Case No:CO/1752/2004

[2004] EWHC 1850 (Admin)

IN THE HIGH COURT OF JUSTICE

QUEENS BENCH DIVISION

ADMINISTRATIVE COURT

Royal Courts of Justice

Strand, London, WC2A 2LL

Date: 30 July 2004

Before :

The H^{on} Mr Justice Collins

Between :

Council For The Regulation Of Healthcare Professionals

V

(1) The General Medical Council

(2) Dr. Anthony Leeper

Mr John Howell Q.C. & Mr Tom de la Mare (instructed by Messrs Bevan Ashford, Solicitors) for the Appellant

Mr Roger Henderson Q.C. & Ms Jemima Stratford (instructed by Messrs Field Fisher Waterhouse, Solicitor) for the First Respondent

Mr Philip Gaisford (instructed by Radcliffes le Brasseur) for the Second Respondent

Hearing date: 16 July 2004

JUDGMENT:

Approved by the Court for handing down (subject to editorial corrections)

Mr Justice Collins:

1. The Council for the Regulation of Healthcare Professionals (CRHP) was established by s.25 of the National Health Service and Health Care Professionals Act 2002 (the 2002 Act). Its general functions include the promotion of the interests of patients and other members of the public in relation to the performance of their functions by the various bodies concerned with regulating the conduct of health care professionals. One such body is the General Medical Council (GMC). CRHP's role includes the promotion of best practices, the formulation of principles relating to good professional self-regulation and the promotion of co-operation between the various bodies. Those bodies must also co-operate with CRHP (s.27(1) of the 2002 Act).
2. Section 29 of the 2002 Act enables CRHP to refer what are described as relevant decisions to this court if it considers any such decision is unduly favourable to an individual health care professional. This was to meet public concern that in the process of self-regulation sometimes too little regard was paid to the protection of the public and too much to the interests of the profession or its members. S.29 is headed 'Reference of disciplinary cases by Council to court'. S.29(1) lists in paragraphs (a) to (j) what are described as directions, disciplinary orders, steps or corresponding measures of the various different professional bodies to which the 2002 Act applies. The reasons for the differences in terminology lie in the particular provisions of the various enactments which govern the bodies. But in all cases the relevant decision will, unless the disciplinary charges are dismissed, be one which produces for the person affected by it adverse consequences, usually in the form of some sort of penalty, which may range from removal from the register so that practice is prohibited to no more than the recording of an adverse finding. Directions of the Professional Conduct Committee (PCC) of the GMC are covered by s.29(1)(c).
3. S.29(2) of the Act extends the application of the section to decisions not to take any disciplinary measure (s.29(2)(a) and (b)) and to decisions to restore to the register (s.29(2)(c)). S.29(4), which is the most important provision for cases such as this, reads:-

   "If the Council considers that –

   (a) a relevant decision falling within subsection (1) has been unduly lenient, whether as to any finding of professional misconduct or fitness to practice on the part of the practitioner concerned (or lack of such a finding) or as to any penalty imposed, or both, or

   (b) a relevant decision falling within subsection (2) should not have been made,

and that it would be desirable for the protection of members of the public for the Council to take action under this section, the Council may refer the case to the relevant court".

The relevant court is this court. S.29(7) provides that if a case is referred it is to be treated as an appeal by the CRHP. S.29(8) provides that on such an appeal the court may –

"(a) dismiss the appeal,

(b) allow the appeal and quash the relevant decision,

(c) substitute for the relevant decision any other decision which could have been made by the Committee or other person concerned, or

(d) remit the case to the committee or other person concerned 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".

4. These provisions have only recently come into force and the court has had to consider how they should be construed. CRHP has submitted that once it has determined that the conditions set out in s.29(4) are fulfilled, the case can be referred to the court. It is to be treated as an appeal (s.29(7)) and so CPR Part 52 will apply. 52.11(3) provides:-

"The appeal court will allow an appeal where the decision of the lower court was –

(a) wrong; or

(b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court".

Accordingly, it is submitted that the unduly lenient test is not applicable and the court must decide whether the decision was wrong. Thus the approach should be the same as that in appeals by practitioners, giving to the disciplinary committee's decision only such deference as is appropriate in all the circumstances.

5. This submission asserts that the approach set out in my decision in *Council for the Regulation of Healthcare Professionals v The Nursing and Midwifery Council* [2004] EWHC 585 (Admin) and that of Leveson J in *Council for the Regulation of Healthcare Professionals v General Medical Council* [2004] EWHC 944 (Admin) is wrong. In each case, it was decided, in relation to an appeal based on s.29(4)(a), that the court had to be persuaded that the relevant decision was unduly lenient if it was to allow the appeal. The test is no different to that applied by the Court of Appeal (Criminal Division) in appeals against unduly lenient sentences and the question to be determined by the court is whether the decision falls within the range of sanctions which the relevant disciplinary body, applying its mind to all the factors relevant to

its jurisdiction, could reasonably consider appropriate. It is submitted that this is not warranted by the statutory language and affords too great a deference and respect to the decision of the disciplinary body.

6. Mr. Howell Q.C. did not argue the point in great detail since he recognised that I was unlikely to be persuaded that the decisions of myself and Leveson J were wrong. In any event, my decision is being taken to the Court of Appeal. He did, however, persuade me to take a fresh look at s.29, particularly as counsel for the respondents in the previous case had not sought to dispute the submissions made by CRHP and so there had not been consideration of the section in the sort of detail that was needed. Leveson J in the *GMC* case did receive more detailed argument and reached the same conclusion.
7. The section is not well drafted. The opening words of s.29(4)(a) coupled with the powers of the court in s.29(8) strongly suggest that CRHP and the court are concerned whether the relevant decision, that is to say, the disciplinary measure referred to in s.29(1), was unduly lenient. S.29(8)(b) and (c) gives power to quash or to vary only the relevant decision. So in this case the notice of appeal identifies the decision of the PCC dated 10 February 2004 which determined to impose conditions on Dr. Leeper's registration. However, the following words of s.29(4)(a) seem to suggest that part only of the relevant decision can be the subject of an appeal, since a distinction is drawn between findings and penalty. It is, as a matter of language, difficult to follow how a finding of professional misconduct can be said to have been unduly lenient. Furthermore, the relevant decision will if it is to fall within s.29(4)(a) rather than s.29(4)(b), usually have involved the imposition of some sort of penalty. It is, however, important to bear in mind that the express powers of the PCC of the GMC are limited to directing erasure or suspension or that conditions should be attached to the doctor's registration (Medical Act 1983 s.36(1)). Following a finding of serious professional misconduct, a decision not to direct that any of those penalties should be imposed can be made. In its guidance for the PCC, the GMC has drawn attention to the fact that the Procedure Rules do not require the Committee to impose a sanction in every case where serious professional misconduct is established. The lowest level of sanction is a reprimand, which does not affect the doctor's registration but will be disclosed if any enquiries are made about the history of the doctor's fitness to practice. Whether or not a reprimand is a direction within the meaning of s.29(1)(c), read with s.36(1) of the Medical Act 1983, it is clearly a penalty, whereas the imposition of no disciplinary sanction is not.
8. If a finding or a lack of a finding which is unduly lenient (perhaps an alternative wording which conveys what is intended might be unduly favourable) results in a decision that the doctor is guilty of serious professional misconduct but that no penalty should be imposed, it is difficult to understand why that should fall within s.29(4)(b) rather than s.29(4)(a). This may even extend to a decision to reprimand if a narrow construction of direction is applied to s.29(1)(c). If s.29(4)(b) applies, there is no need to decide at any stage that the penalty or any finding was unduly lenient. Thus there is a wholly anomalous situation since, if the result is a failure to impose a penalty or perhaps the imposition of the least severe penalty, undue lenience is irrelevant.
9. The primary purpose behind s.29 is to ensure that health care professionals are properly dealt with if their conduct falls below the standards expected of them so that the public are properly protected. Thus one would expect the powers conferred on CRHP to extend to cases where there has been a decision not to take any proceedings in addition to those where proceedings

have been taken but have resulted in a wrongful acquittal or a failure to impose an adequate penalty. But if s.29(2)(a) and (b) deal with wrongful acquittals, there is no provision for a failure to take proceedings.

10. Since s.29(4)(a) distinguishes between findings and penalties, it must in my view cover acquittals as well as the imposition of inadequate penalties. This means that 'direction' in s.29(1) (or step or corresponding measure) must be construed to include a direction not to impose a penalty or to make a finding which might lead to a penalty. While I do not doubt that this is a purposive construction, it avoids the anomalies to which I have referred and does not in my view amount to an unacceptable construction of the language used in a section which, because of the attempt to deal with the disparate provisions relating to the various health care bodies, is not easy to construe sensibly. What this means is that where the relevant body or person has taken disciplinary proceedings which have resulted in an unduly lenient decision, whether an acquittal or an inadequate penalty, s.29(4)(a) will apply. S.29(2)(a) and (b) will apply where there has been a failure to take proceedings at all. The relevant committee is whichever committee has the responsibility to make a final decision as to whether proceedings should be brought and the provision referred to is the enactment in question, not the specific section or provision of that enactment. This means that a sensible distinction is drawn between s.29(4)(a) and s.29(4)(b), the latter dealing with two discrete matters and the former with all possible outcomes of a disciplinary hearing.

11. In support of his contention that the test of undue lenience was only to be applied by CRHP, Mr. Howell Q.C. drew my attention to *London Borough of Barking & Dagenham v Jones,* an unreported decision of the Court of Appeal of 30 July 1999. That case concerned an application by the local authority for an injunction which, pursuant to s.222 of the Local Government Act 1972, could only be applied for if the local authority considered it 'expedient for the protection or protection of the interests of the inhabitants of this area' to do so. In it, Brooke LJ, who gave the leading judgment, applied observations of Lord Donaldson, M.R. in *Mole Valley DC v Smith* [1992] 24 H.L.R. 442 @ 450, where he said:-

"It is not for the courts in these proceedings to review the decision of the respondent councils under section 222 … Where the balance of the public interest lies is for the respondent councils to determine and not for this court".

I can see that this may well apply to the question whether it is desirable for the protection of members of the public for CRHP to take action under s.29, although the court is in as good a position as CRHP to decide that issue. In any event, the wide discretion given to the court under s.29(8) will enable it to decline to direct a different result if, notwithstanding that the direction was unduly lenient, it is persuaded that no action should be taken in the circumstances. But there is no reason to apply it to the question whether the direction or any finding or lack of finding was unduly lenient. S.36 of the Criminal Justice Act 1988 gives the Attorney General power to refer a case to the Court of Appeal if it appears to him that 'the sentencing of a person in the Crown Court has been unduly lenient'. It has never been suggested that this does not limit the powers of the Court of Appeal. CRHP may refer a case if it considers that the direction is unduly lenient. Since by s.29(7) a referral is treated as an appeal, CPR 52.11(3) applies. But 'wrong' in context means

whatever the primary legislation regards as wrong – in this case, that the direction was unduly lenient. The Rules cannot determine the construction of the primary legislation. Thus I have no doubt that the court should only act to vary a direction if persuaded that it was unduly lenient.

12. I heard some arguments about the opportunity for remittal if undue lenience were to be the test for the court as well as for CRHP. I see no difficulty if my construction of the section is correct. If any penalty was unduly lenient, the court may itself substitute the appropriate penalty if there is no choice. If, for example, the only proper penalty was erasure, the court will so direct. But if there is a choice or if the details are not necessarily clear (for example, the appropriate length of a suspension or the precise conditions which should be imposed) remittal may be the correct result. If a finding or a lack of a finding was unduly lenient, remittal will I suspect be the usual result unless the court is satisfied that no different decision would or should be made. If the court believes that a different decision might reasonably be made, the body in question should be given the opportunity to decide in the light of the judgment of the court. If the court is satisfied that the direction was unduly lenient, it can require that a greater penalty be imposed and will remit unless there can be only one possible penalty.
13. Since CRHP's powers to refer cases are based on a concern that the public should be protected and are not intended to punish a health professional for whatever lapse he has been guilty of, I agree with Leveson J that double jeopardy is not applicable and with what he says in Paragraph 18 of his judgment in the *GMC* case. The need to establish undue lenience is the way in which Parliament has recognised that to allow an appeal against a disciplinary sanction will expose the respondent to a greater penalty than that imposed or to a rehearing despite his acquittal. That Parliament should have set the test higher than that applicable to appeal by individuals is in the circumstances not in the least surprising.
14. In reaching its decision whether to appeal, CRHP has, on advice, adopted a five-step test. It is as follows:-

"1. Which provision of s.29(4) does the CRHP rely on?

2. Does the CRHP consider that any finding of fact by the PCC was unduly lenient or otherwise wrong?

3. Does the CRHP consider that the penalty imposed by the PCC was unduly lenient?

4. If so, what sanction does the CRHP consider the PCC should have imposed as a minimum?

5. Is it desirable for the protection of members of the public for the CRHP to refer the case to court?"

Mr. Henderson Q.C. has criticised the fourth question on the ground that the true question was whether the penalty imposed by the PCC was outside the range of sanctions which could reasonably have been considered appropriate. I do not accept this criticism since, if what in CRHP's view should have been imposed as a minimum is more severe than that in fact imposed, it must

follow that it is regarded as outside the range which could be regarded as appropriate.

15. This case involved an inappropriate sexual relationship by Dr. Leeper with a patient who has been called Mrs. A. Mrs. A made a statement which was not put before the PCC. Following discussions between counsel appearing for Dr. Leeper and on behalf of the GMC, it was decided that that statement need not go before the PCC but that material allegations in it, which were admitted, should be put forward by counsel when outlining the case to the PCC. CRHP asked for copies of the witness statements from Mr. & Mrs. A and of the formal complaints. There was an issue raised as to whether they should be provided (although not initially, they were at a later stage provided). Particularly in cases involving sexual allegations, it is not unusual for complainants to be reluctant to give evidence and to relive their experiences. Accordingly, agreements may be reached between counsel as to the admissions which can be regarded as acceptable to avoid the need for complainants to give evidence. If CRHP is concerned that a penalty may be unduly lenient, it may have to consider whether there has been what can be described as 'under prosecuting', that is to say, a failure to put before the relevant disciplinary committee a proper picture of the extent of any misconduct. While I do not intend to give any general guidance about what should or should not be provided to CRHP if a request is made, it seems to me that any statement or formal complaint must be produced on request. Further, CRHP may, if for good reason it believes that there has or may have been under prosecuting, seek an explanation from the GMC as to why the counsel or solicitor who appeared on behalf of the GMC considered any particular agreement was appropriate. An understandable concern to avoid putting a complainant through the ordeal of giving evidence must not prejudice the proper protection of the public from a health professional if what he has done requires that he be dealt with more severely if the full extent of his wrongdoing is put before the relevant committee. But it is important that complainants should not be deterred from coming forward by concerns that they will be forced to relive their ordeal. If the court is persuaded that any arrangement was reasonable and was in the public interest, it will not allow an appeal. Mr. Henderson submitted that inquiries were unnecessary where competent and experienced advocates had made the relevant decision unless there was some objective evidence that things had gone wrong. Even the most competent and experienced are capable of making mistakes and, if CRHP is concerned that an unduly lenient penalty has been imposed, it is entitled to investigate whether any such decision was justified. I should make it clear that it is not suggested that the agreement in this case resulted in the PCC failing to receive a full and proper explanation of Dr. Leeper 's misconduct.
16. Dr. Leeper who is now 49 years old was a general practitioner in a practice based in Sudbury. He worked at all material times in a branch surgery in Clare, where he had been a sole practitioner from 1992 until 2000, when he joined the Sudbury-based practice. On 9 February 2004 he appeared before the PCC facing a charge which alleged that between March 2002 and February 2003 he had engaged with a patient, Mrs. A, in an emotional and a sexual relationship. The charge set out in some detail the allegations upon which the GMC was relying. It read as follows:-

"That being registered under the Medical Act,

1. At all material times you were a U.K. registered general practitioner employed at Hardwicke House surgery, Stour Street, Sudbury, Suffolk CO10 2AY.

2. Mrs. A joined the practice in early 2000 as a patient.

(a) You treated Mrs. A on a number of occasions between 2000 and 2003.

(b) Mrs. A had a history of depression and you were aware, or should have been aware of that history.

3. In the period between approximately March 2002 and February 2003, you were engaged with Mrs. A in an emotional relationship.

(a) In the period between approximately March 2002 and February 2003, you were engaged with Mrs. A in a sexual relationship.

(b) In particular,

(i) On 13 March 2002 you embraced Mrs. A at the Stonehall Surgery during consultation.

(ii) On 13 March 2002 you exchanged personal mobile telephone numbers with Mrs.A.

(iii) In or about March 2002 you invited Mrs. A to come to the surgery after it was closed saying that "It will be fine and no one will see you. I will let you in at the door at the side".

(iv) In the course of that meeting you kissed Mrs. A and touched her intimately.

(v) Subsequently you invited Mrs. A to your Cottage in Wickhambrook and had sexual intercourse with her.

(vi) On another occasion between March and April 2002 you visited Mrs. A at home.

(vii) In April 2002 Mrs. A consulted you to have an Intra Uterine Device (IUD) fitted.

(viii) In May Mrs. A consulted you and you expressed feelings for her and said "I don’t want to come between you and your husband".

(ix) On an occasion shortly after you invited Mrs. A to your Cottage. When she arrived you gave her a glass of wine, kissed her and sexual intercourse took place.

(x) A week later Mrs. A saw you in the surgery and she said that she did not want to see you again.

(xi) Some months later Mrs. A consulted you with a trapped nerve and you complemented her on her hair.

(xii) You spoke to Mrs. A a few days later and asked if you could meet her in the surgery in the evening and she did not agree.

(xiii) On another occasion at the end of 2002, you met Mrs. A and drove her in your car to a secluded spot and had sexual intercourse with her there.

(xiv) On a further occasion at the end of 2002 you drove Mrs. A to a secluded field and had sexual intercourse with her in your car.

(xv) In January 2003 you sent a text message to Mrs. A's mobile telephone. When Mrs. A telephoned you, you arranged to meet her and had sexual intercourse.

(xvi) On 28 January you met Mrs. A when she was on the way to work and fondled her in her car.

(xvii) In mid February you met Mrs. A at Wickhambrook by arrangement and had sexual intercourse with her there.

(xviii) later in February you met Mrs. A in the pub near Bury St. Edmunds and had sexual intercourse in your car.

4. You continued to treat Mrs. A after the commencement of the relationship with her.

5. You did not make arrangements for Mrs. A to be,

(a) transferred to a different practitioner or, in the alternative,

(b) transferred to a different practice.

6. You sought to persuade Mrs. A not to disclose the full extent of the relationship during the course of telephone calls made to her on more than one occasion in late February 2003.

7. Your behaviour as particularised above was inappropriate in that,

(a) you used your professional position to pursue a sexual relationship with your patient.

(b) you did not act in the best interests of your patient.

And that in relation to the facts alleged you have been guilty of serious professional misconduct".

All the allegations were admitted and it was accepted that they constituted serious professional misconduct. Mrs. A was a vulnerable patient who had

consulted Dr. Leeper because she was suffering from depression and he gave her counselling. When he gave evidence to the PCC in mitigation of his conduct, he said this:-

"Q. Now you have heard Mr. Martin open his case and describe your relationship with Mrs. A. was that description in all its salient features correct?

A. Yes, that is correct.

Q. That being so, could I just ask you then for your reflections on that relationship. First of all was it the right thing to do?

A. No, it was a wrong thing to do, and I openly admit it and recognise it, and I openly accept that this was a case of serious professional misconduct.

Q. The expression "abuse of trust" was used. Do you accept that that is a proper description of what occurred?

A. I do accept it unreservedly. It was certainly not my intention to abuse this trust, but I recognise that it is a very special thing that is given by the patient to a doctor, this trust, and whilst I did not intend to abuse it, sadly I did. And I suspect that the relationship, whilst I believed it was mutual, it could never ever be equal, because by the mere fact that this trust is bestowed upon me by the patient, that cannot make the relationship equal, and I accept it now, totally and unreservedly.

Q. And what do you want to say to this committee and to the profession, the medical profession, and to Mr. And Mrs. A in relation to your conduct?

A. I would like to give my unreserved apology, especially to the complainants Mr and Mrs. A, and I would also like to give my unreserved apology to my medical profession. I am fully aware that the Council, General Medical Council, is here to protect patients, and it has to have the public's interest at heart, and I accept that and acknowledge it, and I am extremely sorry to have caused the profession this embarrassment".

17. It is necessary to expand on the facts set out in the charge in order to explain why this seemed a particularly bad case. In late October 2000 Dr. Leeper commenced a friendship which developed into an affair with a woman so that his marriage was put under enormous strain. He received counselling with his wife from a psychotherapist in order to try to save his marriage. A letter from the psychotherapist was before the PCC. In it, she stated that he had great difficulty in coming to terms with the breakdown of his marriage and felt that he was a failure. He was consumed with guilt. The lady who is now his partner fell pregnant and he faced the added difficulty in March 2002 of having to tell his children about the situation. In May 2002, the psychotherapist informed him she was returning to America in October 2002 so that their work together began to cease. She felt that he was beginning to come to terms with the situation, but was facing added pressures because of financial problems resulting from his divorce. In addition, his children refused to see him. The psychotherapist concluded in her letter:-

"I think Dr. Leeper was very naïve and extremely vulnerable. The shame and guilt he felt was overwhelming and his need to be punished for his transgressions meant he put in jeopardy the most important thing in his life, being a doctor".

18. Dr. Leeper of course knew that Mrs. A was suffering from anxiety and was emotionally dependent on him. She trusted him. Inappropriate conduct occurred when Dr. Leeper began to tell Mrs. A of his own problems and embraced and started to touch her. Sexual intercourse occurred shortly thereafter when she went at his invitation to his cottage. She tried to stop the relationship, and there was a gap for a few weeks. However, sexual intercourse occurred again. At the end of May 2002, Dr. Leeper told Mrs. A that he did not want to come between her and her husband and she acted to end the relationship. He then moved in to live with his partner and his daughter who had just been born.
19. The misconduct was the more serious because it did not come to an end in May 2002. Mrs. A attended Dr. Leeper on 3 December 2002 because she had suffered a trapped nerve in her arm. He was then living with his partner in what he said was a firm relationship. He is indeed fortunate that his partner has apparently forgiven him and has stood by him. But he started up his affair with Mrs. A again and sexual intercourse occurred on several occasions. In February 2003 Mrs. A and Dr. Leeper had sexual intercourse in his car. She was concerned that they had been observed and sent him a text message which said:-

"Hi Michael, hope you are okay after yesterday. Please don't worry. Hope you enjoyed it as much as I did".

20. Dr. Leeper's partner discovered this. He sought to persuade Mrs. A to say that there had been only one occasion when sexual intercourse took place. He informed his partners what had happened and they decided that he could no longer be part of the practice. He ceased to work as a doctor and has only very recently joined a practice.
21. There can be no doubt that this was a bad case of its type. The relationship started because of advances made by Dr. Leeper during a consultation. It was not a single episode and, after she had brought it to an end, he started it again some 6 months later. He was well aware that what he was doing was likely to harm her having regard to her emotional state and the depression from which she was suffering, quite apart from the effect it was likely to have on her marriage. He was satisfying his own emotional needs at the expense of his patient. In his favour he admitted his wrongdoing and showed real and genuine remorse for what he had done, recognising the harm that he had inflicted. He was suffering from depression himself and was undoubtedly acting out of character, but he knew he was doing wrong. Indeed, the fact that he was continuing throughout this period to act as a doctor and, as will become apparent, a very good doctor shows that he must have realised that he was committing serious professional misconduct.
22. There was, however, powerful mitigation. No less than about 250 testimonials were put before the PCC. These were from patients and fellow practitioners and all testified to the quality of the services he provided. They were, as Mr. Henderson submitted, a formidable testament to what an excellent doctor he was. Mr. Howell has suggested that many of them may not have been aware

of the extent of his wrongdoing and that the woman with whom he had the adulterous affair was a vulnerable patient. Even if this were so (and it is clear that some of them were aware of the extent of his wrongdoing) it does not detract from the assessment of him as a doctor and the overwhelming wish of so many of his patients that he should be able to remain as their general practitioner.

23. Once what he had been doing had become known – it is no doubt another aggravating feature that he only ended the relationship because his partner found out what was happening – he sought help from a psychiatrist. He said he had learnt to come to terms with his vulnerability and to talk to others about it. He said that the affair recommenced in December 2002 when he was seriously affected by his ex-wife's going to court to obtain an order for financial provision. He said, and the PCC clearly accepted, that there was now no danger that he would lapse again. Dr. Webb, the psychiatrist, had written two reports which were before the PCC. His diagnosis was that Dr. Leeper had been functioning in a highly stressed state for a number of years and that 'at some time during 2001 or 2002 in technical terms his defence mechanisms decompensated – in lay language, he snapped'. He had an inherited susceptibility to depressive disorder. He set himself obsessively high standards and was peculiarly susceptible to the effects of new sources of stress. In March 2003, he was prescribed anti-depressant drugs and given advice, which he took, that he should not work for at least 3 months. In the subsequent report dated 6 February 2004, Dr. Webb was able to say that his mental state had improved markedly. He had not reacted in inappropriate fashion to additional stress caused by continuing litigation in relation to his divorce and his inability to see his children. Dr. Webb 's prognosis was as follows:-

    "Once these matters are dealt with and he has sorted out his difficulties within the partnership contract [that is, a dispute arising from the termination of his partnership] I believe he will make a full recovery from his condition.

    The risk of relapse in future years is mitigated by the fact that both he and his partner have developed considerable insight into his condition and are well aware of its effects on their lives.

    In difficult circumstances he has been able to be analytical about his symptoms of depression versus the effects of stress. I see him as likely to be able to spot any relapse coming and take appropriate action were the need to arise".

24. The GMC's Indicative Sanctions Guidance for the Professional Conduct Committee is the equivalent to a sentencing guide. It helps to achieve a consistent approach to the imposition of penalties where serious professional misconduct is established. The PCC must have regard to it although obviously each case will depend on its own facts and guidance is what it says and must not be regarded as laying down a rigid tariff. It points out that the purpose of the sanctions is not to be punitive, but to protect the public interest, which includes the maintenance of public confidence in its profession and upholding proper standards of conduct. It notes that erasure has been upheld by the Privy Council despite strong mitigation particularly in cases involving sexual misconduct, dishonesty or a failure to provide an acceptable level of

treatment or care. In Paragraph 27 under the heading 'Sexual misconduct' it is said:-

"This encompasses a wide range of conduct from criminal convictions for sexual assault, to sexual misconduct with patients, colleagues or patients' relatives. The misconduct is particularly serious however, where there is an abuse of the special position of trust which a doctor occupies. In such cases erasure has therefore been judged the appropriate sanction:

'The public, and in particular … patients, must have confidence in the medical profession whatever their state of health might be. The conduct as found proved … undoubtedly undermines such confidence and a severe sanction was inevitable. Their Lordships are satisfied that erasure was neither unreasonable, excessive nor disproportionate but necessary in the public interest'.

In dealing with suspension, this is said, at Paragraph 18:-

"Suspension can be used to send out a signal to the doctor, the profession and public about what is regarded as unacceptable behaviour. Suspension from the register also has a punitive effect in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the period of suspension. It is likely to be appropriate for misconduct that is serious, but not so serious as to justify erasure (for example where there may have been acknowledgment of fault and where the Committee is satisfied that the behaviour or incident is unlikely to be repeated)".

25. The Guidance led CRHP to contend that erasure was the appropriate sanction and that anything less than suspension could not conceivably be justified.
26. After very careful consideration extending over some 9 hours, the PCC decided that the appropriate sanction was to impose conditions on Dr. Leeper's registration. It stated as follows:-

"The Committee have carefully considered all the evidence they have heard in this case. You have admitted and it has been found proved that between March 2002 and February 2003 you were engaged in an emotional and sexual relationship with Mrs. A, a patient of yours, who had a history of depression.

The Committee consider that the facts found proved in this case represent a serious abuse of your professional position and a serious breach of the trust which Mrs A was entitled to expect of a doctor.

Inappropriate behaviour by a doctor towards patients is always a matter of grave concern to this Committee. This is particularly so in the case of vulnerable patients. Such behaviour reflects adversely on the doctor concerned and undermines the trust which the public places in the profession as a whole.

The Council's guidance, "Good Medical Practice" (May 2001) states that the doctor-patient relationship depends on trust. Doctors must not abuse their

professional position by establishing improper relationships or using their position to gain any advantage over their patients.

Taking all these facts proved into consideration, the Committee have found you guilty of serious professional misconduct.

The Committee have heard of your own profound distress at the breakdown of your marriage and isolation from your children but do not accept that this in any way diminishes the seriousness of your professional misconduct in forming a sexual relationship with Mrs. A, whether or not there had been any mutual consent. All patients must be regarded as potentially vulnerable and Mrs. A, because of her depressive illness, was clearly vulnerable. The primary responsibility of all doctors is to their patients but they also have a responsibility to the profession to ensure that their professional standards are not compromised.

In determining the action which should be taken against your registration, the Committee have taken into consideration the submission of your counsel, your own evidence, and the exceptional quality and number of testimonials strongly in your favour from patients, doctors, nurses and others within your local community. They have noted your public apology, your expressions of regret and your solemn undertaking that such behaviour will never be repeated. The Committee recognise that by admitting all the heads of charge, you have spared Mrs. A the further distress of appearing before the Committee. They have noted your willingness to admit your shortcomings and your inappropriate behaviour. They also note that there have been no previous proceedings brought against you by the General Medical Council in relation to your fitness to practise and that there have been no subsequent complaints against you since these events. The Committee have also heard from you that you have not practised medicine for a year.

In coming to their decision, the Committee have considered the issue of proportionality and have balanced the interests of patients and the public against your interests. The Committee have a duty to ensure the protection of the public, the maintenance of public confidence in the profession and the maintenance of proper standards of behaviour by all medical practitioners.

The Committee have decided that it is necessary to take action against your registration and have considered the range of sanctions available. The Committee are of the view that any sanction imposed must mark strong disapproval of your behaviour. They concluded that a reprimand would be insufficient.

The Committee seriously considered whether to order your erasure. In these particular circumstances, and mindful of the words of Lord Hoffman in the Privy Council judgment of Bijl (Appeal No.78 of 2000), "Procedures for dealing with doctors who lapse from professional standards 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 and punishment", they concluded that erasure would be disproportionate and not in the public interest. Similarly, a period of

suspension would be punitive and serve no purpose in addressing the deficiencies which led to your professional misconduct.

In order to retain the service of a competent doctor with an otherwise unblemished career, the Committee have determined to impose conditions on your registration for a period of two years as follows:

1. For the duration of these conditions you must not work in a single handed practice and you will obtain a substantive post in a group practice.

2. In that practice you will work with and be responsible to an experienced general practitioner with a background in training.

3. You shall consult with your postgraduate dean and then appoint a mentor approved by him for a period of two years to assist in the development of your self-management skills, in particular, maintaining appropriate boundaries. You will meet with the mentor at regular intervals.

4. You shall arrange for the provision of reports on your progress from your mentor and from your GP trainer to the General Medical Council.

The Committee will resume consideration of your case at a meeting to be held before the end of this two-year period. The Committee will then consider whether it is necessary to take any further action in relation to your registration. You will be informed of the date of the meeting and you will be invited to attend. The Committee would expect to see reports of your progress with particular references to self-management skills, in particular, maintaining appropriate boundaries.

The effect of the foregoing direction is that, unless you exercise your right of appeal, your registration will be subject to conditions for a period of two years commencing 28 days after formal notice of this direction is deemed to have been served upon you".

27. Mr. Howell has made a number of specific criticisms of the reasoning. He submits that the dictum of Lord Hoffman in *Bijl* has been misunderstood. That case involved a failure of medical care during an operation and involved a serious but honest failure. I see no reason to doubt that what Lord Hoffman said was intended to have and is properly regarded by the GMC as having general application, but the seriousness of the misconduct in question will dictate whether leniency is appropriate in a particular case. But there is an obvious public interest that the services of a competent and useful doctor should be retained if there is no danger to the public in so doing. Mr. Howell goes on to argue that the PCC could not properly have decided that there was no danger to the public since it felt it necessary to impose conditions. I disagree. The PCC was entitled to conclude that the existence of the conditions would remove any danger. It was entitled to accept Dr. Leeper's evidence which in this respect was supported by Dr. Webb, a professional whose opinion could properly be afforded considerable weight. I do not think that the PCC 's view was wrong. It is of course possible to argue the contrary case and Mr. Howell has done that with ability. But the points he makes, largely those which are relied on as aggravation of the misbehaviour, do not

properly take account of Dr. Webb's opinion or the evidence put before the PCC by Dr. Leeper.

28. The PCC's reasons for rejecting suspension are, however, flawed. They are contained in one sentence:-

"Similarly, a period of suspension would be punitive and serve no purpose in addressing the deficiencies which led to your professional misconduct".

29. This fails to consider the need to send out the right signals to the profession and to the public and to mark the seriousness of the misconduct. There is inevitably an element of punishment involved, but that is not the reason for imposing the sanction. In my view, Dr. Leeper's misconduct could not properly have attracted a sanction below that of suspension. I am satisfied that erasure was not needed and the matters of mitigation relied on by the PCC fully justified the decision not to erase. What it should have done was to suspend and impose the conditions at the conclusion of the suspension which, because Dr. Leeper had in fact not practised medicine for 12 months, could properly be for a shorter period than 12 months – see s.36(3)(c) of the Medical Act 1983. Mr. Henderson's submission that to impose conditions can be regarded as more severe than to suspend I do not find persuasive and it is contrary to the scheme of the 1983 Act.

30. I am therefore satisfied that the direction of the PCC was unduly lenient. However, I am equally satisfied that there is now no need to impose any suspension on Dr. Leeper. He has just started in practice again and it would not be in the public interest to remove him from practice having regard to his abilities as a doctor. To add to the stresses upon him and to expose him to the risk of suspension would in my view be wrong both for him and for the public. That being so, what I propose to do (subject to counsel urging a different course) is to remit the case with a direction that it should be noted against Dr. Leeper's registration that the court has decided that the decision to impose conditions was unduly lenient and that the PCC should have suspended him from practice. Beyond this no further action should be taken.

31. I only add that my decision in this case would not have been any different had I applied the test that Mr. Howell submitted to be correct rather than that undue lenience had to be established.

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