Neutral Citation Number: [2017] EWHC 2534 (Admin)

Case No: CO/4470/2016 and CO/4005/2017

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/10/2017

Before:

MR JUSTICE JAY

- -

Between:

GENERAL MEDICAL COUNCIL	**Appellant**
- and –	
DR ROBERT STONE	**Respondent**

- -
- -

Jenni Richards QC (instructed by **GMC Legal**) for the **Appellant**
Angus Moon QC and Claire Watson (instructed by **MDDUS**) for the **Respondent**

Hearing date: 6th October 2017

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

....

MR JUSTICE JAY

MR JUSTICE JAY:

Introduction

1. This is the appeal of the General Medical Council ("the GMC") brought under section 40A of the Medical Act 1983 against a determination of a Medical Practitioners Tribunal ("MPT") given on 4th August 2016 suspending the registration of Dr Robert Stone ("the doctor") for a period of 12 months and ordering a review hearing.

2. The GMC's essential argument is that the sanction imposed by the MPT was insufficient to protect the public, and that the doctor should have been erased from the medical register.

3. The GMC also appeals against the determination given by the MPT at the review hearing on 10th August 2017 that the doctor's fitness to practise was no longer impaired because of the remedial steps he had taken. The destiny of this second appeal is entirely dependent on the outcome of the first.

4. At the outset of the hearing I made a reporting restriction in relation to the doctor's health condition. This has meant that two versions of this Judgment have been prepared: a full version for the parties and their legal advisors, and a redacted version to be placed in the public domain. This is the redacted version.

Essential Factual Background

5. The doctor is a GP who qualified in 1977. Following an investigation, it was alleged by the GMC that the doctor had engaged in an improper sexual and emotional relationship with one of his patients, a vulnerable woman who has been designated at all material times as Patient A (her identity is protected by a further reporting restriction). The relationship lasted between November 2011 and July 2014, and during its course the doctor continued to act as Patient A's GP. In around March 2014, perhaps coinciding with the beginning of the breakdown in the relationship, Patient A's health deteriorated and there were three occasions in March and April 2014 when she attempted to take her own life. When the relationship ended, the doctor informed the partners at his practice and self-reported to the GMC.

6. The hearing before the MPT commenced on 27th July 2016. The doctor did not admit all of the allegations and gave oral evidence before the MPT. Patient A's witness statement was admitted in evidence as hearsay; she was now deceased. The doctor admitted that he visited Patient A at her home in order to engage in sexual activity with her; that he sent her text messages which were of a sexual and personal nature; that on one occasion he had Patient A to stay at his house in order to pursue his sexual relationship with her; that on numerous occasions he engaged in sexual activity with Patient A in a consulting room at the GP practice; that on numerous occasions during this period he treated Patient A clinically as a patient; and, that he knew her to be vulnerable. The nature of Patient A's vulnerability was apparent from the medical records which the GMC relied on before the MPT, and which the doctor knew or ought

to have known about as her treating GP. In short, Patient A had a history of depression; she exhibited suicidal ideation with a recorded suicide attempt; she had problems with alcohol abuse and dependency; and she had relationship difficulties. All these matters were admitted by the doctor.

7. Apart from certain matters of detail which were not critical to the overall gravity of his misconduct, the doctor disputed one important head of charge, namely that he had been dishonest in relation to providing two supportive letters (one being to the Asset Letting Agency) regarding Patient A on or about 1st October 2012 and 17th May 2013, in relation to her claim for benefit support. The dishonesty concerned his failure to disclose his sexual relationship with her. At paragraphs 48-51 of its Findings of Fact, the MPT upheld the GMC's case and characterised the seriousness of the doctor's dishonesty in these terms:

> "49. The tribunal finds that an ordinary informed member of the public would consider the production of these letters, in the circumstances, to be deceitful and dishonest. This would be the case even though the contents of the letters are true and accurate. The recipients of these letters would not have accepted them as valid if they knew of your relationship with Patient A because the nature of your relationship with her undermines your independence and the reliability of their contents. You were well aware that you were involved in an affair with Patient A at the time and were actively concealing this from your family and partners. The tribunal determined that if you had reflected even for a moment at that time, you would have realised that your actions were dishonest and it is unlikely that you would have written the letters.
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> ……
>
> 51. The tribunal finds that you knew you were making a misrepresentation of your position in providing these letters but you justified your actions by stating that you were writing them solely from a GP perspective and not a personal one. The tribunal finds that it is unlikely that you could wholly separate the two and so considers that your justification was self-deceiving."

8. At Stage 2 of the proceedings (sc. misconduct and impairment, per Cranston J in Cheatle v GMC [2009] EWHC 645 (Admin)), the GMC received evidence from Dr John Hook, MRCPsych, a Medical Consultant Psychotherapist. He had previously practised in the NHS as a Consultant Psychiatrist. The MPT "considered [that] Dr Hook gave detailed, comprehensive evidence" which it accepted. In the circumstances, it has been necessary to examine this evidence with some care. I have read Dr Hook's lengthy report at least three times.

9. The doctor's account to Dr Hook was that although Patient A initiated the relationship he considered his own conduct to be "criminal … massively wrong, hurtful, and destructive". The doctor described his mother as being domineering and controlling. At the time the doctor's relationship with Patient A started his wife's career was taking off, and she was working long hours. Dr Hook conducted a mental state examination of

the doctor and various questionnaires, inventories and other standardised assessment tools were applied. Dr Hook's formal diagnosis was [REDACTED].

10. Dr Hook summarised the position in his report in these terms:

> "He has engaged in an inappropriate sexual relationship with a patient. Whilst on the face of it, it appears that the relationship with Patient A was sexually motivated I am of the opinion that there is an alternative explanation based in his character pathology and personal circumstances for these behaviours. In my view the combination of the above factors created a perfect storm in which he was confused by his own feelings and behaviours to a degree which interfered with and overrode his professional judgement. She represented aspects of his mother – dominating and demanding but with a more obvious vulnerability which he responded to in the hope of rescuing her from her unhappy situation. His psychological needs become predominant and caused internal conflict with his professional ethical code. He was not able to sufficiently prioritise his patient's needs over his own. I do not think that his behaviour was sexually predatory.
>
> He is suffering from [REDACTED]. This is the main source of vulnerability and risk. The features in relation to the allegations are his social inhibition, non-assertiveness, being overly accommodating self-sacrificing and self-deprecating which created a propensity to become involved with a troublesome relationship which could only be self-destructive and damaging to the patient."

11. Dr Hook's oral evidence to the MPT included the following:

> "The behaviour following on from whatever is going on in his mind. I am suggesting that in these perfect storms the drives are so strong that normal judgement, sane judgement, professional judgement, is easily overridden to an extent, and this relates to what I was saying early on, that it is almost impossible to put oneself in that position because it is qualitatively different state of mind, one that we, for the reason which you are asking the question, find ourselves – it is incredibly difficult to get one's head round what it is like to be in a state of mind to be driven to do something that another part of your mind, the sane part of your mind, tells you is going to be a disaster.
>
> …
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> I think what I suggested earlier on is that the perfect storm had already begun by the time sex occurs; that actually there is a moment, as I said earlier, and I can only place it – I cannot tell you exactly when that moment was but I suspect that moment right at the beginning when she leans forward and strokes his

> arm is the beginning of the storm and there is virtually no way back from that point on. There are lots of points from a rational point of view that we would all say "Of course there were points that you should not have done this"; what I am saying is the psychological drivers are sufficiently strong to override all those judgements. To come to your other point, that the rest of my report falls away, what I said to you I think a few moments ago is that it does not fall away. These are not mutually exclusive ideas. What I am saying is that the psychological driver for me, my understanding, is the prime driver.
>
> …
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> What I am saying about will is it gets overridden by the unconscious processes of drivers that drove Dr Stone at that moment. But to answer the other part of your question, no, of course not everyone with [REDACTED] gets into this sort of scrape. It is a rare event. Rare events are of themselves unpredictable. That is why you have to look at what is going on in their lives, and what I am not privy to in preparing this report is what was going on in the patient's mind and therefore getting a rounder view of what the interaction was that propelled this forward, but that would be another key factor in the process."

12. The MPT's assessment of Dr Hook's report was that it contained a "plausible and psychologically coherent narrative". The MPT repeated and endorsed his metaphor of the "perfect storm". The MPT further stated that the doctor was highly unlikely to repeat this behaviour, and noted with implied acceptance of it Dr Hook's view that there is increasing evidence that [REDACTED] is amenable to treatment.

13. Mr Angus Moon QC submitted that this MPT was particularly well-placed to assess and understand Dr Hook's evidence because the Chair is a consultant psychiatrist and the lay member is a counsellor. I do not place much weight on this, preferring to adopt the more general approach that the MPT is an expert tribunal familiar with medical reports and experienced in disciplinary cases.

14. The MPT also received a considerable amount of testimonial evidence including evidence from professional sources, as well as impressive oral evidence from Dr Alefounder, Head of Clinical Services.

15. The doctor's own evidence at Stage 2 was summarised by the MPT as follows:

> "9. The tribunal found you to be a thoughtful and genuine witness. You gave an honest account of your experience, for which you have shown considerable remorse. You did not seek to blame, or partially blame, anyone other than yourself for your actions.
>
> 10. You told the tribunal that you were desperately sad for what you had done and that you could do nothing to repair the damage. You described the situation as sordid and despicable.

> 11. You told the tribunal that you had found it particularly difficult to understand and empathise with Patients A's attachment to you and some of her feelings but that you had made progress with this. You also said that you continued to find issues of unequal power in relationships difficult.
>
> 12. You told the tribunal that with the support of your family you were now optimistic for the future and that you would like to return to practice, should the opportunity be given."

16. The MPT's conclusions on the issue of misconduct were as follows:

> "28. The tribunal determined that, by acting dishonestly, you failed to abide by one of the most fundamental tenets of the medical profession.
>
> 29. The tribunal finds that your pursuance of the sexual relationship with Patient A and your dishonesty breaches numerous fundamental tenets of GMP and amounts to serious misconduct."

17. The MPT's conclusions on the issue of impairment of fitness to practise were as follows:

> "33. The tribunal considered that you have not yet developed a fully integrated view of events that incorporates all the personal, social and circumstantial factors that led to them. In particular, the tribunal considered that you remain limited in your understanding of the impact your behaviour has on others including Patient A. In addition, issues of power imbalance in relationships continue to trouble you.
>
> 34. The tribunal has taken into account all the psychological, social and personal factors that contributed to your behaviour. It is, however, mindful that you made a series of conscious and moral choices to behave in this way with a vulnerable patient over a prolonged period and in doing so disregarded fundamental tenets in GMP.
>
> 35. The tribunal notes that you did not seek to dissuade the tribunal from making a finding of impairment which is a further indicative of the developing insight you have shown.
>
> 36. The tribunal has also been mindful of the interest of Patient A, especially as she cannot make her wishes known. She was an extremely vulnerable woman who has stated that she felt 'emotionally traumatised' by these events.
>
> 37. Furthermore, the tribunal finds that your misconduct was so serious that members of the public and medical profession would find it deplorable. By your actions you have brought the medical

> profession into disrepute. The tribunal finds that a finding of impairment is necessary to maintain proper professional standards and conduct for members of the profession and to promote and maintain public confidence in the profession."

18. At Stage 3 of the proceedings, sanction, the MPT referred again to the "written testimonials from numerous colleagues, friends and family members". The MPT noted the GMC's submission that the only appropriate outcome in this case was erasure. Counsel for the GMC specifically referred the MPT to those paragraphs in the Sanctions Guidance (March 2016 edition) indicating that erasure was likely to be the appropriate outcome. The submission on behalf of the doctor was that a period of suspension would reflect the seriousness of his misconduct while promoting the public interest, and give time to enable him to complete the therapy recommended by Dr Hook.

19. In its Determination on Sanction the MPT expressly referred to the Sanctions Guidance and the "overarching objective" to protect the public as set out in the Medical Act 1983. As is extremely familiar to all practitioners in this area, public protection embraces three elements: viz. (1) to protect, promote and maintain the health, safety and wellbeing of the public, (2) to maintain public confidence in the profession, and (3) to promote and maintain proper professional standards and conduct for members of that profession. Further, the MPT expressly stated that it had paid regard to the principle of proportionality and had taken into account the matters referred to in earlier determinations during its deliberations on sanction.

20. The MPT balanced the aggravating and mitigating factors of the case. The former comprised the following:

> "17. Patient A was known by you to be particularly vulnerable. During this time you treated her for the very conditions that made her vulnerable. You were her trusted GP and you engaged in a personal and sexual relationship with her for over two years."

21. As for the mitigating factors:

    (1) The MPT accepted Dr Hook's evidence as to the doctor's disorder interacting with a number of social and personal factors to create a "perfect storm". The MPT described these factors as "very powerful in determining your behaviour". The MPT also accepted that the doctor's behaviour was not sexually predatory. In short:

    > "20. The tribunal considers that your actions involved a choice. The choice that you made was the wrong one and this involved a vulnerable patient. It does however consider that your [REDACTED] and the psychological, personal and social factors that were at play at the start and during this affair meant you were less able to resist acting in this way. The tribunal considers that you were not predatory. You in fact wanted to help and care for Patient A and having made the wrong choice you were very confused by your different professional and personal responsibilities."

(2) The doctor has fully acknowledged his wrongdoing and has fully accepted responsibility for it.

(3) The doctor has shown genuine and profound remorse and shame.

(4) The doctor has gained significant insight and has taken many steps to remediate "the factors which have caused this to occur".

(5) The testimonial evidence is persuasive in that it demonstrates that the doctor is of previous good character, is trusted by many, and there has been no repetition.

(6) There is a public interest in permitting a competent doctor to continue in practice for the public good.

22. In following the Sanctions Guidance the MPT adopted the standard "bottom up" approach and rejected the possibility of taking no action and imposing conditions on the doctor's registration. Under the rubric of "suspension", it referred expressly to paragraphs 86, 87, 91, 114 and 118 of the Sanctions Guidance.

23. In weighing the aggravating and mitigating factors, the MPT observed that the only factor which mitigated the serious misconduct at the time it occurred was the doctor's [REDACTED]. On this aspect:

> "38. The tribunal considered this does mitigate your misconduct to a sufficient degree and that it is able to conclude that your behaviour falls short of being fundamentally incompatible with continued registration."

24. The further mitigating factors (i.e. those which post-dated July 2014) "strengthened its view that suspension was a proportionate and sufficient sanction in this case". In particular, the doctor was highly unlikely to find himself in the same circumstances again, and the likelihood of repetition was very low.

25. As for the finding of dishonesty:

> "40. The tribunal gave separate consideration to the issues of dishonesty. The tribunal found that your dishonesty was inextricably bound up with your personal and sexual relationship with Patient A and the inevitable conflict of that dual relationship. The tribunal concluded that as your dishonest misconduct does not stand alone the same mitigating factors apply."

26. And overall:

> "41. The tribunal is satisfied that a period of suspension is sufficient to maintain public confidence and trust in the profession. It has determined that the maximum period of 12 months is appropriate to send a message to the profession and the public and allow you the time to undertake the recommended psychotherapy.

> 42. The tribunal has determined that your suspension will be subject to a review hearing, which will be held towards the end of your suspension period. The tribunal suggests that the review tribunal may be assisted by:
>
> - Further report from a psychotherapist
> - Reports from any other treatment you may receive
> - Self-reflective log
> - Evidence of CPD
> - Appraisal documents
> - Any other documents you feel may be relevant at the time.
>
> 43. The tribunal has determined not to erase your name from the medical register. It considers that this would be a disproportionate response. There are significant mitigating factors in this case, which have been outlined above, in particular the abnormal state of mind you were in during time of misconduct and the special circumstances around it."

The Sanctions Guidance

27. The March 2016 edition of the Sanctions Guidance was jointly promulgated by the GMC and the Medical Practitioners Tribunal Service. I am not aware that there was any input by the MDU, the MPS or the BMA. It is fairly discursive in style and arguably could be more precise. I accept, however, that a balance falls to be struck between the interests of clarity, consistency and prescriptiveness on the one hand and the need to maintain flexibility and discretion on the other. I note from the MPTS website that there is now a 2017 edition. The Sanctions Guidance does not have the normative status of Guidelines issued by the Sentencing Council in criminal cases (see section 125 of the Coroners and Justice Act 2009) but everyone agrees that relevant provisions of the Sanctions Guidance must be considered by MPTs at both the impairment of fitness to practise and the sanctions stage. Members of MPTs have training in this regard.

28. In my judgment, the provisions of the Sanctions Guidance which are relevant to the present case include paragraphs 1, 2, 3, 20, 24, 51 ((d) and (e)), 61, 85, 86, 87, 101, 102, 103, 136, 137, 139, 140, 143 and 144. I have set these out in the Annex to this Judgment.

The Legal Framework

29. Section 40A of the Medical Act 1983, as amended, provides so far as is material:

> "(1) This section applies to any of the following decisions by a Medical Practitioners Tribunal—
>
> (a) a decision under section 35D giving—
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> (i) a direction for suspension, including a direction extending a period of suspension;
>
> …
>
> (d) a decision not to give a direction under section 35D;
>
> …
>
> (2) A decision to which this section applies is referred to below as a "relevant decision".
>
> (3) The [GMC] may appeal against a relevant decision to the relevant court if they consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.
>
> (4) Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient—
>
> (a) to protect the health, safety and well-being of the public;
>
> (b) to maintain public confidence in the medical profession; and
>
> (c) to maintain proper professional standards and conduct for members of that profession.
>
> …
>
> (6) On an appeal under this section, the court may—
>
> (a) dismiss the appeal;
>
> (b) allow the appeal and quash the relevant decision;
>
> (c) substitute for the relevant decision any other decision which could have been made by the Tribunal; or
>
> (d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court, and may make such order as to costs (or, in Scotland, expenses) as it thinks fit."

30. In GMC v Jagjivan and another [2017] EWHC 1247 (Admin) the Divisional Court (Sharp LJ and Dingemans J) assimilated the familiar jurisprudence relevant to registrant

appeals under section 40 of the Medical Act 1983 to this new jurisdiction under section 40A. Paragraphs 39 and 40 of the Divisional Court's judgment are material:

> "As a preliminary matter, the GMC invites us to adopt the approach adopted to appeals under section 40 of the 1983 Act, to appeals under section 40A of the 1983 Act, and we consider it is right to do so. It follows that the well-settled principles developed in relation to section 40 appeals (in cases including: *Meadow v General Medical Council* [2007] QB 462; *Fatnani and Raschid v General Medical Council* [2007] 1 WLR 1460; and *Southall v General Medical Council* [2010] 2 FLR 1550) as appropriately modified, can be applied to section 40A appeals.
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> In summary:
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> i) Proceedings under section 40A of the 1983 Act are appeals and are governed by CPR Part 52. A court will allow an appeal under CPR Part 52.21(3) if it is 'wrong' or 'unjust because of a serious procedural or other irregularity in the proceedings in the lower court'.
>
> ii) It is not appropriate to add any qualification to the test in CPR Part 52 that decisions are 'clearly wrong': see *Fatnani* at paragraph 21 and *Meadow* at paragraphs 125 to 128.
>
> iii) The court will correct material errors of fact and of law: see *Fatnani* at paragraph 20. Any appeal court must however be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses, who the Tribunal, unlike the appellate court, has had the advantage of seeing and hearing (see *Assicurazioni Generali SpA v Arab Insurance Group* (Practice Note) [2003] 1 WLR 577, at paragraphs 15 to 17, cited with approval in *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] 1 WLR 1325 at paragraph 46, and *Southall* at paragraph 47).
>
> iv) When the question is what inferences are to be drawn from specific facts, an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR Part 52.11(4).
>
> v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence: see *Fatnani* at paragraph 16; and *Khan v*

> *General Pharmaceutical Council* [2017] 1 WLR 169, at paragraph 36.
>
> vi) However there may be matters, such as dishonesty or sexual misconduct, where the court "is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal …": see *Council for the Regulation of Healthcare Professionals v GMC and Southall* [2005] Lloyd's Rep Med 365 at paragraph 11, and *Khan* at paragraph 36(c). As Lord Millett observed in *Ghosh v GMC* [2001] 1 WLR 1915 and 1923G, the appellate court "will afford an appropriate measure of respect of the judgment in the committee … but the [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances".
>
> vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice, because the overarching concern of the professional regulator is the protection of the public.
>
> viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the Tribunal's decision unjust (see *Southall* at paragraphs 55 to 56)."

31. Ms Jenni Richards QC also relied on paragraphs 58 and 59 of the judgment of Sales J in Yeong v GMC [2009] EWHC 1923 (Admin):

> "58. I do not accept this submission. The FTPP was entitled to conclude that Dr Yeong's case was one in which the question of remedial steps and compliance with improved practising standards for the future was of less importance than the imposition of a sanction which would convey a clear public statement of the importance with which the fundamental standard of professional conduct in relation to relationships between medical practitioners and patients is to be regarded. In *Bevan*, Collins J affirmed the importance of that standard of behaviour: see [19]-[20], [26]-[28] and [30]. He also affirmed that, as decided by the Privy Council in *Ghosh v General Medical Council* [2001] 1 WLR 1915 at 1923, the court should accord an appropriate measure of respect to the judgment of the Committee (now, the FTPP) and held that the court should only intervene if persuaded that the penalty imposed was outside the range of what could be regarded as reasonable, having regard to the principle that the sanction should be one which is appropriate and necessary in the public interest: [24]-[25]. This is an approach which allows to the FTPP a margin of judgment to decide on sanction, even if a court might not itself have chosen to impose such sanction.

> 59. In my judgment, the sanction imposed by the FTPP in the present case was well within the margin of judgment available to the FTPP. I do not find it possible to say that the sanction imposed was wrong. Although there were mitigating features in Dr Yeong's case, there were also aggravating features (in particular, the period of time over which he engaged in the relationship with GN). The FTPP took all these points into consideration, and was entitled to reach the conclusion it did as to the appropriate sanction to be imposed. The fact that Collins J in *Bevan* chose to impose the same sanction in what could be regarded as a more serious case in some respects does not show that the FTPP has erred, or exceeded its margin of judgment, in the present case."

32. Mr Moon referred me to additional authority and made a number of submissions on the foregoing authorities, including those referenced in Jagjivan and Yeong. I agree with Mr Moon that Lord Millett in Ghosh provides a helpful summary of the constraints inherent in this appellate jurisdiction where the court exercises a second-order review function (my language not Lord Millett's). In my view, Lord Millett and Sales J are *ad idem*. I disagree with Mr Moon that paragraph 40 of Jagjivan is limited to the question of impairment of fitness to practise and does not cover sanction: the Divisional Court has expressly referred to the jurisprudence relevant to sanction, and in my view there can be no logical difference between Stage 2 and Stage 3, because both entail the exercise of an expert judgment. Mr Moon submitted, on the basis of paragraph 36 of Lord Wilson JSC's judgment in Khan, that the court should be more deferential in misconduct cases related to professional performance (i.e. cases involving patients) than in cases which are not, but I cannot see how that helps him. Lord Wilson was referring to the decision of the Privy Council in Dad v GDC [2000] 1 WLR 1538 where the context for the lower level of deference was a serious driving offence unrelated to the dentist's professional performance. I agree with Mr Moon that the tribunal does not have to cover every point (see, for example, Stanley Burnton J in Threlfall v General Optical Council [2004] EWHC 2683 (Admin)), although would observe that this is very much context-specific, and much depends on the intrinsic merit and quality of any point that has not been expressly mentioned: the more salient that it is or appears to be, the stronger the force of any submission that express reference should have been made to it. Finally, I strongly disagree with Mr Moon that much may be gained by undertaking a close comparison of the facts of two of Collins J's cases, namely R (oao Bevan) v GMC [2005] Lloyd's Rep Med 321 and Giele v GMC [2006] 1 WLR 942. On the contrary, these cases turned very much on their own facts, and (at least arguably) a more interventionist judicial approach which is inconsistent with Yeong and Jagjivan.

33. The degree of deference which should be paid to the expert MPT must depend on the context and the nature of the issues under scrutiny. An attempted review of matters of primary fact meets the traditional obstacle that this court cannot determine for itself matters of witness credibility and reliability, save in very clear cases. I should interpolate that the case I am deciding is not about witness credibility and reliability. A review of matters of inference, evaluation and judgment is constrained by the twin considerations that this court is exercising a secondary judgment and the MPT is an expert tribunal. However, the context is important because dishonesty and sexual misconduct cases are ordinarily more familiar to this court than, for example, cases

involving a doctor's clinical performance. Plainly, deference is on a spectrum and no precise formulation of its intensity should be attempted. But, at least as a general rule, the clearer it is that the tribunal has covered all relevant considerations, the harder it will be for this court to intervene. This is because the issue will tend to dissolve into one about weight and expert evaluation.

34. Finally, I note at this stage that Ms Richards placed particular reliance on paragraph 40(vii) of Jagjivan – matters of personal mitigation are likely to carry considerably less weight in regulatory than in criminal proceedings. In this particular regard, I prefer to follow this authority rather than the second sentence of paragraph 24 of the Sanctions Guidance, to the extent that the latter suggests that more weight may be given to personal mitigation if the concern is about public confidence in the profession. This is always an important concern, particularly in the more serious cases. I do also note that the Sanctions Guidance does make clear that the tribunal is less able to take mitigating factors into account in cases of a more serious nature.

The GMC's Grounds

35. Ms Jenni Richards advanced four grounds which I may briefly encapsulate.

36. The first ground is that the MPT either misconstrued or failed to consider the Sanctions Guidance, in particular paragraphs 52, 102, 103, 127, 139 and 144. An examination of paragraph 103 reveals that there were numerous respects in which the doctor's misconduct rendered erasure a likely sanction: see sub-paragraphs (a)-(e), (h) and (j). It was incumbent on the MPT specifically to grapple with these paragraphs, and make clear that the gravity of the doctor's misconduct had been balanced against any mitigating features of the case. This has not happened, and consequently the MPT also failed adequately to consider two central issues within the overarching objective, in particular the need to maintain public confidence and maintain proper professional standards and conduct.

37. The second ground is that the MPT placed disproportionate weight on the evidence of Dr Hook. Although the GMC has never disputed the diagnosis of [REDACTED], with the two other related traits, the extent to which this disorder could properly serve to mitigate the gravity of the doctor's misconduct has been considerably overplayed. In oral argument Ms Richards characterised this as "unreasonable and inappropriate". The MPT correctly recognised in its Stage 2 determination that the doctor made a conscious choice to act as he did, but then cut across this approach by wrongly asserting that he "in fact wanted to help and care for Patient A and having made that wrong choice [he was] very confused by [his] different professional and personal responsibilities".

38. The third ground is that the MPT failed to give appropriate weight to the issue of dishonesty, and merely incorporated this issue within the wider consequences of the doctor's sexual misconduct.

39. The fourth ground is that the MPT's sanction was simply wrong in the light of the seriousness of the doctor's misconduct, and that – even if grounds 1, 2 and 3 are not well-founded – the only appropriate sanction is that of erasure.

The Doctor's Defence

40. Mr Moon's submissions on behalf of the doctor were well-structured, powerfully delivered and astute.

41. Mr Moon emphasised the MPT's positive findings in relation to the doctor's acquisition of insight and the low risk of repetition, although there remained work to be done. The MPT took into account the submissions of the GMC's Counsel on the issue of sanction as well as the March 2016 edition of the Sanctions Guidance. The MPT explicitly weighed up the aggravating and mitigating features of this case, and said in terms that erasure would be a "disproportionate response" on account in particular of the doctor's "abnormal state of mind … and the special circumstances around it".

42. The logic of the GMC's case, submitted Mr Moon, is that erasure was the only appropriate sanction in the public interest. Yet the Sanctions Guidance does not create categories of sanction; the furthest it may go is to indicate what is "likely"; and all these cases turn on their own facts. Thus, the bar from the GMC's perspective is placed very high indeed, and it must show how and why the MPT, fully seized on the issues, came to a conclusion which was "wrong".

43. Mr Moon pointed out that suspension is an onerous sanction and provides significant public protection. The MPT continues to be involved in the process (c.f. erasure) because there is a review hearing.

44. In relation to the first ground, Mr Moon submitted that the MPT had regard to relevant provisions in the Sanctions Guidance because the GMC's Counsel specifically referred the MPT to those. It is not obliging on an expert disciplinary tribunal in these circumstances to articulate its detailed reasons on every point; a general explanation of the basis of the determination is what is required, and was here provided. Mr Moon submitted that it is clear from the MPT's decision read as a whole that it fully understood the seriousness of the doctor's misconduct in all its aspects. Furthermore, it is also clear that the only reason why the MPT did not erase the doctor was his [REDACTED].

45. Mr Moon further submitted that the MPT appropriately balanced the interests of existing and potential patients in having access to a competent doctor against the wider public interests within the second and third limbs of the overarching objective. In conducting that balance, it was open to the MPT to decide that a severe, but not the most severe, sanction should be imposed.

46. As for the second ground, Mr Moon submitted that the MPT was entitled to take into account Dr Hook's evidence and to accord to that evidence the weight it did. Mr Moon further submitted that there is no inconsistency between the MPT's findings at Stage 2 and Stage 3, both in relation to the seriousness of the doctor's misconduct and the nature of his conscious choice. In particular, there is no tension between the proposition that the doctor possessed a conscious choice and the later proposition that he was confused by his different personal and professional responsibilities. Furthermore, the GMC has not appealed the MPT's finding that in the circumstances of this case the doctor's misconduct was not fundamentally incompatible with his remaining in practice.

47. As for the third ground, Mr Moon submitted that it is clear that the MPT did give separate consideration to the issue of dishonesty: it said so. Further, the weight to be given to the doctor's dishonesty was for the tribunal, and this MPT was entitled to conclude that this aspect of the matter was "inextricably bound up" with his sexual misconduct.

48. Mr Moon's submission on the fourth ground was that the MPT well knew that the only realistic choice here was between the maximum period of suspension and erasure. If the GMC cannot succeed on its first three grounds, it must fail on the fourth. I agree with Mr Moon's submission on the fourth ground, and need say no more about it.

Discussion and Conclusions

49. Any objective assessment of the seriousness of the doctor's misconduct in this case must entail the following catalogue of considerations. This was a lengthy sexual relationship with an obviously vulnerable patient. The doctor continued to treat his patient during the currency of that relationship, so (1) was well aware of patient A's mental state at all material times, and (2) was failing to respect the clear boundary between his professional practice and his personal life. This was not a momentary lapse of judgment or a "one off" in the sense of amounting to misconduct of brief duration. The doctor had plenty of opportunity to reflect on the wisdom of his actions before this relationship began, and could have taken steps to prevent it happening: by, for example, transferring Patient A to another doctor within the practice. Given the vulnerability of Patient A, serious psychological harm was foreseeable if not probable. That it coincided with the cooling and then breakdown in their relationship was always on the cards, and should have been anticipated from the outset.

50. Moreover, the doctor's dishonesty was a serious additional feature of the present case. It is true that the dishonesty consisted in omitting to disclose the very sexual relationship which lay at the centre of the GMC's primary allegations, and certainly was not at the gravest end of the spectrum, but the doctor took a separate decision to assist Patient A by writing the letters he did. This amounted to a separate error of judgment which was not coextensive with the original error in beginning this sexual relationship in the first place, and then continuing that relationship over the months and then the years.

51. Looking specifically at paragraph 103 of the Sanctions Guidance, the following sub-paragraphs are clearly relevant: "(a) a particularly serious departure from the principles set out in Good Medical Practice where the behaviour is fundamentally incompatible with being a doctor; (b) a deliberate or reckless disregard for the principles set out in Good Medical Practice and/or patient safety; (c) doing serious harm to others (patients or otherwise) either deliberately or through incompetence and particularly where there is a continuing risk to patients …; (d) abuse of position/trust …; (e) violation of patient's rights/exploiting vulnerable people …(h) dishonesty, especially where persistent and/or covered up; (i) putting their own interests before those of their patients …". The Guidance does not state that the presence of any of these factors indicates that erasure is appropriate, and I agree with Mr Moon that there is no such thing as a "category" of erasure case. Further, there is considerable overlap between these paragraphs. Additionally, sub-paragraph (a) tends to circularity inasmuch as conduct which is fundamentally incompatible with being a doctor can only be defined with

reference to the gravity of the conduct under consideration, coupled with the wider public interest. Even so, the instant case was surely one where any reasonable MPT properly directing itself as to the governing principles and the Sanctions Guidance would have to be giving very serious consideration to erasing the doctor.

52. Paragraphs 137, 139, 140 and 144 of the Sanctions Guidance are also highly relevant to this case, because they are specifically directed to sexual relationships with vulnerable patients. The doctor clearly abused the special position of trust which he occupied *vis-à-vis* Patient A, and this was a serious case of its type. I agree with Mr Moon that paragraphs 127ff of the Sanctions Guidance, dealing with "more serious action", cover both suspension and erasure. However, paragraphs 140 and 144, taken together, indicate that erasure is likely to be the appropriate sanction in a case possessing all the features I have summarised.

53. In a case involving all the foregoing objective features, I would at the very least have expected the MPT expressly to set out paragraphs 103, 137, 140 and 144 in the Determination on Sanction. They were so obviously apposite. Yet, the MPT did not do so. This is not a matter of elevating form over substance. First of all, had the MPT referred in appropriate detail to the considerations set out under paragraphs 103, 137, 139 and 144 of the Sanctions Guidance without providing these exact rubrics, I would have had no difficulty with its decision-making. The converse obviously applies. Secondly, the MPT did refer in general terms to the Sanctions Guidance and stated that it was taken into account, but in my judgment there is no indication that the MPT grappled with the seriousness of this case, including the salient features I have itemised, in the context of sanction. Instead, there is merely a generalised assertion that erasure would be a disproportionate sanction and that the doctor's conduct was not incompatible with his continued registration. I agree with Ms Richards that there was a failure properly to consider the objective features of the instant case, to demonstrate that their gravity had been fully understood, and then to address and explain how the available mitigation operated to justify the imposition of the sanction of suspension. Although paragraph 38 of the Determination on Sanction does make it clear that the doctor's [REDACTED] was *the* factor which took his case from erasure into suspension, that is insufficient in my view to transcend the earlier failings I have identified. I return to this point below.

54. In these circumstances, I agree with Ms Richards that her first ground has been made out. Moreover, the consequence of it being correct is that the MPT also failed adequately to protect the public by giving sufficient weight to the second and third limbs of the overarching objective.

55. The second ground gives rise to a point of principle.

56. The Sexual Offences Guideline published by the Sentencing Council makes clear that "mental disorder" is a mitigating factor. In the context of the criminal law, psychiatric evidence is relevant to issues of mental illness in the context of the defence of insanity, and "abnormality of mind" in the context of diminished responsibility. In R v Alexander Blackman [2017] EWCA Crim 190, the Court Martial Appeal Court held that psychiatrists could give admissible and relevant evidence as to whether the test of diminished responsibility set out in section 2 of the Homicide Act 1957 as amended by section 52(2) of the Coroners and Justice Act 2009 was met in any given case, although ultimately the satisfaction of the statutory test was for the court.

57. The duty of the MPT was fundamentally different from that of a criminal court, not least because the doctor has committed no criminal offence and, in any event, the defence of diminished responsibility is only available in homicide cases. My reasons for referring briefly to the criminal law are only to lend some limited support to Mr Moon's case that it was open to the MPT to give weight to the evidence of Dr Hook in the context of personal mitigation, and that Dr Hook was entitled to opine on the extent to which the doctor's self-control was impaired by his [REDACTED].

58. However, in my judgment considerable caution is required in this sort of case, for a number of reasons. In this disciplinary context, personal mitigation carries far less weight than it might in the domain of the criminal law, because all three elements of the tripartite public interest are always in play. Secondly, the MPT's assessment, no doubt based on Dr Hook's evidence, that the doctor's behaviour could be explained by the interaction between his [REDACTED] and "a number of social and personal factors at the time of your misconduct", is to my mind deeply questionable. The doctor was not acting under impulse or on the spur of the moment (c.f. Marine Blackman and his adjustment disorder). He, as a professional man, made a considered decision over a course of time to embark on what he knew to be a wholly inappropriate sexual relationship with a vulnerable patient. In a psychiatric, psychotherapeutic or medical context it may make perfect sense to apply a deterministic model of human motivation and behaviour, but I fail to see how that applies to a regulatory context. In my judgment, in evaluating the weight to be given to Dr Hook's evidence the MPT should have proceeded on the premise that it had set out in its Stage 2 Determination: namely, that the doctor "made a series of conscious and moral choices to behave in this way with a vulnerable patient over a prolonged period". What was relevant to impairment was equally relevant to sanction.

59. Instead, the full force of paragraphs 29 and 34 of the MPT's Determination on Impairment was not carried through into paragraphs 18, 20, 38 and 43 of its Determination on Sanction. In these paragraphs the causative potency of the doctor's [REDACTED] is expressed in different terms, with the penultimate sentence of paragraph 18 being most closely adherent to what I have called the deterministic model. The second sentence of paragraph 20 is more measured ("less able to resist"), but the paragraph as a whole fails to give sufficient weight to the question of the doctor's personal responsibility in these circumstances. On two occasions it is said that the doctor made the "wrong" choice, which in my view amounts to a serious understatement. The final sentence of paragraph 20 – "you in fact wanted to help and care for Patient A and having made the wrong choice you were very confused by your different professional and personal responsibilities" – represents an unsatisfactory analysis of the position. To the extent that it relies on one sentence in Dr Hook's report ("… in the hope of rescuing her from her unhappy situation"), I have to say that this is both an unfortunately worded and overly benevolent interpretation. On any view, paragraph 20 does not represent a fair and objective assessment of what the doctor did and why he may have done it.

60. Confronted with expert evidence of this nature, the MPT should in my opinion have drawn a distinction between the doctor's moral and professional responsibilities and duties, and factors which an expert in mental health would take into account in reaching a diagnosis. There is some link between these two aspects, but in the circumstances of the present case it could only have been modest.

61. Had it been clear that the MPT was giving modest weight to Dr Hook's evidence, I would have taken a different view. However, my analysis of the first ground has led me to conclude that this was an extremely serious case of sexual misconduct, such that only weighty mitigation could properly have brought it into suspension territory. It follows, in my judgment, that the MPT gave excessive weight to Dr Hook's evidence in evaluating the tripartite public interest. Put another way, the wider public interest is not upheld by tribunals accepting expert evidence of this nature, and applying a "plausible and psychologically coherent narrative" to the issues under scrutiny. Ms Richards' second ground must, therefore, be upheld.

62. Ms Richards' third ground raises a short point, and had it stood alone I would have required some persuading that it could be sufficient for the present purposes of section 40A. It is true that the MPT said in terms that it "gave separate consideration to the issue of dishonesty". However, in its view the doctor's dishonesty was "inextricably bound up" with his sexual misconduct, and "as your dishonest misconduct does not stand alone the same mitigating factors apply". Overall, I do not read paragraph 40 as saying that the doctor's dishonesty was adding to the seriousness of this case, whereas in objective terms it clearly did. Further, the MPT had already effectively decided to suspend the doctor at the end of paragraph 38 of its Determination on Sanction, which decision was "strengthened" (paragraph 39) by other mitigation. This additional mitigation, although substantial, could not logically impact on the seriousness of the doctor's misconduct at the time it occurred.

63. I cannot accept Mr Moon's submission that the GMC is hamstrung by the fact that it has not appealed the finding that the doctor's behaviour falls short of being fundamentally incompatible with continued registration. This finding flows from its antecedent finding that the doctor's mitigation constitutes the critical difference between erasure and suspension, and in this regard the GMC's case is covered by its second ground.

Disposal

64. I have upheld the GMC's first, second and third grounds of appeal. It follows that the MPT's decision on sanction must be quashed.

65. Under section 40A(6) of the Medical Act 1983, I can substitute for the MPT's Determination on Sanction my own determination (sub-paragraph (c)) or remit the case to the MPT for further consideration in the light of my Judgment (sub-paragraph (d)). The former course is appropriate only where the outcome is so clear that there would be no point in remission: *pace* Collins J in paragraph 33 of Giele.

66. With some regret, because the doctor is clearly a decent man who has learned from his errors, and there is a public interest in permitting a competent doctor to continue in practice in a profession which is losing too many experienced GPs for various reasons, I am driven to conclude that this case falls into the somewhat rare category of case where I am able safely to conclude that the doctor must be erased. Given the gravity, duration and extent of the doctor's misconduct, and giving appropriate weight to the available mitigation, paying sufficient regard to the overarching objective drives me to conclude that erasure is the only appropriate sanction.

67. No separate order is necessary in relation to the GMC's second appeal. It has been wholly superseded by my ruling on its first appeal.

68. I invite Counsel to draw up and agree a form of Order.

ANNEX: SANCTIONS GUIDANCE

About This Guidance

1. This document provides guidance to tribunals on imposing sanctions on a doctor's registration, including why a tribunal should impose sanctions and what factors it should consider. It provides a crucial link between two key regulatory roles: setting standards for the medical profession, and taking action when a doctor's fitness to practise is called into question because they have not met the standards.

2. When serious concerns have been raised about a doctor, the case may be referred to the MPTS for a hearing. Medical practitioners tribunals use this guidance to make sure they take a consistent approach when deciding: a) whether to issue a warning when a doctor's fitness to practise is not impaired b) what sanction to impose, if any, when a doctor's fitness to practise is impaired.

3. This guidance makes sure that the parties are aware from the outset of the approach that the tribunal will take to imposing sanctions. The tribunal should use its own judgement to make decisions, but must base its decisions on the standards of good practice established in Good medical practice and on the advice given in this guidance.

…

Taking a Proportionate Approach to Imposing Sanctions

20. In deciding what sanction, if any, to impose the tribunal should consider the sanctions available, starting with the least restrictive. It should also have regard to the principle of proportionality, weighing the interests of the public against those of the doctor (this will usually be an impact on the doctor's career, e.g. a short suspension for a doctor in training may significantly disrupt the progression of their career due to the nature of training contracts.

…

24. The tribunal needs to consider and balance any mitigating factors presented by the doctor against the central aim of sanctions (see paragraphs 14–16). The tribunal is less able to take mitigating factors into account when the concern is about patient safety, or is of a more serious nature, than if the concern is about public confidence in the profession.

…

Circumstances Surrounding the Event

51. Aggravating factors that are likely to lead the tribunal to consider taking more serious action include:

d) abuse of professional position (see paragraphs 136–142), particularly where this involves: i) predatory behaviour (see paragraphs 141–142) ii) vulnerable patients (see paragraphs 139–140);

e) sexual misconduct (see paragraphs 143–144) …

…

61. The tribunal's written decision is known as the determination. It must give clear and cogent reasons (including mitigating and aggravating factors that influenced its decision) for imposing a particular sanction. It must show that it started by considering the least restrictive option, working upwards to the most appropriate and proportionate sanction. This is particularly important where the sanction is lower, or higher, than that suggested by this guidance and/or where it differs from those submitted by the parties. In addition, the determination should include a separate explanation as to why the sanction should last for a particular period.

…

85. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

86 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).

87 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 (see paragraphs 24–45).

…

101. The tribunal may erase a doctor from the medical register in any case – except one that relates solely to the doctor's health and/or knowledge of English – where this is the only means of protecting the public.

102 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.

103 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 fundamentally incompatible with being a doctor.

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

c) Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below at paragraphs 123–126 regarding failure to provide an acceptable level of treatment or care).

d) Abuse of position/trust (see Good medical practice, paragraph 65: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').

e) Violation of a patient's rights/exploiting vulnerable people (see Good medical practice, paragraph 27 on children and young people, paragraph 54 regarding expressing personal beliefs and paragraph 70 regarding information about services).

f) …

g) …

h) Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 114–122).

i) Putting their own interests before those of their patients (see Good Medical Practice paragraph 1: – 'Make the care of [your] patients [your] first concern' and paragraphs 77–80 regarding conflicts of interest).

j) …

Cases that Indicate More Serious Action is Likely to be Required

…

Abuse of professional position

136. Trust is the foundation of the doctor-patient partnership. Doctors' duties are set out in paragraph 53 of Good medical practice and in the explanatory guidance documents Maintaining a professional boundary between you and your patient and Ending your professional relationship with a patient.

137. Doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.

…

139. Where a patient is particularly vulnerable, there is an even greater duty on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of certain characteristics or circumstances, such as: a) presence of mental health issues …

…

140. Using their professional position to pursue a sexual or improper emotional relationship with a vulnerable patient is an aggravating factor that increases the gravity of the concern and is likely to require more serious action against a doctor.

…

142. More serious action, such as erasure, is likely to be appropriate where a doctor has abused their professional position and their conduct involves predatory behaviour or a vulnerable patient, or constitutes a criminal offence.

Sexual Misconduct

143. This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child pornography) to sexual misconduct with patients, colleagues, patients' relatives or others. See further guidance on sex offenders and child pornography at paragraphs 145–153.

144. Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases.