Case No: CO/2495/2005

Neutral Citation Number: [2005] EWHC 2143 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: Friday, 14th October 2005

Before:

Mr Justice Collins

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Between:

Henricus GIELE	Appellant
- and -	
General Medical Council	Respondent

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(Transcript of the Handed Down Judgment of
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Kieran Coonan QC (instructed by Radcliffes Le Brasseur) for the Appellant
Eleanor GREY (instructed by Field Fisher Waterhouse) for the Respondent

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Judgment
As Approved by the Court

Mr Justice Collins:

1. This is an appeal against the sanction of erasure imposed by a Fitness to Practise Panel of the General Medical Council (GMC) on 19 March 2005. The sanction follows a finding of serious professional misconduct based upon a sexual relationship between the appellant and a patient, Mrs A, which lasted for over a year until about October 2002.

2. The appellant contested the allegations made against him, denying that there had been a sexual relationship and asserting that Mrs A had imagined that there had due to her mental state in that she was suffering from some sort of psychosis or erotomania. The Panel accepted that she had been truthful and rejected the appellant's account. Since his defence involved calling a number of expert witnesses to deal with Mrs A's mental state, the hearing took a very long time. It lasted no less than 29 days, spread over 15 months between December 2003 and March 2005. Hearings of these lengths which have to be conducted with substantial gaps due largely to the difficulties in bringing Panel members together are clearly undesirable. I am bound to say that to take 29 days for a case of this nature seemed to me to be prima facie unacceptable. One of the problems appears to be the lack of any means whereby the defence case can be properly identified in advance. It is apparent that the GMC should seriously consider amendments to its Rules to ensure that there is power, which should be exercised robustly but fairly to avoid unnecessary delays and length of hearings, to ensure that issues are properly identified and, so far as possible, evidence on both sides served in advance. I am not in a position to nor do I seek to cast any blame in this case, but the present system can undoubtedly result in a substantial and unnecessary expenditure of money which the profession through its contributions to the GMC will have to bear. The sooner steps are taken to avoid these altogether too lengthy hearings the better.

3. One of the effects of the procedure has been that the appellant and Mrs A had this hanging over their heads for a long time and, when the Panel eventually came to consider the appropriate sanction, well over 2 years had passed since the relationship had come to an end and the complaint to the GMC had been made.

4. The appellant was born on 30 November 1964 and so is now 40. He qualified as a doctor in Australia and in 1994 became a Fellow of the Royal Australian College of Surgeons. His speciality is plastic surgery. He came to the United Kingdom in 1995 as an overseas fellow in plastic surgery at the Radcliffe Infirmary and since 1997 he has been employed at the Radcliffe Infirmary and the Nuffield Orthopaedic Centre as consultant plastic, reconstructive and hand surgeon. He has been a Fellow of the Royal College of Surgeons since 1998. Apart from plastic surgery, he is an expert in reconstructive surgery, particularly to the hand.

5. I have used the word expert advisedly. There were before the Panel a large number of testimonials from colleagues, nurses and patients which spoke of his great talents as a surgeon. Many have repeated their views since the decision expressing their horror at the sanction because it will deprive the medical world of the services of a uniquely talented surgeon. In passing judgment, the Panel described him as 'a respected and competent surgeon, providing a valued service in a specialised field', and as a 'skilled and highly regarded consultant'. The testimonials use adjectives such as outstanding, excellent, invaluable and irreplaceable. He has been prepared to undertake surgery

which has been beyond the capacity of many others and has often been successful. A letter from a senior children's nurse at the Radcliffe says: -

> "Since the news was received that Mr Giele has been taken off the register I have taken phone calls from a number of parents of Mr Giele's patients, whose children still require further surgery. These parents start by asking if the news is true and when I reply it is, they then burst into tears. One mother said to me that it was only Mr Giele who hadn't given up on her child and she really did not know what she was going to do"

There are other letters from patients or their parents expressing the greatest dismay at the loss of his services and from colleagues who state that that loss will be a penalty imposed on his existing and future patients. In addition, he is clearly an inspirational teacher and trainer. It is worth quoting in full a letter from a colleague, which was before the Panel, and the contents of which were confirmed in a letter written since the decision. He writes: -

> "I give wholehearted support to Mr Henk Giele as a colleague, clinician and a person of integrity.
>
> I have worked with Henk Giele intermittently over the past seven years both during my training and subsequently as a consultant colleague. In my opinion he is one of the most outstanding plastic surgeons of his generation in terms of his technical mastery, his international reputation for innovation and research and his talents in medical education. He has remarkable clinical skill, and an enviable ability to communicate enthusiastically and honestly, putting both patients and his team at ease. He talks to patients with clarity, honesty and humility.
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> As a leader and educator he has an infectious enthusiasm for surgery, and is always surrounded by a dynamised team. He is popular with staff and is extremely good at multidisciplinary medicine with enviable insight and respect for other specialists and healthcare workers.
>
> Of all his attributes, I am most impressed by his constant striving to help patients with seemingly insolvable problems, achieving successes despite considerable odds. He has an amazing ability to empathise with the plight of patients (and the parents of children) with cancer, paralysis, chronic pain and deformity."

6. Mrs A is now 41. In December 2000 she was taken to the Radcliffe as an emergency suffering from Necrotising Fasciitis. The condition is sometimes popularly known as the flesh-eating bacteria. The appellant led a major operation which undoubtedly saved her life. When she came round she was told that by a nurse and so, not surprisingly, she was immensely grateful to the appellant. In early February 2001 she had to return to see the appellant because there were concerns that her scarring might

be infected. Her feelings towards him were, to use her own words, that she was 'quite in awe of him … I felt he was something of a hero'.

7. She needed a further operation which the appellant performed in June 2001. She saw the appellant on 31 July 2001. She described his attitude towards her as flirtatious. She said in her evidence: -

> "I have to tell you that, before that consultation, I had started to feel attracted towards Dr Giele. I felt that he was attracted to me, or I suspected that he was. By the end of that consultation, I was left in no doubt that he was."

At the end of August, she had a telephone conversation with the appellant and she felt that 'we had certainly … crossed the boundary between patient and doctor' and 'I admired him very much, and I was very attracted towards him, and I had started to look forward to seeing him at appointments'.

8. In mid September, she told the appellant of her feelings towards him and that she thought it was 'perhaps best to get things out into the open'. The first kiss came at a meeting in late September. On 24 October she went to his house in the evening and intercourse took place. About a week later, she went for the second time. It was not a great success since she drank too much and that, coupled with medication she was taking in the form of anti-depressants, made her ill.

9. It was at about this time that she was referred to a counsellor by her general practitioner. There is no indication that at any time before then the appellant was aware of any psychiatric problems. About a month later, she told the appellant she was seeing a therapist. According to her, he said he was sorry she had gone into counselling because of him, but he would still like to continue to see her. She continued: -

> "At that time, that is what I wanted too, so I continued to see him and I stopped therapy, which was completely the wrong way round."

10. Once the relationship had started, Mrs A received no treatment from the appellant. He remained on the hospital records as her consultant and as a result she received follow up appointments but she did not keep them. According to her, she asked him to take her off his list but he did not do so.

11. She used to speak to him regularly over the telephone. In the summer of 2002, he seemed to become distant and she thought the relationship was over. But she saw him and intercourse took place in September 2002. The last occasion was 2 October 2002. By then, affection had disappeared and in early November she told him she was going to the GMC. She did so.

12. It was suggested at the hearing that the relationship had had an adverse effect on Mrs A's recovery from her condition. She had had a day operation in August 2002 and had left the hospital before she should have done because, she said, she did not wish to come into contact with the appellant. This was somewhat curious since the sexual relationship continued until October. However, there was no justification for that

suggestion and certainly no proof that her after care had been in any way compromised.

13. The charge against the appellant was, as is the practice of the GMC, broken down into a series of allegations. They were set out in what is described as a Notice of Inquiry. It read: -

> "That, being registered under the Medical Act,
>
> 1. At all material times you were a consultant plastic surgeon employed by the Oxford Radcliffe NHS Trust ("the hospital")
>
> 2. On 21 December 2000 Mrs A was admitted to the hospital suffering from necrotising fasciitus and was referred to you for specialist care.
>
> 3. She remained under your care as an impatient and outpatient until 14 August 2002;
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> 4. From about July 2001 you conducted a relationship with Mrs A which was,
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> a. personal,
>
> b. flirtatious;
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> 5. From about October 2001 you conducted a sexual relationship with Mrs A;
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> 6. You knew, prior to the commencement of the sexual relationship or shortly thereafter, that Mrs A came from an unstable background and was emotionally fragile;
>
> 7. The relationship with Mrs A came to an end in about October 2002;
>
> 8. Your conduct at heads of charge 4 and 5 above was,
>
> a. inappropriate,
>
> b. an abuse of trust;
>
> 9. And that in relation to the facts you have been guilty of serious professional misconduct."

The appellant admitted heads 1,2, 4(a) (with the qualification that the relevant date was September 2001 instead of July 2001) and 7 only insofar as it related back to what was admitted in 4(a). All other heads were denied.

14. The Panel found all the heads proved as charged. They were satisfied that Mrs A had given a truthful account of her sexual relationship with the appellant. She was

suffering from a depressive illness at the material time but not from a psychotic illness. On those findings, the appellant's counsel accepted, as was inevitable, that he must be found guilty of serious professional misconduct.

15. To assist in deciding what should be the appropriate sanction, the Panel was referred to the Indicative Sanctions Guidance published by the GMC. The edition in force at the time was that of May 2004. As has now been confirmed in a number of decisions of this court, the contents of the Guidance are helpful and will assist to ensure that practitioners know what they may face if they are found guilty of serious professional misconduct and to promote consistency. However, it must always be borne in mind that the Guidance is what it says it is and does not lay down any rigid tariffs: each case will depend on its own facts.

16. Paragraph 10 sets out the purpose of the sanctions in these words: -

> "The purpose of the sanctions is not to be punitive, but to protect patients and the public interest, although they may have a punitive effect."

This is of fundamental importance. It recognises the two essential elements, which to some extent overlap. I do not think it is helpful to seek to analyse which of the two is the more important and it is equally clear that the need to protect patients extends to potential patients. Thus maintenance of the public's faith in the profession can ensure that those who need medical attention will not be inhibited from seeking it because they will know that doctors who are guilty of serious professional misconduct will be dealt with in an appropriate fashion.

17. Paragraphs 11 and 12 seek to explain what is covered by the public interest. They read: -

> "11. There is clear judicial authority that the public interest includes
>
> a. The protection of patients
>
> b. The maintenance of public confidence in the profession,
>
> c. Declaring and upholding proper standards of conduct.
>
> 12. The public interest may also include the doctor's return to safe work."

The point is then made that any sanction must be proportionate. The Regulations require that the Panel consider the possible sanctions in ascending order of severity, starting with reprimand and progressing through the imposition of conditions and suspension to erasure. The Guidance considers the philosophy behind the sanctions and some broad criteria as to their use. It states that erasure is appropriate where 'this is the only means of protecting patients and/or maintaining public confidence in the medical profession'. It cites an observation of Lord Hoffmann in *Bijl v GMC* [2002]

Lloyds Med. Rep. 60 at p.62 that the Panel's concern with public confidence in the profession should not be carried to the extent of feeling it necessary to sacrifice the career of 'an otherwise competent and useful doctor who presents no danger to the public in order to satisfy a demand for blame or punishment'. It goes on to say that those words should be weighed against observations of Sir Thomas Bingham, M.R., in *Bolton v Law Society* [1994] 1 W.L.R. 512 as approved by the Privy Council in *Gupta v GMC* [2002] 1 W.L.R. 1691. Those observations were: -

> "The reputation of the 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."

18. The guidance points out that decisions to erase have been upheld despite strong mitigation in particular in three areas, namely sexual misconduct, dishonesty and failing to provide an acceptable level of treatment or care. Sexual misconduct will be regarded as particularly serious where there is an abuse of the special position of trust, which a doctor occupies (see Paragraph 28). The GMC's publication Good Medical Practice made the point that doctors 'must not use their position to establish improper personal relationships with patients.'

19. Mrs A, as the Panel recorded in its reasons, 'admitted that she was persistent in pursuing the appellant, that she became obsessed with him, and was in love with him. She wanted him to reciprocate'. But that was no mitigation. There can be no doubt that the appellant did use his position as her doctor to establish and to maintain the relationship. It is not uncommon for doctors to earn gratitude from patients and in some case that gratitude can develop into more. But the doctor must resist any advances that are made since he must know that they have resulted from the doctor patient relationship. The misconduct will inevitably be regarded as more serious if the patient is vulnerable and this is why a psychiatrist will always be at greater risk of the most severe sanction since he will almost always know that his patient was particularly vulnerable. In this case, the appellant had no reason to suspect particular vulnerability when the relationship began, but by November 2001 he was aware that she was in need of counselling and was having therapy. The picture she painted was of him using her for his sexual needs but showing no intention of fostering any long term loving relationship. It follows that he must have been aware that the continuation of the relationship could harm her.

20. I have had to consider the correct approach in cases of sexual misconduct and the weight to be attached to testimonials in a number of cases. I do not intend to burden this judgment with lengthy explanations or citations from my and other judgments. In *Council for the Regulation of Healthcare Professionals v GMC & Southall* [2005] EWAC 579 (Admin), having cited extensively observations of Sir Thomas Bingham M.R. in *Bolton v Law Society* (supra) and Lord Hoffmann in *Bijl v GMC* (supra), I said this (Paragraph 14): -

> "It follows that in my view testimonials can in the case of doctors be accorded greater weight than in the case of solicitors. The requirement of absolute honesty so that there can be absolute trust in a solicitor is obviously of paramount importance. That he may be a good solicitor is obviously something to be taken into account, but the public interest in

> him being able to continue to practise is not so important. Thus testimonials which establish that a doctor is, in the view of eminent colleagues and of nursing staff who have worked with him, one who is not only competent but whose loss to the profession and to his potential patients would be serious indeed can, in my opinion, be accorded substantial weight."

21. The GMC has always regarded improper sexual relationships with patients as misconduct which is very serious indeed. They will often constitute an abuse of trust and will be particularly reprehensible if the patient is vulnerable and known to be so by the doctor. In the past, erasure was virtually automatic and was almost always upheld by the Privy Council on appeal. The legal assessor in this case put before the Panel a synopsis of a number of cases involving sanctions for improper relationships with patients. Many of them were ancient. This was in my judgment entirely unhelpful. Before 2000, a doctor who had been erased could apply for reinstatement after 10 months. Thus in many cases, apart from the stigma of erasure, the effect was no more than suspension. Now, erasure is for a minimum of 5 years. This means that there will be an inevitable loss of skill and for some, particularly if they are older, it will spell the end of their career. It will certainly be very difficult indeed to resume practice. It is this problem of lack of practice leading to loss of skill that led Mr Coonan (who did not appear below) to say that, if suspension were to be ordered instead of erasure, it would be appropriate to impose a requirement that there be a hearing towards the end of the period of suspension to decide whether any conditions should be imposed to ensure that when he resumed practice the appellant should undergo any necessary retraining or monitoring.

22. I do not suggest that improper relationships with patients are regarded any less seriously. When she addressed the Panel on the appropriate sanction, counsel for the GMC cited observations of mine in *Bevan v GMC* [2005] EWAC 174 (Admin). She said: -

> "We submit that 'sexual relationships with a patient will lead the Panel in any but the most exceptional case to think in terms of erasure' and that is a quotation from the case referred to yesterday involving Dr Bevan. We submit that this is not an exceptional case and therefore do invite the Panel to consider erasure."

What I said in *Bevan's* case at paragraph 20 was this: -

> "Sexual relationships with a patient will lead the [Panel] in any but the most exceptional case to think in terms of erasure, but erasure is not inevitable. Suspension will be sufficient if there are circumstances, which show that leniency is appropriate, particularly bearing in mind that an application for reinstatement cannot be made for at least 5 years, whereas suspension can last for at most 12 months in the first instance, that being subject to a power to extend the period or to impose conditions on its expiry."

23. I have said elsewhere that for a doctor to engage in an improper relationship is to court erasure. But I have also emphasised that erasure is not to be regarded as inevitable. Nor did I say that erasure would be the appropriate sanction in any but an exceptional case. The Panel would think in terms of erasure but would only erase if that was in the circumstances of the particular case 'the only means of protecting patients and/or maintaining public confidence in the medical profession': see Paragraph 22 of the Indicative Sanctions Guidance.

24. In giving the advice to the Panel, the legal assessor said this: -

> "I would remind you of various cases that may or may not help you in your decision about sanctions. Essentially the bulk of the cases go to this type or set of offences. Sexual misconduct with vulnerable patients tend to attract erasure but, as [counsel for the appellant] has said, if you feel there are exceptional circumstances, you may, if you so wish, reduce that – if I can call it that – to suspension.
>
> Suspension generally is used where the penalty would seem to be outside the range of what is reasonable or may if it were to be erasure. You have to ask yourselves, 'Is this reasonable?' 'Is it going to be wrong to erase in this case?' 'Are there exceptional circumstances?'"

25. She referred to a number of cases, but, as I understand it, only summaries were available to the Panel.

26. That advice was erroneous. The Panel had to approach the question of sanctions starting with the least severe. It was not a question of deciding whether erasure was wrong but whether it was right for the misconduct in question after considering any lesser sanction. Furthermore, it was wrong to ask whether there were exceptional circumstances to avoid erasure. Exceptional circumstances would only avoid the possibility of erasure. A panel member asked whether there was any definition of exceptional circumstances and was given no satisfactory answer. That is not surprising since what is exceptional will depend on the facts of a particular case. But in my judgment it was in this case and will in most cases be unhelpful to talk in terms of exceptional circumstances. The Panel must look at the misconduct and the mitigation and decide what sanction is appropriate, no doubt bearing in mind that improper sexual relationships with a vulnerable patient are always regarded as most serious. That the Panel did have regard to the advice from the assessor is clear from these words in its judgment: -

> "Notwithstanding the impressive mitigation advanced on Mr Giele's behalf, the Panel determined that suspension would neither protect the public interest nor would it be sufficient to maintain public confidence in the profession. The Panel considered whether there might be exceptional circumstances in this case which could lead to the imposition of a lesser sanction. It decided that there were no exceptional circumstances in this case and that the proportionate sanction was therefore that of erasure."

Before saying this, the Panel had said that it had considered the appropriate sanction starting at the lowest. However, what it said shows that it did not carry out its functions in a proper way since it was influenced by the wrong advice given to it.

27. There was no suggestion that patients would be endangered if the appellant was permitted to continue to practise. There was no risk that he would behave in such a way again. There was no indication of inappropriate behaviour with patients in his past and the testimonials gave no support to any concerns in that regard. Thus the Panel properly directed itself that it had to balance the interests of existing and potential patients in having access to a competent surgeon against the wider public interest in the maintenance of confidence in the profession, the upholding of proper standards of conduct and confidence in the system of professionally led regulation.

28. The Panel cited observations of Lightman, J in *Wentzel v GMC* [2004] EWHC 381 Admin. Dr Wentzel was responsible for the inpatient care of the complainant in that case at a psychiatric hospital. He formed an inappropriate relationship with her and, in breach of instructions from the Trust for which he worked, pursued that relationship, which included sexual intercourse in the full knowledge of the complainant's vulnerability. She attempted suicide. He denied sexual intercourse had taken place, but the Committee found that it had. The three interests which had to be weighed were public confidence in the medical profession, the public interest in retaining the services of a doctor with considerable abilities and commitments and the interest of the doctor in not having his career cut short. Lightman, J decided that, of those three, the maintenance of public confidence in the medical profession was the paramount interest.

29. I do not doubt that the maintenance of public confidence in the profession must outweigh the interests of the individual doctor. But that confidence will surely be maintained by imposing such sanction as is in all the circumstances appropriate. Thus in considering the maintenance of confidence, the existence of a public interest in not ending the career of a competent doctor will play a part. Furthermore, the fact that many patients and colleagues have, in the knowledge of the misconduct found, clearly indicated their views that erasure was not needed is a matter which can carry some weight in deciding how confidence can properly be maintained. It is, incidentally, not in the least surprising that Dr Wentzel's appeal was dismissed, having regard to the facts of his case.

30. Ms Grey submitted that it would be wrong to allow a practitioner who was more skilled and whose loss would accordingly be a greater blow to avoid a sanction which would otherwise be appropriate and would have been imposed on the less skilled. So long as the public interest in retaining the services of a competent practitioner is a relevant consideration, it is inevitable that the weight to be attached to this aspect will to some extent depend on the abilities of the practitioner in question. It must be obvious that misconduct which is so serious that nothing less than erasure would be considered appropriate cannot attract a lesser sanction simply because the practitioner is particularly skilful. But if erasure is not necessarily required, the skills of the practitioner are a relevant factor.

31. The appellant chose to contest the allegations and so to put Mrs A through the ordeal of giving evidence and being subjected to hostile cross-examination. This cannot properly be used to justify the imposition of a more severe sanction than the

misconduct deserved, but it does mean that there was no mitigation. It disclosed a lack of remorse or regret and such conduct may in some cases (but not in this case) indicate a lack of insight so that it can be said that there was a danger of recurrence. It was undoubtedly a matter which the Panel could take into account.

32. There were in this case some aggravating features. The relationship continued when the appellant was aware of Mrs A's vulnerability and he does seem to an extent to have been using her for his sexual gratification. Although she set her cap at him, he took advantage of her and undoubtedly abused his position as her surgeon. Nevertheless, I am satisfied that erasure, which would be likely if not to end his career at least to make it extremely difficult to commence practice again, was not essential. Equally, if there had been no question of any erroneous self-direction, I might have found it difficult to say that the decision was clearly wrong. I bear in mind that the Panel has its own expertise. Ms Grey submitted that in judging what was necessary to maintain public confidence in the profession the Panel was in a better position than a judge of this court. While I entirely accept that due weight must be attached to the Panel's judgment, I do not believe that the Panel will necessarily 'have a greater familiarity with current issues which touch upon that matter' (to use Ms Grey's language). If there is some special factor, the Panel should indicate what it is. If it does not, I do not see why a properly advised judge should be in a worse position at least where matters of professional competence are not in issue.

33. There can be no doubt that the improper sexual relationship which was established in this case could have merited erasure. However, the mitigation and in particular the testimonials might well have tipped the balance against it. But the Panel approached the issue of sanction in the wrong way, clearly believing that there should be erasure unless exceptional circumstances existed. Accordingly, I am entitled to form my own view. I am entirely satisfied that erasure was not required and that public confidence in the profession, which must reflect the views of an informed and reasonable member of the public, would not be harmed if suspension was imposed. Suspension for 12 months is itself a severe penalty for any practitioner and I am satisfied that for the misconduct in this case it will provide an appropriate sanction.

34. As I have already said, Mr Coonan himself submitted that there should be consideration at the end of that period whether any further action should be taken. I do not think that (subject of course to the appellant acting inappropriately during the period of suspension) there is likely to be any justification for extending the period of suspension, but conditions may be needed to ensure that the appellant demonstrates all necessary skills to go back to practice as a consultant surgeon. I am far from saying that any conditions will be needed; that will be a matter for the relevant panel in due course.

35. Accordingly, I shall allow this appeal and quash the decision that the appellant be erased. I do not propose to remit it for reconsideration since I am, as I have indicated, satisfied that suspension is the right sanction. I shall therefore substitute a suspension for 12 months with a requirement that there be a further hearing at the end of that period to determine whether any further action is needed.