IN THE HIGH COURT OF JUSTICE

QUEEN'S BENCH DIVISION

ADMINISTRATIVE COURT

Neutral Citation Number: [2019] EWHC 1111 (Admin)

No. CO/4811/2018

Royal Courts of Justice

Tuesday, 9 April 2019

Before:

MR JUSTICE MARTIN SPENCER

B E T W E E N:

MICHAEL KERN — Appellant

- and -

GENERAL OSTEOPATHIC COUNCIL — Respondent

MR M. PAUL (instructed by William Graham Law) appeared on behalf of the Appellant.

MR A. FAUX (instructed by the General Osteopathic Council) appeared on behalf of the Respondent.

J U D G M E N T

MR JUSTICE MARTIN SPENCER:

1 In this appeal the appellant, Michael Kern, appeals against the determination of the professional conduct committee of the General Osteopathic Council, whereby it decided that the appellant should be struck off the register for unacceptable professional conduct in relation to a patient referred to in the proceedings before the PCC, and again in this appeal, as "Patient A".

2 The facts of this matter are that the appellant, born on 31 May 1956 and now aged 62, was first registered with the respondent council on 8 May 2000. As well as teaching and writing on craniosacral therapy (CST) he practises as an osteopath from his home in North London. In 1989 he co-founded the Craniosacral Therapy Education Trust which offers training, introductory seminars and advanced seminars in biodynamic CST.

3 The victim, Patient A, was studying CST in London and sought treatment from the appellant, not because she felt she had health issues which required CST, but because she was curious about the appellant's techniques from an educational perspective. She first saw the appellant as a patient on 30 March 2006. There were some 10 to 12 sessions until the end of August 2006. In these sessions there was no impropriety at all and the relationship remained appropriate. However, at the end of August 2006, things changed.

4 The appellant was teaching a workshop in Switzerland and Patient A decided to enrol on the workshop. She described how on the first day she offered the appellant a shiatsu massage because he appeared to her to be tired and this took place in a small therapy room in the vicinity of the conference room. In return, the appellant offered Patient A some CST and, after this had finished, he then invited her to come back with him to his room. There sexual contact took place, but not full penetrative sex, with mutual masturbation and, on the part of the appellant, ejaculation. This continued for the rest of the workshop and, thereafter, after their return to London, after each of the further CST sessions. Patient A described the appellant putting his hands under her clothes and touching her on her breasts and in her genital area. She said that after each session of treatment there would be sexual contact for about ten minutes. However, on no occasion was there penetrative sex.

5 The relationship came to an end in the summer of 2007 when sexual contact following the treatment sessions ceased and Patient A last saw the appellant on 19 September 2007. Before that, on 10 August 2007, Patient A sent the appellant an email in which she said she was feeling really depressed and was trying to "differentiate what is about you and what is about me." She said she realised that as a client she had been feeling not just angry and disappointed with the appellant, but also sad since the previous summer, presumably a reference to what had started in Switzerland. In reply, on 11 August 2007, the appellant confessed to feeling disappointed with himself saying:

> "I am truly and deeply sorry for losing clear boundaries with you and will do anything I can to support you to move through your feelings around this."

In reply, Patient A said that she had been made confused by the loss of boundaries and was having difficulty seeing things clearly.

6 There was some further email contact between the appellant and Patient A during 2008. For example, Patient A recommended the appellant to a friend of hers whose baby needed treatment and the appellant sent Patient A an email from Russia, where he was at the time, thanking her. However, in the November 2008 there was further more substantive contact. There are emails from late November and early December 2008 when there was

a suggestion of meeting up for tea or lunch, but an arrangement to meet on 16 December 2008 was cancelled by Patient A on 10 December 2008.

7 In early November 2008, Patient A said that the appellant had telephoned her quite late in the evening and, after exchanging pleasantries, said that he had separated from his partner and invited her to come over to his house. In her statement she said:

> "I said 'no' as I felt as if he wanted to use me without considering the impact of his actions. I was shocked that he had no awareness of what he had done to me, which made me worry that he could do it to other patients."

8 It was alleged before the PCC that this had been an attempt by the appellant to re-establish an improper personal relationship with Patient A, it being suggested that the appellant's intention had been to resume his sexual relationship with Patient A.

9 In November 2017 Patient A made her complaint to the General Osteopathic Council. In her complaint, she described how she had decided to leave London in 2017 and told her friend about the experience with the appellant and as she felt it was "something I had not sorted out in my life". Having talked it through, she felt she should do something about it, because she believed she was still affected by what had happened and, therefore, decided to bring the complaint.

10 The appellant, in his witness statement dated 12 April 2018, accepted that he had behaved inappropriately. He said:

> "The basic issue is that I inappropriately engaged in a personal and sexual relationship with Patient A in 2006/2007 during a time that I was still treating her. I agree with her that it should not have happened and I have been deeply regretful ever since. I also acknowledge her statement that she 'felt that part of me enjoyed the experience and also felt responsible for the experience' as all interactions were consensual. However, I also understand that it was my responsibility as her practitioner to be the guardian of professional boundaries which I failed to keep."

11 The appellant drew attention to the fact that he had admitted his "transgression" in his email of 11 August 2007 and had offered her a sincere apology. He explained what had happened in November 2008 as follows:

> "I was actually wanting to make contact with her to find out how she was doing as I felt a mixture of concern, guilt and loneliness. I did not wish to 'use her' and, whilst her version of the situation is understandable, I am sorry that my somewhat confused motivation was misinterpreted. When after a few emails she informed me that she did not wish to meet up or speak, I did not contact her again."

12 The allegations before the PCC were as follows:

> "You, Michael Kern, are guilty of unacceptable professional conduct contrary to s.20(1)(a) of the Osteopaths Act 1993 in that:
>
> (1) Between 30 March 2006 and 8 August 2007 Patient A attended several treatment sessions with you.

(2) During one or more sessions referred to in para.1 above, you groomed Patient A by (a) asking her if she wanted to be held or words to that effect, and (b) putting your arms around Patient A when she disclosed that her father had committed suicide.

(3) From 27 August to 1 September 2006, and subsequent to the establishment of a practitioner/patient relationship, you pursued and conducted a sexual relationship with Patient A; namely, when Patient A attended a workshop in Switzerland run by you, you invited Patient A to your room on several occasions and you and Patient A engaged in sexual activity.

(4) From September 2006 until the summer of 2007, Patient A attended sessions with you at which you and Patient A engaged in sexual activity.

(5) On 23rd February 2007 you invited Patient A to your house where you and Patient A engaged in sexual activity.

(6) In early November 2008 you attempted to re-establish an improper personal relationship with Patient A by asking Patient A if she would like to come over to your house or words to that effect.

(7) Your actions as described in para.2, 3, 4, 5, and 6 above were (a) not clinically justified, (b) not in Patient A's best interests, (c) a transgression of professional and sexual boundaries, (d) an abuse of your professional position."

13 Allegations 1, 3, 4, 5 and 7, in so far as 7 related to allegations 1, 3, 4, and 5, were admitted by the appellant. He denied allegations 2 and 6. Allegation 2, the allegation of grooming, was found not proved by the PCC, but allegation 6 was found proved. In so deciding, the PCC stated at para.28 of their determination:

"The committee considered that the context to the invitation to come to the registrant's house contained in this phone call was significant. The registrant and Patient A had not communicated for some time. The last time he had invited her to his house (in February 2007) they had had sex. Indeed, most of their sexual contact had taken place at his house, albeit mainly in the treatment room. Patient A felt that the registrant had invited her to his house in order to 'use' her. The committee, therefore, considered it more likely than not that this was the registrant's intention in inviting Patient A to his house.

Given the exchange of emails between the registrant and Patient A in August 2007, in which there had been at least some acknowledgement of the loss of clear boundaries on the part of the registrant, to attempt to resume the sexual relationship was in the committee's view improper. It therefore found this allegation proved on the balance of probabilities. It followed that the committee also found allegation 7 proved in respect of this allegation."

14 In relation to the matters either admitted by the appellant or found proved by the committee, the PCC found that the appellant was guilty of unacceptable professional conduct. It said:

> "32. The committee's findings were that the behaviour demonstrated by the registrant fell far short of the required standards of a registered osteopath. His conduct exhibited multiple departures from the code of practice and clearly had the potential to undermine public trust and confidence in the profession. Though the registrant was not acting as an osteopath at the time of the events in question, he was on the osteopathic register, was an experienced practitioner, had written about professional boundaries in a book he had published and had been involved in the education of other practitioners. He rightly accepted that in initiating and pursuing a sexual relationship with a patient under his care he was guilty of unacceptable profession conduct.
>
> 33. On his own admission, the registrant had not only engaged in sexual activity with Patient A, but had done so repeatedly in the context of professional consultations. This was a gross abuse of his professional position. He had attempted subsequently to re-establish the relationship, despite his awareness of the effect it had had on Patient A. Patient A had been left confused and distressed by the registrant's actions. The committee had no doubt that the facts of the case would certainly convey a serious degree of opprobrium and moral blameworthiness to the ordinary intelligent citizen. It therefore found that the facts and particulars found proved amounted to unacceptable professional conduct by the registrant."

15 The PCC then went on to consider sanction, directing itself in accordance with the decision of *Arunachalam v GMC* [2018] EWHC 758. The principles set out in that case included:

> (i) The committee should make and demonstrate in its determination a proper evaluation of the mitigating factors in deciding on sanction.
>
> (ii) Personal mitigation counts for less than in other contexts, because of the need to maintain public confidence in the profession.
>
> (iii) The law does not require that in all sexual misconduct cases removal from the register should follow. The severity of the sanction required to maintain and preserve public confidence in the profession "must reflect the views of an informed and reasonable member of the public."
>
> (iv) Despite a zero tolerance attitude towards sexual misconduct, the law is not so inflexible that every transgression of this kind must be met with removal from the register.

16 The committee drew attention to the mitigating factors: the appellant's previous good character; his expression of regret and candour in engaging with the respondent in its investigation; his early admissions to most of the allegations; the testimonials provided by a wide range of patients and other practitioners speaking to his professional competence and good character; and his own stressful personal circumstances at the time of the events. Furthermore, the PCC took account of the fact that the appellant had initiated efforts of his own accord to address his behaviour through therapy and further training. Thus, he had sought professional help from a psychologist shortly after the events in question and long before Patient A's complaint came to light. They accepted that this suggested some degree of insight about his conduct. Furthermore, the PCC recognised that there was no suggestion of any similar behaviour with any other patient.

17 The committee also made reference to aggravating factors which they found to be present including:

> (1) The case was not an isolated event, but a deliberate course of conduct over a significant period of time.
>
> (2) Patient A was vulnerable, yet he knowingly and repeatedly engaged in sexual activity with her, notwithstanding her evident emotional distress during treatment sessions. The fact that the treatment sessions were arranged at the end of the day, after which the sexual activity occurred, suggested a degree of calculation and exploitation.
>
> (3) In prioritising his own emotional needs over those of Patient A, the appellant's behaviour had harmed Patient A and there was no possible excuse for such behaviour.
>
> (4) His behaviour was a gross abuse of his professional position, which was highly likely to damage the standing of osteopaths generally.

18 The committee considered each sanction in turn in order of seriousness and appropriately rejected admonishment or conditions of practice. Considering a suspension order it said:

> "43. The committee then considered whether a suspension order would address the facts of the situation. It concluded that it would not. Despite taking into account all the mitigation offered on behalf of the registrant, including the numerous positive testimonials, the passage of time and the apparently successful nature of his practice subsequently, the committee considered that the registrant's misconduct represented a reckless and particularly serious departure from the relevant professional standards."

19 Thus, the committee was led to consider striking the appellant's name off the register. It said:

> "44. The maintenance of appropriate professional boundaries remains essential to the relationship of trust between practitioner and patient. The gross breach of trust in this case has the potential to cause great damage to confidence in the osteopathic profession generally. The registrant's admitted and proven misconduct is fundamentally incompatible with his continued registration. The committee considered that the public interest in this case could only be protected by the imposition of the sanction of removal from the register and no lesser sanction could appropriately reflect its seriousness."

Thus, the PCC decided to remove the appellant's name from the register.

20 By his notice of appeal, the appellant first asserts that the PCC was wrong to find charge 6 proved on the basis that the reasoning for the decision was inadequate, the PCC failed to grapple with the evidence advanced by the appellant and was wrong in law to find that the telephone call to Patient A constituted an attempt to re-establish an improper relationship as it could not, in the circumstances, have been any more than merely preparatory to so doing. Secondly, it is asserted that the decision to remove the appellant from the register was wrong, again, saying that the reasoning was inadequate and the PCC had failed to grapple with the evidence or mitigation advanced by the appellant. It is further suggested that the

sanction was unnecessary for the protection of patients and was otherwise excessive in all the circumstances of the case.

21 The jurisdiction of the High Court to hear appeals from the PCC is derived from s.31 of the Osteopaths Act 1993. It is also governed by the provisions of Part 52 of the Civil Procedure Rules. This appeal comes before the High Court pursuant to CPR 52.21(3) which provides:

> "(3) The appeal court will allow an appeal where the decision of the lower court was—
>
> (a) wrong; or
>
> (b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court."

22 The jurisdiction of the High Court is also derived from the provisions of CPR 52 DPD 19.1(1)(j) which applies the provisions of para.19.1 to an appeal to the High Court under s.31 of the Osteopaths Act 1993. The Practice Direction further provides (2):

> "Every appeal to which this paragraph applies must be supported by written evidence and, if the court so orders, oral evidence and will be by way of rehearing."

23 This provision applies equally to appeals from, for example, the Professional Conduct Committees of the General Medical Council and the Nursing and Midwifery Council and, therefore, guidance from the courts on previous occasions in relation to the approach of the High Court to such appeals are equally applicable to the appeal in this case.

24 In *Raschid v General Medical Council* [2007] 1 WLR 1460 Laws LJ gave the following guidance:

> "The High Court will correct material errors of fact and of course of law and it will exercise a judgment, though distinctly and firmly a secondary judgment, as to the application of the principles to the facts of the case."

25 Further, I adopt and apply the guidance given by Mostyn J in *Luthra v GMC* [2013] EWHC 240 at paras.3 to 6 as follows:

> "3. I have been given a bundle of authorities but the principles have all been succinctly captured by Laws LJ in the decision of Raschid.
>
> 4. Taking the reasoning of Laws LJ in combination with CPR 52.11(3) the governing principles are:
>
> i) I can only overturn the decision of the FTPP if I am satisfied that it was either wrong or unjust because of a serious procedural or other irregularity in its proceedings.
>
> ii) In determining whether the decision was wrong I must pay close regard to the special expertise of the FTPP to make the required judgment.

> iii) Equally, I must have in mind that the exercise is centrally concerned with the reputation and standards of the profession, and the protection of the public, rather than the punishment of the practitioner.
>
> iv) The High Court will correct material errors of fact and of law and it will exercise a judgment, though distinctly and firmly a secondary judgment, as to the application of the principles to the facts of the case.
>
> v) Where the appeal is against a sanction my decision must not constitute an exercise in re-sentencing or the substitution of one view of the merits for another."

26 Furthermore, in relation to the third numbered principle, Mostyn J reminded himself, as I remind myself now, of the dictum of Sir Anthony Clarke MR in *GMC v Meadow* [2007] 1 QB 462 at para.32:

> "The purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past."

27 In relation to sanction, it may have consequences for the individual and his or her family which are deeply unfortunate and even unintended but that does not make the sanction wrong if it is otherwise right because:

> "The reputation of the professions is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price."

28 As Mostyn J said in *Luthra's* case:

> "The reason that the reputation of the profession is so important is not a reflection of a collective *amour propre*. It is an aspect of the need to protect the public. The public must be able to approach doctors, lawyers and other professionals with complete faith that they are both honest and competent. Without that faith the problems that would arise are too obvious to state."

29 I would add only this. The provisions of CPR 52.21 suggest that every appeal will be limited to a review of the decision of the lower court, unless the court considers in the circumstances of an individual appeal it would be in the interests of justice to hold a rehearing. This would seem to suggest that the provisions of CPR 52.21 are only applicable to appeals which are by way of review, rather than appeals, such as this, which are statutorily by way of rehearing. The application of the provisions of CPR 52.21 to appeals from the decisions of the professional conduct committees of the various health care regulatory bodies would seem to elide this distinction between appeals by way of review and appeals by way of rehearing. However, in my judgment, although in a rehearing case the High Court will be more ready to overturn a finding of the PCC, it will not generally rehear the evidence and see the witnesses for itself. This has two important consequences. First, the PCC, having had the benefit of hearing and assessing the witnesses, will be in the best position to make judgments about the credibility and reliability of those witnesses and the facts which lie behind the case. Secondly, the High Court will not have the same

knowledge and experience of the profession as the PCC will have and will, therefore, defer to the judgments of the PCC where those judgments involve matters pertaining to the particular health care profession in question.

Charge 6.

30 In relation to the finding of the PCC in respect of charge 6, it is submitted on behalf of the appellant by Mr Paul that in reaching its conclusion the PCC failed to consider any of the following important points made by the appellant in his defence.

> (1) The appellant's telephone call to Patient A did not come completely out of the blue. They had exchanged a number of emails between May 2007 and May 2008, well after any sexual activity between them had stopped. These emails indicate the nature and tone of the appellant's relationship with Patient A. They did not contain any sexual or suggestive references.
>
> (I should interpose that Mr Paul accepts today that the sexual activity ended in August 2007 and, therefore, the reference to between May 2007 and May 2008 being well after any sexual activity between them had stopped was incorrect. He wrote his submissions upon the incorrect assumption that the sexual activity had finished in February 2007.)
>
> (2) The appellant did not contemplate inviting Patient A to his house at the outset of the conversation. Patient A confirmed in her evidence that the appellant first asked if she wanted to join him at a 5Rhythms class, 5Rhythms being a therapeutic movement class which is held in public and attended by approximately a hundred people.
>
> (3) During the phone call, the appellant and Patient A were talking for about ten minutes and exchanging catch-up information. Well into this conversation Patient A asked about his news and it was only in response to this enquiry that the appellant told her that he had separated from his partner.
>
> (4) During the conversation, Patient A revealed that she was waving to a friend who was waiting for her. The appellant could hear a male voice and, at that point, asked her if he was her boyfriend. Mr Paul submits that this was not his opening gambit in the conversation and it was not in context an unusual or an inappropriate enquiry.
>
> (5) The appellant could not possibly have known that Patient A was in the Camden Town area when he made the phone call. His invitation to her to come to his house to continue their conversation was only made once Patient A had revealed that she was in fact in the vicinity.
>
> (6) The appellant's only intention in inviting Patient A to his house was to talk to her and to catch up with her as a friend.

31 It is suggested by Mr Paul that the PCC failed to give proper consideration to the appellant's evidence on charge 6 and, if it did take any of the points made by the appellant into account, it is impossible to glean from the decision what weight was given to that evidence by the PCC. It is further asserted that the decision was premised upon a significant error of fact; namely, that the last time he had invited her to his house in February 2007 they had had sex. Mr Paul submits that this is wrong because, on the evidence of both Patient A and the appellant, she had attended on a number of further occasions at the appellant's house in the summer and autumn of 2007 when no sexual contact had occurred. Thirdly, it is

submitted that the PCC were wrong to place any weight or reliance on Patient A's belief or suspicion that it had been the appellant's intention or motivation in inviting her to his house to resume sexual contact.

32 Finally, the appellant submits that this was inappropriately charged as an attempt when what was in reality being alleged was improper motivation on the appellant's part. It is submitted that it would be seriously unfair to registrants if the nature of an attempt were infinitely malleable and registrants could not ascertain whether or not conduct might amount to unacceptable professional conduct by constituting an attempt. Reference is made to the meaning of "attempt" within the criminal law as being an act which is more than merely preparatory to an offence and, on the basis that an invitation to come to the appellant's house could be no more than merely preparatory to re-establishing of a sexual relationship, this was insufficient to amount to an attempt. It is submitted that the much broader construction of the word "attempt" in this case "verges on the prosecution of the registrant for thought crime and results in serious unfairness."

33 On behalf of the respondent, Mr Faux refutes the grounds of appeal in relation to charge 6. He denies that there was a factual error forming part of the premise for the finding. He submits that all the PCC were doing was "properly noting that on the previous occasion, when the appellant had initiated contact for purposes other than treatment, sexual activity had followed." This was, he submits, plainly a relevant and important matter which the PCC could properly take into account when considering the appellant's motive for seeking to meet Patient A at his home late at night in November 2008.

34 The respondent further submits that the reasons given by the PCC were sufficient to enable the appellant to understand why his explanations were rejected. It is submitted:

> "It is clear that the PCC concluded that, given the full context of the phone call, it was more likely than not that the true purpose of the phone call was the appellant seeking to restart a sexual relationship with Patient A, that is an attempt."

(I interpose to say that, whilst it may not have been the purpose of the phone call when it was initiated, it became part of the purpose of the phone call, on the respondent's submission, once the appellant had ascertained that Patient A was in the vicinity and invited her back to his house.)

35 The respondent further submits that it was plainly relevant for the PCC to take into account how Patient A perceived the motive behind the phone call in considering whether the appellant had a sexual motive in relation to his invitation to her.

36 Finally, it is submitted by the respondent that the analogy with the criminal law in relation to the meaning of "attempt" is inappropriate. Mr Paul submits that attempt was not used in this charge as a term of art, as it is used in a criminal charge, but was more an allegation that the appellant had inappropriately sought to resume his sexual relationship with Patient A. Thus, everyone at the hearing before the PCC understood the charge to mean that the contact with Patient A by telephone in November 2008 in inviting her back to his house had been motivated by a wish or desire to resume sexual contact.

37 In my judgment, the submissions of respondent are correct in this regard. No one at the hearing could have been in any doubt that the import of the charge was that, in contacting Patient A by telephone and inviting her back to his house, the appellant was motivated by his wish or desire to re-establish sexual contact with her and this was inappropriate. Thus, the issue for the PCC was what lay behind the making of that invitation that she should

come to his house and all the circumstances, including the late hour, the fact that he was inviting Patient A to his home in circumstances where he was alone there having split up with his partner, were such as to lead to the conclusion that the invitation was sexually motivated. The PCC was entitled to take into account the fact that the appellant had previously invited the complainant to his house and sexual contact had taken place there in February 2007. In my judgment, despite the denials by the appellant, the conclusion to which the PCC came was one to which they could reasonably come.

38 I would also comment that in the context of this case charge 6 will surely have played a very minor role, if any role at all, in the PCC's consideration of sanction. By the time of this telephone call, Patient A had ceased to be a patient of the appellant under active treatment. She was by now a former patient. Furthermore, no sexual contact in fact took place. Compared to the other charges and the activity of the appellant in engaging in sexual contact, not just with someone who was his patient but even on the occasions of treatment, the allegation under charge 6 pales into insignificance. Given that no sexual contact took place and the nature of the charge was restricted to the appellant's motivation rather than his actual conduct, there is a sense in which the appellant is right that what was alleged was morally wrong, rather than actually wrong. That is not to say that the conduct, inviting Patient A back to his home, was not improper when motivated, as it was, as the PCC found, by sexual desire, but that would certainly not, in my judgment, by itself justify erasure from the register. The gravamen of this case lies in the other charges.

39 I therefore turn to sanction. The appellant argues that the reasons for the decision in the decision notice do not come close to satisfying the need for, in the words of Hayden J in *Wisniewska* [2016] EWHC 2672 (Admin):

> "...coherent reasoning and particularly the need to demonstrate the weight given to mitigating factors in demonstrating a proportionate sanction."

40 These mitigating factors are, Mr Paul submitted, firstly, the appellant's insight into his failings. He gave extensive evidence on this point, recognising he had caused harm to Patient A through his behaviour, and had undertaken extensive self-evaluation and therapy. Mr Paul submitted there was no serious likelihood of recurrence. Second, that the conduct was an isolated example in 31 years of practice. Third, there was no evidence to suggest that the appellant poses any danger to the public. Fourth, there has been no repetition of the conduct since November 2008. Fifth, he was under substantial pressure in his personal life at the time of the conduct. Sixth, he has expressed genuine remorse, both to the panel and to Patient A in person. Seventh, there is substantial evidence that he has taken rehabilitative and corrective steps. Eighth, he has an excellent record in practise as a practitioner and teacher. Mr Paul drew to the court's attention the large body of references from patients, students and colleagues, which I have read in detail.

41 Mr Paul submits that the present case is closely analogous to *Arunachalam* where Kerr J said at para.64 to 65:

> "... Looking at the list of mitigating features set out in the decision, the tribunal sets them out and says that it took them into account. The tribunal must therefore have taken account of them in some way, but it is quite impossible to say from the decision what weight it gave to those features.

> 65. During the hearing, I repeatedly asked Ms Beattie where in the decision there is any reference to the tribunal's evaluation of the mitigating features it set out in its list. She repeatedly answered using the verb 'identify', saying correctly that the mitigating features had been identified. The tribunal, she argued, had clearly taken into account because it stated in the decision that it had done so, but she was not able to point to any passage in the decision where the mitigating features were evaluated and weighed in the scales against the aggravating features. That is because there is no such passage in the decision. This is not a mere drafting point. It is a failure of approach which means the decision should not stand unless obviously correct, despite the failure."

42 Mr Paul went on to refer the court to para.67 of Kerr J's judgment in *Arunachalam* where he said:

> "... the tribunal did not properly balance the mitigating features against the aggravating ones at the stage of considering suspension. Among them were two and a half years of trouble free service since the allegations and many years of the same, before they were made. That was attested to in the various testimonials, which were not solicited just for the purpose of the disciplinary proceedings, but included many glowing appraisals created in a context that had nothing to do with the proceedings."

43 Mr Paul submitted that the similarities between *Wisniewska* and *Arunachalam* and the instant case are obvious and striking and, if anything, the failures of reasoning in the instant case are more serious than they were in *Arunachalam*.

44 Mr Paul in his oral submissions further referred to para.42 of the decision and submitted that it was unclear why they were looking at the matters referred to there in the context of conditions of practice, but then they were not germane to the question of interim suspension. In para.42 of the determination the panel had said in relation to its consideration of whether conditions of practice would be appropriate:

> "The committee concluded that conditions of practise would not be appropriate or proportionate to address the seriousness of the case. There was no condition of practise that would practically address the registrant's unacceptable behaviour. In addition, the committee was concerned that the registrant had not demonstrated sufficient insight to merit the imposition of conditions. He had persisted in behaviour that he knew was wrong and harmful to Patient A at the time. Despite his subsequent remedial activity, the committee was not satisfied on the basis of the evidence before it that the registrant had eliminated all risk of his acting as a rescuer in future. That is in the way he said he had in this case with the attendant ill-effects."

45 The reference to "rescuer" was a reference to part of the appellant's evidence before the PCC on day three of the hearing where he said this. Asked the question "Why this patient?" he said:

> "I think there were a few elements. I think what I touched on, and, again, I do not know how much to go into this very sort of personal psychotherapy kind of area, but what I recognised was a part of me that

> I would call 'the rescuer'. It was to see somebody in distress and want to make it better. I think and, again, this was a family dynamic that I explored in the psychotherapy sessions, that I recognised that this was a role that I had kind of previously taken as a child in my family to kind of make things better.
>
> I think particularly after the shared experience in Switzerland there was something in me that resonated with patient A. You know there was a part of me that wanted to kind of hold her and make her better and feel that. In a way maybe to be the sort of father figure. You know she had lost her father. She was expressing that distress and I mistakenly wanted to take that role with her. I say hugely mistakenly, because I was very aware of her emotional need and I was also very aware of my emotional need in the midst of it and which basically I also acted upon. I did not just act upon her emotional need, which would have been what should have happened within any kind of therapeutic professional relationship. I also acted on my emotional need within that situation. That is what I worked on."

46 The point made by Mr Paul, and accepted to a degree by Mr Faux on behalf of the respondent, is that any ongoing risk to the public was not reflected by the fact that no interim suspension was imposed pending this appeal, and that indicates that the panel took the view that the registrant did not constitute an ongoing danger to the public.

47 Mr Paul submitted that, given the acceptance by the committee that not all incidences of sexual impropriety between a practitioner and a patient will result in removal from the register, it was appropriate to consider the seriousness of the conduct and, in that regard, he relied the fact that at no stage had there been full penetrative sex. He submitted that it is thus clear that the appellant had retained a degree of sensitivity and respect for Patient A by accepting and respecting her wishes and he had not sought to persuade her to engage in full penetrative sex when she had made it clear that this was not something she was prepared to do at that stage.

48 He submitted that the reasoning of the PCC did not go far enough to enable the appellant to understand why suspension would not have been a sufficient sanction in this case. If this was because it disbelieved his evidence in relation to insight and what he had done, then it should have said so and should have said why. He repeated that which he had submitted in his written argument, namely that there had been an inadequate weighing of the mitigating and aggravating features respectively and, for that reason, the conclusion was flawed in its reasoning. He submitted that too serious a view had been taken in the overall circumstances of this case and that there should have been suspension.

49 Mr Paul referred me to the Indicative Sanctions Guidance of the General Osteopathic Council, which deals with suspension at para.43 and removal of the osteopath's name from the register at para.47. He said that para.A and para.B of para.43 applied. Firstly, there has been a serious breach of the osteopathic practice standards. That is accepted. B, complete removal of the osteopath from the register, would not be in the public interest, but any sanction lower than a suspension would not be sufficient to protect the public interest. He therefore submitted that this was a case for suspension.

50 For the respondent, Mr Faux submitted that the reasons set out in the determination, albeit succinct, were appropriately structured and certainly satisfied the requirements to give adequate reasons. He submitted that it was made clear to the appellant why his name was

being removed from register, namely that, notwithstanding the extent of mitigation, in the view of this panel his behaviour in pursuing a sexual relationship with a vulnerable patient over a period of time, in circumstances that caused her some harm, was incompatible with registration and the imposition of any sanction, short of removal, would undermine public trust and confidence in the osteopathic profession as a whole.

51 In relation to the issue whether suspension would have been sufficient, he submitted that the PCC had rejected that submission and concluded that only removal would meet the public interest in the case. He said that the PCC's focus was appropriately on the difficulty in retaining public confidence in the profession generally if a practitioner who was guilty of such a gross breach of trust were retained in the profession. He supported the PCC's conclusion that the appellant's conduct in this case had been fundamentally incompatible with registration such as that they had directed his removal.

52 He submitted that within their decision, and indeed by the decision not to order an interim suspension, the PCC had made clear that they accepted that the appellant did not pose an immediate risk to harm of patients. He submitted that the PCC had been advised on and taken note of the case law, reminding them that removal was not an automatic consequences of sexual misconduct in a profession. He said that their conclusions, regarding the significantly aggravating features of the relationship, were based on their reasonable view of the evidence before them.

53 He referred to the correct approach of the committee towards sanction, whereby they ensured that the sanction they imposed was the least severe that met the public interest. He submitted that by testing each sanction in turn against the criteria of meeting the public interest, they acted in accordance with the principle of proportionality. He submitted that it was clear that the panel concluded that the imposition of a sanction lesser than removal would unacceptably compromise the achievement of the legitimate objective of maintaining public confidence in the profession. He said that, given that they had properly concluded that this was a case where a professional person had abused his position of trust in order to pursue a sexual relationship and that the relationship had resulted in harm to the patient and given the well-known principles enunciated in *Bolton v Law Society* this conclusion was not surprising.

54 Mr Faux reminded me that the approach of the High Court is that the PCC is a specialist committee with knowledge of what is necessary in order to maintain the respect of the public for the profession of osteopathy. They have a specialist knowledge, including an awareness of the CHRE Guidance, which sets out the risks of harm associated with breaches of professional/patient trust and this reminds panels, expressly, that when considering mitigation advanced they must:

> "Bear in mind the principles set out in this guidance, principally, that any sexualised behaviour towards a patient or carer can cause enduring harm."

Discussion

55 In my judgment, the starting point is the advice that was given to the PCC by their legal advisor, which was as follows:

> "Recent case law does provide you with some further guidance as to the approach to sanction in cases of sexual or alleged sexual misconduct. I refer you to the case of *Arunachalam v GMC*. There are four principles I suggest to be drawn from that case. The circumstances of the case,

which are somewhat different to this case you may think, are that a doctor was complained about by two junior female colleagues who complained of inappropriate, but not overtly sexual, text messages and inappropriate behaviour in the sense of over familiar touching and hugging. The panel in that case decided to erase the doctor. He succeeded on appeal.

The appeal in the High Court. The principles I suggest you should draw in these circumstances are, firstly, that in arriving at a decision on sanction the committee should demonstrate in its written decision a proper evaluation of all the mitigating factors in deciding on the appropriate sanction. Secondly, and this is a well-known principle derived from the case of *Bolton v Law Society* [1994] 1 WLR 512, personal mitigation counts for less in cases such as this than in other contexts, because of the need to maintain public confidence in the profession. Of course the committee will be well aware of the well-known quote from *Bolton*:

> 'The reputation of a profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price.'

The third principle I suggest you should adhere to in arriving at a sanction is that it is not the law that in sexual misconduct cases erasure should follow. The severity of sanction required in order to preserve public confidence in the profession must reflect the views of an informed and reasonable member of the public. That principle is derived from another GM case *Giele v GMC* [2006] 1 WLR 942. Lastly, despite a zero tolerance attitude towards sexual misconduct in health care contexts, generally the law is not so inflexible that every transgression of this kind must be met with erasure.

Now, having said all that and those principles that you should bear in mind, you will of course look very carefully at the Hearings and Sanctions Guidance which set out, as the parties have demonstrated to you, the clear approach to considering the sort of sanction that should apply. I suggest you bear in mind those principles, as well as the Hearings and Sanctions Guidance, in arriving at your decision."

56 In my judgment, this case is in a different category to *Wisniewska* and *Arunachalam* and this puts into perspective Mr Paul's submissions about the reasoning and approach of the PCC in weighing the mitigating factors against the aggravating factors. As stated in *Bolton v Law Society*, where a case involves dishonesty by a solicitor, which strikes at the heart of the trust put into the solicitor's profession by the public, the protection of the reputation of the profession means that less regard will be had to personal mitigation. It seems to me that what is true of dishonesty in relation to solicitors is equally true of sexual relationships in relation to health care professionals.

57 Members of the public reveal to health care professionals their most intimate details and secrets in the belief that the professional will remain just that, professional and objective. The crossing of the boundary into a sexual relationship with the patient, and that is a sexual relationship of any kind, whether or not it includes penetrative sex, undermines the fundamental trust which patients put in their therapists and thus strikes at the heart of the

relationship between doctor or any other health care professional,including osteopaths, and patient.

58 For these reasons, again, I prefer the submissions of Mr Faux to those of Mr Paul in relation to sanction. Once we are into the realm of an inappropriate sexual relationship between an osteopath and his patient, the sanction of removal from the register must be within the reasonable band of sanctions available to the panel and this is archetypically the kind of case where the court should and does defer to the expertise, knowledge and experience of the panel.

59 In my judgment, the reasoning, albeit succinct, was adequate in explaining to the registrant and the public why the panel had decided to take the course which it did and this case does not approach the boundary where this court can say that the reasoning or decision was flawed so as to enable the court to quash the decision and substitute its own decision instead. Undoubtedly, the erasure of this appellant's name from the Register of Osteopaths is a loss to the profession and I refer, again, to the testimonials which with one voice refer to the great work which this appellant has done in this profession and in relation to many patients, but that is the price which this profession is prepared to pay to uphold its reputation generally and instil confidence in the public in the high standards which this profession rightly sets itself. The panel determined that this strong message needed to be sent out to the public and I am not prepared to say it was wrong in so doing.

60 For those reasons, this appeal is dismissed.

CERTIFICATE

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admin@opus2.digital

This transcript has been approved by the Judge.