

91. Accordingly, the Tribunal found paragraph 5(a) of the Allegation not proved.

Paragraph 5b

92. The Tribunal considered whether Mr Dixon failed to arrange assessment by relevant specialists prior to Patient D's surgery, specifically: a gastroenterologist or IBS specialist for

evaluation of abdominal pain and IBS symptoms, and an anorectal physiologist for assessment and possible non-operative management.

93. Both experts, Mr S and Professor T, agreed Patient D was discussed at a MDT meeting, which concluded that biofeedback therapy and anorectal physiologist input were not appropriate or recommended in her case. The Tribunal noted that it was Mr S's opinion that Mr Dixon held an overtly dominant position at MDTs with a surgery first approach leading to a group bias. However, the Tribunal noted that in relation to Patient D it is apparent that Mr Dixon sought advice from, and listened to, the opinions of other members.

94. Regarding referral to a gastroenterologist, the Tribunal noted it was Professor T's opinion that an integral part of colorectal surgical practice is providing advice on IBS symptoms and managing functional bowel conditions. Mr Dixon gave evidence that the predominant clinical issue was anatomical prolapse causing the majority of symptoms, and that correcting the prolapse might improve or alleviate abdominal symptoms.

95. The Tribunal regarded that both experts agreed that IBS is not treated surgically and that surgical intervention with LVMR surgery was aimed at providing resolution to ODS and rectal prolapse symptoms. Professor T considered it reasonable clinical practice to proceed with prolapse surgery first, address the anatomical correction required, before managing other functional bowel symptoms.

96. The Tribunal noted that Patient D had ongoing bowel symptoms that had been investigated previously before referral to Mr Dixon. It considered that the prolapse was graded as severe (grade 3/4), with limited non-surgical treatment options available for this anatomical problem; biofeedback and physiotherapy were considered but not recommended by the MDT, which both experts accepted as appropriate. It noted that while Mr S favoured a more conservative approach, this was not unanimously supported by the evidence.

97. Therefore, the Tribunal concluded that Mr Dixon's management, focusing on the anatomical correction prior to other treatments, was within the range of reasonable medical practice.

98. Accordingly, the Tribunal found paragraphs 5b(i) and 5b(ii) of the Allegation not proved.

Paragraph 5c

99. In respect of the DPG undertaken by Patient D, the Tribunal noted it was the opinion of Mr S that this is a functional test which was more objective than an EUA. Furthermore, Professor T was of the opinion that offering LVMR surgery based on these findings of the proctogram would be standard practice for a patient wishing to have surgical treatment.

100. Taking into account the opinions of the experts, Patient D's evidence and that of Mr Dixon the Tribunal considered that Mr Dixon's offer to proceed to surgery was based on symptoms supported by a functional test and discussed at a MDT. Accordingly, the Tribunal found paragraph 5c (i) not proved.

101. The Tribunal noted that both experts agreed the LVMR surgery carried risks of serious complications, including mesh-related issues. The Tribunal further noted that whilst Patient D did not specifically recall all of her discussions with Mr Dixon, it was apparent from her evidence that some of the risks of the LVMR surgery were discussed with her. She stated that she may have recalled Mr Dixon mentioning a 75% success rate. Patient D recalled discussions about mesh types and possible erosion problems, indicating some understanding of risks. It is elective surgery, and Patient D was aware it might not be a perfect solution; she understood functional outcomes might vary and that surgery might not fully resolve her symptoms. In her witness statement Patient D stated that she understood the purpose of the surgery and that she enquired about recovery. In response to that question, she stated that Mr Dixon has suggested a "*wait and see*" approach.

102. The Tribunal noted that it was Mr Dixon's evidence that it was his practice to explain that approximately 75% of patients benefit, but about 25% might not see the desired outcome and it was difficult to predict who those patients might be. Patient D in her evidence recalled some discussion but could not recall precise percentages.

103. The Tribunal noted that the experts agreed that to obtain informed consent from a patient the risks relating to a procedure needed to be communicated to the patient prior to the date of the procedure so they have adequate time to weigh up the options. It further noted that both experts considered informing a patient of rare but highly consequential complications such as visceral and vascular injury on the day of surgery was below the standard expected of a reasonably competent surgeon. Both experts were of the opinion that this was not seriously below the standard expected.

104. The Tribunal considered that the consent process documentation available to it showed some limitations. In particular, on the day of surgery, Mr Dixon recorded consent very briefly at 8:25 am, just minutes before theatre time. The Tribunal noted that he later regretted the lateness of this documentation. Patient D confirmed the risk discussion was brief and close to surgery time, consistent with the consent note.

105. It noted that both experts agreed that while the risk discussion was documented, having it so shortly before surgery is not ideal and falls short of expected standards. Earlier discussions about risks were not clearly documented, and Mr Dixon did not record them in his handwritten notes. The Tribunal also considered Patient D's evidence that in her opinion being told this information so late in the day was too late. She told the Tribunal that she was, at the time of being told the risks, already gowned and ready for surgery and was already committed to proceeding; however, it was also her evidence that had she had known this information earlier she may have considered things differently.

106. The Tribunal, taking all of the above into account considered that the patient was aware in general terms of potential functional outcomes, including potential uncertainty in recovery, the formal informed consent, of rare but highly consequential complications was given too late and too briefly.

107. Accordingly the Tribunal found paragraph 5(c)(i)(1) not proved but 5 c(ii) (2) proved.

Paragraph 6

108. The Tribunal noted that the documentary evidence shows that multiple letters were sent by Spire Healthcare, at the relevant time, requesting patient records relating to patients treated by Mr Dixon. These letters are exhibited in Dr V's witness statement. It noted that there is no refutation or dispute that the letters were sent to Mr Dixon. Mr Dixon responded to these requests as shown in the evidence.

109. Accordingly the Tribunal found paragraph 6 of the Allegation proved.

Paragraph 7 in relation to Patient E

110. The Tribunal considered the evidence concerning the creation of the Spire Records relating to Patient E. It was noted that the Spire Hospital admission documentation recorded that the patient was admitted at 9:40am on 21 August 2015 and that the proposed surgical

start time was 10:30am. However, the handwritten record provided by Mr Dixon, not contained within the Spire Hospital notes, appeared to suggest that he first consulted with Patient E at 8.00am. Mr Dixon's evidence was that the time actually reads 9.10am and not 8.00am. This note detailed what appears to be a preoperative discussion including consent.

111. The Tribunal also noted that it was Mr Dixon's evidence that "*Morning patients were all asked to arrive in reception for 7.15*" and that he would often go down to reception and collect the patient. However, the Tribunal noted from other documentation available to it that this was not the case in respect of patients attending hospital for private surgery and there was, within the bundle of documents, evidence of patients being requested to attend at various times of the day to be admitted ahead of surgery.

112. The Tribunal noted that in respect of Patient E, it appeared that the proposed admission time was 10.00am and it considered that it was more likely than not that the patient arrived early and was checked in at around 9.40am when the admission documents were completed by Nurse X. The Tribunal also bore in mind Mr Dixon's evidence that when he undertook surgical lists these would usually commence at 8.30am and therefore considered it improbable that he would be in a position to meet his patients in reception and walk them to their rooms, particularly when they were checking in at different times during the day. The Tribunal noted that the Spire hospital records included a prescription chart indicating that at 10.00am Mr Dixon had prescribed a preoperative enema. The Tribunal considered that taking into account Mr Dixon's evidence that surgical days were busy it was unlikely he would have visited the patient twice pre-surgery.

113. On the balance of probabilities, the Tribunal determined that the note was created after Mr Dixon's clinical involvement in Patient E's care had ended. Accordingly, the Tribunal found 7(a) proved in relation to Patient E.

114. The Tribunal reviewed the available documentation and noted that a consent form had indeed been signed by Patient E on the day of surgery. Accordingly, the Tribunal found no clear evidence that this amounted to a false reference, and therefore 7(b)(i) was found not proved in relation to Patient E.

115. In relation to allegation 7(b)(ii) with regard to Patient E, the Tribunal noted that both the letter of the previous outpatient clinic and subsequent letter to the patient's GP were sparse in detail. The Tribunal considered that it had no documentation or evidence before it

that the note contained any false reference to giving additional information to Patient E before the procedure. On that basis, 7(b)(ii) was found not proved in relation to Patient E.

116. The Tribunal found no specific documentation or content in the Spire Records indicating additional detail as to Mr Dixon's decision-making prior to the procedure. It was apparent to the Tribunal that Mr Dixon would have seen Patient E prior to the surgery on 21 August 2015 and did not have sufficient information before it to conclude whether any of the information contained in the note was a false reference.

117. Accordingly, 7biii was found not proved in relation to Patient E.

118. In reaching its determination in relation to paragraph 7(c) regarding Patient E, the Tribunal did note that Mr Dixon had given evidence in relation to preparing summaries relating to a patient's treatment in order to add this to his LVMR research database and noted that he would draft these utilising notes he continued to hold for the particular patient. The Tribunal therefore considered that it was more likely than not that this is how he would have created notes after his involvement in the care of patients had ended and accordingly, most of the information in the note may have been correct and simply drawn from other sources of information and made to look as if it was made contemporaneously.

119. The Tribunal noted that in his witness statement Mr Dixon maintained that the information contained in these documents was not concocted but do not “....*in substance, go beyond the information that is elsewhere in the medical records*”.

120. The Tribunal was satisfied that Mr Dixon failed to inform Spire that the records in question had been created after his clinical involvement with Patient E had ceased. This omission was material, as the context in which records were created could impact their interpretation. Consequently, 7(c) was found proved in relation to Patient E.

Paragraph 7 in relation to Patient F

121. The Tribunal considered the documents submitted by Mr Dixon in relation to Patient F, including consultation notes purportedly from July 2005. The Tribunal noted that one of these documents was undated, lacked the patient's name, but had similarities in content to a dictated GP letter dated 1 July 2005.

122. The Tribunal noted that Mr Dixon asserted that the consultation note did not relate to Patient F and should be disregarded. However, it was considered that the note was provided to Spire in response to a request for Patient F's contemporaneous records. The Tribunal noted Mr Dixon's evidence as to how he stored his patient notes at home, in particular, that they were not always in one place. It considered it more likely than not, that in response to Spire's request for patient information, Mr Dixon would have checked the various places he stored patient records and compiled batches of the notes relating to each patient.

123. Further, the Tribunal noted the document dated 15 July 2005 appeared on Spire-headed paper, despite it being accepted by all parties that Spire was not incorporated until 31 August 2007. The Tribunal noted that it was Mr Dixon's evidence that these notes were created after August 2007 as part of a review process for his database. The Tribunal noted the following in Mr Dixon's witness statement:

"I carried out this same process in the hospital medical records departments of the three private hospitals in which I worked. In Spire's case, this was in the confines of the basement. This also included a review of the notes that I kept at home. I extracted the missing data entry points and noted them on the Spire hospital headed notepaper given to me by my secretary at the time to which I added hospital address labels, where available, for identification details, applied so as not to obscure the Spire Hospital header."

124. The Tribunal considered that the notes provided followed a pattern consistent with Mr Dixon's consultation note style, including structure, phrasing, and signature. It also noted that content of the first note appeared to follow on from his handwritten note on the referral letter from a gynaecologist. Furthermore, the Tribunal noted the document dated 15 July 2005 incorporated Patient F's hospital sticker from 2005 and the post operative note appeared to be written on its reverse.

125. The Tribunal also gave little weight to Mr Dixon's evidence that he created the notes in the process of updating his database. In his oral evidence Mr Dixon confirmed that he input data into the database, and accordingly, the Tribunal considered that such notes would not be required if updating the information oneself. Given the context, including Mr Dixon's own admission that he was under pressure when fulfilling the Spire request for information, that his records were chaotic, and that he may have submitted them without carefully reviewing them, the Tribunal found it more likely than not that the records were created or

compiled after his involvement in Patient F's care had ended when he could not locate the original notes.

126. On that basis, the Tribunal found paragraph 7a of the Allegation proved in relation to Patient F.

127. The Tribunal concluded that it could not safely determine that the information contained in the records was false. While there were discrepancies in the notes regarding post procedural matters — including a clinical inconsistency between Mr Dixon's note dated 16 July 2005 which recorded removal of a catheter, and nursing records from the same day showing the catheter remained in situ at 11:40am and was removed the following day, the Tribunal accepted that such inconsistencies might arise from retrospective note making rather than a deliberate falsehood. The Tribunal also noted that the document referenced the patient's insurance number which it did not consider necessary for inputting in to a research database. It was of the opinion that this information was incorporated to make it appear as if it were a contemporaneous note. It was considered more likely than not that Mr Dixon compiled the information from other sources and that the inaccuracies were the result of later reconstruction rather than fabrication.

128. Accordingly, paragraphs 7(b)(i)–(iii) were found not proved in relation to Patient F.

129. The Tribunal was satisfied that Mr Dixon failed to disclose that the notes submitted in relation to Patient F had been created or reconstructed after his involvement in her care had ended. In particular, the Tribunal was concerned by the use of Spire-headed paper for a patient's consultation, which would mislead readers as to the timing and authenticity of the documents. This omission amounted to a failure to ensure Spire were aware of the context of creation.

130. Therefore, the Tribunal found paragraph 7c proved in relation to Patient F.

Paragraph 7 in relation to Patient G

131. The Tribunal considered the documents submitted in relation to Patient G, in particular the handwritten entry of Mr Dixon dated 7 March 2007. It was noted that Spire was not yet incorporated at the time of the entry, and that one of the pages was on Bupa-headed paper. It appeared to the Tribunal that four pages of a consultation note had been stapled together with the first page being Patient G's GP referral letter. It noted the

documents followed a familiar format to Mr Dixon's consultation notes and the last page was signed by Mr Dixon and made reference to an action to refer the patient to a clinical radiographer.

132. In his oral evidence Mr Dixon stated that this note did not relate to a consultation but was in the format of the summary he would compile for his research database. However, the Tribunal noted that it appeared that Mr Dixon's consultation notes relating to other patients mirrored this exact same format.

133. The Tribunal noted that the presence of both Bupa and Spire-headed paper in relation to the same consultation was indicative of confusion or retrospective compilation. It appeared likely that Mr Dixon, under pressure, assembled documents without properly checking the details of the letterhead. The inclusion of relevant information, the structured nature of the note, and the signature at the end all suggested that Mr Dixon intended this to be treated as a contemporaneous document.

134. The consistency in structure and presentation with Mr Dixon's other consultation notes suggested that this document had been created retrospectively to appear as part of the patient's original records.

135. Given these considerations, the Tribunal concluded that the note was created after Mr Dixon's involvement in Patient G's care had ended, and that it was subsequently presented as if contemporaneous. Accordingly, paragraph 7(a) was found proved in relation to Patient G.

136. The Tribunal then turned to whether the documents contained any false references to obtaining consent, providing additional information before the procedure, or explaining clinical decision-making. It was noted that this appeared to be the first consultation for the patient, and there was no additional documentation available to compare or verify the accuracy of the content.

137. While it was accepted that Mr Dixon may have compiled the note using his database or pre-existing resources, the Tribunal found no evidence to demonstrate that the information itself was false. As such, although the document was found to have been created after the fact, it was not possible to determine that any of the content was false.

138. For those reasons, paragraph 7b, including subparagraphs (i), (ii), and (iii), was not found proved in relation to Patient G.

139. In addition, the Tribunal was satisfied that Mr Dixon failed to ensure that Spire were aware that the records had been created after his involvement in Patient G's care had ended. Therefore, the Tribunal found paragraph 7c in relation to Patient G proved.

Paragraph 7 in relation to Patient H

140. The Tribunal considered the consultation note on Spire-headed paper purporting to be Patient H's first consultation on 6 January 2005. The note has Patient H's sticker and included details of the patient's symptoms, which began around Christmas, as well as elements of examination, history and GP's name. The Tribunal found it implausible that such a detailed document was a draft or a summary for his research database, as Mr Dixon claimed. The note was signed, and presented as a full consultation note rather than a summary for research purposes. The Tribunal noted Mr Dixon's clarification of the information he collected for his research database and considered that this note contained significantly more factual information than required for research purposes.

141. The Tribunal made comparison with an alternative consultation note provided by Mr Dixon in his witness statement which purported to be his note of the consultation on 6 January 2005. He stated that this was written on the reverse of the GP referral letter. It noted that the format of this note was similar to the note in question but contained less details. The Tribunal noted that this had not been provided to Spire at the time of their request for documents. The Tribunal found this similarity compelling and concluded that it was more likely than not that Mr Dixon had compiled the note on the Spire-headed paper using his usual format, after the fact, utilising other resources held by him.

142. The Tribunal considered that this note could not have entered the records accidentally or without review. Instead, it found that the document had been purposefully compiled by Mr Dixon after the consultation had taken place.

143. Accordingly, paragraph 7a was found proved in relation to Patient H.

144. In respect of 7b(i), the Tribunal noted that consent for an EUA and colonoscopy was documented separately, but the note did not itself record consent being obtained. There was no evidence that this absence constituted a false reference.

145. As for subparagraphs 7b(ii) and 7b(iii), the Tribunal noted that while the consultation note contained a substantial amount of information, it could not determine whether this content was based on the actual consultation or compiled later using other sources. There was no evidence of overt fabrication. Although the notes appeared to have been enhanced or expanded retrospectively, the Tribunal did not find that they contained false references to having provided additional information or to decision-making processes.

146. On that basis, paragraph 7b, including (i), (ii), and (iii), was found not proved in relation to Patient H.

147. The Tribunal was satisfied that Mr Dixon failed to make clear to Spire that the records submitted had been created or reconstructed after his clinical involvement with Patient H had ended. The nature and style of the note, together with its use of Spire-headed paper, suggested an intention to present the document as contemporaneous. Mr Dixon was aware that the notes would be scrutinised and relied upon, and his failure to clarify their true origin risked misleading readers about the timing and context in which the record was made.

148. Therefore, paragraph 7c was found proved in relation to Patient H.

Paragraph 7 in relation to Patient I

149. The allegation in relation to Patient I regarded the second page of a three page note of a consultation on 8 November 2005. The note was documented on Spire-headed papers despite of the fact that Spire had not been incorporated until 31 August 2007.

150. The Tribunal heard oral evidence from Patient I and accepted that his recollection of events, while at times unclear, was understandable given the passage of time. His account included some unusual or unlikely details, but overall was not deemed to be deliberately misleading. The Tribunal did not criticise the patient and acknowledged that lapses in memory were inevitable for events occurring many years ago. Patient I's evidence was treated with caution due to difficulties recalling dates and inconsistencies in detail. The Tribunal also considered the particular phrases Patient I recalled Mr Dixon using during his consultations with him. However, it considered that, having heard from Mr Dixon, it was apparent that his language was more technical in nature it was more likely than not that such phraseology was not used.

151. However, the Tribunal did consider that Patient I's evidence regarding his profession prior to retirement and for whom he had worked for to be compelling. In cross-examination Patient I contradicted Mr Dixon's evidence that he had been an ornamental plasterer and had worked for a particular company and confirmed that he had been a "XXX" and had never worked for that company. The Tribunal considered that these facts would be clear within the recollection of the Patient. The Tribunal noted that after hearing Patient I's evidence in this regard, Mr Dixon changed his recollection of the patient to him being a "XXX" who was doing some consultancy work for the company in question at the relevant time. The Tribunal noted that this alternative was not put to Patient I in cross examination in which to verify the information and considered that Mr Dixon's recollection of the interactions with Patient I were not entirely clear, which again, was understandable after such a long passage of time. The Tribunal could not be sure that Mr Dixon's alternative recollection of Patient I's employment was correct and considered this inconsistency as further evidence of the unreliability of Mr Dixon's retrospective accounts.

152. The documentation considered included three pages, the first was on a blank sheet and bore no patient name but was dated 8 November 2005. The second page was on Spire-headed paper upon which Mr Dixon has written Patient I's name. The final page was on a blank sheet of paper and signed by Mr Dixon. The Tribunal noted that both Patient I and Mr Dixon were in agreement that a consultation did occur on 8 November 2005 despite the incorrect date being stated in a subsequent letter to Patient I's GP.

153. The Tribunal found it significant that the note followed the same structural format as Mr Dixon's typical consultation notes with the three pages seemingly forming a narrative of the consultation including a diagram and the phrase 'keen to proceed'. The note also set out the next steps including Patient I being added to the NHS waiting list and being referred for a DPG.

154. In his witness statement Mr Dixon did not dispute page one of the note and suggested that it was written on the back of his previous letter to the GP. He was not able to explain the Spire-headed page of the note other than to say that "*it was not written post 2019 or in 2020 as alleged by Dr [V]...*"

155. However, in his oral evidence Mr Dixon then stated that he did not believe that the second and third page belonged to Patient I. Whilst he agreed that they appeared to follow his usual pattern of a consultation note and the information on these pages was relevant to Patient I his evidence was that they do not relate to Patient I's consultation. He told the

Tribunal that the notes were “*a summary of the diagnosis.... Based on contemporaneous notes elsewhere and my letter to him*”.

156. The Tribunal also noted that the initial consultation note of September 2005 contained a diagram detailing Mr Dixon’s findings and to which he would have access to in subsequent clinics. The Tribunal saw no reason why such a diagram would be required on a second consultation or on a summary document. When the anomaly was put to Mr Dixon he accepted that a diagram on the summary document was not required and admitted that “*it looks fishy*”.

157. The Tribunal considered that these details, including the comments of Mr Dixon, made it more likely than not that these records had been retrospectively compiled to appear contemporaneous.

158. Further documentary evidence confirmed a letter to the GP following this consultation referring to Patient I being added to the NHS waiting list and a letter to Patient I cancelling the DPG. The Tribunal considered that the detail in the notes supported the likely sequence of events. The Tribunal considered the note in question to be a full consultation note rather than a summary, as Mr Dixon had claimed.

159. On the balance of probabilities, the Tribunal determined that the consultation note was created after Mr Dixon’s clinical involvement had ended.

160. Accordingly, paragraph 7a was found proved in relation to Patient I.

161. The Tribunal considered whether the notes included any false references to consent, additional information, or clinical decision-making.

162. The consultation note was lengthy and included details not mentioned in correspondence with the GP. While the Tribunal accepted that the note may have drawn on other sources or been reconstructed with knowledge of what the Spire Review would be looking for, there was no evidence that the specific content was false. The Tribunal had no independent corroboration of the precise information provided at the time and could not say with confidence that any specific statement in the notes was fabricated.

163. Therefore, paragraph 7b, including subparagraphs (i), (ii), and (iii), was found not proved in relation to Patient I.

164. The Tribunal accepted that Mr Dixon submitted the consultation notes as if they were contemporaneous, without informing Spire that they had been compiled after the event. The documents followed Mr Dixon's usual note format, including a diagram, and were submitted in a manner suggesting they had been created at the time of consultation. His own evidence in relation to earlier consultations suggested that he typically had prior patient records available and would not need to redraw diagrams unless reconstructing notes later.

165. The Tribunal was satisfied that this omission constituted a failure to ensure that Spire was aware that the records were created after his clinical involvement had ended.

166. Accordingly, paragraph 7c was found proved in relation to Patient I.

Paragraph 7 in relation to Patient J

167. The Tribunal considered a consultation note dated April 2004 which bore a hospital sticker for Patient J on Spire-headed paper. As Spire was not incorporated until 2007, it was immediately clear that the note could not have been created contemporaneously. The note followed Mr Dixon's established format for preoperative and postoperative notes, including signed and dated entries for each segment of the consultation.

168. The Tribunal found that this structure and presentation mirrored other pre and post operative records submitted by Mr Dixon. The practice of dating and signing off each individual section of the document was considered inconsistent with a mere summary. Mr Dixon, when questioned in cross-examination, admitted that it "*looks like a contemporaneous document*" and appeared "*more worrying*". Furthermore, Mr Dixon stated that he was "*kicking himself*" that he had destroyed the original.

169. The Tribunal was satisfied that this note had been reconstructed and was presented as if contemporaneous. On that basis, paragraph 7a was found proved in relation to Patient J.

170. The Tribunal then considered whether the document included any false references to obtaining consent, providing additional information before the procedure, or setting out decision-making reasoning.

171. The Tribunal noted a discrepancy regarding a post-procedural matter between Mr Dixon's note stating that the patient could eat, and drink and the drain and catheter could be

removed on 24 April 2004. However, the Spire inpatient nursing records confirm that the patient was seen by Mr Dixon and these actions were advised on 25 April 2004. While this inconsistency did not lead the Tribunal to conclude that the content of the entire note was false, it was determined that it was more likely than not that Mr Dixon had constructed the note at a later time and may have filled in gaps based on assumption, which led to inaccuracies.

172. Although there was some evidence that consent had been discussed at the time, the Tribunal concluded that the reference to post-procedural events, specifically the timing of the drain and catheter removal was inaccurate. This was the only part of the record found to include a false reference. The remainder of the note, while created after the fact, did not contain other demonstrably false content and may have reflected Mr Dixon's usual practices or expectations.

173. Accordingly, paragraph 7(b) was found not proved in its entirety in relation to Patient J, but the Tribunal found that there was a false reference in respect of post-procedural care, namely the timing of Mr Dixon's post operative instructions to the nursing staff.

174. The Tribunal was satisfied that Mr Dixon submitted this document as if it were created at the time of the consultation and failed to inform Spire that it had, in fact, been created retrospectively. The use of Spire-headed paper for a consultation dated several years before Spire's incorporation was deliberately misleading, and Mr Dixon did not take any steps to qualify or explain the context of the note's creation.

175. Therefore, paragraph 7c was found proved in relation to Patient J.

Paragraph 7 in relation to Patient K

176. The Tribunal considered the handwritten pre and post operative note dated 1 April 2011, which recorded that the Patient K was seen by Mr Dixon at 8:30am. However, this was inconsistent with other documentary evidence showing that the patient had originally been scheduled to arrive at 12:00pm and was subsequently asked to attend at 9:30am due to revised start times. It was Mr Dixon's evidence that the amended time of 9.30am must have actually been 7.30am however, there was no evidence to support this assertion. The Tribunal considered that it was more likely than not that the contemporaneous Spire notes were correct and Patient K was asked to arrive at 9.30am.

177. The patient's theatre time was recorded as 11:15am, and nursing checks confirmed her admission from 9:30am onwards. The Tribunal found no contemporaneous record placing the patient in the hospital prior to 9:30am and considered Mr Dixon's account implausible in this regard. It concluded that the assertion of an 8:30am consultation could not be reconciled with the other contemporaneous notes.

178. On the balance of probabilities, the Tribunal determined that Mr Dixon did not see the patient at 8:30am and that the note had been created after the fact to give the appearance of contemporaneity.

179. Accordingly, paragraph 7a was found proved in relation to Patient K.

180. The Tribunal then considered whether the note contained any false references as defined in subparagraphs 7b (i) to (iii). The consultation note recorded that the patient understood the reason for the procedure and that it carried low risk. There was no evidence to suggest that these entries were false. The Tribunal inferred that consent had been obtained, and that the patient had undergone the procedure as planned.

181. The Tribunal considered that it had no evidence before it that the note contained any false reference giving addition information to Patient K before the procedure. Furthermore, the Tribunal found no specific evidence indicating additional detail relating to Mr Dixon's decision making prior to the procedure. The Tribunal had seen GP letters relating to consultations from the 31 January 2011 and 19 March 2011 during which it appeared matters were explained to Patient K. It was apparent to the Tribunal that Mr Dixon was likely to have seen Patient K prior to surgery on 1 April 2011. Accordingly, it did not have sufficient information before it to conclude whether any of the information contained in the note was false.

182. The Tribunal also noted a signed consent form which corroborated the inference that consent had been given. The Tribunal considered it likely that Mr Dixon had drawn together existing information when compiling the note at a later time.

183. Although the Tribunal was satisfied that the note was not contemporaneous, it found no evidence that any of the content was fabricated or false. Therefore, paragraph 7b, including subparagraphs (i), (ii), and (iii), was found not proved in relation to Patient K.

184. The Tribunal concluded that Mr Dixon submitted the consultation note in a manner

suggesting it had been written at the time of the consultation. There was no indication in the documents submitted that the record had been created retrospectively or compiled using other resources. Given that the timing stated in the note could not be reconciled with hospital admission records, and that it was submitted without clarification, the Tribunal was satisfied that Mr Dixon failed to inform Spire that the record had been created after his clinical involvement had ended.

185. Accordingly, paragraph 7c was found proved in relation to Patient K.

Paragraph 8a

186. The Tribunal considered Mr Dixon's evidence in relation to his knowledge of the Spire Review's focus at the time he disclosed the records referenced in paragraph 7. Mr Dixon stated during his oral evidence that he had not seen the terms of reference of the Spire investigation until that day.

187. However, the Tribunal found this explanation implausible. It was Mr Dixon's evidence that he kept requesting the terms of reference of the investigation via his solicitors. Furthermore, it noted a letter dated 12 April 2018 from Dr W, Mr Dixon's solicitor, that the terms of reference had been received:

"12 April 2018

Dear Mr [Y]

MPS Member: Mr Anthony R Dixon

Thank you for your letter dated 3 April explaining your understanding of Mr Dixon's difficulties in regard to the medical records of his patients. I note that attached to your letter were the Spire terms of reference and process. Although your points are noted, it remains our position that Mr Dixon maintains a duty of confidentiality to his patients, and therefore consent should be obtained before the records are sent to Spire. I simply do not understand the reluctance on Spire's part to write and obtain appropriate consent from the patients concerned. This should be straightforward.

However, in the interests of progressing matters, and also demonstrating his willingness to cooperate, Mr Dixon will write to each of the patients explaining that a

request has been made for their records to be sent for a review by Spire. I enclose a copy of the letter that Mr Dixon will be sending to the patients. As soon as consent is forthcoming Mr Dixon will arrange for you to receive copies of the records.

Yours sincerely

Dr [W]"

188. The Tribunal considered it inconceivable that Mr Dixon's solicitors would not have shared the terms of reference with him, particularly given the seriousness of the matters under review and taking into account Mr Dixon's oral evidence that he was continually asking for them.

189. The Tribunal considered that Mr Dixon's own evidence in this regard was inconsistent. During cross examination he conceded that he was aware of what Spire were investigating at the relevant time. On considering all of the evidence available to it the Tribunal was satisfied that Mr Dixon knew, at the relevant time that the Spire Review was investigating issues including consent, pre-operative information, clinical decision-making, and complications in relation to Patients E–K.

190. Accordingly, the Tribunal found that paragraph 8a(i) to (iv), was proved in its entirety in relation to Patients E–K.

Paragraph 8b

191. The Tribunal found that this element flowed directly from the findings under paragraph 7. Mr Dixon either created or compiled the Spire Records after his involvement in the care of Patients E–K had ended, and it was inconceivable that he would not have been aware of this at the time of their submission.

192. Therefore, paragraph 8b was found proved in relation to Patients E–K.

Paragraph 8c

193. The Tribunal's findings under paragraph 7b (i-iii) supported the conclusion that the Tribunal did not find that the records relating to pre-procedural matters contained false information. However, the Tribunal was cognisant that in order to create documents after the fact it was more likely than not that Mr Dixon utilised other information available to him

in respect of the particular patients to create the notes and suggest they were made contemporaneously. Accordingly, the Tribunal noted that whilst the information incorporated into the notes may not have been false per se they were fabricated to look as though they were contemporaneous and contained much, if not all of the information being requested by Spire as part of the Spire Review.

194. Accordingly, and for the same reasons as set out in the findings under paragraph 7b (i-iii), paragraph 8c(i) to (iii), was found not proved in relation to the relevant patients.

Paragraph 8d

195. The Tribunal found that the format, structure, and presentation of the Spire Records were such that a reasonable reader would believe them to be contemporaneous clinical notes. Mr Dixon presented these records without indicating that they had been prepared at a later date. The Tribunal was satisfied that he must have known that this would give a false impression of their origin and timing.

196. This conclusion followed directly from the Tribunal's findings under paragraphs 7c and 8a–b.

197. Therefore, paragraph 8d was found proved in relation to Patients E–K.

Paragraph 9

198. The Tribunal considered whether Mr Dixon's actions, as found proved under paragraph 7, were dishonest by reason of the matters found proved under paragraph 8.

199. The Tribunal first considered the subjective limb of the *Ivey* test. The Tribunal was satisfied that Mr Dixon knew the purpose of the Spire Review and the specifics of what they were looking into. Mr Dixon's own evidence, as well as the correspondence from Dr W supported the conclusion that Mr Dixon was aware of the terms of reference, despite his claim that he had not seen them in full. The Tribunal found it implausible that his legal representatives would have failed to share the Spire Review's scope with him. It was accepted, even in submissions, that the terms of reference must have been known to him, whether directly or via his legal team.

200. The Tribunal had already found that the records relating to Patients E–K had been compiled after the fact and, in the main, included information about consent, pre-operative discussions, and clinical decision-making. Mr Dixon submitted these records to Spire without disclosing their true origin and contemporaneity. In doing so, the Tribunal found that he must have known that he was presenting the records in a deliberately misleading way.

201. Turning to the objective element of dishonesty. The Tribunal was satisfied that an ordinary decent person would consider it dishonest to submit clinical notes to a professional review, purporting them to be contemporaneous records, while knowing that they had in fact been compiled or reconstructed after the events described. The submission of those records, without any indication that they had been created retrospectively, would in the Tribunal's view be seen as an attempt to deliberately mislead. The Tribunal therefore determined this conduct lacked integrity and was dishonest.

202. Accordingly, the Tribunal found paragraph 9 proved.

Paragraph 10a

203. The Tribunal heard evidence from Patient L during the proceedings and considered her evidence to be fair and measured on the basis that she readily accepted that with the passage of time, her recollections were not always clear.

204. The Tribunal noted that within papers submitted by Mr Dixon in civil proceedings was a note dated 22 October 2009, the “*22 October Record*”. It was apparent, from a clinic schedule document provided by Mr Dixon during the course of these proceedings, that a consultation with Patient L had taken place on 22 October 2009 and this was followed up by Mr Dixon writing a letter to Patient L’s GP practice on 23 October 2009. The Tribunal noted that it was Mr Dixon’s evidence that his actual note of the 22 October 2009 was detailed on the clinic schedule document and the 22 October Record related to the morning of her subsequent surgery. The Tribunal noted this clinic schedule note only became available during the course of these proceedings and was not provided to the solicitors in the civil proceedings previously, in spite of Mr Dixon being required to produce records at the relevant time.

205. The Tribunal considered the evidence of Dr Z that there was a discrepancy in the content of the 22 October Record in that it referred to the results of an anorectal physiology

(ARP) test which took place on 27 October 2009 and therefore the results of the test could not have been known and reported on 22 October 2009.

206. The Tribunal further noted that it was Mr Dixon's evidence that the 22 October Record was actually a pre-operative note relating to the surgery on 21 November 2009, and the day and date on the 22 October Record was incorrect in respect of both the date and the month.

207. The Tribunal considered that the format of the 22 October Record, if a preoperative note, did not follow Mr Dixon's usual practice as seen in other documents. It was on plain paper with no letterhead, not on inpatient Spire lined paper, had no patient sticker, no mention of time and did not reference his usual observations such as the patients position on the list, whether a preoperative enema was required and when drinks could be consumed.

208. The Tribunal considered that Mr Dixon's evidence in relation to the inconsistency of the dates was not plausible. In particular, he maintained that the day and month on the note should be 21 November 2009 and that "*everyone on that day was confused about what day and month it was*".

209. The Tribunal was not satisfied with Mr Dixon's explanation that the incorrect date was simply an error. It considered that the date on the 22 October Record did read 22 October 2009, and because it contained information that could not possibly have been known on 22 October 2009 it was more likely than not to have been created after Patient L's care had ended.

210. Accordingly, the Tribunal found paragraph 10(a) proved.

Paragraph 10b

211. The Tribunal considered that the inclusion of ARP test results within the 22 October Record amounted to false information. The test had not taken place at the time the note was purportedly written, and so the reference to those results could not have been contemporaneous and was therefore false at the relevant time.

212. The Tribunal noted that whilst the 22 October Record did contain information that was ultimately correct, it was false as of 22 October 2009. The Tribunal considered that it was more likely than not that the incorporation of this detail was a result of creating the note at a

later date and erroneously incorporated information which could not have been known on 22 October 2009.

213. Accordingly, paragraph 10b was found proved.

Paragraph 10c

214. The Tribunal was also satisfied that Mr Dixon failed to inform Patient L's solicitors that the 22 October Record had been created retrospectively. The document was presented without any indication that it had been compiled after the events it described. In circumstances where the 22 October Record was submitted in legal proceedings and purported to contemporaneously document key aspects of the patient's care, this omission was deliberately misleading.

215. Mr Dixon's failure to clarify the origin and timing of the note supported the conclusion that he intended for it to be taken as contemporaneous. The Tribunal found this was deliberate.

216. Accordingly, paragraph 10c was found proved.

Paragraph 11a

217. The Tribunal had found under paragraph 10a, that the 22 October Record was created after Mr Dixon's involvement in Patient L's care had ended. The inclusion of information about the ARP test, which did not take place until 27 October 2009, confirmed that the note could not have been written on 22 October 2009. Mr Dixon's role in creating and submitting the document during civil proceedings led the Tribunal to conclude that he knew it had been produced retrospectively.

218. Accordingly, paragraph 11a was found proved.

Paragraph 11b

219. Given the Tribunal's findings under paragraph 10b, it followed that Mr Dixon knew the note contained false information, namely, the reference to a test result that did not yet exist at the time the note was dated. The Tribunal therefore found that he was aware that the note contained false information at the time it was created and disclosed.

220. Accordingly paragraph 11b was found proved.

Paragraph 11c

221. The Tribunal accepted that the 22 October Record was not found in the original Spire medical records. There was no evidence to suggest that it had ever formed part of Patient L's contemporaneous hospital record. In the absence of any such evidence and given the timing of its disclosure during the civil proceedings, the Tribunal inferred that Mr Dixon knew it had not been contemporaneously provided to Spire.

222. Accordingly, the Tribunal found paragraph 11c proved.

Paragraph 11d

223. The Tribunal was satisfied that the 22 October Record was structured and presented in a manner that implied it was a contemporaneous clinical record. Mr Dixon dated the note and included clinical commentary in his usual format. By submitting the document without clarifying that it had been created after the fact, Mr Dixon allowed it to be interpreted as a contemporaneous note. The Tribunal concluded that he knew this would deliberately mislead readers.

224. Accordingly, paragraph 11d was found proved.

Paragraph 12

225. The Tribunal considered whether Mr Dixon's actions, as found proved under paragraph 10, were dishonest by reason of the knowledge set out under paragraph 11.

226. In respect of the subjective limb of the test set out in /vey the Tribunal had determined that Mr Dixon had created the 22 October Record after his involvement in Patient L's care had ended, that he knew it contained false information, and that it had not been contemporaneously provided to Spire. Despite this, he submitted the record to Patient L's solicitors during the course of civil proceedings, without any clarification that the document had been created retrospectively.

227. The Tribunal was satisfied that in applying the objective limb of the test set out in *Ivey*, an ordinary decent person would consider it dishonest for a doctor to submit a fabricated clinical record in the context of legal proceedings, particularly when that record was likely to be relied upon in assessing clinical care. Subjectively, the Tribunal found that Mr Dixon knew the true origin of the document and that his actions would give a false impression of its authenticity and timing.

228. The Tribunal concluded that any ordinary decent person would regard this conduct as dishonest, and that Mr Dixon was aware of that at the time.

229. Accordingly, paragraph 12 was found proved.

Paragraph 13a

230. The Tribunal considered whether each of the six letters described in Schedule 3, addressed to Patient M's GP and disclosed in the course of civil proceedings in 2021, had been created or amended after Mr Dixon's involvement in Patient M's care had ended. These included, among others, the letter dated 2 February 2009, the letter dated 26 May 2009 and the letter dated 8 April 2010.

231. The Tribunal noted that it was Dr Z's evidence that on receiving records from patients' GPs and Mr Dixon's personal records he notified the GMC of various discrepancies between the letters received by the Patient M's GP signed by Mr Dixon and letters from Mr Dixon's papers which purported to be letters to the same GP on the same day.

232. The Tribunal noted that it was Mr Dixon's evidence that the discrepancies were the "*result of duplicate dictations of the same letter by me, or of my editing or correcting letters by hand, but on these occasions, been giving to sign and earlier version with my secretary having the later version on her computer when she came to print it out for my records.*"

233. Mr Dixon also told the Tribunal that his usual practice was to dictate his clinic letter to the GP with the patient in the room to check if it was correct, made sense, and if the patient had any questions. The Tribunal considered that if this was correct there should not be significant parts of a dictation missing requiring duplication of a dictation.

234. Mr Dixon told the Tribunal that, due to technological problems, on some occasions parts of dictations would not be typed and on some occasions he would re-dictate whole

tape of letters in its entirety. Mr Dixon also told the Tribunal that even when he signed a letter it would not necessarily mean that he had read it, and he often didn't read a letter until he was putting it in his own file and then realise that it needed amending. Mr Dixon also told the Tribunal that on some occasions he would also update a letter for his own reference as he would not usually have details relating to a patient that were contained within their NHS files and may incorporate them into a letter in order to, essentially jog his own memory.

235. In considering the letters in Schedule 3 the Tribunal noted that the amendments contained significant additions, including references to patient satisfaction, post-operative advice, treatment risks, and quality of life scores, which were not present in the versions received by the GP. The Tribunal also noted Mr Dixon's evidence that he was "*gobsmacked*" on being told of the discrepancies in the letters. The Tribunal considered that the amendments did not represent minor typographical or grammatical corrections, but additional swathes of information, and in relation to the first letter, a repetition of much of the information originally provided to Mr Dixon by the GP. The Tribunal also noted that the second amended letter to the GP contained information that was recorded in Mr Dixon's own handwritten note of the relevant consultation. The Tribunal could therefore not determine any plausible alternative explanation as to why this letter had been amended as, even if Mr Dixon's evidence was correct in that he often updated letters, there was no need to update them to incorporate matters dealt with in consultation notes, particularly if the information was not pertinent to the GP.

236. The Tribunal considered that Mr Dixon's various alternatives as to why multiple letters may exist were a convenient way of explaining the existence of two sets of different letters. The Tribunal considered that it was more likely than not that the letters within Mr Dixon's files disclosed in the civil proceedings came about because they were produced some time after the care of Patient M had ended.

237. The Tribunal noted that the letters were disclosed in 2021, long after Mr Dixon's clinical involvement with Patient M had ended. The Tribunal considered the timing and content of the amendments in light of the litigation process and concluded that they were made with that process in mind. On the balance of probabilities, the Tribunal was satisfied that the letters had been created or amended after the period of clinical care.

238. Accordingly the Tribunal found paragraph 13a of the Allegation proved.

Paragraph 13b

239. The Tribunal next considered whether the Patient M letters included false references. These included references to Mr Dixon explaining Patient M's condition to her and her husband, discussing the risks of the proposed treatment, noting Patient M was pleased with the outcome, directing her to additional information, advising her to return in the event of complications, and stating her functional or Quality of Life scores.

240. The Tribunal noted that the first letter, dated 2 February 2009, included the line "*I explained the problem to Patient M and her husband, who was present.*" In her oral evidence Patient M confirmed that her husband did attend this appointment but could not recall this specific exchange. The Tribunal did not consider this sufficient to amount to a false reference. The second letter dated 26 May 2009 states that risks of the proposed treatment were discussed and understood. This content was not found in the GP version of the letter and the Tribunal considered it to have been added retrospectively. However, in the absence of direct evidence that the information was false, the Tribunal did not find that the GMC had discharged the burden in this instance. In the letter 8 April 2010 Mr Dixon's version contained the additional line that the patient was "*not only feeling much better, but much more confident and optimistic*". Patient M confirmed in her evidence that she was pleased and did feel more optimistic. Accordingly, it found it was not possible to conclude that the reference to Patient M being pleased with the outcome of her treatment was false.

241. In Mr Dixon's version of the letter dated 8 April 2010 it was stated that Patient M should "*come straight back*" if she developed any complications. The Tribunal noted that this reference was not included in the letter received by the GP. In her evidence Patient M did recall that during a follow up appointment Mr Dixon did suggest to contact his clinic if she needed "*to come back again*". Accordingly, the Tribunal could not conclude that the reference to returning in the event of complications was false.

242. The Tribunal was presented with various extracts of evidence from Mr Dixon demonstrating that Patient M's quality of life scores was recorded in his records. The Tribunal further noted that Patient M gave no evidence in relation to whether quality of life scores was discussed or not. Accordingly, the Tribunal could not conclude whether the references to such scores were false.

243. The Tribunal found that although there were discrepancies between the amended and GP versions of the letters, there was insufficient evidence to demonstrate that the information was false rather than reconstructed from clinical records. The Tribunal

acknowledged that the letters had likely been amended or retyped, but it was not satisfied that paragraphs 13b(i)–(vi) could be proven to be objectively false.

244. Accordingly paragraph 13b is found not proved in its entirety.

Paragraph 13c

245. The Tribunal considered whether Mr Dixon failed to ensure that Patient M's solicitors were aware that the letters described in Schedule 3 had been created after his involvement in her care had ended.

246. The Tribunal accepted that the letters were disclosed by Mr Dixon in the course of civil proceedings in 2021. The Tribunal was satisfied, for the reasons already given in relation to paragraph 13a, that the Patient M Letters, although dated between 2009 and 2011, had in fact been created or amended at a later time. This was particularly apparent from the discrepancies between different versions of the same letter. There were substantive additions, including the retrospective insertion of risk discussions and Quality of Life metrics which did not appear in the original GP communication.

247. The Tribunal noted that in his witness statement Mr Dixon describes his process for dictating letters and notes, and also that his approach to documentation was sometimes imprecise. Nonetheless, he also stated, "*I would sign the final versions of letters before they were sent to the GP.*" The Tribunal was not persuaded that the letters provided were contemporaneously created or that Mr Dixon made any effort to distinguish between original and amended versions when disclosing them. Furthermore, the Tribunal found it implausible that these were simple updates for Mr Dixon's personal records.

248. Further, the Tribunal found that Mr Dixon knew by 2021 that issues regarding the discussion of risks, consent, and contemporaneous note-keeping were central to ongoing concerns about his practice, including in other civil proceedings and the Spire Review. In that context, it was incumbent upon him to make clear whether the letters he disclosed were contemporaneous, amended later, or retrospectively created. There was no evidence before the Tribunal that Mr Dixon made any such clarification to Patient M's solicitors.

249. The Tribunal rejected the suggestion that the letters were innocuous updates. It found the content of the amendments substantive, with additions that could influence legal or clinical understanding of the care provided. Although it accepted that some of the added

information may have been drawn from other contemporaneous documents, the central issue was Mr Dixon's failure to ensure that the documents were transparently dated or accompanied by any explanation of their retrospective construction.

250. Accordingly, the Tribunal found paragraph 13c proved.

Paragraph 14

251. For all the reasons set out above, the Tribunal determined that paragraph 14a is proved.

252. The Tribunal was not satisfied to the requisite standard that the Patient M Letters included false references of the kind alleged, or that Mr Dixon knew them to be false at the time of disclosure. Accordingly, paragraph 14b is not proved in its entirety.

253. The Tribunal determined that Mr Dixon knew the versions of the letters disclosed were not those sent contemporaneously to the GP, and that he failed to ensure this was made clear to Patient M's solicitors. The Tribunal therefore found paragraph 14c proved.

254. The Tribunal was satisfied that Mr Dixon's actions would give the false impression that the Patient M Letters were contemporaneous. Accordingly, paragraph 14d is proved.

Paragraph 15

255. The Tribunal next considered whether Mr Dixon's actions as set out at paragraph 13 were dishonest by reason of the matters found proved at paragraph 14.

256. In respect of the subjective limb of the test set out in *Ivey* the Tribunal had already determined that Mr Dixon created and/or allowed the creation of the Patient M Letters after his involvement in her care had ended (paragraph 13a), and that he failed to ensure that her solicitors were aware of that fact (paragraph 13c). It had further found that Mr Dixon knew these were not the contemporaneous GP communications and that his actions would give the false impression that the letters were contemporaneous (paragraphs 14a, 14c, and 14d).

257. Although the Tribunal did not find the specific references alleged in paragraph 14b to be false, it remained satisfied that the letters were retrospectively constructed and misleading in form and presentation.

258. The Tribunal was mindful that, at the time Mr Dixon disclosed the Patient M Letters in 2021, he was already facing scrutiny regarding the quality and contemporaneity of his note-keeping and communications. He was aware of the broader concerns raised in the Spire Review, particularly as to consent, risk discussions, and documentation and knew the limitations in his recordkeeping practices. He had formal consultation notes available to him and yet disclosed letters with significant additional retrospective content without any caveat or clarification.

259. The Tribunal applied the objective test of dishonesty as set out in *Ivey*. It was satisfied that Mr Dixon subjectively knew the letters were not contemporaneous and that he had not disclosed that fact. Applying the standards of ordinary decent people, the Tribunal determined that creating or amending those letters and submitting them in the course of civil litigation, knowing they would be taken as contemporaneous GP communications, was dishonest.

260. Accordingly, the Tribunal found paragraph 15 proved.

Paragraph 16

261. The Tribunal considered Patient N presented as a fair and reliable witness. His evidence was consistent and measured, and while he did not recall every detail, he was candid about the limits of his memory and offered thoughtful clarification where required. In particular, Patient N was adamant that he had never lived, worked, or studied in Cardiff. He stated he had been XXX. Despite this, Mr Dixon maintained during his evidence that, in order to justify why letters relating to Patient N were sent to a GP in Cardiff, Patient N must have been on work experience in Cardiff. The Tribunal found that explanation to be implausible and considered Mr Dixon to be grasping at straws. Patient N's account, that he had no connection with Cardiff whatsoever, was accepted.

262. Turning to paragraph 16a, the Tribunal reviewed the records submitted in May 2022 during civil proceedings brought by Patient N. The documents, which included handwritten notes and letters, bore structure and content similarities to other materials, suggesting that they followed Mr Dixon's formulaic notetaking practice. The Tribunal considered that a record of particular interest was the note of Patient N's first post-operative consultation with Mr Dixon on 5 April 2012.

263. The Tribunal noted that it was accepted that Patient N's post-operative consultation took place two weeks following surgery, rather than the usual six weeks, and this was more than likely to accommodate Patient N returning to XXX. However, the Tribunal noted that this note contained several inaccuracies. In particular, it did not make reference to the matter that the surgical wound at Patient N's navel was not healing. The note also included a claim that Patient N was feeling better, and that his potency was normal, which Patient N disputed. The Tribunal accepted Patient N's evidence that he was recovering XXX and had not resumed sexual activity by that point. The Tribunal also had regard to the evidence of Dr Z, who concluded that, based on the content and context, at least some of the documents must have been created after the fact. Mr Dixon did not amend the "6/52" reference as he was writing up the consultation when he recognised the review was only at two weeks.

264. The Tribunal considered that Patient N's evidence was compelling in relation as to how he felt 2 weeks post surgery and that he had not yet tested the triggers to the cause of his pain, namely dehydration and sexual intercourse. The Tribunal therefore considered that statements to the contrary that the note was not taken contemporaneously. In addition, the fact that the note made no reference to the navel wound not healing in spite of the fact Mr Dixon's note made reference to a different wound which was now resolved. The Tribunal therefore determined that it was more likely than not that one or more of the Patient N records were created after Mr Dixon's involvement in Patient N's care had ended.

265. Accordingly, the Tribunal found paragraph 16a to be proved.

266. In relation to paragraph 16b(i), the Tribunal considered the reference in Mr Dixon's records to having told Patient N that he had a rectal prolapse. Patient N accepted that he had suffered from a prolapse XXX but had not experienced those issues since. While he did not remember being told this at the time, the Tribunal could not be satisfied that Mr Dixon's note was false. It was possible that the prolapse was not as symptomatic as that of which he recalled XXX and that Mr Dixon had in fact explained the finding to Patient N, who may not have understood or recalled it.

267. As a result, paragraph 16b(i) is found not proved.

268. Turning to paragraph 16b(ii), concerning the discussion of alternatives to the LVMR procedure, the Tribunal accepted Patient N's evidence that he could not clearly recall the content of his discussions with Mr Dixon. However, he did not state that alternatives were never discussed. The Tribunal had regard to Patient N's witness statement which read,

"Between the first and second pre-operative appointments, Dr Dixon told me he had had a round table colorectal case discussion with other specialists and had discussed my case. He explained it was agreed that the LVMR surgery was the best option for me. Dr Dixon had also told me that he had seen my NHS scans and reassured me that because of my anatomy, the surgery would work."

269. The Tribunal was therefore not satisfied that the reference was false and determined paragraph 16b(ii) to be not proved.

270. In respect of paragraph 16b(iii), the GMC conceded that the alleged post-operative appointment two weeks after surgery did, in fact, take place.

271. The Tribunal accepted that evidence and accordingly found paragraph 16b(iii) not proved.

272. Turning to paragraph 16b(iv), the Tribunal noted that Patient N explained that, at the time of the post-operative consultation, he was still recovering, his navel wound had not healed, and had not yet resumed sexual activity. As such, he could not have commented meaningfully on matters such as potency, which the note suggested was normal. The Tribunal found this reference implausible, and the note to be misleading. While Patient N accepted that he may have been feeling slightly better generally, this was because his triggers to pain had not been tested.

273. Accordingly, the Tribunal found paragraph 16b(iv) proved.

274. In respect of 16b(v), the Tribunal considered the reference to Patient N's sphincter contraction being good post-operatively. Patient N stated he continued to experience problems in this regard. While there may have been some degree of improvement, the Tribunal was not satisfied that the evidence demonstrated the recorded assessment to be false. The term 'good' was subjective and not clearly defined, and the Tribunal did not have sufficient evidence to determine that the assessment was untrue.

275. Therefore, paragraph 16b(v) is found not proved.

276. In respect of paragraph 16c, the Tribunal considered whether Mr Dixon failed to ensure that Patient N's solicitors were aware that at least some of the Patient N Records had

been created after his clinical involvement had ended. The Tribunal accepted that while some of the records may have originated during Mr Dixon's care, there was at least one post-operative note containing information that was demonstrably inaccurate and created after the fact. Mr Dixon did not provide any explanation or caveat to Patient N's legal representatives about the retrospective nature of the document.

277. As such, the Tribunal found that paragraph 16c is proved.

Paragraph 17

278. In relation to paragraph 17(a), the Tribunal was satisfied that Mr Dixon knew that at least some of Patient N's records had been created after his involvement in Patient N's care had ended. This conclusion is based particularly on the post-operative note dated two weeks after the procedure, which was found to have been created after the event.

279. The Tribunal therefore found paragraph 17(a) proved.

280. Turning to paragraph 17b, the Tribunal considered each subparagraph in light of its previous findings under paragraph 16b. In relation to 17b(i), the Tribunal noted that although Patient N denied being told he had a rectal prolapse, it was possible, influenced by his previous XXXexperiences, that he had not understood or retained that information. The Tribunal could not be satisfied that the note was false in this regard, and therefore found 17b(i) not proved.

281. In respect of paragraph 17b(ii), the Tribunal noted that Patient N himself had conceded that it was possible that alternatives to the LVMR procedure had been discussed. The notes provided by Mr Dixon were consistent with his usual style and contained reference to such discussions.

282. The Tribunal therefore could not be satisfied that the statement was false, and found paragraph 17b(ii) not proved.

283. The Tribunal also found paragraph 17b(iii) not proved. The GMC had conceded that the post-operative appointment referenced in the notes had in fact taken place, and there was no evidence to the contrary.

284. As to paragraph 17b(iv), the Tribunal considered the timing and content of the relevant note. Patient N had given clear and reliable evidence that, although he was seen two weeks after surgery, he had not yet resumed sexual activity at that time and could not therefore have reported improvements in one of his main symptom areas. His evidence was that his pain on intercourse had not yet been tested. The Tribunal found this part of the note implausible and misleading and was satisfied that it amounted to a false reference.

285. Accordingly, based on its findings at paragraph 16 b(iv) the Tribunal found paragraph 17b(iv) proved.

286. In respect of paragraph 17b(v), which related to post-operative sphincter contraction, the Tribunal considered the evidence to be too vague to reach a definitive conclusion. While Patient N stated that he continued to experience issues, there was insufficient evidence to determine whether or not Mr Dixon's record of the contraction being 'good' was false. The Tribunal was not satisfied to the requisite standard of proof and found 17b(v) not proved.

287. In relation to paragraph 17c, the Tribunal was satisfied that at least some of the notes in question had not been provided contemporaneously to Spire. The notes were absent from Spire's medical records, and the Tribunal had already concluded that some had been created after the relevant clinical events.

288. In those circumstances, the Tribunal found paragraph 17c proved.

289. The Tribunal next considered paragraph 17d. It was alleged that the letters within the Patient N Records had not been provided contemporaneously to Patient N's GP. The Tribunal reviewed the available evidence and noted that some letters had been sent to GPs in Bristol and Swansea, while others had been misdirected to Cardiff. The Tribunal accepted that these administrative errors were not the result of deliberate withholding by Mr Dixon, and that they were later corrected. This was supported by a summary prepared by Mr Dixon, which outlined the correspondence history concerning Patient N's GP and provided context regarding administrative processes and errors which provided a plausible explanation.

290. In those circumstances, the Tribunal found paragraph 17d not proved.

291. Finally, in respect of paragraph 17e, the Tribunal considered whether Mr Dixon's actions would have given a false impression that the Patient N Records were contemporaneous. It had already found that the note dated two weeks after surgery

contained false information and had been prepared after the fact. The note was signed and dated, and presented in a format that suggested it was produced contemporaneously. The Tribunal was satisfied that Mr Dixon knew, at the time, that the note would give a misleading impression of its timing and origin. Accordingly, paragraph 17e was found proved.

Paragraph 18

292. The Tribunal next considered whether Mr Dixon's actions as set out at paragraph 16 were dishonest by reason of the findings at paragraph 17. Applying the test set out in *Ivey*, the Tribunal first considered Mr Dixon's state of knowledge and belief. The Tribunal had found that Mr Dixon knew the post-operative note in question had been created at a later time and that it contained false information.

293. In the Tribunal's judgment, an ordinary decent person, possessing the same knowledge as Mr Dixon at the time, would consider it dishonest to allow such a note to be disclosed to solicitors, in the course of civil proceedings, without any indication that it had been created after the fact. Accordingly, the Tribunal found paragraph 18 proved.

Paragraph 19

294. The Tribunal considered the evidence in relation to the letter dated 21 February 2010 addressed to Patient O's GP ('the 21 February Letter'), which was disclosed by Mr Dixon to Patient O's solicitors in or around July 2022 during the course of civil proceedings. The Tribunal examined whether this letter had been created, or allowed to be created, after Mr Dixon's involvement in Patient O's care had ended, and whether he failed to ensure that Patient O's solicitors were aware of that fact.

295. It was accepted that Patient O had surgery on 19 February 2010. A brief post operative letter was received by the GP signed by Mr Dixon dated 20 February 2010. The Tribunal noted the additional 21 February Letter addressed to the GP but only within Mr Dixon's records was more comprehensive on the detail of the operative findings referring to the patient by name and with details specific to her unlike the more generic letter received by the GP. Whilst Mr Dixon's evidence was that he may dictate twice, a brief note after theatre and another on his ward round, the 21 February Letter referred to the patient having '*had her op today*' and '*we will discuss with her tomorrow*'. Given that the surgery took place on 19 February, if the second letter was dictated on that day or the day after, as Mr Dixon claimed, it raises discrepancies in the timeline.

296. The Tribunal considered that Mr Dixon's evidence included an explanation that the secretarial date was incorrect. He also suggested that the letter received by the GP was for a different patient who was on the same operation list, having the same procedure but Patient O's details and GP had been applied in error.

297. The Tribunal considered whether Mr Dixon's explanation that Dr AA referred to in the letter dated 20 February 2010 was associated with the correct practice, noting that he has previously dealt with a Dr BB to whom the 21 February Letter was addressed. In addition, Mr Dixon also questioned whether the 21 February Letter was received or scanned by the GP at the time. On balance, the Tribunal accepted that during 2010 the GP practice had paper filing and digitisation was not yet complete; it was not inconceivable that one letter may not have been correctly scanned or uploaded to the correct patient's record.

298. Despite the similarities, the Tribunal was not persuaded by the GMC's submissions that the letter had clearly been created after Mr Dixon's involvement in care had ended. There were plausible alternative explanations, and the evidence did not establish, on the balance of probabilities, that the document was constructed after the fact. Equally, the Tribunal did not find Mr Dixon's explanation particularly compelling. However, the burden rested with the GMC and the Tribunal concluded that it had not been discharged.

299. Accordingly, the Tribunal determined that paragraph 19a is found not proved.

300. In light of that finding, the Tribunal also determined that paragraph 19b is found not proved.

301. As a consequence of these conclusions, the Tribunal determined that paragraphs 20 and 21 are found not proved.

Paragraph 22

302. The Tribunal first considered whether the letter dated 30 June 2010 ('the 30 June Letter'), disclosed by Mr Dixon to Patient P's solicitors during civil proceedings in around April 2022, had been created or allowed to be created after Mr Dixon's involvement in Patient P's care had ended.

303. The Tribunal noted that Patient P was an NHS patient who underwent surgery on 26 June 2010. Her surgery is summarised in a letter of 26 June from Mr Dixon to Patient P's GP on North Bristol NHS Trust stationary. This letter was not within the disclosure Mr Dixon disclosed in civil proceedings. However, he provided the 30 June Letter, not received but addressed to her GP written on Spire-headed paper, in spite of Patient P being a NHS patient. The Tribunal noted that this further letter, contained a detailed list of events relating to Patient P's care more detailed operative findings and a suggestion of further surgery if no improvement.

304. In considering Mr Dixon's oral and written evidence, the Tribunal found a number of inconsistencies. In his witness statement Mr Dixon stated the 30 June letter was dictated following a post-operative review on 26 June 2010. He also provided a transcript of a note, but not a copy of the note suggesting a post operative review. During oral evidence, he stated that he dictated the 26 June Letter to go in the NHS notes and the 30 June Letter was dictated for his own notes. The Tribunal considered this explanation to be implausible. In his witness statement Mr Dixon makes reference to notes of a review round on 26 June, although the Tribunal noted that it had not seen a copy of this note. Accordingly, the Tribunal could see no plausible reason for these notes to be typed into a letter form for a practitioner's own records, as a note of the procedure and results already existed. Yet the 30 June Letter was typed on Spire headed paper and presented in a style that clearly addressed Patient P's GP. The Tribunal considered it implausible that a letter presented in such a form, with the structure, content and tone of a GP letter, would have been drafted solely for Mr Dixon's personal use. The Tribunal determined that it was more likely than not that this letter was created when Mr Dixon was asked to disclose documents in legal proceedings and was created by reference to the notes he held in his own file. The Tribunal noted that Mr Dixon may or may not have held a copy of the 26 June letter to Patient P's GP as this would have been within NHS notes, not retained by Mr Dixon personally.

305. Further, there was no satisfactory explanation for why an NHS patient would be the subject of a private-style letter dictated onto Spire headed paper, nor why the letter was disclosed during the civil proceedings as if it had been contemporaneously sent. Mr Dixon claimed the 30 June Letter corresponded with notes he had made at the time of Patient P's care, yet he failed to provide that note. The Tribunal found his explanation unconvincing, particularly given the absence of corroborating evidence that the 30 June Letter had ever been sent to Patient P's GP. In contrast, a letter dated 26 June 2010 to the GP was sent, and the Tribunal could see no rationale for preparing a further, fuller letter, addressed to the GP, if it was not in fact intended to be sent at the time.

306. In his witness statement Mr Dixon provided further information, suggesting the 30 June Letter contained no additional information than was documented elsewhere. However, he provided to the Tribunal a copy of a letter to Patient P dated 9 June 2010 of which he explains in detail risks and complications of surgery stating, “*new onset dyspareunia is rare*”. The Tribunal noted that Mr Dixon also gave evidence that this side effect was only known years later “*short term dyspareunia that did not require treatment was first reported in 2015.*”

307. The Tribunal found that the 30 June Letter read more as a retrospective account of events, structured in a factual list format and containing details that were not obviously relevant to a treating GP. Taking all these factors together, the Tribunal determined that Mr Dixon created or allowed the letter to be created after his involvement in Patient P’s care had ended.

308. Accordingly, paragraph 22a was found proved.

309. The Tribunal then considered paragraph 22b, which alleged that Mr Dixon failed to ensure that Patient P’s solicitors were aware the 30 June Letter had been created after his involvement in her care had ended. The Tribunal found that Mr Dixon had presented the 30 June Letter as a contemporaneous GP letter. He did not include any caveat or clarification that the letter had been created at a later date, nor that it was based on other sources. Indeed, the Tribunal found that Mr Dixon’s explanation that the letter had been prepared solely for his own records was undermined by his decision to provide it to solicitors during civil litigation, thereby passing it off as a contemporaneous document.

310. The Tribunal concluded that it was more likely than not that Mr Dixon had drafted the letter with the benefit of hindsight, using other available documentation to construct a fuller narrative for the purpose of the civil proceedings.

311. The Tribunal determined that paragraph 22b was found proved.

Paragraph 23

312. At the time of his actions as described at paragraph 22, the Tribunal is satisfied that Mr Dixon knew the 30 June Letter had been created after his involvement in Patient P’s care had ended. The letter was addressed to Patient P’s GP and dated in a manner which clearly

gave the impression that it had been created contemporaneously. It purported to reflect information that would be expected to be relayed promptly following treatment. The Tribunal rejected Mr Dixon's evidence that it was merely a note to himself. The content and structure of the document reflected a formal communication and did not resemble a personal aide-memoire.

313. The Tribunal concluded that it was not simply the form or heading of the letter, but the fact it was addressed and framed in the language of a GP correspondence which would lead any reasonable observer to believe it had been produced contemporaneously and sent. Mr Dixon's claim that it was created for his own records was implausible in light of the presentation and content of the document. For these reasons, the Tribunal determined that Mr Dixon knew the letter had been created after his involvement in Patient P's care had ended, that it had not been provided contemporaneously to Patient P's GP, and that his actions would give the false impression that the letter was contemporaneous.

314. Accordingly, the Tribunal found paragraphs 23(a), 23(b), and 23(c) of the Allegation proved.

Paragraph 24

315. The Tribunal next considered whether Mr Dixon's actions at paragraph 22 were dishonest by reason of paragraph 23. Applying the test in *Ivey*, the Tribunal found that Mr Dixon knew the letter had been created at a later date and that it had not been provided contemporaneously to the GP. The letter was nevertheless disclosed in the course of civil proceedings as if it were a contemporaneous record. Given the Tribunal's findings at paragraphs 22 and 23, and applying the objective standard of ordinary decent people, the Tribunal was satisfied that such conduct would be regarded as dishonest.

316. The Tribunal therefore determined that paragraph 24 is found proved.

Paragraph 25

317. The Tribunal considered whether, on or before around 2 October 2023, during the course of a GMC investigation into Mr Dixon's fitness to practise, he allowed to be disclosed handwritten records for consultations with Patient Q in February 2017 and April 2017 ('the Patient Q notes') that were created or allowed to be created after his involvement in the

patient's care had ended, and whether he failed to ensure that the GMC were aware of this fact.

318. In reaching its decision, the Tribunal had regard to the relevant documentary evidence, including the consent form and the clinic letter. The Tribunal noted that the consent form, which was signed and held by Spire, included the intended benefit to “*Rx any Rec Prolapse*” it understood this to mean “*to treat any rectal prolapse or recurrent prolapse*”, which matched the treatment ultimately provided. The Tribunal accepted that although there were imperfections in the document, specifically, that this was not listed in the proposed area of treatment in box 2 of the consent form, there was no dispute that the operation of a re-do LVMR was carried out for the intended benefit as listed in box 3.

319. The Tribunal also considered the evidence of Mr S, who had reviewed the records and expressed concern that certain notes did not align with the subsequent operation. A GP letter preceding the surgery, and the consent form detailed the procedure as outlined in box 2 of the consent form, Mr Dixon's handwritten notes suggested a discussion of revision rectopexy which is ultimately the surgery the patient received. Without any evidence from the patient of their understanding of what the planned procedure was, Mr S could not add any additional opinion. It was acknowledged that Mr S may not have had access to the full set of documents at the time of forming his views, and it remained unclear whether he had reviewed all relevant material prior to raising his concerns. The Tribunal noted that the GMC's case on this point appeared to rest largely on inferences drawn from the timing and content of the notes, rather than direct evidence that they were constructed after the fact.

320. In light of the contemporaneous documentation, namely, the signed consent form and the operative records, and the absence of any clear or compelling indication that the notes were fabricated or retrospectively altered, the Tribunal was not satisfied on the balance of probabilities that the Patient Q notes were created after Mr Dixon's involvement in the patient's care had ended.

321. Accordingly, the Tribunal determined that paragraph 25a was not proved.

322. As to paragraph 25b, the Tribunal found that, given its determination that the Patient Q notes were likely contemporaneous, there was no requirement for Mr Dixon to inform the GMC that the notes had been created at a later date. There was therefore no failure in this regard, and the Tribunal determined that paragraph 25b was not proved.

323. In conclusion, paragraph 25 in its entirety was not proved.

324. In view of the Tribunal's findings that the Patient Q notes were more likely than not created contemporaneously, and that the consent and procedural documentation supported this conclusion, the Tribunal found paragraphs 25a and 25b not proved. As a result, it followed that paragraphs 26a and 26b were also not proved, and there was no basis on which to find dishonesty under paragraph 27.

325. Accordingly, the Tribunal determined that paragraphs 25, 26, and 27 were found not proved.

Paragraph 28

326. The Tribunal next considered whether in or around May 2024, in the course of civil proceedings initiated by Patient R, Mr Dixon allowed to be disclosed to Patient R's solicitors a handwritten record dated 11 June 2010 and timed at 1830 hours ('the 1830 Note').

327. The Tribunal noted that there was no dispute that Patient R underwent surgery on 11 June 2010. There was evidence to suggest the clinical day had been a busy one, and that procedures may have run later than scheduled. The Tribunal accepted it was plausible that Mr Dixon had gone to see Patient R pre-operatively to apologise for a delay and may have been called away, resulting in the time of the consultation being struck through and completed subsequently without a further time entry. The Tribunal considered that the absence of a second time was likely a human error, and not indicative of fabrication.

328. The Tribunal considered the evidence that the 1830 Note was not part of the NHS records but was located within Mr Dixon's records. It noted Mr Dixon's own assertion that he would not take NHS notes home with him. However, it was also his evidence that he would extract or record information to feed into his database. The Tribunal considered that the brevity of the 1830 Note was consistent with that purpose, rather than the more comprehensive content seen in other disputed records. The Tribunal further considered the explanation that the note may have been created at the time to support Mr Dixon's research collation, which was not inherently inconsistent with contemporaneous creation.

329. Although the GMC relied on the absence of the note in the NHS file and on Dr Z's evidence that it did not appear in the Trust's records, the Tribunal noted that neither party provided compelling or conclusive evidence on this point. The Tribunal was not persuaded

that the note had been fabricated after the event for the purpose of litigation. It found it plausible that the note had been created contemporaneously or near contemporaneously, possibly for Mr Dixon's own records or database, and that its absence from the NHS file could have resulted from administrative error.

330. Accordingly, the Tribunal found that the GMC had not discharged the burden of proof in respect of paragraph 28a. It was not satisfied, on the balance of probabilities, that the 1830 Note had been created after Mr Dixon's involvement in Patient R's care had ended. Therefore, 28a was found not proved.

331. Turning to paragraph 28b, given that the Tribunal did not find the note had been created after the doctor's involvement in Patient R's care, it followed that Mr Dixon was not under an obligation to alert Patient R's solicitors to such a matter.

332. Accordingly, paragraph 28b of the Allegation was also found not proved.

Paragraph 29

333. As the Tribunal has not found paragraph 28 proved, it follows that it cannot be satisfied that, at the time of his actions, Mr Dixon knew the 1830 Note had been created after his involvement in Patient R's care had ended, or that his actions would give the false impression that the 1830 Note was contemporaneous.

334. Accordingly, paragraph 29 is not found proved.

Paragraph 30

335. In light of the Tribunal's finding that paragraph 29 is found not proved, it follows that paragraph 30 is also found not proved.

The Tribunal's Overall Determination on the Facts

336. The Tribunal has determined the facts as follows:

Clinical concerns

Patient A

1. On 22 June 2007, you performed a stapled trans anal rectal resection procedure on Patient A:
 - a. which was not clinically indicated; Withdrawn under Rule 17(6)
 - b. without adequately considering non-operative treatments. Withdrawn under Rule 17(6)

Patient B

2. Before performing a laparoscopic ventral mesh rectopexy ('LVMR') procedure on Patient B on 20 June 2014 you failed to:
 - a. consider non-operative treatments; **Determined and found not proved**
 - b. carry out all necessary tests and investigations; **Determined and found not proved**
 - c. involve other specialists in your assessment and treatment plan, including a dietitian. **Determined and found not proved**
3. On 14 April 2017 you performed a re-look laparotomy on Patient B for postoperative complications following an anterior resection and loop ileostomy procedure you performed on Patient B on 8 April 2017, but failed to adequately explain the complications to Patient B. **Determined and found proved**

Patient C

4. On 24 February 2017, you performed an LVMR on Patient C which was not clinically indicated. **Determined and found not proved**

Patient D

5. Before performing an LVMR and sacrohysteropexy on Patient D on 21 April 2017 ('Patient D's Procedure') you failed to:
 - a. allow sufficient time to trial non-operative treatment; **Determined and found not proved**
 - b. arrange for Patient D to be assessed by the following specialists in order for them to consider non-operative treatments:

- i. a gastroenterologist with an interest in abdominal pain / an IBS specialist; **Determined and found not proved**
 - ii. an anorectal physiologist; **Determined and found not proved**
- c. obtain informed consent in that you:
- i. placed too great an emphasis on anatomical correction of a proctographic image; **Determined and found not proved**
 - ii. did not inform Patient D that:
 - 1. the functional outcome might not be what they would hope for/expect; **Determined and found not proved**
2. Patient D's Procedure involved risk of a number of potentially serious complications. **Determined and found proved**

Probaty concerns: Spire Review Patient concerns

6. Between approximately 5 March 2018 and 19 October 2020, you were contacted by Spire Healthcare ('Spire') as part of a review ('the Spire Review'), who requested that you provide them with records for patients you had treated at Spire. **Determined and found proved**

Patients E-K

7. On 17 March 2020 *and on or around 4 November 2020* you allowed to be disclosed to Spire, through your legal representatives, medical records for Patients E-K, as described in Schedule 1 ('the Spire Records'):
- a. which you created/allowed to be created after your involvement in the care of Patients E-K had ended; **Determined and found proved**
 - c. that included one or more false references to you:
 - i. obtaining consent before procedures; **Determined and found not proved**

- ii. giving additional information to one or more of Patients E-K before the procedures; **Determined and found not proved**
 - iii. providing further detail as to your decision making before carrying out a procedure; **Determined and found not proved**
 - d. and you failed to ensure that Spire were aware that the Spire Records had been created after your involvement in Patients' E-K care had ended.
Determined and found proved
- 8 At the time of your actions as described at paragraph 7, you knew:
- a. the Spire Review was looking into:
 - ii. whether you had obtained consent for the procedures carried out on Patients E-K; **Determined and found proved**
 - a. the information provided to Patients E-K before any proposed procedure; **Determined and found proved**
 - b. your decision-making regarding the choice of procedures for Patients E-K; **Determined and found proved**
 - c. the occurrence and management of complications; **Determined and found proved**
 - b the Spire Records had been created after your involvement in the care of Patients E-K had ended; **Determined and found proved**
 - c. the Spire Records included one or more false references to you:
 - i. obtaining consent before procedures; **Determined and found not proved**
 - ii. giving additional information to one or more of Patients E-K before the procedures; **Determined and found not proved**

- iii. providing further detail as to your decision making before carrying out a procedure; **Determined and found not proved**
 - d your actions would give the false impression that the Spire Records were contemporaneous. **Determined and found proved**
9. Your actions as set out at paragraph 7 were dishonest by reason of paragraph 8
Determined and found proved

Patient L

10. Between March 2018 and March 2020, in the course of civil proceedings initiated against you by Patient L in relation to a procedure you had performed on her in November 2009, you allowed to be disclosed to Patient L's solicitors a handwritten record dated 22 October 2009, as described in Schedule 2 ('the 22 October Record'):

- a. which you created after your involvement in Patient L's care had ended;
Determined and found proved
 - b. which contained false information as set out in Schedule 2; **Determined and found proved**
 - c. and you failed to ensure that Patient L's solicitors were aware that the 22 October Record had been created after your involvement in Patient L's care had ended. **Determined and found proved**
11. At the time of your actions as described at paragraph 10 you knew:
- a. the 22 October Record had been created after your involvement in Patient L's care had ended; **Determined and found proved**
 - b. the 22 October Record contained false information as set out in Schedule 2;
Determined and found proved
 - c. the 22 October record had not been provided contemporaneously to Spire;
Determined and found proved
 - d. your actions would give the false impression that the 22 October Record was contemporaneous. **Determined and found proved**

12. Your actions at paragraph 10 were dishonest by reason of paragraph 11. **Determined and found proved**

Patient M

13. In 2021, in the course of civil proceedings initiated against you by Patient M in relation to procedures you had performed on her between 200911 and 201112 you allowed to be disclosed to Patient M's solicitors, letters as described in Schedule 3, addressed to Patient M's GP ('the Patient M Letters'):

- a. which you created/allowed to be created after your involvement in Patient M's care had ended; **Determined and found proved**
 - b. which included false reference to:
 - i. you explaining Patient M's condition to Patient M and her husband; **Determined and found not proved**
 - ii. discussion of risks of the proposed treatment plan; **Determined and found not proved**
 - iii. Patient M being pleased with the outcome of her treatment; **Determined and found not proved**
 - iv. you directing Patient M to additional information about the proposed treatment; **Determined and found not proved**
 - v. you advising Patient M to 'come straight back' if she developed any complications; **Determined and found not proved**
 - vi. Patient M's functional and Quality of Life scores; **Determined and found not proved**
 - 2. and you failed to ensure that Patient M's solicitors were aware that the Patient M Letters had been created after your involvement in Patient M's care had ended. **Determined and found proved**
14. At the time of your actions as described at paragraph 13, you knew:

- a. the Patient M Letters had been created after your involvement in Patient M's care had ended; **Determined and found proved**
 - b. the Patient M Letters included false reference to:
 - i. you explaining Patient M's condition to Patient M and her husband; **Determined and found not proved**
 - ii. discussion of risks of the proposed treatment plan; **Determined and found not proved**
 - iii. Patient M being pleased with the outcome of her treatment; **Determined and found not proved**
 - iv. you directing Patient M to additional information about the proposed treatment; **Determined and found not proved**
 - v. you advising Patient M to 'come straight back' if she developed any complications; **Determined and found not proved**
 - vi. Patient M's functional and Quality of Life scores; **Determined and found not proved**
 - c. the version of the Patient M Letters you allowed to be disclosed were not the letters sent contemporaneously to Patient M's GP; **Determined and found proved**
 - d. your actions would give the false impression that the Patient M Letters were contemporaneous. **Determined and found proved**
15. Your actions as set out at paragraph 13 were dishonest by reason of paragraph 14.
Determined and found proved

Patient N

16. In around May 2022 in the course of civil proceedings initiated against you by Patient N in relation to procedures you had performed on him in March 2012, you allowed to be disclosed to Patient N's solicitors handwritten notes and letters ('the Patient N Records')

- a. which you created/allowed to be created after your involvement in Patient N's care had ended; **Determined and found proved**
- b. which contained false reference to:
 - i. you telling Patient N that he had a rectal prolapse; **Determined and found not proved**
 - ii. discussion of alternatives to the LVMR procedure; **Determined and found not proved**
 - iii. an appointment two weeks' post-surgery that did not take place;
Determined and found not proved
 - iv. Patient N saying he felt much better after surgery; **Determined and found proved**
 - v.
 - v. Patient N's sphincter contraction being good after surgery; **Determined and found not proved**

c. and you failed to ensure that Patient N's solicitors were aware that the Patient N Records had been created after your involvement in Patient N's care had ended. **Determined and found proved**

17. At the time of your actions as described at paragraph 16, you knew:

- a. the Patient N Records had been created after your involvement in Patient N's care had ended; **Determined and found proved**
- b. the Patient N Records contained false reference to
 - i. you telling Patient N that he had a rectal prolapse; **Determined and found not proved**
 - ii. discussion of alternative to the LVMR procedure; **Determined and found not proved**

- iii. an appointment two weeks' post-surgery that did not take place;
Determined and found not proved
 - iv. Patient N saying he felt much better after surgery; **Determined and found proved**
 - v. Patient N's sphincter contraction being good after surgery; **Determined and found not proved**
- c. the Patient N records had not been provided contemporaneously to Spire;
Determined and found proved
- d. the letters within the Patient N Records had not been provided contemporaneously to Patient N's GP; **Determined and found not proved**
- e. your actions would give the false impression that the Patient N Records were contemporaneous. **Determined and found proved**
18. Your actions at paragraph 16 were dishonest by reason of paragraph 17. **Determined and found proved**

Patient O

19. In around July 2022 in the course of civil proceedings initiated against you by Patient O in relation to procedures you had performed on her on 19 February 2010, you allowed to be disclosed to Patient O's solicitors a letter dated 21 February 2010 and addressed to Patient O's GP ('the 21 February Letter'):
- a. which you created/allowed to be created after your involvement in Patient O's care had ended; **Determined and found not proved**
 - b. and you failed to ensure that Patient O's solicitors were aware that the 21 February Letter had been created after your involvement in Patient O's care had ended.
Determined and found not proved
20. At the time of your actions as described at paragraph 19, you knew:

- a. the 21 February letter had been created after your involvement in Patient O's care had ended; **Determined and found not proved**
 - b. the 21 February Letter had not been provided contemporaneously to Patient O's GP; **Determined and found not proved**
 - c. your actions would give the false impression that the 21 February Letter was contemporaneous. **Determined and found not proved**
21. Your actions as set out at paragraph 19 were dishonest by reason of paragraph 20.
Determined and found not proved
- Patient P**
22. In around April 2022 in the course of civil proceedings initiated against you by Patient P in relation to procedures you had performed on her on 26 June 2010, you allowed to be disclosed to Patient P's solicitors a letter dated 30 June 2010 and addressed to Patient P's GP ('the 30 June Letter')
 - a. which you created/allowed to be created after your involvement in Patient P's care had ended; **Determined and found proved**
 - b. and you failed to ensure that Patient P's solicitors were aware that the 30 June Letter had been created after your involvement in Patient P's care had ended.
Determined and found proved
 23. At the time of your actions as described at paragraph 22, you knew:
 - a. the 30 June Letter had been created after your involvement in Patient P's care had ended; **Determined and found proved**
 - b. the 30 June Letter had not been provided contemporaneously to Patient P's GP;
Determined and found proved
 - c. your actions would give the false impression that the 30 June Letter was contemporaneous. **Determined and found proved**
 24. Your actions as set out at paragraph 22 were dishonest by reason of paragraph 23.
Determined and found proved

Patient Q

25. On or before around 2 October 2023, during a GMC investigation into your fitness to practise, you allowed to be disclosed to the GMC handwritten records for consultations with Patient Q in February 2017 and April 2017 ('the Patient Q notes'):

a. which you created/allowed to be created after your involvement in Patient Q's care had ended; **Determined and found not proved**

b. and you failed to ensure that the GMC were aware that the Patient Q notes had been created after your involvement in Patient Q's care had ended. **Determined and found not proved**

26. At the time of your actions as described at paragraph 25, you knew:

a. the Patient Q notes had been created after your involvement in Patient Q's care had ended; **Determined and found not proved**

b. your actions would give the false impression that the Patient Q notes were contemporaneous. **Determined and found not proved**

27. Your actions as set out at paragraph 25 were dishonest by reason of paragraph 26.
Determined and found not proved

28. Patient R

28. On around 13/14 May 2024, in the course of civil proceedings initiated against you by Patient R in relation to a procedure you had performed on her in June 2010, you allowed to be disclosed to Patient R's solicitors a handwritten record dated 11 June 2010 and timed at 1830 hours ('the 1830 Note'):

a. which you created after your involvement in Patient R's care had ended;
Determined and found not proved

b. and you failed to ensure that Patient R's solicitors were aware that the 1830 Note had been created after your involvement in Patient R's care had ended. **Determined and found not proved**

29. At the time of your actions as described at paragraph 28 you knew:

- a. the 1830 Note had been created after your involvement in Patient R's care had ended; **Determined and found not proved**
 - b. your actions would give the false impression that the 1830 Note was contemporaneous. **Determined and found not proved**
30. Your actions as set out at paragraph 28 were dishonest by reason of paragraph 29.
Determined and found not proved

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

Determination on Impairment - 04/08/2025

1. At the conclusion of the facts stage in relation to Mr Dixon's misconduct, Ms Fairley informed the Tribunal that Mr Dixon was currently subject to an existing order of suspension in relation to a separate case. Ms Fairley invited the Tribunal to review that matter ('the Review Case'), alongside the impairment and sanction stages of the current misconduct, pursuant to paragraphs 21A and 22 of the General (Fitness to Practise) Rules 2024 ("the Rules").
2. The Legally Qualified Chair (LQC) advised the Tribunal that paragraph 21A of the Rules now applied:

"(1) If since the previous hearing, a new allegation against the practitioner has been referred to the MPTS for them to arrange for it to be considered by a Medical Practitioners Tribunal, it shall first proceed with that allegation in accordance with rule 17(2)(a) to (j).

(2) The Medical Practitioners Tribunal shall thereafter proceed in accordance with rule 22 except that, when determining whether the fitness to practise of the practitioner is impaired and what direction (if any) to impose under section 35D (5), (6), (8) or (12) of the Act, it shall additionally have regard to its findings in relation to the new allegation."

3. The Review Case was first considered by a Medical Practitioners Tribunal (MPT) in July 2024 (“the 2024 Tribunal”) and first reviewed on the papers in January 2025. In summary, the 2024 Tribunal found that Mr Dixon performed operations on five patients without obtaining or documenting informed consent, that one of these operations was not clinically indicated, that he failed to provide adequate post-operative care for one patient in that he made an inappropriate comment to them, and that he failed to acknowledge or address another patient’s ongoing symptoms as possible postoperative complications which amounted to serious misconduct. The 2024 Tribunal found that Mr Dixon’s fitness to practise was impaired and directed a substantive 6-month suspension with a review.

4. On 1 July 2024 new allegations were referred for consideration by a MPT by the GMC. In January 2025, upon review, it was determined that, because paragraph 21A of the Rules requires that if new allegations are referred for MPT consideration, these should be considered before a doctor’s fitness to practise is reviewed. Accordingly, the suspension was extended with no consideration of impairment.

5. This Tribunal now has to decide, in accordance with Rules 21A and 22, whether Mr Dixon’s fitness to practise is impaired by reason of his misconduct having regard to both the Review Case and its findings in relation to the current Allegation.

The Evidence

6. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. It received a testimonial bundle on behalf of Mr Dixon which included: testimonials from colleagues, medical staff, patients, patients’ relatives and others.

Submissions on behalf of the GMC.

7. Ms Fairley reminded the Tribunal that whether Mr Dixon’s fitness to practise is impaired was a matter for the Tribunal’s professional judgment alone and that there was no burden or standard of proof at this stage. She stated that, when considering impairment, the Tribunal should keep in mind the statutory overarching objective.

8. Ms Fairley submitted that, at this stage, there was a two-stage test to be applied. First, whether there has been misconduct and, if so, whether such conduct amounted to serious misconduct. In the event serious misconduct was established the Tribunal should

then go on to consider whether Mr Dixon's fitness to practise is currently impaired. She also referred the Tribunal to the relevant case law when considering misconduct and impairment.

9. Ms Fairley submitted that the following paragraphs of Good Medical Practice (2013) ('GMP') were engaged in this case:

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

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.

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

49. You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:

a their condition, its likely progression and the options for treatment, including associated risks and uncertainties

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

71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

- a You must take reasonable steps to check the information is correct.*
- b You must not deliberately leave out relevant information.*

10. Ms Fairley submitted that GMP requires doctors to provide information to patients in a way they can understand, and she submitted that Mr Dixon's failure in relation to Patient B is clearly a breach of that obligation.

11. She further submitted that the Tribunal have noted in their determination, the evidence of Patient B, where it was apparent that he did not understand the complication that occurred during his procedure until, in effect, it was explained to him in the hearing. She submitted that the Tribunal have the expert evidence of Mr S, where he sets out clearly that the incident should have triggered the statutory duty of candour and that Mr Dixon's failure represented conduct seriously below the standard expected. She submitted that this failure could amount to serious misconduct.

12. In respect of Patient D, she submitted that patient underwent an elective procedure, not an emergency. Ms Fairley reminded the Tribunal that Mr S described the procedure as one to treat functional, but not life-threatening, health deficits. In his evidence, he explained that in such circumstances the requirement to provide all required information and obtain informed consent was significant.

13. She submitted that it was Mr S's opinion that this failure was seriously below the expected standard. She further stated that the onus was on Mr Dixon to ensure he had obtained informed consent and failure to do so could amount to serious misconduct.

14. In respect of the dishonesty elements of the Allegation Ms Fairley submitted that the matters found proved involve multiple instances of what could be described as active dishonesty. She stated that the dishonesty was conducted over a significant period of time and involved interactions with two different institutions. Accordingly, she submitted that such conduct could not be characterised as a momentary lapse or an aberration.

15. In respect to the allegations relating to Patients E to K of the Spire Review, Ms Fairley submitted that the Tribunal have found that Mr Dixon was aware of the scope of the review when he created and submitted the false records. She submitted that Mr Dixon created the false records, intending them to appear as and be treated as contemporaneous, in the full knowledge of the areas of his practice that were under scrutiny.

16. Ms Fairley submitted that the allegations found proved relating to the Spire Review represented multiple individual actions of retrospectively creating documents intended to deceive those reviewing them. She stated that such conduct would be considered to be

deplorable by fellow practitioners, and indeed the wider public. She submitted that his actions were calculated acts of dishonesty and clearly amount to serious misconduct.

17. Ms Fairley further submitted that the allegations relating to patients L, M, N and P, found proven by the Tribunal also represented conduct of active dishonesty.

18. She submitted that the Tribunal has determined that, by 2021, Mr Dixon knew that issues regarding discussion of risks, consent and his contemporaneous note keeping were central to ongoing concerns about his practice and that Mr Dixon purposefully created and submitted misleading clinical records and GP letters.

19. Ms Fairley submitted that the conduct found proved in relation to Patients L, M, N and P does not represent minor alterations to documents. The false documents were created with the intention of them being interpreted as contemporaneous documents and submitted in the context of potential legal proceedings. She submitted that they were created knowing they could influence the clinical or legal understanding of the care provided to those patients by Mr Dixon. She submitted that deliberately creating misleading documents within that context represents dishonesty of the very most serious kind. She asserted Mr Dixon's dishonesty with respect of those four patients' records, each individually was, in and of itself, serious misconduct.

20. Turning to impairment she submitted that Mr Dixon has not demonstrated any insight during the course of his evidence before the Tribunal. The GMC acknowledged that the Tribunal have received numerous testimonials, and that Mr Dixon was clearly a highly regarded surgeon, and indeed the testimonials confirm that. However, she submitted that the Tribunal do not have any evidence of Mr Dixon having reflected on his conduct in any way.

21. In respect of the review matters, she submitted that the Tribunal has the determination of the previous case, which led to a suspension for a period of six months. The 2024 Tribunal directed a review so that the review Tribunal could be satisfied Mr Dixon had addressed the matters set out at paragraph 164 of the Sanctions Guidance ("SG"), and, in particular, that he understood the gravity of the misconduct, he had fully remediated his misconduct, developed his insight and would not pose a risk of repetition of the misconduct.

22. Ms Fairley submitted that there is no evidence before this Tribunal of any remediation work or further reflection on the failings identified by the 2024 Tribunal. Nor is

there any indication of developing insight into his previous misconduct. She reminded the Tribunal that there was reference in the 2024 Tribunal determination to Mr Dixon arranging mentoring in respect of a number of the issues arising. However, there was no evidence before this Tribunal of such process having taken place.

23. She further submitted that there is no evidence before the Tribunal in respect of insight or remediation in order to satisfy this Tribunal that there is no risk of repetition, or indeed that Mr Dixon understands the gravity of the allegations found proved. Ms Fairley submitted that the allegations found proven represent deliberate acts of dishonesty in respect of 11 different patients and two clinical concerns, which amount to serious misconduct.

24. Ms Fairley stated that when considering the test laid out by Dame Janet Smith in *The Fifth Shipman Report*, Mr Dixon's misconduct falls foul of three of the four limbs. She submitted that his conduct brings the profession into disrepute, breaches fundamental tenets of the profession and was dishonest.

25. Ms Fairley submitted that this is a case where the overarching objectives of upholding proper professional standards and maintaining public confidence in the profession would be undermined if a finding of impairment were not made in these particular circumstances.

Submissions on behalf of Mr Dixon

26. Mr Basu submitted that the matters found proved against Mr Dixon fall into two categories, dishonesty and clinical findings. He stated that, taking into account the expert evidence, particularly the rationale provided by Professor T, the clinical findings on their own would certainly not justify a finding of serious misconduct and impairment. He submitted that the clinical findings are on the milder end of the scale.

27. In relation to the dishonesty findings, he submitted that he could not say very much, at this stage, to assist the Tribunal in relation to the question of whether this is serious misconduct, or whether Mr Dixon's fitness to practise is currently impaired.

The Relevant Legal Principles

28. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgment alone.

29. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to serious misconduct, and then, if so, whether the misconduct impairs Mr Dixon's fitness to practise.

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

31. With regard to impairment, the Tribunal considered the test laid out by Dame Janet Smith in *The Fifth Shipman Report*, cited in *CHRE v NMC and P Grant [2011] EWHC 927 (Admin)*:

- a) *Whether the registrant has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;*
- b) *Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;*
- c) *Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession;*
- d) *Whether the registrant has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

32. The Tribunal also took into account the ruling of Mr Justice Silber in the matter of *Cohen v General Medical Council [2008] EWHC 581 (Admin)*, and noted that at the impairment stage, it ought to take account of any evidence and/or any submissions that the doctor's failing is; easily remediable; already been remedied; or highly unlikely to be repeated.

33. In reaching its decision at this stage, the Tribunal has borne in mind the statutory overarching objective:

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

The Tribunal's Determination on Impairment

Misconduct in relation to Patient B

34. The Tribunal found proved that Mr Dixon failed to adequately explain to Patient B the complications that occurred during the operative procedure. While Mr Dixon contended that he had spoken to the patient in the recovery room and that the patient was *compos mentis*, having had a “*very careful*” anaesthetic, the Tribunal found this account to be implausible taken into account the evidence of Professor T. The Tribunal also noted the patient’s evidence who recalled talking with Mr Dixon in the recovery room but could not recall the specifics of the conversation. The Tribunal accepted the evidence of Patient B, who stated that he had no recollection of any such conversation, and noted that Mr Dixon had not ensured that Patient B was fully informed once his condition had stabilised.

35. Both experts instructed in the case agreed that Mr Dixon failed to discharge his professional duty of candour, as required by paragraph 55 of GMP which states:

- 55. You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:*
- a put matters right (if that is possible)*
 - b offer an apology*
 - c explain fully and promptly what has happened and the likely short-term and long-term effects*

They told the Tribunal that the Spire discharge letter sent to Patient B and his GP was inaccurate and incomplete. The experts both noted that follow up letter sent to Patient B’s GP omitted key details regarding the intraoperative complications and did not reflect the seriousness of what had occurred. Mr S and Professor T agreed that it was a missed opportunity to ensure Patient B was informed of the complications experienced during the procedure.

36. Patient B was very unwell before and after the relook laparotomy procedure. Mr Dixon accepted this fact and acknowledged that Patient B required encouragement to keep him "*mentally robust*" following the surgery but failed in his duty to ensure that the patient was given a clear and honest explanation of what had occurred. The Tribunal accepted the evidence that, for over eight years, Patient B lived under the misapprehension that he had been "*bleeding to death*" during the operation, a belief that caused him considerable anxiety. The experts were clear that Mr Dixon ought to have taken steps to correct this misunderstanding by providing a full and accurate disclosure to the patient and the GP. This did not occur.

37. The Tribunal noted that Mr Dixon did not agree with the concerns raised by the expert witnesses, nor did he accept that his conduct had fallen below the standards required. In particular, he did not accept their opinion that Patient B's colon was subject to a mechanical blockage. In his evidence he stated that, "*Not to criticise the two experts, I have not spoken to Prof Q ...I was the operating surgeon, I would always defer to the operating surgeon as only the surgeon can say what was there*".

38. The Tribunal noted that while Mr Dixon acknowledged that his own standards had not been met in relation to his usual practice of sending a post operative letter to the GP. He failed to recognise the missed opportunities to address the patient's concerns, or to correct the record. The Tribunal considered this to be a serious omission.

Patient D

39. The Tribunal considered the circumstances surrounding the consent obtained from Patient D in relation to an elective surgical procedure carried out by Mr Dixon.

40. The procedure was known to carry significant risks, including the possibility of serious inadvertent intraoperative injury which, although rare, would be highly consequential. The Tribunal noted that these risks as per Mr Dixon's documentation were first introduced to her only shortly before the operation was due to take place. She stated that she felt that surgery was her only option, she was already prepared for surgery at that time, was nervous and could not take everything in.

41. The Tribunal found that to introduce and discuss such serious potential consequences on the day of surgery was below the expected standard of care, particularly in the context of

an elective procedure where the patient might reasonably have required additional time to consider her options or seek further information.

42. The Tribunal noted that both expert witnesses agreed that the process by which consent was obtained fell below, but not seriously below, the standard expected of a reasonably competent practitioner. The Tribunal accepted this view. It acknowledged that while not all risks can be discussed in detail, there is a professional obligation to highlight material risks, particularly those with significant consequences for the patient.

43. The Tribunal further accepted that Patient D could have declined to proceed at any point, and that she ultimately did give consent to the operation. However, it was not satisfied that her consent was fully informed in accordance with GMP guidance.

44. The Tribunal concluded that, in this instance, the consent process used by Mr Dixon was inadequate and fell below the expected professional standard. However, taking into account the opinions of both expert witnesses, it considered that the conduct, whilst misconduct, did not amount to serious misconduct.

The Spire Review

45. The Tribunal considered the allegations found proved that Mr Dixon knowingly created retrospective clinical notes and subsequently misrepresented them as contemporaneous during the course of the investigation undertaken by Spire. The Tribunal also noted its earlier findings that Mr Dixon's actions in this regard were deliberately misleading and dishonest.

46. It was alleged, and accepted by the Tribunal, that the medical records in question related to seven patients and were prepared and submitted over a period of time, in circumstances where Mr Dixon was aware he was the subject of an active investigation and the terms of reference of that investigation were known to him. The Tribunal noted that these records were disclosed to Spire in a manner that implied they had been created contemporaneously.

47. The Tribunal found that Mr Dixon's notes were not contemporaneous, and that he reconstructed them from other resources without making any effort to indicate that they were retrospective.

48. The Tribunal was satisfied that this was not a case of poor documentation or inadvertent error, but a course of conduct involving the deliberate creation of misleading records, in circumstances where Mr Dixon was subject to an investigation.

49. The Tribunal was of the view that members of the public are entitled to place complete reliance upon a doctor's honesty. The relationship between the profession and the public is based on the expectation that medical practitioners will act at all times with integrity. Dishonesty, even where it does not result in actual harm to patients, is particularly serious because it can undermine the public's trust and confidence in the medical profession.

50. The Tribunal concluded that, taking account of all the circumstances in this case, Mr Dixon's dishonest conduct fell far below the standards expected of a doctor, was contrary to GMP and breached a fundamental tenet of the medical profession namely that of honesty and integrity. The Tribunal therefore concluded that Mr Dixon's actions amounted to misconduct and that that misconduct was serious.

Patients L, M, N and P

51. The Tribunal then considered the allegations found proved that Mr Dixon knowingly created retrospective clinical notes and letters to GPs and subsequently misrepresented them as contemporaneous whilst providing documents in potential civil legal proceedings. These disclosures spanned a period of over four years. The Tribunal noted its earlier findings in this regard, that Mr Dixon's actions in this regard were deliberately misleading and dishonest.

52. The Tribunal noted that each of the documents was created with the intention to purposefully mislead the reader. The amended letters addressed to the GPs did not contain simply minor alterations to those received by the respective practices, but significant additions to cover issues, including but not limited to treatment risks. Furthermore, clinical notes contained comprehensive details in respect of risk and consent. The Tribunal noted that these were matters of which, Mr Dixon was aware, were an on-going concern. In addition, in respect of two of the patients Mr Dixon's clinical notes made false reference to certain information.

53. The Tribunal considered that this conduct amounted to further incidents of repeated and sustained professional dishonesty and was behaviour which would be considered deplorable by peers and the public alike. Such conduct breached the fundamental tenets of

the profession, which would have the effect of undermining the public's trust and confidence in it. Accordingly, the Tribunal concluded that Mr Dixon's actions amounted to misconduct and that that misconduct was serious.

Impairment

54. The Tribunal, having found that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Mr Dixon's fitness to practise is currently impaired.

55. The Tribunal in considering whether Mr Dixon's misconduct was potentially remediable, it concluded that where there was a significant, repeated and sustained pattern of behaviour, it would be difficult to remediate without significant development of insight. In addition, in relation to the dishonesty findings, the Tribunal reminded itself that whilst a finding of impairment does not necessarily follow a finding of dishonesty, it would nevertheless be an unusual case where dishonesty was not found to impair a registrant's fitness to practise. The Tribunal was mindful of its findings that Mr Dixon's actions had been multiple, deliberate and repeated. They breached a fundamental tenet of the profession and represented a significant departure from the standards expected of doctors as set out in GMP.

56. The Tribunal then looked at the factors of the test set out in *Grant*, above. It took into account that misconduct had been determined. It found that Mr Dixon had brought the profession into disrepute, that he had breached fundamental tenets of the profession and there had been multiple instances of dishonesty. Therefore, factors b, c and d in *Grant* were engaged.

57. The Tribunal then went on to consider whether there was any evidence before it of insight or remediation on the part of Mr Dixon and whether there was any risk of the conduct being repeated in the future.

58. The Tribunal took into account the various testimonial letters provided by Mr Dixon at this stage of proceedings. It noted that the testimonials provided a great deal of information relating to Mr Dixon's impeccable surgical skill and the Tribunal had no doubt of his technical surgical ability. However, the testimonial evidence did not address the question of honesty

and integrity in the context of the Allegation. Accordingly, the Tribunal concluded that these had limited relevance when considering impairment in relation to the dishonesty findings.

59. The Tribunal was not provided with any evidence of insight from Mr Dixon at this stage in the proceedings. He had not provided any witness statement or reflection on the Tribunal's findings.

60. Mr Dixon denied the allegations against him, which he was entitled to do. The Tribunal reminded itself that denial of misconduct does not *necessarily* equate to lack of insight. However, it also considered the circumstances of this case and the evidence before it. In particular, the Tribunal noted the manner in which Mr Dixon had approached evidence which contradicted his own. Whilst the Tribunal acknowledged that Mr Dixon was fully entitled to reject the evidence of another witness, it noted that his evidence with regards to particular witnesses changed during proceedings in order for new information to fit within his own narrative. He presented an alternative perspective on the matter and firmly asserted that his version was correct.

61. In particular, the Tribunal noted Mr Dixon's stance in relation to evidence relating to patients B, I and N. He stated that Patient B was incorrect in his recollection of when he pursued a motorcycling hobby and that he had subsequently taken up cycling. It was Patient B's evidence that he had never pursued cycling as a hobby and only took up motorcycling latterly. In respect of Patient I, when it became apparent during cross-examination that the patient had never been an ornamental plasterer, as stated in Mr Dixon's witness statement, Mr Dixon, in his oral evidence, did not accept that his own recollection could be wrong but provided an alternative narrative which, he says, explained his incorrect statement. Furthermore, in relation to Patient N, whose evidence was that he had never lived, studied in or had any connection with Cardiff, Mr Dixon's evidence to explain why correspondence had been addressed to a GP surgery in Cardiff, was that Patient N "*maybe have been on work experience there*".

62. The Tribunal noted that Mr Dixon's evidence appeared to change and/or evolve at any time he had before him information that contradicted his original evidence. Likewise, when matters were put to him that he could not explain he made generic, implausible statements such as, in relation to Patient L and the 22 October Record "*everyone on that day was confused about what day and month it was*".

63. The Tribunal also considered that in respect of the discrepancies in letters to GPs, Mr Dixon's evidence was that these were always a result of third-party issues. For example, secretarial health, dictaphone tape failure, postage issues, and destruction by GP practices were reasons given. It was apparent to the Tribunal that at no time did Mr Dixon accept that there might have been any personal responsibility or accountability for the discrepancies.

64. The Tribunal considered that Mr Dixon's response to contradictory evidence and his propensity to blame others or change his evidence to fit the evidence of others, indicated an attitudinal behaviour which demonstrated that he currently had little or no insight with respect to an acknowledgment and/or reflection of his conduct.

65. Furthermore, in the absence of any evidence from Mr Dixon relating to insight or remediation arising from the Tribunal's findings, the Tribunal had nothing before it to satisfy it that such conduct would not occur again in the future. Accordingly, there remained a risk of repetition of the misconduct.

The Review Case

66. The Tribunal reminded itself of the overarching objective and that there is no burden or standard of proof at the impairment stage; the question is a matter for the Tribunal's judgment. The Tribunal also noted that in a review case, there is a "*persuasive burden*" on the practitioner to satisfy the reviewing Tribunal that they are safe to return to unrestricted practice.

67. The Tribunal considered that the critical issue in the Review Case was whether Mr Dixon had developed his insight into his failures which the 2024 Tribunal had found amounted to serious misconduct.

68. The Tribunal noted paragraph 500 of the 2024 Tribunal determination '*He stated that he planned to provide mentorship, be that through on-line forums, podcasts, e-learning or face to face discussions. He said that he would happily volunteer to support other doctors who have found themselves in a similar position and that the most important piece of advice he could give was to be totally honest, open, have insight and own any mistakes'*'.

69. The Tribunal noted that Mr Dixon has made no meaningful effort to remediate his previous failings. It was particularly concerned that, although one year had passed since the determination of the 2024 Tribunal, no evidence of remediation has been provided. This was

in spite of an earlier indication that he would take steps to address the concerns raised. Mr Dixon has not submitted any reflection, remediation plan, or evidence of learning, nor has he demonstrated any insight into the serious misconduct identified.

70. The Tribunal noted that the 2024 Tribunal had, at paragraph 508 of its determination, determined that a finding of impairment was necessary in respect of the overarching objective. The Tribunal considered that, had it been looking at the Review Case in isolation, it would have reached the same conclusion and there was nothing currently before it to alter that position.

Conclusion

71. The Tribunal considered whether a finding of impairment was necessary in order to uphold the overarching objective namely: *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.*

72. The Tribunal was in no doubt that Mr Dixon's misconduct had undermined public confidence in the medical profession and that he had failed to maintain the proper standards expected of him, as set out in GMP.

73. The Tribunal considered that public confidence in the profession would be adversely affected if a finding of impaired fitness to practise was not made in relation to the misconduct. It involved serious dishonesty.

74. The Tribunal concluded that a finding of impairment is necessary to maintain both public confidence in the medical profession, and to uphold proper professional standards and conduct for members of that profession.

75. The Tribunal has therefore determined that Mr Dixon's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 06/08/2025

1. Having determined that Mr Dixon's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 22(1)(h) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

2. The Tribunal has taken into account all the evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction. The Tribunal also received a Report on Mentoring Sessions ("Mentor Report") from Mr BB. The report was dated July 2024 – January 2025.

Submissions on behalf of the GMC

3. Ms Fairley submitted that the decision as to the appropriate sanction, if any, to impose in this case was a matter for the Tribunal, exercising its own independent judgment. She said that there was no burden or standard of proof at this stage. She referred the Tribunal to the relevant paragraphs of the Sanctions Guidance (5 February 2024) ('SG'). She said that the reputation of the profession as a whole was more important than the interests of an individual doctor.

4. In terms of mitigating features Ms Fairley submitted that in relation to this case, the GMC acknowledge that Mr Dixon has provided positive testimonials as to his clinical practice, however, there are no other mitigating features identified within the SG.

5. She submitted that this is not a case where taking no action would be appropriate, or indeed conditions, given the serious findings in relation to repeated dishonesty. She submitted that suspension may be appropriate where the misconduct is serious but falls short of being incompatible with continued registration.

6. She referred the Tribunal to paragraph 93 of the SG which states that suspension may be appropriate where there may have been acknowledgement of fault and where the Tribunal is satisfied the behaviour or incident is unlikely to be repeated.

7. Ms Fairley submitted that this is clearly not the case here. She stated that the Tribunal have before them very limited evidence of insight or attempts at remediation. She further added that the comments made by Mr Dixon in the course of his evidence suggested that,

any reflection he had made, related to the impact of his conduct on himself and his reputation rather than on the wider profession.

8. Ms Fairley submitted that suspension may be appropriate where the misconduct was serious but falls just short of being incompatible with continued registration. She submitted that the misconduct found in this case was so serious that it was not compatible with continued registration and therefore that would not be appropriate. Ms Fairley submitted that the appropriate sanction in this case was one of erasure.

9. Ms Fairley submitted that the following paragraphs of the SG were engaged in this case in respect of erasure:

"108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.

109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.

b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety...

h Dishonesty, especially where persistent and/or covered up...

j Persistent lack of insight into the seriousness of their actions or the consequences.

10. Ms Fairley submitted that the dishonesty, that has been found proved in relation to this case, is so significant that it is fundamentally incompatible with continued registration. The dishonesty represents a course of conduct involving the deliberate creation of misleading records and, in circumstances where Mr Dixon was subject to both an investigation and potential legal proceedings.

11. She submitted that the Tribunal have found the documents to be dishonest and were created to purposefully mislead the reader about aspects that Mr Dixon knew to be of particular concern in respect of his conduct. She submitted that they also include, in relation to two of the patients, active false information.

12. Ms Fairly submitted that the overall misconduct represents multiple instances of deliberate dishonesty spanning a period of over four years. She submitted that such deliberate and calculated dishonesty is wholly contrary to the standards and conduct expected of doctors and fundamentally undermines the public's confidence in the profession.

13. She submitted that when considering the SG and paragraph 109, the dishonesty in this case does represent a particularly serious departure from GMP and deliberate disregard for the principles set out in GMP. It represents persistent dishonesty, and Mr Dixon has demonstrated negligible insight.

14. She submitted that the misconduct found proven in this case, which is properly described as repeated and sustained professional dishonesty, is such that no lower sanction would be sufficient to fulfil the statutory overarching objective, and in particular to promote and maintain public confidence in the profession and promote and maintain proper professional standards and conduct for members of that profession.

Submissions on behalf of Mr Dixon

15. Mr Basu submitted that the findings of the Tribunal are serious; the Tribunal have found serious misconduct and that Mr Dixon's fitness to practise is impaired. However, he also stated that it is important for the Tribunal to look at all of the circumstances and all of the evidence before it. He submitted that the testimonials speak very highly of Mr Dixon. He submitted that these individuals still wished to put forward their testimonials, knowing what the Tribunal has found against Mr Dixon, including dishonesty and knowing that there has been a previous Tribunal finding of serious clinical misconduct.

16. Mr Basu submitted that within the testimonials there are a number of patients who have referred to Mr Dixon's skills and ability and how he helped them. He stated that Mr Dixon has been fully registered with the GMC for 41 years and throughout that time has performed tens of thousands of successful operations and his work has allowed numerous patients to live enjoyable, extended lives.

17. Mr Basu submitted that Mr Dixon has been an eminent surgeon in his field, founder of the pelvic floor society and he was extremely well thought of by his peers and a leading light. He submitted that he is a university reader, which is equivalent to an associate professor.

18. He submitted that Mr Dixon has had the most spectacular, public and dreadful fall from grace and that is because of the matters that this Tribunal and the previous Tribunal have found proven. He submitted that due to the findings that the Tribunals have made these are entirely deserved.

19. He submitted that erasure is not necessary in this case because of the particularly striking fall from grace of this particular doctor. These matters have been eight years in the making, and that is also part of the salutary effect this will have on other doctors who misconduct themselves. He submitted that it is an entirely deserved eight years that Mr Dixon has been through.

20. He submitted that professional disciplinary Tribunals do not punish people for not admitting their guilt. He submitted that you do not get punished for defending yourself because the standard of proof is, on the balance of probabilities. He said that Tribunals do not achieve certainty, as there is always a degree of uncertainty.

21. He submitted that people defend themselves and, every now and then, someone's defence may subsequently turn out to be well founded. Mr Dixon has not accepted his wrongdoing. He submitted that Mr Dixon has defended himself, entirely properly.

22. He submitted that the dishonesty found against Mr Dixon led to no financial gain and it did not improve his position in any litigation or in the Spire Review. He submitted that the vast majority of the relevant matters consisted of Mr Dixon, putting together information in one document, which the Tribunal found to be a concocted document, but from other genuine sources.

23. He submitted that they are two matters where it was found that the documents included information which were not genuine facts. He stated that one was the patient who had told Mr Dixon he was very much better at a given date, however the Tribunal found he was not better at that date. In addition, in another note there was reference to a test result that was performed later than stated, although it was a genuine test result.

24. He submitted that Mr Dixon has not gained financially or otherwise, nor has the Patients' clinical presentation changed, nor their clinical result by any of the matters that the Tribunal has found proved. There is no harm that has been shown against any of these patients and no benefit in the proceedings that he is facing.

25. Mr Basu argued Mr Dixon's actions are not persistent acts of dishonesty because the Tribunal do not know when these documents were put together. He said it has been suggested it is over four years, but that is when the documents were provided, not when the documents were created.

26. He submitted that the Tribunal have not made any findings as to the time scale or the persistence. However, he acknowledged the findings that a number of documents that have been submitted by Mr Dixon was done so dishonestly.

27. Mr Basu submitted that Mr Dixon is clinically an excellent doctor according to the testimonial providers and his very public fall from grace is entirely deserved on the Tribunal's findings. He submitted that Mr Dixon has been punished enough, and erasure is not necessary to achieve the statutory objectives of the GMC.

28. He submitted that Mr Dixon will not, in any event practice again and it is not possible for a surgeon to practice under the radar. He submitted that Mr Dixon has not practised since 2017. Mr Dixon retired when these matters came to light and he was suspended by his employer, so there is no danger from this doctor.

The Tribunal's Determination on Sanction

Aggravating and Mitigating Factors

29. The Tribunal first considered the aggravating factors in this case.

The Tribunal noted the following paragraphs of the SG:

'51 It is important for Tribunals to consider insight, or lack of, when determining sanctions ...

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
- ...

54 Where the GMC, or another regulator, has previously made findings of impaired fitness to practise and imposed a sanction on the doctor's registration, the Tribunal may wish to consider this as an aggravating factor in relation to the case before it.

30. The Tribunal identified the following aggravating factors in this case:

31. The Tribunal considered that there had been a serious departure from the standards expected of a doctor. Honesty lies at the very heart of the profession of a doctor. The Tribunal considered that the dishonesty demonstrated by Mr Dixon was premeditated and sustained, with concocted documents being provided to two bodies on numerous occasions over a four-year period. It considered that there had been a serious breach of trust in the public's confidence in doctors, as well as the confidence of clinicians in their fellow professionals.

32. The Tribunal considered Mr Dixon's lack of insight to be an aggravating feature. The Tribunal accepted that Mr Dixon was entitled to defend the Allegation. However, having found matters proved against him Mr Dixon has not demonstrated any acknowledgment of the Tribunal's determination and has not accepted his wrongdoing. There has been no insight shown at all in respect to the gravity of the findings. There was nothing before the Tribunal to suggest that he recognised that he should have behaved differently or that he has taken any steps to remediate.

33. In particular, the Tribunal noted that any reference in evidence or submissions to an apology from Mr Dixon was qualified and offered no acceptance of responsibility. In his witness statement he stated how sorry he was "*to hear of the difficulties and experience that the patients involved... have encountered since their surgery*" and his mentor commented in the Mentor Report that Mr Dixon felt "*extremely remorseful for his reported poor patient outcomes*". However, the Tribunal concluded that there was nothing before it to

demonstrate that he had reflected on and acknowledged the damage his conduct may have in respect on the reputation of the profession.

34. As to the review case, the Tribunal noted that several months has passed since the 2024 Tribunal's determination. This Tribunal has found in its impairment determination that Mr Dixon had failed to reflect on his serious misconduct in that time.

35. The Tribunal noted Mr Dixon during the hearing has not expressed genuine regret, or any meaningful remediation of his serious misconduct. It noted its findings in the impairment determination that in both cases, Mr Dixon's lack of insight makes it difficult for him to reflect upon and remediate his misconduct. The Tribunal was of the view that Mr Dixon's continued lack of insight into the serious misconduct in both cases, and consequently his limited remediation, was an aggravating feature.

36. Finally, Mr Dixon has now received two findings of impaired fitness to practise, both concerning serious matters.

37. The Tribunal moved onto mitigating factors.

38. The only mitigating factors which the Tribunal was satisfied is that Mr Dixon has cooperated with the GMC's inquiries and had submitted a number of testimonials.

39. The Tribunal considered the positive testimonials provided on Mr Dixon's behalf. It observed the feedback was limited and related, primarily, to clinical and or personal dealings with Mr Dixon. It noted that there was no substantive testimonial dealing with honesty and integrity. In all the circumstances, the Tribunal considered the testimonials carried little relevance or weight.

40. The Tribunal also considered the Mentor Report. It noted that this report, like the testimonials, dealt with clinical matters and did not reflect on matters such as integrity and honesty.

41. With respect to the review case, the Tribunal noted, Mr Dixon has not undertaken any meaningful remediation following the 2024 Tribunal's determination. Mr Dixon still does not have insight and has not remediated or reflected on his misconduct.

No action

42. The Tribunal first considered whether to conclude the case by taking no action. The Tribunal determined that there are no exceptional circumstances in this case which would warrant the taking of no action in the context of the facts found proved and the Tribunal's determination on impairment. It considered that taking no action would be insufficient, proportionate, or in the public interest.

Conditions

43. The Tribunal next considered whether to impose conditions on Mr Dixon's registration. It had regard to the relevant paragraphs of the SG when considering whether to impose conditions and noted that any conditions would need to be appropriate, proportionate, workable and measurable. It had regard to the following paragraphs of the SG:

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."*

44. The Tribunal noted the types of cases outlined in the SG which advise when conditions might be appropriate. The SG also advises that conditions may be workable where a doctor has insight. In this matter the Tribunal has concluded that there is no evidence of insight. The Tribunal therefore determined that this was not a case where conditions would be appropriate or workable, and in any event, it considered that it would be difficult to formulate conditions that address dishonesty.

Suspension

45. The Tribunal then went on to consider whether a period of suspension would be appropriate.

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

47. The Tribunal noted paragraphs 92 and 93 of the SG:

"92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e. for which erasure is more likely to be the appropriate sanction because the Tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the Tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The Tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions..."

48. As to the review case, the Tribunal noted that the 2024 Tribunal had, at that time, considered Mr Dixon's serious misconduct of clinical failings to be potentially remediable and, on that basis, imposed a six-month suspension. However, the Tribunal considered that matters had evolved significantly since the 2024 Tribunal. In particular, this Tribunal took account of the dishonesty established in the present case, as well as the oral evidence given by Mr Dixon during the course of this hearing.

49. The Tribunal was of the view that the issue of dishonesty in this current case, in combination with the concerns raised in the review case, now had to be assessed holistically and in the round. This included a careful consideration of Mr Dixon's current level of insight, the extent to which he had demonstrated meaningful remediation, and his engagement with the regulatory process. In this context, the Tribunal concluded that the gravity of the new findings altered the overall assessment of Mr Dixon's fitness to practise taking into account the statutory overarching objective.

50. With respect to both the dishonesty and the review case, the Tribunal had regard to its findings at the impairment stage. It considered that there has not been a clear acknowledgment of fault. On the contrary, it has found that Mr Dixon lacks insight, and that there is a risk of repetition of his serious misconduct in both cases.

51. The Tribunal was of the view that Mr Dixon has made no meaningful attempt to remediate the misconduct identified by the 2024 Tribunal. It noted that, despite the opportunity provided by the period of suspension, there was no evidence that Mr Dixon had critically reflected on the seriousness of his failings or developed genuine insight. Consequently, the Tribunal concluded that his efforts in respect of the review case had not resulted in substantive remediation.

52. With regard to the findings of dishonesty in the current hearing, the Tribunal similarly found that Mr Dixon lacks proper insight. He has not accepted the findings of the Tribunal, acknowledged the gravity of his actions nor demonstrated any attempt to remediate this misconduct. These conclusions are consistent with the reasons outlined in the Tribunal's determination on impairment and reinforce the overall assessment of ongoing risk to public confidence and maintaining proper professional standards and conduct.

53. The Tribunal considered that given Mr Dixon's very limited insight in both cases, coupled with the passage of time since the 2024 determination, realistically it now appears unlikely that he will remediate his behaviour. It concluded that imposing a period of suspension would be not adequate to uphold the overarching objective. The Tribunal went on to consider the option of erasure.

Erasure

54. The Tribunal, considering all the circumstances in this matter, determined that erasure was the appropriate and proportionate sanction.

55. In arriving at this view, the Tribunal considered that the following paragraphs 108 and 109 of the SG were engaged.

"108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards

designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.

109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.

b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety...

h Dishonesty, especially where persistent and/or covered up.

i Putting their own interests before those of their patients.

j Persistent lack of insight into the seriousness of their actions or the consequences.

56. It also considered paragraph 128 of the SG:

128 Dishonesty, if persistent and/or covered up, is likely to result in erasure

57. The Tribunal noted the dishonesty in this case involved multiple patient records, was persistent and covered up. The Tribunal concluded that Mr Dixon lacks insight into this serious misconduct and has not taken any steps to remediate it. In particular, Mr Dixon does not acknowledge the Tribunal's impairment decision and appears not to fully appreciate the seriousness of the misconduct or its implications for public confidence in the profession. The Tribunal acknowledged that Mr Dixon did not obtain any financial gain from his dishonesty. However, it considered that he stood to gain personally by seeking to protect his professional reputation. In doing so, Mr Dixon placed his own interests above those of his patients, prioritising self-protection over his duty to uphold public trust in the profession and maintain proper professional standards and conduct.

58. The Tribunal also had regard to paragraph 164 of the SG, the relevant parts of which describe three purposes of a review hearing at (a), (c) and (d), namely that:

“... the Tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):

a they fully appreciate the gravity of the offence

c they have maintained their skills and knowledge

d patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.”

59. The Tribunal, having regard to its conclusions at the impairment stage, observed that Mr Dixon has not satisfied it in respect of any of points (a), (c), or (d). Mr Dixon has not undertaken any remediation to address the serious misconduct found proven by the 2024 Tribunal. Furthermore, the period of suspension served since the 2024 Tribunal’s decision has not led to any demonstrable progress in developing his insight. The Tribunal found no evidence of reflection, acknowledgment of wrongdoing, which reinforces the ongoing concerns about Mr Dixon’s fitness to practise.

60. The Tribunal considered the submissions made on behalf of Mr Dixon where it was suggested that erasure was not necessary because his striking fall from grace would have a salutary effect on other practitioners and the serious misconduct would be publicly reported due to its seriousness and significance. The Tribunal was not swayed by these submissions. It considered that because of the seriousness of its findings, together with its concerns regarding a lack of insight and remediation, a proportionate sanction was required to balance the interests of the public with those of Mr Dixon and it was mindful of paragraph 19 of the SG which states that:

“19 ... 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”.

The Tribunal noted that Mr Dixon was acutely aware of his fall from grace, but it considered that this was not sufficient to outweigh the interests of the public in relation to maintaining public confidence in the profession.

61. In all the circumstances, the Tribunal found that Mr Dixon has now demonstrated a persistent lack of insight into the seriousness of his actions not only for patients and

colleagues, but also for public confidence in the medical profession. More broadly, the Tribunal considered his ongoing lack of insight into both findings of impairment to be a significant aggravating factor, and one which weighs heavily in favour of erasure from the medical register.

62. Accordingly, the Tribunal has directed that Mr Dixon's name be erased from the medical register. It considered that this was the only sanction which promotes and maintains public confidence in the profession, and promotes and maintains proper professional standards and conduct for members of the profession.

Schedule 1

Patient	Record
Patient E	Note of a pre-operative consultation purportedly held at 08:00am on 21 August 2015
Patient F	Record purporting to relate to a consultation in July 2005 on Spire headed paper
Patient G	Records purporting to relate to consultation in March 2007 on Spire headed paper
Patient H	Records purporting to relate to a consultation in 'Christmas week 2004' on Spire headed paper
Patient I	Records purporting to relate to a consultation in 2005 on Spire headed paper
Patient J	Records purporting to relate to a consultation in April 2004 on Spire headed paper
Patient K	Note of a pre-operative consultation purportedly at 08:30am on 7 April 2011

Schedule 2

Description	False information
Handwritten note of consultation dated 22 October 2009 stating 'Has had ARP [upward arrow] resting pressure', indicating that Patient L underwent an anorectal physiology test and this test indicated increased resting pressure	Patient L did not undergo ARP until 27 October 2009 Patient L did not have a consultation with you on 22 October 2009

Schedule 3

Letters
2 February 2009 letter
26 May 2009 letter
24 November 2009 letter
12 February 2010 letter
8 April 2010 letter
9 February 2011 letter