Neutral Citation Number: [2023] EWHC 1918 (Admin)

Case No: CO/154/2023

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26/07/2023

Before :

THE HON. MRS JUSTICE STEYN DBE

- -

Between :

Dr Antonio METASTASIO	**Appellant**
- and -	
GENERAL MEDICAL COUNCIL	**Respondent**

- -
- -

Ben Rich (instructed by **Weightmans LLP**) for the **Appellant**
Peter Mant (instructed by **GMC Legal**) for the **Respondent**

Hearing date: 5 July 2023

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 26 July 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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THE HON. MRS JUSTICE STEYN DBE

Mrs Justice Steyn :

A. Introduction

1. On 8 December 2022, a Medical Practitioners Tribunal ('the Tribunal') directed that the name of Dr Antonio Metastasio should be erased from the medical register on grounds of misconduct. Dr Metastasio appeals against that decision pursuant to s.40 of the Medical Act 1983.

2. Dr Metastasio trained and qualified as a Psychiatrist, becoming a Member of the Royal College of Psychiatrists in 2009. At the relevant time he was practising as a Consultant Psychiatrist for Camden and Islington NHS Trust ('the Trust'), which ran Highgate Mental Health Centre ('Highgate MHC').

3. On 22 November 2017, a young woman ('Patient A'), who had diagnoses of Emotionally Unstable Personality Disorder ('EUPD') and Bipolar Affective Disorder, was referred by South Camden Crisis Resolution Team ('the Crisis Team') to St Pancras Hospital in relation to risk of suicide, alcohol addiction and use of cocaine. Shortly thereafter, Patient A was transferred and admitted to Highgate MHC. She was an in-patient at Highgate MHC between 23 and 30 November 2017. Whilst Patient A was an in-patient, Dr Metastasio was her treating Consultant Psychiatrist. It was in this capacity that he first met Patient A. He had four direct interactions with Patient A whilst she was an in-patient, speaking to her during ward rounds on 23, 27, 28 and 30 November 2017.

4. The allegations against Dr Metastasio arose from his contact with Patient A after she had been an in-patient at Highgate MHC. Patient A, using a pseudonym (which I shall refer to as 'M'), was working as a sex worker and appearing in pornographic films. In 2018, Dr Metastasio began following M on social media, he contacted her several times, paid her for sexual services on 14 February 2019, and then sought a further meeting with her in August 2020. Patient A complained to the Trust when Dr Metastasio contacted her again in August 2020. In short, the Tribunal found that Dr Metastasio had engaged in this conduct knowing that 'M' was his former patient. The Tribunal concluded that his fitness to practise was impaired by reason of misconduct and that the only appropriate and sufficient sanction was one of erasure.

5. The grounds of appeal are:

   i) Ground 1: The Tribunal's finding of fact that the Appellant knew that M, the sex worker and "*porn star*" who he approached for sexual services, was Patient A who he had treated, was wrong and contrary to the evidence. This ground relates to allegations 7(a) and 7(b)(i) and (ii).

   ii) Ground 2: The Tribunal's factual findings on allegations 1(a), 4(a)(i) and (ii), 4(b), 4(c)(i) and (iii) and 6(a) were based on the finding referred to in Ground 1. If that finding was wrong, these consequential findings cannot stand. In any event, the Appellant contends that they were wrongly made, given all the evidence before the Tribunal.

   iii) Ground 3: If the appeal succeeds on Ground 1 and/or Ground 2, then the finding of current impairment of Dr Metastasio's fitness to practise cannot stand.

iv) Ground 4: If the factual findings and impairment decision are found to have been wrongly made (i.e. if the appeal succeeds on Grounds 1 and/or 2 and 3), then the sanction decision cannot stand.

v) Ground 5: Even if the preceding grounds fail, the sanction of erasure was wrong in all the circumstances. The Tribunal should have imposed a lesser sanction, such as suspension.

6. At the outset of the hearing I made an anonymity order, pursuant to CPR 39.2(4), that the identity of 'Patient A'/'M' must not be disclosed. This order is necessary to protect her interests given the clear evidence that she is vulnerable by reason of her mental health.

B. <u>The legal framework</u>

The over-arching objective

7. The "*over-arching objective*" of the General Medical Council ('the GMC') in exercising their functions is the protection of the public: s.1(1A) of the Medical Act 1983 ('the 1983 Act'). Section 1(1B) of the 1983 Act provides:

> "The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—
>
> (a) to protect, promote and maintain the health, safety and well-being of the public,
>
> (b) to promote and maintain public confidence in the medical profession, and
>
> (c) to promote and maintain proper professional standards and conduct for members of that profession."

The Tribunal's three-stage approach

8. Where an allegation is made against a registered medical practitioner under s.35C of the 1983 Act, the Medical Practitioners Tribunal Service must arrange for the Tribunal to consider the allegation. The Tribunal's consideration proceeds in three stages. First, the Tribunal makes findings as to which (if any) of the factual allegations have been proved. Then the Tribunal determines on the basis of the proven allegation whether the medical practitioner's fitness to practise is impaired. Finally, the Tribunal makes a determination as to sanction.

Appeal by way of re-hearing

9. Medical practitioners have a statutory right of appeal to challenge a decision of the Tribunal. Section 40 of the 1983 Act provides, so far as relevant,

> "(1) The following decisions are appealable decisions for the purposes of this section, that is to say—

> (a) a decision of a Medical Practitioners Tribunal under section 35D above giving a direction for erasure, for suspension or for conditional registration or varying the conditions imposed by a direction for conditional registration;
>
> …
>
> (4) A person in respect of whom an appealable decision falling within subsection (1) has been taken may, before the end of the period of 28 days beginning with the date on which notification of the decision was served under section 35E(1) above, or section 41(10) below, appeal against the decision to the relevant court.
>
> …
>
> (5) In subsections (4) and (4A) above, "the relevant court"—
>
> …(c) in the case of any other person means the High Court of Justice in England and Wales.
>
> (7) On an appeal under this section from a Medical Practitioners Tribunal, the court may—
>
> (a) dismiss the appeal;
>
> (b) allow the appeal and quash the direction or variation appealed against;
>
> (c) substitute for the direction or variation appealed against any other direction or variation which could have been given or made by a Medical Practitioners Tribunal; 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 … as it thinks fit.
>
> (9) On an appeal under this section from a Medical Practitioners Tribunal, the General Council may appear as respondent; and for the purpose of enabling directions to be given as to the costs of any such appeal the Council shall be deemed to be a party thereto, whether they appear on the hearing of the appeal or not."

10. CPR r.52.21 provides, so far as relevant:

> "(1) Every appeal will be limited to a review of the decision of the lower court unless – (a) a practice direction makes different provision for a particular category of appeal; or (b) the court considers that in the circumstances of an individual appeal it would be in the interests of justice to hold a re-hearing.

> (2) Unless it orders otherwise, the appeal court will not receive – (a) oral evidence; or (b) evidence which was not before the lower court.
>
> (3) The appeal court will allow an appeal where the decision of the court was – (a) wrong; or (b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court.
>
> (4) The appeal court may draw any inference of fact which it considers justified on the evidence. …"

11. CPR PD 52D, para 19.1 states:

> "(1) This paragraph applies to an appeal to the High Court under … (e) section 40 of the Medical Act 1983; …
>
> (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 re-hearing."

12. In *Sastry v General Medical Council* [2021] EWCA Civ 623, [2021]] 1 WLR 5029, Nicola Davies LJ (giving the judgment of the Court) observed at [102]:

> "Derived from *Ghosh* are the following points as to the nature and extent of the section 40 appeal and the approach of the appellate court: (i) an unqualified statutory right of appeal; (ii) the jurisdiction of the court is appellate, not supervisory; (iii) the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the tribunal; (iv) the appellate court will not defer to the judgment of the tribunal more than is warranted by the circumstances; (v) the appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate; (vi) in the latter event, the court should substitute some other penalty or remit the case to the tribunal for reconsideration."

13. In *Sastry* at [108], the Court of Appeal affirmed that the approach identified by the Privy Council in *Ghosh* [2001] 1 WLR 1915, and approved by the Supreme Court in *Khan* [2017] 1 WLR 169, is appropriate in section 40 appeals which are by way of re-hearing.

The approach on appeal to the Tribunal's findings of fact and inferences

14. In *Gupta v General Medical Council* [2001] UKPC 61 [2002] 1 WLR 1691, Lord Rodger observed at [10] that:

> "… the appeals are conducted on the basis of the transcript of the hearing and that, unless exceptionally, witnesses are not recalled. In this respect these appeals are similar to many other appeals in

> both civil and criminal cases from a judge, jury or other body who has seen and heard the witnesses. In all such cases the appeal court readily acknowledges that the first instance body enjoys an advantage which the appeal court does not have, precisely because that body is in a better position to judge the credibility and reliability of the evidence given by the witnesses. In some appeals that advantage may not be significant since the witnesses' credibility and reliability are not in issue. But in many cases the advantage is very significant and the appeal court recognises that it should accordingly be slow to interfere with the decisions on matters of fact taken by the first instance body. The reluctance to interfere is not due to any lack of jurisdiction to do so. Rather, in exercising its full jurisdiction, the appeal court acknowledges that, if the first instance body has observed the witnesses and weighed their evidence, its decision on such matters is more likely to be correct than any decision of a court which cannot deploy those factors when assessing the position. In considering appeals on matters of fact from the various professional conduct committees, the Board must inevitably follow the same general approach. Which means that, where acute issues arise as to the credibility or reliability of the evidence given before such a committee, the Board, duly exercising its appellate function, will tend to be unable properly to differ from the decisions as to fact reached by the committee except in the kinds of situation described by Lord Thankerton in the well known passage in *Watt or Thomas v Thomas* [1947] AC 484, 487-488." (Emphasis added.)

15. In *General Medical Council v Jagjivan* [2017] EWHC 1247 (Admin), Sharp LJ observed at [40(iii) and (iv)]:

> "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)* [2002] EWCA Civ 1642; [2003] 1 WLR 577, at paragraphs 15 to 17, cited with approval in *Datec Electronic Holdings Ltd v United Parcels Service Ltd* [2007] UKHL 23, [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)."

16. Mostyn J addressed [40(iii) and (iv)] of *Jagjivan* in *Sait v General Medical Council* [2019] EWHC 3279 (Admin) at [16]:

> "I agree with these statements where the specific facts from which inferences are drawn, or the evaluation formed, are undisputed or derive from unchallengeable documents. But where the underlying specific facts themselves are found, and the evaluation formed, following oral evidence in respect of which a credibility assessment has been made, then it seems to me that there must be no less appellate caution applied as would be the case where the challenge is to a primary concrete fact. This much is clear from the judgment of Lord Hodge in *Beacon Insurance Company Ltd v Maharaj Bookstore Ltd* [2014] UKPC 21. He stated:
>
>> 16. In *Piglowska v Piglowski* [1999] 1 WLR 1360, 1372 Lord Hoffmann referred to the advantage that a judge at first instance had in seeing the parties and the other witnesses when deciding questions of credibility and findings of primary fact. He suggested that an appellate court should also be slow to reverse a trial judge's evaluation of the facts and quoted from his earlier judgment in *Biogen Inc v Medeva plc* [1997] RPC 1, 45:
>>
>>> "The need for appellate caution in reversing the trial judge's evaluation of the facts is based upon much more solid grounds than professional courtesy. It is because specific findings of fact, even by the most meticulous judge, are inherently an incomplete statement of the impression which was made upon him by the primary evidence. His expressed findings are always surrounded by a penumbra of imprecision as to emphasis, relative weight, minor qualification and nuance … of which time and language do not permit exact expression, but which may play an important part in the judge's overall evaluation."
>>
>> 17. Where a judge draws inferences from his findings of primary fact which have been dependent on his assessment of the credibility or reliability of witnesses, who have given oral evidence, and of the weight to be attached to their evidence, an appellate court may have to be similarly cautious in its approach to his findings of such secondary facts and his evaluation of the evidence as a whole. In *re B (a Child)* (above) Lord Neuberger at para 60 acknowledged that the advantages that a trial judge has over an appellate court in matters of evaluation will vary from case to case. The form, oral or written, of the evidence which formed the basis on which the trial judge made findings of primary fact and whether that evidence was disputed are important variables. As Lord Bridge of Harwich stated in *Whitehouse v Jordan* [1981] 1 WLR 246, 269-270:

> "[T]he importance of the part played by those advantages in assisting the judge to any particular conclusion of fact varies through a wide spectrum from, at one end, a straight conflict of primary fact between witnesses, where credibility is crucial and the appellate court can hardly ever interfere, to, at the other end, an inference from undisputed primary facts, where the appellate court is in just as good a position as the trial judge to make the decision."

See also Lord Fraser of Tullybelton, at p 263G-H; *Saunders v Adderley* [1999] 1 WLR 884 (PC), Sir John Balcombe at p889E; and *Assicurazioni Generali SpA v Arab Insurance Group (Practice Note)* [2003] 1 WLR 577 (CA), Clarke LJ at paras 12-17. Where the honesty of a witness is a central issue in the case, one is close to the former end of the spectrum as the advantage which the trial judge has had in assessing the credibility and reliability of oral evidence is not available to the appellate court. Where a trial judge is able to make his findings of fact based entirely or almost entirely on undisputed documents, one will be close to the latter end of the spectrum."

17. In *R (Dutta) v General Medical Council* [2020] EWHC 1974 (Admin), Warby J observed:

> "21. … the points of most importance for the purpose of this case can be summarised as follows:
>
> (1) The appeal is not a re-hearing in the sense that the appeal court starts afresh, without regard to what has gone before, or (save in exceptional circumstances) that it re-hears the evidence that was before the Tribunal. 'Re-hearing' is an elastic notion, but generally indicates a more intensive process than a review: *E I Dupont de Nemours & Co v ST Dupont (Note)* [2006] 1 WLR 2793 [92-98]. The test is not the 'Wednesbury' test.
>
> (2) That said, the appellant has the burden of showing that the Tribunal's decision is wrong or unjust: *Yassin* [32(i)]. The Court will have regard to the decision of the lower court and give it 'the weight that it deserves': *Meadow* [128] (Auld LJ, citing *Dupont* [96] (May LJ)).
>
> (3) A court asked to interfere with findings of fact made by a lower court or Tribunal may only do so in limited circumstances. Although this Court has the same documents as the Tribunal, the oral evidence is before this Court in the form of transcripts, rather than live evidence. The appeal Court must bear in mind the advantages which the Tribunal has of hearing and seeing the witnesses, and should be slow to interfere. See *Gupta* [10], *Casey* [6(a)], *Yassin* [32(iii)].

> (4) Where there is no question of a misdirection, an appellate court should not come to a different conclusion from the tribunal of fact unless it is satisfied that any advantage enjoyed by the lower court or tribunal by reason of seeing and hearing the witnesses could not be sufficient to explain or justify its conclusions: *Casey* [6(a)].
>
> (5) In this context, the test for deciding whether a finding of fact is against the evidence is whether that finding exceeds the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible: *Yassin* [32(v)].
>
> (6) The appeal Court should only draw an inference which differs from that of the Tribunal, or interfere with a finding of secondary fact, if there are objective grounds to justify this: *Yassin* [32(viii)].
>
> (7) But the appeal Court will not defer to the judgment of the tribunal of fact more than is warranted in the circumstances; it may be satisfied that the tribunal has not taken proper advantage of the benefits it has, either because the reasons given are not satisfactory, or because it unmistakably so appears from the evidence: *Casey* [6(a)] and cases there cited, which include *Raschid* and *Gupta* (above) and *Meadow* [125-126], [197] (Auld LJ). Another way of putting the matter is that the appeal Court may interfere if the finding of fact is 'so out of tune with the evidence properly read as to be unreasonable': *Casey* [6(c)], citing *Southall* [47] (Leveson LJ).
>
> 22. Ms Hearnden places heavy reliance on another passage from *Southall* [47], where Leveson LJ observed that:
>
> '… it is very well established that findings of primary fact, particularly if founded upon an assessment of the credibility of witnesses, are virtually unassailable.'
>
> However, it is clear from paragraph [47] read as a whole, that this sentence does not purport to represent a distinct principle, imposing a more exacting test than those I have identified. Rather, it is intended to be a distillation of the jurisprudence I have summarised. …"

The Sanctions Guidance

18. The GMC has published guidance to tribunals on imposing sanctions on a doctor's registration ('the Sanctions guidance'). Paragraph 14 of the Sanctions guidance states:

> "The main reason for imposing sanctions is to protect the public. This is the statutory overarching objective, which includes to:

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

19. Paragraph 17 of the Sanctions guidance states:

> "Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession (see paragraph 65 of *Good medical practice*). Although the tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor."

20. In deciding what sanction, if any, to impose the tribunal should consider the sanctions available, starting with the least restrictive, and it should have regard to the principle of proportionality. However, once the tribunal has determined that a certain sanction is necessary to protect the public, and is therefore the minimum action required to do so, that sanction must be imposed: Sanctions guidance, §§20-21.

21. Where a tribunal finds a doctor's fitness to practise is impaired by reason of misconduct, it can (a) take no action; (b) agree to accept undertakings that have been agreed between the doctor and the GMC; (c) impose conditions on the doctor's registration for up to three years; (d) suspend the doctor's registration for up to 12 months; or (e) erase the doctor's name from the medical register: Sanctions guidance, §66. If the sanction of erasure is imposed, the doctor "*cannot apply to be restored to the medical register until five years have elapsed*": Sanctions guidance, §111.

22. In relation to suspension, the Sanctions guidance states:

> "92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. <u>A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration</u> (ie 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).
>
> …
>
> 97 <u>Some or all of the following factors being present</u> (this list is not exhaustive) <u>would indicate suspension may be appropriate</u>.

a A serious breach of *Good medical practice*, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.

…

e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f No evidence of repetition of similar behaviour since incident.

g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour." (Emphasis added.)

23. In relation to erasure the Sanctions guidance states:

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

109 <u>Any of the following factors being present may indicate erasure is appropriate</u> (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 129–132 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 Offences of a sexual nature, including involvement in child sex abuse materials (see further guidance below at paragraphs 151 - 159).

g Offences involving violence.

h Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 120–128).

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 Persistent lack of insight into the seriousness of their actions or the consequences." (Emphasis added.)

24. Under the heading "*Cases that indicate more serious action is likely to be required*", the Sanctions guidance states (omitting footnotes):

"**Abuse of professional position**

…

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

144. Personal relationships with former patients may also be inappropriate depending on:

a the nature of the previous professional relationship

b the length of time since it ended (doctors must not end a professional relationship with a patient solely to pursue a personal relationship with them – see *Maintaining a professional boundary between you and your patient*)

c the vulnerability of the patient (see paragraphs 145–146)

d whether the doctor is caring for other members of the family.

Vulnerable patients

145 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
>
> …
>
> e history of abuse or neglect.
>
> 146 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.
>
> **Predatory behaviour**
>
> 147 If a doctor has demonstrated predatory behaviour, motivated by a desire to establish a sexual or inappropriate emotional relationship with a patient, there is a significant risk to patient safety, and to public confidence and/or trust in doctors. More serious action is likely to be appropriate where there is evidence of (this list is not exhaustive):
>
> a inappropriate use of social networking sites to approach a patient outside the doctor-patient relationship
>
> …
>
> 148 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."

25. In *Bevan v General Medical Council* [2005] EWHC 174 (Admin), Collins J stated:

> "19. Every medical practitioner must know that a sexual relationship with a patient will almost inevitably be regarded as serious professional misconduct and will court erasure. There is always the element of a breach of trust and a concern that advantage is being taken of a vulnerable individual. This is particularly the case where a patient has any psychiatric problems and it is not in those circumstances surprising that erasure has been upheld, however harsh the penalty might seem, where a psychiatrist has entered into such a relationship with one of his patients.
>
> …
>
> 49. It is of course necessary that doctors who transgress and are guilty of sufficiently serious professional misconduct should be erased, even though they are good doctors otherwise. It is of course axiomatic that if there is any danger of repetition erasure

will be appropriate. But, as I have said, sexual relations with a patient do not in my judgment automatically mean that there must be erasure, albeit they may mean that erasure will be considered as an option, and indeed perhaps even as the most probable option in most cases. But it is also in the public interest that good doctors should be able to continue in practice if that can be done consistently with the sending out of the message that particular forms of conduct will not be tolerated and the public can be satisfied that serious penalties will result."

C. The Allegations

26. The Allegations considered by the Tribunal were:

"That being registered under the Medical Act 1983 (as amended):

1. Subsequent to treating Patient A as an inpatient in Highgate Mental Health Centre between 23 and 30 November 2017, you:
   a. inappropriately followed Patient A on Twitter in 2018;
   b. sent Patient A messages, asking to meet her:

      i. via Twitter on:
         1. 30 May 2018;
         2. 18 October 2018;
         3. 21 December 2018;
      ii. via the inbox of a website named in Schedule 1 ('the Website') between October 2018 and February 2019.

2. On or before 14 February 2019, you booked to meet Patient A through the Website.

3. On 14 February 2019, you
   a. met with Patient A ('the Contact');
   b. gave Patient A alcohol;
   c. paid Patient A for sexual contact and/or intercourse;
   d. engaged in sexual contact and/or intercourse with Patient A.

4. During the Contact with Patient A you:
   a. referred to:
      i. previously treating Patient A;
      ii. matters relevant to her health as described at Schedule 2;
   b. asked Patient A not to tell anyone about the Contact;
   c. told Patient A that you:
      i. had recognised her;
      ii. did not want to be 'Me too'd' or words to that effect;
      iii. may get into trouble.

> 5. On 26 August 2020, you sent Patient A a message via WhatsApp requesting to meet up with Patient A.
>
> 6. Your conduct at the following paragraphs was sexually motivated:
> a. Paragraph 1;
> b. Paragraph 2;
> c. Paragraph 3a to 3c;
> d. Paragraph 5.
>
> 7. You engaged in the conduct as set out in paragraphs 1 to 5 when you knew:
> a. Patient A had been your former patient;
> b. Patient A was and/or had previously been vulnerable due to:
> i. the nature of the matters set out in Schedule 3;
> ii. your previous treatment of Patient A.
>
> And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct."

27. Dr Metastasio made no formal admissions to any of the allegations, as framed. But there was a substantial degree of common ground as to the facts. In particular, Dr Metastasio admitted that he began following 'M' on Twitter in April/May 2018; sent messages to her via Twitter on 30 May 2018, 18 October 2018 and 21 December 2018 seeking to meet her; booked to meet 'M' via the AdultWork website on 14 February 2019; met 'M' on 14 February 2019 and engaged in oral sex for which he paid her; and then sent her a message via WhatsApp on 26 August 2020 seeking to meet her again. There was also no dispute that Patient A and M were, in fact, the same person.

28. The central issue was whether Dr Metastasio knew when he engaged in the conduct described that she had been his patient. The Tribunal rejected Dr Metastasio's evidence that he did not recognise her or know she was a former patient.

D. Grounds 1 and 2: the Tribunal's findings on the issue of knowledge and credibility

29. The Appellant submits that the Tribunal's chain of reasoning was, first, that Dr Metastasio was aware in November 2017, when Patient A was an in-patient at Highgate MHC, that she was a sex worker; secondly, flowing from that initial finding, that when he saw her Twitter account in Spring 2018 that he recognised her and; thirdly, they inferred that it was not a coincidence that he found her.

30. The Appellant contends that it was only because the Tribunal had already made those findings that it considered the inconsistencies in Patient A's account were insufficient to undermine her credibility. The Appellant submits that the initial findings are flawed, and as a consequence the whole chain of reasoning breaks down. On behalf of the Appellant, Mr Ben Rich acknowledges that findings of primary fact, if founded upon an assessment of the credibility of witnesses, are "*virtually unassailable*" (*Southall*, [47]), but he submits that the challenge here is largely to the inferences the Tribunal drew rather than to primary facts, and so the court is under less of a disadvantage and

may draw the inferences it considers justified in accordance with *Jagjivan* (see paragraph 15 above).

31. In my judgment, the Appellant's criticisms are not justified. The Tribunal determined, on the balance of probabilities, that "*Dr Metastasio would have been aware of Patient A's activity as a sex worker whilst she was an in-patient*" at Highgate MHC (Determination on Facts, §34). The analysis underlying this conclusion was as follows.

32. First, the "*care notes*" which were uploaded by the Crisis Team, and made immediately available to Highgate MHC (Dr Metastasio's evidence, transcript day 2, 81A-B), recorded Patient's A "*risk event history*" in the following terms:

> "SCCRT Gatekeeping 22/11/17
> Nil new risks identified
>
> SCCRT DISCHARGE 26/09/17:
> Nil new risks identified
> [Patient A] <u>continues to work in the sex industry as a porn model</u>, if her mental state was to decline her risk of exploitation may increase as her risk taking behaviours increase.
> She is currently demonstrating capacity to make these work decisions and <u>wishes to continue this modelling work</u>."
>
> (Emphasis added; Determination on Facts, §29)

33. Secondly, the context in which Patient A was admitted to Highgate MHC on 23 November 2017 was that she "*had suicidal ideation and increasingly strong thoughts of taking an overdose*". The Tribunal was "*mindful that one of the 'risk factors' highlighted in the medical notes was that Patient A was a sex worker*". (Determination on Facts, §30) The Tribunal stated:

> "… the fact that she was a sex worker was a significant part of Patient A's history, and a very relevant factor that had to be considered by those treating her both in respect of her suicide risk and her alcoholism" (Determination on Facts, §32).

34. I note that Dr Metastasio described "*her suicidality*" as "*the main risk*" at the time (transcript day 2, 81F). Although earlier in his evidence he had suggested that being a sex worker was not, *per se*, a risk factor, in response to questions from the Chair, he acknowledged that the fact that Patient A "*was continuing to work in the sex industry, certainly in the relatively recent past*" would have been "*relevant to the assessment of her suicide risk*"; and in response to the question whether he would "*expect either a nurse or the junior doctor who is providing you with the handover to give you that information as relevant information to risk*", he said "*yes, yes, yes*" (transcript, day 2, 123D-H).

35. Thirdly, the Tribunal acknowledged that the "*notes of the face-to-face meetings between Patient A and Dr Metastasio did not contain any reference to her work as a sex worker*". This was consistent with Patient A's evidence from the outset that "*she did not discuss her work with Dr Metastasio*". The Tribunal evidently accepted this evidence and considered it understandable that "*her work in the sex industry may be a*

topic of conversation that would not be discussed with her face to face" given that she had "*risk factors such as suicidal ideations and a past history of sexual abuse with diagnoses of bipolar disorder; emotionally unstable personality disorder and alcohol addiction*" (Determination on Facts, §32).

36. Fourthly, the Tribunal noted Dr Metastasio's account that he did not read the medical notes and other members of staff would provide the background and risk factors of a patient's case to him. No notes were taken of the 'board meetings' which Dr Metastasio said in oral evidence were held between 9am and 10am each day at which staff would discuss the patients on the ward, including risk factors, and which he agreed were multi-disciplinary team ('MDT') meetings. The Tribunal drew the inference that, particularly when Patient A was first admitted, her work in the sex industry would have been discussed privately in an MDT as a risk factor. (Determination on Facts, §§31-32)

37. Fifthly, Dr Metastasio's evidence was that "*the fact Patient A was a sex worker was not mentioned to him, either as a risk factor, or at all*" (Determination on Facts, §31). The Tribunal rejected his evidence as implausible given the matters I have referred to above and against "*the backdrop of Patient A's recent notoriety*" (Determination on Facts, §33).

38. That was a reference to articles published in two national newspapers four months prior to Patient A's admission to Highgate MHC, which were adduced in evidence by Dr Metastasio, in which it was reported that a (named) high profile politician had a "*selfie*" with a "*porn star*" named 'M' (giving Patient A's pseudonym) while visiting Whittington Hospital (which, as the Tribunal said, was adjacent to Highgate MHC). The articles, the second of which was written by Patient A, contained a number of photographs of Patient A. The Tribunal considered that the "*ensuing media coverage and controversy*" would have been a subject of interest to those working at Highgate MHC, and it would have been of more interest to Dr Metastasio than would otherwise have been the case given that he acknowledged that by November 2017 he was using sex workers, and in evidence he had described the primary appeal (or "*first drive*") to meet 'M' in 2019 as being "*the fact that she was a porn star*" and "*famous in that profession*" (Determination on Facts, §§26-28 and 33; transcript day 2, 79C-E).

39. Mr Rich contends that in inferring that staff gossiped about Patient A's "*notoriety*" and that such gossip had been passed on to him, the Tribunal has gone beyond what can reasonably be inferred on the evidence. He submits that the Tribunal made the error of principle identified by Warby J in *Dutta* ([42]) of asking themselves who they believed before considering the objective facts as shown by the contemporaneous documents.

40. I reject the contention that the Tribunal made any such error of reasoning. The Tribunal focused on the contemporaneous medical records which showed that the fact that the Appellant continued to work in the sex industry (at least until recently) had been identified to Highgate MHC by the Crisis Team as a risk factor. The Tribunal's assessment that it was a "*significant part of Patient A's history*" and a "*very relevant factor that had to be considered by those treating her both in respect of her suicide risk and her alcoholism*" was clearly justified on the evidence.

41. The medical records and the witness evidence were consistent in indicating that her work in the sex industry was not discussed with Patient A. But refraining from discussing it with her, given her history and health, was understandable and not in any

way inconsistent with such a relevant risk factor being discussed when Patient A was not present. On Dr Metastasio's evidence, he would not himself have read the medical notes but instead relied on other members of staff to give him an oral briefing regarding patients. There were no notes of the MDT (or 'board') meetings, or otherwise of any oral briefing that Dr Metastasio received regarding Patient A. The Tribunal had to determine whether they believed Dr Metastasio's evidence that – although he ought to have been told - no one mentioned to him, at any time during the week that Patient A was an in-patient, that she worked in the sex industry.

42. The Tribunal, unlike this court, had the advantage of seeing and hearing Dr Metastasio give evidence. In my judgment, having carefully reviewed the evidence and transcripts of the whole hearing, there is no basis on which I could find that the conclusions the Tribunal drew from the evidence were wrong. Moreover, I do not accept the Appellant's characterisation of the Tribunal's "*chain of reasoning*". The way in which the Determination on Facts is set out reflects the fact that the Tribunal have considered each allegation in turn. But their assessment of the Appellant's credibility on matters addressed later in their decision is plainly relevant, and it is not realistic to treat their assessment of credibility on this initial point as uninfluenced by their overall assessment (see in particular paragraphs 44-50 and 57 below). This was a case in which the credibility and reliability of the evidence given by Dr Metastasio and Patient A was central and crucial, and this court must necessarily be very slow to interfere.

43. The relevance of the recent publicity regarding Patient A's visit to the adjacent hospital was merely that it provided a further means, additional to the primary route of reading the case notes, by which one or more members of staff responsible for briefing Dr Metastasio were likely to have become aware of the risk factor of Patient A's work in the sex industry, increasing the likelihood that it would have been mentioned it to him. In my view, this was not an unreasonable inference in circumstances where Patient A was an in-patient for a week and having regard to the nature and timing of the newspaper reports and the proximity of Whittington Hospital. But in any event, I also agree with Mr Peter Mant, Counsel for the GMC, that this was merely a supplementary point. Accordingly, I reject the contention that the Tribunal was wrong to conclude that Dr Metastasio was aware of Patient A's work in the sex industry while she was an in-patient.

44. Underpinning the Tribunal's finding that when Dr Metastasio started to follow 'M' on Twitter, he knew that she was his former patient were the following matters. The contemporaneous medical notes showed that Dr Metastasio had spoken directly with Patient A during his ward rounds on 23, 27, 28 and 30 November 2017. The medical records do not state how long those conversations took, but some idea of the length of the interaction can be gained from the length and content of the notes of what was discussed.

45. In his first statement, Dr Metastasio said he had "*no memory of seeing her*", but he accepted, looking at the medical records, that he saw Patient A on these four occasions. In his first statement, he said the first conversation with Patient A "*may have taken as long as 20 minutes*". He did not think he would have seen her "*for very long*" during the second ward round. As the medical records showed that during the third ward round he had reviewed her medication and discussed the various options with her, Dr Metastasio said in his first statement that "*would also have been a fairly long conversation so again may be 20 minutes or so*". And he said in his first statement that

the conversation during the fourth and final ward round "*would have been a short discussion*". In his oral evidence, Dr Metastasio said he would have spoken to Patient A during the first ward round for "*between ten and 20 minutes*" (transcript, day 2, 85G); during the third ward round for "*five, ten minutes, no more than that*" (transcript, day 2, 90A); and the conversation during the last ward round would have been "*fairly brief*" (transcript, day 2, 90E and 91F).

46. In her first statement, Patient A remembered having "*two long conversations with him*", when she was first admitted and when she was discharged. In her oral evidence she said she was struggling with alcohol at the time, her memory of her time as an in-patient was "*pretty much a blur*", and although she remembered speaking to Dr Metastasio on two occasions she could not recall the length of those conversations.

47. The medical notes recorded that Patient A was "*calm*", she engaged well and showed "*good rapport*" and "*good use of eye contact*" during these interviews. She was described as "*well kempt*", "*appropriately dressed*" and "*good self-care*" was described as evident. The notes were not consistent with any suggestion that Patient A would have looked dishevelled while she was an in-patient.

48. The Tribunal stated in the Determination on Facts:

> "35. In her oral evidence, Patient A said that on her Twitter account she regularly posted photographs of herself and links to her AdultWork account and films. The Tribunal had within the exhibit bundle examples of the sort of posts she would upload, dated to 2019. The purpose of these posts was to advertise and promote herself as a porn actress, her escort services and her work in the sex industry. Patient A stated that the pictures that she posted on her Twitter feed were regularly updated and that she did not remove any photos. They remained on her Twitter timeline and could be viewed by anyone visiting her Twitter feed. She said that whilst her hair colour and /or style may have changed a little, her face had not changed. She said that when she was admitted to hospital on 23 November 2017, she had a mid-brunette 'bob' style haircut.
>
> 36. The Tribunal considered the fact that Patient A was not deleting photos from her Twitter page and that there were different pictures and videos of her with different hairstyles and/or colour. The Tribunal further had before it the pictures that Patient A had on her Twitter feed around the time of her admission to hospital in November 2017, and then in 2018. It was of the view that Patient A did not look very different and was still recognisable. There would have been numerous photographs on her Twitter account showing her face in full. There were also short films of her on Twitter and longer ones on the AdultWork website."

49. Dr Metastasio's evidence was that he had looked at "*numerous images*", in the form of photographs and videos (including short, edited versions on Twitter and pornographic films on other websites), of 'M' before he had sent her any messages (transcript day 2,

76H-79A). He accepted, as was evident in the documents before the Tribunal, that her face was clearly shown in many of these images. By then, he had also seen the newspaper articles which contained photographs of her in which, again, her face was clearly shown. The Tribunal concluded that having looked at these images "*before making the decision to follow her on Twitter*", he would have recognised her as Patient A who he had treated as an in-patient 4-5 months earlier (Determination on Facts, §37). The Tribunal did not believe Dr Metastasio's evidence that he did not recognise her.

50. There is no basis on which I could find that the Tribunal was wrong in its determination that Dr Metastasio's evidence on this point was not credible. My conclusion at paragraph 42 above applies equally to the Tribunal's finding that when Dr Metastasio watched films of Patient A, and looked at numerous photographs of her, quite simply he would have recognised (and did recognise) the woman he had spent a considerable period of time of speaking with directly, only a few months earlier, while she was an in-patient and he was her treating Consultant.

51. The Tribunal considered that it was no coincidence that Dr Metastasio ended up following, messaging and arranging to meet a woman who happened to be a former patient. On analysis of the Tribunal's determinations, I accept Mr Mant's submission that in stating that he "*targeted*" her (Determination on Sanction, §23), the Tribunal was referring to the fact that he followed Patient A on Twitter, repeatedly contacted her, met her and then sought to meet her again, *knowing* that she had been his patient. It did not amount to a finding that having treated her as an in-patient he deliberately *set out* to find her. The finding of misconduct was dependent only on Dr Metastasio knowing that 'M' was a former patient when he engaged in the identified conduct. Even if that were wrong, the suggestion that it would have been very difficult, knowing her real name and what she looked like, to have found the Twitter and AdultWork accounts in which she used a pseudonym, ignores the fact that once he saw the newspaper reports, as Dr Metastasio accepted he had before he messaged her, he would have known the pseudonym she used. Moreover, irrespective of precisely how and when he first came across the newspaper articles, and Patient A's Twitter and AdultWork accounts, the Tribunal's conclusion that when he did so he recognised the woman who had been his patient is unimpeachable.

52. The Tribunal's conclusion that Dr Metastasio engaged in the conduct set out in paragraphs 1 to 5 of the Allegations (save that it was not proved he sent the message referred to in Allegation 1(b)(ii)), *knowing* that M/Patient A was his former patient (Allegation 7(a)), was also based on their assessment of the evidence given by Dr Metastasio and Patient A about their meeting on 14 February 2019.

53. There was no dispute, and the contemporaneous evidence showed, that Dr Metastasio sent messages to M/Patient A via Twitter on 30 May 2018, 18 October 2018 and 21 December 2018 seeking to meet her. Her evidence was that she did not see the first two messages but responded to the third, although that did not result in a meeting. Nor was there any dispute that on 14 February 2019 Dr Metastasio booked a one hour "*outcall meeting*" for 8.30pm via her AdultWork account. There was nothing in Dr Metastasio's messages, account username or profile to indicate to Patient A the real name of the client who was booking her services.

54. As the Tribunal observed in their Determination on Facts, both witnesses agreed that on 14 February 2019:

i) "*they met outside a pub near to the hotel where Dr Metastasio was staying*" (§52);

ii) "*they then went up to his hotel room*" (§52);

iii) "*Dr Metastasio gave Patient A a glass of prosecco*" (§52);

iv) "*Dr Metastasio paid Patient A £200 for the outcall booking*" (§53);

v) "*prior to the sexual contact, she and Dr Metastasio took a shower together in the bathroom*" (§82);

vi) "*he engaged in sexual contact with Patient A in the form of oral sex*" (§54);

vii) "*towards the end of the meeting Dr Metastasio had spoken of not wanting to be 'Me too'd' or words to that effect*" (§75, §105).

55. However, Patient A and Dr Metastasio gave conflicting accounts of their conversation during this meeting. Patient A said that Dr Metastasio remembered her and acknowledged treating her as a patient. After this was acknowledged, he had commented on her self-harm scars and offered her help. Patient A accepted that she was probably the first to have mentioned the word "*bipolar*". Dr Metastasio denied that he had recognised her as a former patient, or that they had had any conversation about him having treated her. He said that after she asked him what he did for a living he told her he was a psychiatrist and they had a "*fairly light*" conversation about psychiatry, during which he recommended to her a book called "*Saving Normal*".

56. As the Tribunal observed, there was "*no documentary or contemporaneous evidence to assist on what was actually said at that time*" (Determination on Facts, §61). In considering the credibility of both witnesses, the Tribunal bore in mind the good character of Dr Metastasio (Determination on Facts, §§ 19, 33, 61 and 71). The Tribunal considered that in all Patient A's accounts "*there was a level of consistency regarding the significant events*" (Determination on Facts, §69) and Dr Metastasio had also given a consistent account (Determination on Facts, §71).

57. The Tribunal found that Patient A was a credible witness (Determination on Facts, §70), and that her account was "*more plausible than Dr Metastasio's*" (Determination on Facts, §73). They explained that:

i) They accepted Patient A's evidence that she immediately recognised Dr Metastasio as the Consultant Psychiatrist who had treated her upon meeting him outside a pub, as arranged. She was clear that she recognised him straight away. He would have been the focus of her attention, as her Consultant, as Counsel for Dr Metastasio recognised in his submissions before the Tribunal. "*When Dr Metastasio began to talk with his distinctive accent, about psychiatry and bipolar disorder, it was more likely than not she would have recognised him then, if not as soon as they met outside the Museum Tavern pub*" (Determination on Facts, §73). Indeed, Patient A's evidence that she recognised Dr Metastasio was not challenged.

ii) Dr Metastasio accepted that he discussed bipolar disorder with Patient A during their meeting on 14 February 2019. The Tribunal considered that, given the purpose of the encounter that evening, Dr Metastasio's account that, without realising he had ever treated her, they had a general chat about psychiatry was "*implausible*". The (agreed) fact that they discussed bipolar disorder was "*far more understandable if there was an acknowledgment and awareness by both parties of the previous doctor/patient relationship and Patient A's previous diagnoses*". In addition, the Tribunal "*did not find it plausible*" that in the context of a discussion of bipolar disorder, "*Patient A would not have indicated that she had such a diagnosis and that Dr Metastasio had treated her for it*". (Determination on Facts, §74)

iii) Patient A said that on 14 February 2019 Dr Metastasio referred to her scars from self-harming, whereas Dr Metastasio denied seeing them or saying anything about them. The Tribunal noted that Patient A's evidence that there were self-harm scars on her arms and legs was consistent with the objective evidence in the medical notes that she had self-harmed for many years, a medical professional had observed visible historical scars on Patient A's arms two months before her encounter with Dr Metastasio on 14 February 2019, and there was reference in the notes to further self-harming in the month before their encounter (Determination on Facts, §§80, 81 and 83). The Tribunal rejected his evidence that the light in the bedroom was such that he had not seen her self-harm scars, finding that as he accepted that she was fully naked for about 15 to 20 minutes, including when they took a shower together in the bathroom, where the light was on, he had "*ample opportunity to observe her scars*" and "*as a trained medical professional, and especially as a Psychiatrist*" he would have noticed that she bore historical self-harm scars. The Tribunal accepted Patient A's account that he referred to them. (Determination on Facts, §§82-84)

iv) Dr Metastasio agreed that towards the end of their meeting on 14 February 2019 he had said to Patient A words to the effect that he did not want to be "*Me too'd*". The Tribunal concluded that on Patient A's account "*this made coherent sense and was a logical thing for Dr Metastasio to say*". If they both knew he had treated her, as Patient A said, "*it would be understandable for him to fear that she might report him*". Whereas on his account he was "*an anonymous psychiatrist*" (having used a false first name in making the booking, and being unidentifiable from his earlier messages), and as far as he was concerned they had never met before, so it was "*difficult to understand why he would have had such a concern*". (Determination on Facts, §75)

v) It was also common ground that Dr Metastasio gave Patient A his phone number, and subsequently contacted her via WhatsApp, using an account that clearly showed his real name and a photograph of himself. The Tribunal considered that it was "*difficult to understand*" why, given his (admitted) concern about being "*Me too'd*", he would have given his real details to an escort who would not otherwise have them, and who he believed (on his account) he had never met before. The Tribunal considered it "*far more plausible*" that he gave her his real details in circumstances where he knew that Patient A already knew who he was. (Determination on Facts, §75)

58. The Tribunal did not misdirect themselves in any way in determining the credibility of the conflicting witness evidence, and their reasons for finding Patient A's evidence more credible than Dr Metastasio's are clear, logical and coherent. It is true that Dr Metastasio gave an explanation for his reference to not wanting to be "Me too'd", namely that he was explaining why he could not publicly voice his support for the "sex work is work" campaign, but there is no sensible basis on which this court could find the Tribunal was wrong to disbelieve him and find that it was far more plausible that he feared being reported for his sexual contact with a woman he knew had been his patient.

59. I do not accept that in reaching the conclusions they did the Tribunal failed to give due weight to the inconsistencies in Patient A's evidence. First, the Appellant raised a number of points regarding Patient A's recollection of events in November 2017. (i) She recalled seeing Dr Metastasio twice while she was an in-patient whereas it was clear from the medical records that she saw him four times. (ii) When interviewed by the Trust she said she first met Dr Metastasio "*via the crisis team at St Pancras Hospital*" and in her first statement she said that she first met him at Highgate MHC after she had been transferred there by the Crisis Team. But in her oral evidence she said she saw him "*at the crisis team*", whereas it is clear from the medical records that she first saw him at Highgate MHC. (iii) She initially said she had seen Dr Metastasio alone, although she said her recollection of whether he was alone or not was blurry and there might have been someone else in the room. It was clear from the medical records that Dr Metastasio did not see Patient A alone during any of his four ward rounds when he spoke to her. (iv) Patient A's evidence was that she thought it was the decision of Highgate MHC that she did not need hospital treatment and could leave whereas the medical records indicated that Dr Metastasio would have preferred her to remain a voluntary in-patient for longer, albeit he accepted that he would have made clear to her that she was not detainable and could be discharged.

60. In my judgment, the Tribunal did not err in not giving weight to these errors of recollection concerning November 2017 when assessing the credibility and reliability of Patient A's evidence concerning the meeting on 14 February 2019. Patient A readily acknowledged that her recollection of her time as an in-patient was "*blurry*", and that was understandable given that she was detoxifying from alcohol and cocaine use. On Dr Metastasio's evidence, two of the conversations they had would have been longer than the others, so it is understandable, given her state of health at that time, that she forgot two of the ward rounds which may have been relatively short meetings. Patient A's error in her oral evidence regarding where she was when she was treated by Dr Metastasio was made in response to a question which she could easily have misunderstood as suggesting that she saw him at St Pancras Hospital, and in the context of her explaining that she was nervous, as she had never given evidence before, and it was early for her (as she was in North America). Patient A made clear that she could not recall whether Dr Metastasio was alone or not, and it is unsurprising that her focus would have been on him as the Consultant who led the conversations, rather than any junior doctor or nurse who accompanied him. Her misunderstanding that she was discharged by Highgate MHC was also understandable in the circumstances.

61. Secondly, the Appellant relies on the fact that in his message of 14 February 2019 he had told 'M' he would be wearing a "*beige coat*". The point was not an allegation of inconsistency or inaccuracy in Patient A's evidence. It was relied on in support of Dr

Metastasio's evidence as indicating that he believed they would not know each other. The Tribunal addressed this point at §76, concluding that it "*did not assist on the issue of whether Dr Metastasio did or did not know that it was Patient A he was meeting*". That conclusion was not wrong given that, as the Tribunal said, when he wrote he had not disclosed his true identity to Patient A. He had to provide her with some description so she would be able to identify him as her client. Even if she recognised him as her treating consultant, she needed some other identifier to know he was her client.

62. Thirdly, the Appellant relies on inconsistencies in her evidence about the meeting on 14 February 2019. (i) In her oral evidence she said that during their meeting on 14 February she was probably the first to raise "*bipolar*". In her statement she had said, "*When we got to the hotel room, Dr M poured some wine and he talked about bipolar and how he could help me with it. Dr M started and led the conversation*". The Appellant suggests that this amounts to saying he was the first to refer to bipolar disorder. (ii) In her statement she said that when she met Dr Metastasio outside the pub, realising who it was she felt "*really awkward*" but she "*didn't know what I could do in the situation because he had paid me, I had accepted the booking and I needed the money. I didn't think I could do anything to stop what was about to happen*". Whereas in her oral evidence she acknowledged that at the point when they met outside the pub, he had not yet paid her. (iii) In her statement she said that she "*wasn't very well at the time and the onus was on Dr M to do something about the fact that he recognised me, not me*"; and that the meeting on 14 February "*really affected my mental health and sent me on a depressive episode*". The Appellant suggests this evidence is inconsistent with a counselling record from the session on 14 February 2019 in which she was recorded as "*doing really well*" and "*feeling physically well*"; and medical records after that meeting showing that she missed a couple of appointments, was recorded as "*doing well*" on 15 April 2019, was discharged on 9 May 2019, and on 27 May 2020 a Psychiatrist recorded that she had been well for the last 12 months.

63. In relation to point (i), the Tribunal noted that Patient A's evidence was that the subject of bipolar came up "*in the context of Dr Metastasio remembering that he had treated her and wanted to help her*". While Dr Metastasio said, "*he initially stated that he was a psychiatrist and that the conversation had then turned in general terms to bipolar diagnoses*" (Determination on Facts, §72). There was no inconsistency in Patient A's evidence that Dr Metastasio started the conversation, which was not just about bipolar disorder, and her acknowledgment that she was probably the first to mention "*bipolar*".

64. In relation to point (ii), the Tribunal considered that in circumstances where Patient A was engaging in sex work at the time to make a living, and she arrived outside the pub having already agreed to the booking, and not expecting to recognise the client as a doctor who had treated her, the Tribunal did not consider that the inaccuracy in saying one of the reasons she felt she had to continue with the encounter was that she had been paid had "*a significant effect on her credibility*" (Determination on Facts, §67). I reject the contention that the Tribunal gave this factor too little weight. That Patient A felt she had to continue the encounter in the circumstances described by the Tribunal, albeit payment for the booking had not yet been made, was understandable and the Tribunal's conclusion as to the weight to give to her inaccuracy was clearly open to them.

65. As regards point (iii), as the Tribunal observed, "*the issues and diagnoses affecting Patient A do not just go away, but are long term conditions, which required Patient A to need ongoing support from the local crisis team*" and that in 2018 and 2019 "*she was*

very likely to have remained vulnerable, given the nature of her problems and the risks she faced of being exploited as a sex worker" (Determination on Facts, §125). There was compelling evidence of her self-harming which she said she would describe as part of a depressive episode. And she explained that she had not initially felt strong enough to report what had occurred. It was clearly open to the Tribunal to find that there was nothing of any substance in the evidence regarding her health such as to undermine her credibility and reliability.

66. Fourthly, the Appellant submits that the Tribunal was wrong not to give weight to the falsity of her statement that, "*I have never made any allegations against anyone of a sexual nature prior to this*". The Tribunal addressed this point at §§62-66 of the Determination on Facts. They considered that "whilst there was a significant history of alleged sex abuse in the past that had clearly been reported to medical professionals, there was not evidence that Patient A had ever made a formal complaint about this alleged abuse with a view to action being taken against the perpetrators before" (§64). Nor was there any evidence of "formal proceedings having taken place", or of any "proceedings in the family court" (§65). The Tribunal stated at §66:

> "Patient A explained that when she made this assertion in her statement she meant that she had never made any formal complaint before in the same way that she had made a complaint against Dr Metastasio. The Tribunal was satisfied that, in Patient A's mind, this distinction would be a meaningful one and that her statement that she had 'never made any allegations against anyone of a sexual nature prior to this', whilst misleading was not a case of her trying to deceive or intentionally be untruthful. The Tribunal accepted that, as she put it, she had never brought an allegation of this nature 'this far'."

67. This was clearly an assessment of Patient A's evidence, having heard and seen her give oral evidence, that was reasonably open to the Tribunal and which cannot be said to be wrong on the materials before the court.

68. Finally, the Appellant contends that the Tribunal failed to deal with the effect on Patient A's credibility and reliability of her diagnosis of EUPD. However, the Tribunal did address the submission made on behalf of Dr Metastasio on this point at §§68-69 of their Determination on Facts. The Tribunal stated that it considered,

> "69. … <u>it had no evidence one way or another as to the effect her past difficulties might have on her reliability</u>. However, the Tribunal did have regard to the accounts she had given about what occurred at various stages, during the Trust investigation on 10th September 2019 and 28th September 2019, in her witness statement dated 20 May 2021 and 26 May 2022, and in her oral evidence before the Tribunal. In all of these accounts there was a level of consistency regarding the significant events, such as the fact that Dr Metastasio had recognised her, spoken about treating her and her self-harm marks, and spoken of not wanting to be 'Me too'd'.

> 70. The Tribunal determined that, making allowances for the passage of time affecting her ability to recall exactly what was said in what order, Patient A has been consistent in her account. It considered her to be a credible witness." (Emphasis added.)

69. The criticism of the Tribunal is unjustified. The Tribunal was plainly right not to speculate as to the effect of EUPD on a witness's credibility and reliability, in circumstances where the Appellant had adduced no evidence to support his submission that her diagnosis should be treated as undermining her evidence.

70. Accordingly, I dismiss Grounds 1 and 2.

E. Grounds 3 and 4: Impairment and Sanction

71. Ground 3 (concerning the finding of impairment) and Ground 4 (concerning sanction) are entirely dependent on the success of the appeal on either or both of Grounds 1 and 2. As I have rejected the appeal on Grounds 1 and 2, Grounds 3 and 4 necessarily also fall to be dismissed.

F. Ground 5: Sanction

The parties' submissions

72. Dr Metastasio appeals against the sanction of erasure from the Medical Register. The Appellant submits that even if, as I have concluded, the facts and finding of impairment are to be taken as found by the Tribunal, nevertheless the sanction of erasure was excessive and disproportionate.

73. Mr Rich submits that the Tribunal rightly treated this case as one concerned with promotion and maintenance of public confidence in the medical profession, and promotion and maintenance of proper professional standards, not as a case concerned with patient safety. He acknowledges that erasure will almost always be *considered* in a case involving sexual contact with a patient, but he submits it is not inevitable (*Bevan*, see paragraph 25 above). He contends that the Sanctions guidance was written with a standard or classic doctor-patient sexual relationship in mind, and this was not such a relationship. The Appellant engaged Patient A to do an act that, at the time, was her work. He engaged her in a professional transaction, rather than a relationship. So it was of a different quality to most doctor-patient relationships. Mr Rich submits that the Tribunal erred in failing to factor in that this was not a classic doctor-patient relationship, although they acknowledged that there was no element of "*grooming behaviour*" (Determination on Sanction, §24).

74. Mr Rich submits it is significant that Patient A was a *former* (rather than current) patient. She had been his patient for only a week, and she had last been his patient around five months before he first sought to make contact with her. He did not have a continuing or long-term therapeutic relationship with her, and Dr Metastasio did not have any reason to believe he would treat her as a patient again. The Tribunal described, as an aggravating factor, the fact that his "*behaviour was extended over a period of over two years, from at least May 2018 to August 2020*". Mr Rich accepts that description is strictly accurate, but submits that it involved a very limited number of contacts, spaced out intermittently with long gaps, rather than a persistent course of conduct. It was not

a relationship involving any real personal connection, and he did not press for contact on the occasions when he received no response.

75. As the Tribunal acknowledged, Dr Metastasio was of good character and respected for his clinical skills in a lengthy career up to that point. The Tribunal accepted that Dr Metastasio "*now understands the seriousness of his actions and the impact they have had on Patient A. In his reflection he has apologised to Patient A and hopes that his apology can help her move on. The Tribunal accepts that this is a sincere apology*" (Determination on Sanction, §34). The Tribunal was "*satisfied that Dr Metastasio had carried out the remedial work that he could be expected to undertake and that there was now a relatively low risk of the conduct being repeated*" (Determination on Sanction, §35). Mr Rich submits that given these findings, it is evident that factors (e), (f) and (g) of §97 of the Sanctions guidance applied, indicating the appropriateness of suspension rather than erasure.

76. While not denying her vulnerability, Mr Rich submits that the medical records support the conclusion that she was, or at least appeared to be, well on the day of the single meeting between Dr Metastasio and Patient A. And the medical records do not support her evidence that the meeting precipitated a period of depression, at least not immediately.

77. Finally, Mr Rich draws attention to the public interest in Dr Metastasio being able to practise again at some point, given his good clinical skills and good record apart from the matters that were the subject of this determination, and the shortage of Consultant Psychiatrists in the NHS.

78. Mr Mant submits that although some of the features in §97 of the Sanctions guidance were present, suspension was not appropriate because the conduct which the Tribunal found proved was "*fundamentally incompatible*" with being registered as a doctor. He contends that factors (a), (b), (c), (d), (e) and (i), identified in §109 of the Sanctions guidance (see paragraph 23 above) were very obviously engaged, and only one of those factors was required to justify erasure. Mr Mant contends that although the Tribunal did not find that he *used* the fact that she had been his patient to engage in a sexual relationship with her (*cf* §143 of the Sanctions guidance: paragraph 24 above), nonetheless, his conduct was a clear abuse of position and trust. Mr Mant refutes the suggestion that this relationship was less serious because Patient A was being paid for sex in the context of her work. That fact made the power imbalance between Dr Metastasio and Patient A all the greater, and the objectification of a patient involved in paying her for sex is bound to fundamentally erode public trust in doctors. It is, he suggests, a very bold submission that where a psychiatrist pays a vulnerable patient for sex, anything less than erasure is warranted.

Analysis and decision

79. On this ground of appeal, the question is whether erasure was "*appropriate and necessary in the public interest or was excessive and disproportionate*"; and "*a court can more readily depart from the [Tribunal]'s assessment of the effect on public confidence of misconduct which does not relate to professional performance than in a case in which the misconduct relates to it*": *Khan v General Pharmaceutical Council* [2016] UKSC 64, [2017] 1 WLR 169, Lord Wilson JSC, [36].

80. It is not suggested that the Tribunal made any error in their *approach* to determining the sanction, and it is plain that they did not. The Tribunal bore in mind that in deciding what sanction, if any, to impose they should consider the sanctions available, starting with the least restrictive. The Appellant does not criticise the Tribunal's determination that "*given the seriousness of its findings at the facts and impairment stages, taking no action would be insufficient to uphold the overriding objective*", and there were no exceptional circumstances to justify taking no action (Determination on Sanction, §§25-26). Nor does he criticise their conclusion that they were "*unable to formulate any conditions which would be an appropriate response to Dr Metastasio's misconduct*" and that "*the imposition of conditions would be neither workable nor sufficient*" to maintain and promote public confidence and maintain standards (Determination on Sanction, §§27-29).

81. The effect of erasure is that Dr Metastasio will not be able to practise for at least five years (Sanctions guidance, §111) whereas the maximum period of suspension for impairment by reason of misconduct is 12 months (Sanctions guidance, §§66 and 99). As Collins J observed in *Bevan* at [26], although the purpose of the sanction is not punitive, erasure "*may well have an effect upon his pension rights, and it will obviously have an effect upon his ability to earn money*".

82. The Tribunal identified the following as aggravating factors:

> "• Dr Metastasio targeted a former patient, who he knew was very vulnerable, for sexual contact, putting his own interests before those of Patient A;
>
> • The behaviour was extended over a period of over two years, from at least May 2018 to August 2020;
>
> • He offered Patient A alcohol during their encounter, when he knew one of her diagnoses was alcohol addiction/abuse;
>
> • He asked her not to tell anyone about their encounter, putting his own interests above her own;
>
> • Dr Metastasio continued with the sexual encounter, having seen Patient A's self-harm scars and sought to contact her again for a second sexual encounter."

83. As I have said, I accept that the first bullet point does not amount to a finding that having treated her as an in-patient he deliberately *set out* to find her. It is also right to say, as Mr Rich did, that the contact was intermittent. Nonetheless, the fact that it involved contacting her repeatedly over time, and seeking to meet her again after their encounter on 14 February 2019, plainly was an aggravating factor.

84. Although Dr Metastasio had treated Patient A for a week, and had not seen her for several months when he first sent her a message, the doctor-patient relationship had not definitively come to an end. He had not left Highgate MHC and had no reason to think that Patient A had left the local area. The nature of her conditions was such that there

was a real possibility of a relapse that could have resulted in Dr Metastasio treating her again.

85. The Tribunal identified the following as mitigating factors:

> "• No previous findings of impaired fitness to practise;
>
> • Positive testimonials that Dr Metastasio is a good clinician;
>
> • This was not a case involving grooming behaviour within the therapeutic relationship between the doctor and the patient.
>
> • The Tribunal accepted that Dr Metastasio had good insight and had made significant attempts to remediate his misconduct."

86. In my judgment, the Tribunal did not err in failing to identify the contact between Dr Metastasio and Patient A as atypical. The Tribunal plainly understood the nature of the contact and that no doubt underlay their finding that Dr Metastasio had not engaged in "*grooming behaviour*". He had not used his professional status to secure Patient A's sexual services: she had accepted the meeting without knowing his real identity. Nevertheless, the transactional nature of the sexual relationship does not make it any less inappropriate than an ordinary sexual relationship. I agree with Mr Mant that the imbalance of power was potentially even greater.

87. Following Patient A on social media, contacting her with a view to meeting for sexual contact, meeting her and paying her for oral sex, and then seeking to do so again, all in the knowledge that she was a vulnerable patient who he had treated in his capacity as a Consultant Psychiatrist, was undoubtedly a serious abuse of his professional position. The Sanctions guidance indicates at §148 that erasure is likely to be appropriate for such conduct.

88. This was a case in which the Tribunal's important findings in respect of remediation, low risk of repetition and insight, were such that it was necessary to give very serious consideration to whether suspension might be appropriate, in accordance with §97 of the Guidance. Nevertheless, I agree with Mr Mant that several of the factors identified in §109 were also clearly present. It is very sad when the name of a doctor, with a good clinical record and with no previous disciplinary record, is erased from the register. And I recognise the profoundly serious impact that erasure has on Dr Metastasio. Ultimately, however, I am not persuaded that the sanction of erasure imposed in this case can be said to be excessive or disproportionate.

G. Conclusion

89. The appeal is dismissed on all grounds.