CO/5469/2017

Neutral Citation Number: [2018] EWHC 813 (Admin)

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

Royal Courts of Justice
Monday, 19th March 2018

Before:

MR JUSTICE ANDREW BAKER

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B E T W E E N :

THE GENERAL MEDICAL COUNCIL — Appellant

- and -

MAHER KHETYAR — Respondent

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MS J RICHARDS QC (instructed by GMC Legal) appeared on behalf of the Appellant (MS A HEARNDON appeared for judgment).

MS F HORLICK and MS P MAUDSLEY (instructed by Bankside Law) appeared on behalf of the Respondent (MR L GLEDHILL appeared for judgment).

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J U D G M E N T

MR JUSTICE ANDREW BAKER:

Introduction

1 This is an appeal brought by the GMC under s.40A of the Medical Act 1983 in respect of a decision of a misconduct tribunal of the Medical Practitioners Tribunal Service (respectively "the Tribunal" and "the MPTS") on 26th October 2017. The Tribunal imposed a sanction on the respondent, Dr Khetyar, of suspension of his registration for 12 months, with a requirement for review by another tribunal prior to expiry. The Tribunal decided not to direct that Dr Khetyar's name be erased from the register.

2 Erasure from the registry (in layman's terms, 'striking off') was the most serious sanction available to the Tribunal under s.35D of the 1983 Act, the Tribunal having found that Dr Khetyar's fitness to practise was impaired. It was submitted to the Tribunal on behalf of the GMC that the proper sanction in this case was erasure, because nothing short of erasure would be sufficient to satisfy the overarching objective of protecting the public. That overarching objective as stated at s.1(1A) of the Act involves the three particular objectives stated at s.1(1B), namely (a) protecting, promoting and maintaining the health, safety and well-being of the public, (b) promoting and maintaining public confidence in the medical profession, and (c) promoting and maintaining proper professional standards and conduct for members of that profession.

3 The GMC's contention on appeal is that the Tribunal's decision that suspension was a sufficient sanction is seriously flawed and wrong by reference to any or all of three grounds of appeal. By a fourth and final ground of appeal, the GMC contends that, standing back, the sanction of suspension did not reflect adequately the nature and seriousness of the misconduct the Tribunal had found proved. It therefore asks the court to quash the decision and substitute a sanction of erasure, or alternatively to remit the matter to the MPTS for a fresh decision as to sanction.

4 The Tribunal was urged on behalf of Dr Khetyar to conclude that the imposition of conditions on his registration was a sufficient sanction. He did not bring any appeal himself – that is to say he has not challenged and does not challenge the Tribunal's rejection of that contention and its decision to direct suspension of his registration – but he resists any suggestion that suspension did not go far enough.

5 I pay tribute at the outset to the clear, careful and helpful submissions addressed to me, both in writing and orally, by Ms Richards QC for the GMC and Ms Horlick, appearing with Ms Maudsley, for Dr Khetyar.

Out of time?

6 Before turning to the substance, I deal briefly with an argument raised by Ms Horlick that the appeal is out of time. Section 40A(5) of the 1983 Act provides that the GMC "may not bring an appeal under this section after the end of the period of 28 days beginning with the day on which notification of the relevant decision was served on the person to whom the decision relates." The relevant notification for that purpose does not refer to the handing down of its determination by the Tribunal, which in this case occurred on 26th October 2017,

but the written notification of the outcome to Dr Khetyar by the MPTS, which in this case occurred by email on 27th October 2017: see as to that *GMC v Narayan* [2017] EWHC 2695 (Admin).

7 This appeal was brought on 23rd November 2017, the 28th day of the 28-day period referred to by the Act if 27th October 2017 was the first day of that period. It was therefore in time. The MPTS notification letter to Dr Khetyar incorrectly informed him that it was deemed served on 26th October and that therefore any appeal had to be lodged on or before 22nd November. That error cannot deprive the GMC of the full 28-day period granted to it by statute in which to bring this appeal; nor would an appeal by Dr Khetyar have been out of time, had he wished to appeal, if lodged on 23rd November.

8 Ms Richards QC submitted if necessary that the statutory 28-day period should be construed as a period of 28 clear days consistently with the rule in CPR 2.8 for periods of time specified by the CPR, Practice Directions, or judgments or orders of the court. On that basis, the appeal would have been in time even if the decision notification was served on 26th October 2017. Ms Richards QC told me in that regard that the GMC routinely calculates time for filing an appeal under the 1983 Act in that way, whether the GMC or the doctor in question is appealing. Appeals by doctors are brought under s.40 of the Act and the language of the 28-day period provision there is identical.

9 I do not have proper evidence of that routine practice on the part of the GMC. On the face of things, it is not supported by the notification letter in this case. Be that as it may, the submission by reference to CPR 2.8 does not arise and I decline in those circumstances to express any view upon it having not heard full argument.

10 Finally, Ms Richards QC referred me to the decision of the Court of Appeal in *Adesina v Nursing and Midwifery Council* [2013] EWCA Civ 818; [2013] 1 WLR 3156 for the proposition that I would have power to grant an extension of time if required. She accepted that the court's jurisdiction in that regard is a very narrow one. Indeed, it is not so much a power to extend time in any ordinary sense; rather, it is a duty not to enforce the apparently absolute bar on appeals brought only after the end of the statutory 28-day period if enforcing that bar would infringe the appellant's rights under Art.6 of the ECHR as enacted into English law by the Human Rights Act 1998. As the Court of Appeal in *Adesina* emphasised, that makes the scope for departure from the 28-day time limit extremely narrow. It will be a rare case indeed where it is overridden by Art.6. This is not such a case.

<u>The approach on appeal</u>

11 The correct approach to be adopted for s.40A appeals was set out by the Divisional Court in *GMC v Jagjivan and PSA* [2017] EWHC 1247 (Admin) at [40] as follows:

> "In summary:
>
> (i) Proceedings under s.40A of the 1983 Act are appeals and are governed by CPR Part 52. A court will allow an appeal under CPR Part 52.21(3) if it is 'wrong' or 'unjust because of a serious procedural or other irregularity in the proceedings in the lower court'.
>
> (ii) It is not appropriate to add any qualification to the test in CPR Part 52 that decisions are 'clearly wrong': see *Fatnani* at para.21 and *Meadow* at paras.125 to 128.

(iii) The court will correct material errors of fact and of law: see *Fatnani* at para.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 paras.15 to 17, cited with approval in *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] UKHL 23, [2007] 1 WLR 1325 at para.46, and *Southall* at para.47).

(iv) When the question is what inferences are to be drawn from specific facts, an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR Part 52.11(4).

(v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence: see *Fatnani* at para.16; and *Khan v General Pharmaceutical Council* [2016] UKSC 64; [2017] 1 WLR 169, at para.36.

(vi) However there may be matters, such as dishonesty or sexual misconduct, where the court 'is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal …': see *Council for the Regulation of Healthcare Professionals v GMC and Southall* [2005] EWHC 579 (Admin); [2005] Lloyd's Rep Med 365 at para.11, and Khan at para.36(c). As Lord Millett observed in *Ghosh v GMC* [2001] UKPC 29; [2001] 1 WLR 1915 and 1923G, the appellate court 'will afford an appropriate measure of respect of the judgment in the committee … but the [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances'.

(vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice, because the overarching concern of the professional regulator is the protection of the public.

(viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the Tribunal's decision unjust (see *Southall* at paras.55 to 56)."

12 Both sides before me accepted that statement of principle.

The Sanctions Guidance

13 The Tribunal referred to the May 2017 Sanctions Guidance published jointly by the GMC and the MPTS for use by medical practitioners tribunals that have found fitness to practise to be impaired when considering what sanction to impose. It was common ground before me that the Tribunal was right to do so. Paragraph 3 of the guidance states that it exists to make sure parties are aware from the outset of the approach a tribunal will take to imposing sanctions, and that whilst a tribunal should use its own judgment in making its decisions, it "must base its decisions on the standards of good practice established in *Good medical practice* and on the advice given in this guidance".

14 In escalating order of severity, the sanctions available to the Tribunal were: to take no action, either without more, which would be exceptional where impairment has been found, or upon agreeing undertakings by the doctor sufficient to address the impairment; to impose conditions on the doctor's continued registration for a defined period up to a maximum of three years, although, if imposed, conditions can be renewed on review; to suspend the doctor's registration for up to 12 months; to erase the doctor's name from the register.

15 Where suspension is imposed, a tribunal may direct that it be reviewed by another tribunal prior to expiry. Where review has been directed, the MPTS has a statutory obligation under s.35D(4A) to arrange for such a review tribunal. Where review has not been directed, nonetheless the Registrar may refer the case during the suspension period for review, and, where that occurs, again the MPTS must arrange for a review tribunal (s.35D(4B)). The Sanctions Guidance includes this advice for tribunals to follow when acting as suspension review tribunals:

> "163. It is important that no doctor is allowed to resume unrestricted practice following a period of conditional registration or suspension unless the tribunal considers that they are safe to do so.
>
> 164. In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. However, in most cases where a period of suspension is imposed, and in all cases where conditions have been imposed, the tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions or further conditions. A review hearing is therefore likely to be necessary, so that the tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):
>
> (a) they fully appreciate the gravity of the offence
>
> (b) they have not reoffended
>
> (c) they have maintained their skills and knowledge
>
> (d) patients will not be placed at risk by resumption of practice or by the imposition of conditional registration."

16 Suspension review tribunals are entitled to renew the suspension for a further period of up to 12 months, in which case they may again direct review; to impose conditions for up to three years; or indeed to impose erasure; as well, of course, as being entitled in an appropriate case to allow the doctor to resume unrestricted practice. For completeness, I should add that special rules apply to cases concerned with a doctor's own ill-health or inadequate knowledge of English. No such considerations arise in this case, and nothing I say in this judgment is intended to relate to that type of case.

17 Ms Horlick emphasised that in the present case the Tribunal had imposed suspension for the maximum period of 12 months with a direction for review. It was, therefore, she said, quite uncertain whether Dr Khetyar would return to practise at the end of the suspension period or at all. On the other hand, erasure is not necessarily permanent, since application can be made for restoration to the register, albeit not until at least five years after erasure was directed. The difference between a maximal suspension and erasure is thus, she contended, not quite so stark as might perhaps be suggested by a simple consideration of the linguistic contrast between 'suspending' and 'striking off'.

18 In my judgment, however, the difference is real and substantial, not only because of the contrasting periods to any first 'review' (five years versus maximum 12 months). Erasure, if properly imposed, will reflect a conclusion that the doctor in question "should not practise again either for public safety reasons or to protect the reputation of the profession". Any application to be restored will start from that premise as of the date of the sanction decision. By contrast, a decision to suspend, though it could potentially lead to erasure, will reflect a conclusion at the date of the sanction decision that neither reasons of public safety nor the protection of the reputation of the profession mean that the doctor in question should not practise again.

19 The text I have just quoted as encapsulating the conclusion required for erasure to be imposed I take from para.92 of the Sanctions Guidance, which identifies when suspension will be appropriate in the following terms:

> "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. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e. for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession)."

20 In substance, therefore, an appeal by the GMC against a suspension, contending that instead erasure should have been the sanction, is an appeal challenging the Tribunal's failure to conclude that on the material before it the doctor in question should not practise again. The Sanctions Guidance advises at paras.20, 21 and 67 that tribunals must consider sanctions from the bottom up; that is to say, starting with the least restrictive and working upwards if and as each possible sanction is successively concluded to be insufficient. Ms Horlick was correct, therefore, in my judgment, in her submission that if the Tribunal in this case properly concluded that suspension was sufficient, it rightly stopped there and imposed that sanction. At the same time, in my judgment, Ms Richards QC was correct in her submission that a proper conclusion that suspension is sufficient cannot be reached without reference to and careful consideration of advice in the Guidance that erasure may be or is likely to be appropriate where that advice is pertinent to the facts of a particular case.

21 That is correct in principle, because by definition Guidance advice as to when erasure may be or is likely to be appropriate is advice as to where the line is to be drawn between the most serious misconduct because of which a doctor should not be allowed to practise again, and misconduct that falls short of that whilst still being very serious. As Ms Richards put it, such advice is an authoritative steer for tribunals as to what is required to protect the public, even if it does not in any particular case dictate the outcome.

22 As part of Guidance at the heart of which is the principle of proportionality (weighing the public interest against the individual interests of the particular doctor), such advice is an authoritative steer in particular as to the application of that principle. Again, of course, it remains advice and not prescription: tribunals must ultimately judge each case on its own merits, and are entitled in principle to depart from that steer. Doing so, however, requires careful and substantial case-specific justification. A "generalised assertion that erasure would be a disproportionate sanction and that the doctor's conduct was not incompatible with his continued registration", where the Guidance gives a clear steer towards erasure, properly considering what it says about important features of the case in question, will be inadequate and will justify the conclusion that a tribunal has not properly understood the gravity of the case before it: see *GMC v Stone* [2017] EWHC 2534 (Admin) at [53].

23 I shall consider individual pieces of advice in the Sanctions Guidance that the Tribunal thought or should have thought applied in this case when I consider the Tribunal's decision. Before turning to that, however, I wish to say something about para.97(a).

24 Paragraph 97 contains seven subparagraphs at (a) to (g), introduced as follows:

> "Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate."

25 As regards erasure, para.109 contains ten sub paragraphs, (a) to (j), introduced as follows:

> "Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive)."

26 Each of paras.97(b) to 97(g) and 109(a) to 109(j) is a particular factor that may be present, the presence or absence of which can be assessed independently of the ultimate question whether suspension at least is required, and, if so, which side of the dividing line between suspension and erasure the case falls. That is what the respective introductory words I have just quoted would lead one to expect. It is then the presence of the factor in question in para.97 or para.109, as the case may be, given those introductory words, that constitutes informative advice as to the location of that dividing line. Paragraph 97(a) by contrast merely states the ultimate conclusion required for the view to be taken that suspension is indeed the proper sanction:

> "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."

27 Thus, a statement by a tribunal that in its view para.97(a) applies or is pertinent, is no more than a statement of its ultimate conclusion that suspension is the correct sanction; it cannot justify or explain that conclusion.

<u>The serious misconduct</u>

28 Dr Khetyar's misconduct related to three young women: Nurse A, Patient B and Patient C. Nurse A was a nurse at Caithness General Hospital where Dr Khetyar was working in October 2004. The detailed facts do not matter for my purposes. The facts proved (Nurse A made other allegations that were found not proved) amounted to a series of minor episodes on 19th October 2004 amounting to sexually motivated pestering or harassment. This was unacceptable behaviour, impermissibly crossing proper professional boundaries, aggravated by Dr Khetyar's seniority relative to Nurse A. The Tribunal concluded that it did go far enough to constitute serious misconduct. It is not clear to me whether there would have been a finding of impairment on the basis of it had it stood alone. In any event, it was an isolated incident, eight years before the much more serious misconduct I am about to outline in relation to Patients B and C that was wholly different in character. I am quite satisfied that the incident with Nurse A as proved could not have justified erasure and could not properly have tipped any balance between suspension and erasure if the misconduct in relation to Patients B and C did not otherwise call for erasure.

29 Patients B and C were sexually assaulted by Dr Khetyar in worryingly similar ways, in July 2012 and July 2013 respectively. Following the incident with Patient C, Dr Khetyar did not

work as a doctor for three years. He had then worked as a doctor again for a period of nine months or so up to April 2017 before the Tribunal hearing with which I am concerned.

30 As regards Patient B, in July 2012 Dr Khetyar was a specialist registrar in London also undertaking locum work through an agency. On 5th July 2012, on a locum shift at St Peter's Hospital in Chertsey, Dr Khetyar encountered Patient B. She had been admitted the previous day having suffered a right-sided pneumothorax (i.e. a collapsed lung). Her lung was aspirated and on the morning of 5th July she had had a chest X-ray to check the success of the procedure. She was moved to a ward and was anxious to know the results of her X-ray. A nurse attended and administered painkillers. Patient B again asked about her X-ray result.

31 Shortly after this, Dr Khetyar arrived at Patient B's bed space, telling her he had her X-ray results. The nurse left and drew the bed curtains closed behind her. Dr Khetyar told Patient B he was going to examine her. He tapped down the right side of her chest and then, without warning, proceeded to cup and squeeze her right breast. He then repeated the same sequence on the left side of her chest, tapping down the side before cupping and squeezing her left breast. Patient B asked again about her X-ray and Dr Khetyar told her it was fine.

32 A little later, Patient B asked the nurse who had attended her for the name of the doctor who had examined her, as she felt the examination had been strange. She told the nurse that the doctor had touched her breasts. The nurse told her she would speak to the ward sisters, and returned shortly with two other nurses, to whom Patient B again disclosed what had happened. The following morning Patient B signed an incident form and disclosed the incident to her parents when they attended to visit her. A different doctor attended her and told her that the lung had not in fact recovered fully; she would require a further procedure. Her family arranged for this to be done in a different hospital, and at the end of the month after her discharge from the other hospital she typed up an account of the incident with Dr Khetyar and contacted Surrey Police.

33 Dr Khetyar was interviewed in November of that year, but ultimately the police did not pursue a prosecution; nor, although the matter had been referred to it, did the GMC at that time take further action, as Patient B indicated she did not wish at that stage to pursue the matter further. The Tribunal heard and accepted expert evidence confirming that what Dr Khetyar had done formed no part of any legitimate respiratory examination. They concluded that there was no other motivation for his actions other than a sexual motivation.

34 As regards Patient C, on 3rd July 2013 Dr Khetyar was working at High Wycombe Hospital. At about 8.00 a.m. that day a patient was brought in with chest pain. Patient C was not that patient but one of the paramedics who brought the patient in. Patient C reported a headache and knocked on the door of the ward office where Dr Khetyar and another doctor were sat, asking if they could find her some paracetamol for the headache. Hence I refer to her as 'Patient' C, the relevant interaction with Dr Khetyar being effectively as patient, not, or not merely, as a medical colleague.

35 Dr Khetyar first suggested that Patient C go to the bay next to the ward office and check her own blood pressure. It was agreed between the experts that there was nothing untoward about this, although it was an unusual step that most doctors would not have taken. When Dr Khetyar himself went to the bay and Patient C reported that her blood pressure reading was normal, he then asked to listen to her heart sounds, which Patient C thought was unnecessary but consented to. Dr Khetyar then attempted to take Patient C to a private room away from the treatment area, normally used as a relatives' room. However, that was found to be locked. Dr Khetyar did not know the code, so he took Patient C back to the cubical

and asked her to undo her shirt. He then drew the cubical curtains around the bed, listened very quickly using his stethoscope to her heart. Having done this, he put his left hand inside her bra and squeezed her left breast for a few seconds, then his right hand inside her bra and squeezed her right breast for a few seconds. He said nothing to Patient C before or during those actions. He then asked a nurse to fetch some paracetamol and, after Patient C took the paracetamol, he left.

36 Patient C was confused and disturbed by the experience and immediately reported it to her ambulance crew colleague. He confirmed her instinct that it was not appropriate; indeed, he said he thought she had just been sexually assaulted and should report it. She contacted her manager on return to her base and the police were subsequently called.

37 The Tribunal found that Dr Khetyar's evidence in relation to his interaction with Patient C, which included a suggestion that he could not see and did not know that his hands had gone inside her bra, to be incredible. They heard and accepted expert evidence that what Patient C had described as having happened, and the Tribunal accepted that explanation, formed no part of any legitimate medical examination called for by her presentation. They concluded that there could be no interpretation of the facts other than a deliberate intent to touch Patient C's breasts in a physical examination that was not clinically indicated. They concluded that where a doctor takes a patient to a private room with no clinical indications for a cardiac examination and proceeds then to squeeze the breasts of the patient, there was no explanation other than sexual motivation for the circumstances.

38 The Tribunal had heard evidence from Patient B, Patient C, the experts I have mentioned and, of course, Dr Khetyar. In relation to Dr Khetyar's evidence they found some of what he said credible but also some of what he said not credible. There were inconsistencies in his account in their judgment. There were unpersuasive explanations. In the Tribunal's view, Dr Khetyar was guilty of embellishing his evidence in retrospectively trying to justify his actions. He gave evidence that lacked focus, that drew in extraneous points and overall lacked credibility. They found him, as a result, to be "largely unreliable" as a witness before them.

39 The Tribunal's conclusion in each case therefore was that, with a sexual motivation, Dr Khetyar had fondled the breasts of a young woman patient "in the guise of a medical examination". That was a gross, flagrant and deliberate abuse of trust between doctor and patient. In each case there were associated medical practice failings. Even if, as Dr Khetyar maintained, and so I understand it still maintains, he was conducting a medical examination properly indicated by the respective patients' presentation, he failed to offer or ensure the presence of a chaperone, and in the case of Patient C attempted to conduct the examination in a private room and failed to communicate why he was conducting the examination or what it would entail.

40 Those are significant failings. A medical examination properly indicated and conducted may involve intimate touching. Conducting such an examination without a chaperone or without adequate explanation to the patient is apt to create real concern in the mind of the patient as to the propriety of what is happening. That in turn is apt to undermine public confidence in the profession. The Tribunal nonetheless concluded that those failings did not amount to serious misconduct in this case. I do not need to express any final view as to that, but in the absence of detailed argument I certainly would not want to be taken to endorse that conclusion. But whether that conclusion was right or wrong, the true gravamen of this case was not those clinical practice shortcomings; the sexually motivated cupping and squeezing of Patient B and Patient C's breasts in each case in the guise of a medical

examination was misconduct of an entirely different character and different order of seriousness.

The sanction decision

41 The Tribunal stated firstly, and in the usual way, that it had reviewed all the evidence it had received for its fact finding and its consideration of impairment. It then referred to testimonials received from colleagues speaking to Dr Khetyar's clinical skills and general good character; to evidence of courses and further learning undertaken since July 2013; to Dr Khetyar's reflective statement and further oral evidence given at the sanctions stage, to which I will return; and to his and his wife's evidence of the hardship that his not being able to work as a doctor had caused and would cause. The Tribunal then summarised the submissions as to sanction it had received on both sides before proceeding to set out its reasoned decision.

42 To understand the criticisms of that decision advanced by the GMC and my consideration of those criticisms, it is important to see the Tribunal's reasoning in full. It was as follows:

> "Tribunal's Approach
> 17. In reaching its decision, the Tribunal has formed its own judgment as to the appropriate sanction. It has applied the principle of proportionality, weighing the public interest with your interests. It has had particular regard to the guidelines set out in SG.
>
> 18. Throughout its deliberations the Tribunal has borne in mind that the purpose of sanctions is not to be punitive, but to protect the public interest. The public interest includes protecting the health, safety, and wellbeing of the public, maintaining public confidence in the profession, and declaring and upholding proper standards of conduct and behaviour.
>
> Aggravating and Mitigating Factors
> 19. The Tribunal first considered the aggravating and mitigating factors in your case. In mitigation, the Tribunal has taken account of your reflective statement. This shows some development of insight, albeit only related to your failings in not offering a chaperone, not explaining your examinations and not recording in the notes. However, it notes that you have sincerely apologised to Nurse A, Patient B and Ms C and there is an acceptance of some of the Tribunal's findings and acknowledgement of the effect of those findings on the reputation of the profession and some recognition of the seriousness of your misconduct. The Tribunal has taken full account of your previous good character. You have not been the subject of any other GMC proceedings. It has taken account of the testimonial evidence adduced on your behalf, and the fact that by all accounts you have continued to work effectively as a doctor in the period since your suspension was lifted. The Tribunal also notes the significant personal difficulties that you have faced.
>
> 20. The Tribunal recognises that you qualified in Syria and registered with the GMC in December 2003. However, it has taken into account paragraphs 27 and 28 of the SG which states:
>
> > '*When a doctor graduates from medical school and begins working in the UK, they may well experience a steep learning curve as they take on new responsibilities. As a doctor's medical career progresses, the tribunal would expect the doctor to gain increased understanding of the social and cultural*

context of their work, appropriate standards, and national laws and regulations that apply to their area of work.

Many doctors joining the medical register have previously worked, lived or were educated overseas, where different professional standards and social, ethnic or cultural norms may apply. Doctors are expected to familiarise themselves with the standards and ethical guidance that apply to practising in the UK before taking up employment, although experience of working as a doctor in the UK plays a key role in their development.'

21. The Tribunal has acknowledged the cultural differences but noted that you had been practising in the UK for some 5 years at the time of the incident with Nurse A and you were well established by the time of the incidents with Patient B and Ms C.

22. The principal aggravating factor is that your conduct was sexually motivated. The Tribunal considered the fact that Nurse A, Patient B and Ms C were young women. In relation to Nurse A, you had persistently followed her and pestered her for her telephone number. The persistence of your advances considerably increases the seriousness of your misconduct.

23. In relation to Patient B, the Tribunal noted that she was a young woman who was in hospital, in pain and was anxious about her x-ray results, when you abused your position of trust and cupped and squeezed her breasts in the guise of a medical examination.

24. In relation to Ms C, although a paramedic who was clearly well informed and knowledgeable on medical examinations, you again abused your position of trust and cupped and squeezed her breasts in the guise of a medical examination. The Tribunal found most troubling her account and her evidence that she did not want to think that you had done something wrong. Her evidence was compelling and clearly demonstrated the impact your actions had on her.

25. The Tribunal notes with concern that by the time you acted as you did in relation to Ms C, you had been involved in not one but two investigations of alleged sexual assault and knew moreover that the absence of a chaperone in your dealings with Patient B was a crucial omission when having to explain your conduct after the event. Further, you had argued in your police interviews in respect of Patient B and Ms C that you were undertaking legitimate clinical examinations.

26. The Tribunal notes that the incidents occurred from 13 to 4 years ago and that there has been no repetition. The Tribunal notes the evidence adduced as to the steps you have taken in remediation, including the completion of relevant courses. It notes that you respected but did not accept the Tribunal's findings on facts and impairment, in relation to sexual misconduct. The Tribunal recognises that it is difficult to demonstrate insight when denying the sexual misconduct occurred.

Tribunal's Decision

No Action

27. The Tribunal first considered whether it would be appropriate and proportionate to take no action against your registration. It was of the view that there are no exceptional circumstances in this case that would justify taking no action and that to do so would be wholly insufficient to protect the public interest.

Conditions
28. The Tribunal next considered whether it would be sufficient to place conditions on your registration. It has borne in mind that any conditions would need to be appropriate, proportionate, workable and measurable. The Tribunal notes that you have already attempted to remedy many of the failings identified and completed appropriate courses. However, the issue of concern in this case has been your sexually motivated behaviour and the Tribunal does not regard conditions as sufficient to maintain confidence in the profession, nor would they adequately uphold proper standards of conduct. Accordingly, it has determined that this course of action would not be an appropriate or proportionate sanction in your case.

Suspension
29. The Tribunal then considered whether it would be appropriate to order that your registration be suspended. In this regard, it has taken account of the paragraphs in the SG that deal with suspension, which state that suspension will be appropriate where the intention is to signal to the doctor, the profession and the public at large, that the conduct at issue is unacceptable, but falls short of being fundamentally incompatible with continuing registration.

30. The Tribunal has taken account of the criteria set out at paragraph 97 of the guidance and considers the following sub-sections are appropriate in your case:

> '*(a) A serious breach of Good medic al practice where the misconduct is not fundamentally incompatible with continued registration and where therefore complete removal from the medical register would not be in the public interest, but which is so serious that any sanction lower than a suspension would not be sufficient to serve the need to protect the public or maintain confidence in doctors*
>
> *(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.*'"

43 Pausing there, I should say that reading the decision fairly to the Tribunal, I interpret para.30 as stating conclusions that paras.97(a), 97(f) and 97(g) of the Sanctions Guidance applied on the facts before it. I have already observed that the first of these does no more than state the ultimate conclusion that suspension was the right sanction and cannot explain or justify that conclusion. The second and third of the grounds of appeal advanced by Ms Richards QC for the GMC specifically challenge the conclusions that paras.97(f) and 97(g) apply.

44 The Tribunal continued thus:

> "31. As expressed in its impairment determination, the Tribunal considers that your behaviour is a serious departure from GMP. You do not accept that your behaviour was sexually motivated or that it could be viewed as such. The Tribunal disagreed. However, it is of the view that you have displayed genuine remorse for your actions and you are developing insight. You have taken appropriate steps to learn from your failings and you have adhered to GMP in your most recent role. You also received positive feedback regarding your performance and the Tribunal has heard evidence how you now always offer chaperones, even with non-intimate examinations. You stated that you have learnt your lesson and the Tribunal is satisfied that the risk of repetition is not high.

32. Given the seriousness of your misconduct, the Tribunal considered whether erasure was the appropriate sanction in your case. It has determined that the sanction of erasure would be disproportionate in your case; particularly as the public interest can best be served by allowing you, in due course, to continue to serve your patients in the field of geriatric medicine. Moreover an order of suspension would send a sufficient signal to you, to the profession and to the public that such misconduct is unacceptable, and would underline the gravamen of your misconduct.

33. In all the circumstances of this case, taking due account of the public interest and exercising its own judgement, the Tribunal has determined that suspension is the appropriate and proportionate sanction.

34. Having determined that suspension is sufficient, the Tribunal then considered what period would be appropriate. The Tribunal notes that although you have undertaken remediation by completing appropriate training and courses you will still need to further reflect and develop your insight. The Tribunal has concluded that in order to signal the seriousness with which it views your misconduct and to allow you sufficient time to further reflect, it is appropriate and proportionate to direct the Registrar to suspend your registration for the maximum period of 12 months.

35. Before the end of the period of suspension, a Fitness to Practise Tribunal will review your case and a letter will be sent to you about the arrangements for the review hearing, which you will be expected to attend. At the review hearing that Tribunal may be assisted by the following:

- A reflective account addressing what you have learned in respect of the Tribunal's findings of facts and impairment and demonstrating your level of insight;

- evidence of your plans for return to medical practice including evidence of how you have maintained your clinical skills and medical knowledge; and

- current testimonials as to your character and conduct during the period of your suspension, written in the knowledge of your suspension by this Tribunal."

Grounds 1 to 3

45 The first three grounds of appeal all concern the Tribunal's treatment or application of the Sanctions Guidance. Ground 1 asserts generally that the Tribunal failed to have proper or sufficient regard to the guidance. Grounds 2 and 3 assert that the Tribunal's findings as to insight and risk respectively are flawed and wrong.

46 Although Grounds 1 to 3 were raised as independent grounds, Grounds 2 and 3 go directly to the Tribunal's conclusion that paras.97(f) and 97(g) of the Guidance applied. In truth, therefore, Grounds 2 and 3 are bound up with the charge that the Tribunal failed to base its decision on the advice given in the Guidance. I find it convenient to take Grounds 1 to 3 together, and indeed to take Grounds 2 and 3 first.

47 The objective facts relevant to issues of insight and risk, and thus to the applicability of paras.97(f) and 97(g), were these as found by the Tribunal:

(1) Dr Khetyar had pretended to conduct legitimate medical examinations on Patients B and C, in each case fondling their breasts for sexual reasons.

(2) Dr Khetyar continued to deny that he had done any such thing, and had given unreliable and in parts incredible evidence in his attempts to describe or explain events.

(3) There had been two similar incidents only a year apart. They were both recent in the relevant chronology, that of Dr Khetyar's working life, given that he had worked for only about nine months since the second incident. The second incident occurred despite the fact that the first led to both a police investigation and a referral to the GMC that went no further only because Patient B did not want matters to be pressed.

(4) Dr Khetyar had, since, undertaken courses relevant to the clinical practice failings he had admitted and relevant to his misconduct in relation to Nurse A. They included what Ms Horlick told me is regarded as the 'gold standard' course concerning the proper maintenance of professional boundaries.

(5) On his terms (that is to say, where his only misconduct had been those clinical practice failings), Dr Khetyar was genuinely sorry he had fallen short of proper standards and sincere in his apologies. Those apologies were recorded in his reflective letter prepared before the hearing, so before the fact-finding and impairment decision that went against him, and were repeated in his oral evidence at the sanctions stage. They were to the effect, so far as material, that if Patients B and C felt their dignity had been invaded or not respected he was truly sorry and he could see how his bad practice as regards chaperones and explaining what he was doing could create that feeling.

48 If indeed Dr Khetyar's only misconduct had been his failures in relation to communication and the use of chaperones, and if that had been held to be serious misconduct impairing fitness to practise so that the question of sanction arose at all, then I can see how the Tribunal could reasonably have concluded that he now had insight and did not present any significant risk of repetition. But I agree with Ms Richards QC's submission that the circumstances provided no basis at all for any conclusion that Dr Khetyar had insight or even was developing insight in relation to his serious sexual misconduct as found by the Tribunal, or for a conclusion that there was not a significant risk of the behaviour being repeated.

49 Of course, no sanction was to be imposed on him for his denials as such; however, insight requires that motivations and triggers be identified and understood, and if that is possible at all without there first being an acceptance that what happened did happen it will be very rare, and any assessment of ongoing risk must play close attention to the doctor's current understanding of and attitude towards what he has done. The courses Dr Khetyar had undergone had no relevance to the true gravamen of the case proved against him, except perhaps in the rather limited sense that if he had indeed learnt to make proper use of the offer of chaperones that might reduce the opportunity for any further sexual assaults on patients. His apologies had nothing to say as to insight or risk or even as to remorse in relation to the sexual assaults found proved by the Tribunal.

50 As regards insight, the Tribunal correctly identified at para.19 of their decision that Dr Khetyar had only shown "some development of insight" as regards his failings in not offering a chaperone, not explaining his examinations and not making proper records. That is not capable of justifying a conclusion that he was developing insight in relation to sexually assaulting patients in the guise of medical examinations. No other basis for that conclusion is identified by the Tribunal.

51 As regards Dr Khetyar's apologies, it seems from the Tribunal's impairment decision that it did appreciate their limited scope. But their limited scope rendered them of no value in considering the proper sanction in relation to the sexual assaults on Patients B and C, and

the Tribunal was, in my judgment, wrong to treat Dr Khetyar's apologies and associated genuine remorse as of any assistance in that consideration.

52 As regards risk of repetition, the Tribunal found the risk not to be high, but para.97(g) called for consideration of whether the risk was significant. Depending on the seriousness of the conduct in question, a quantitatively small but nonetheless real (not fanciful) chance of re-occurrence might be significant. In any event, the Tribunal's conclusion was consistent with there being a substantial risk of repetition; in other words, on any view, a significant risk. Furthermore, in my judgment, the Tribunal's analysis of the facts is badly flawed. It described the situation as one in which "the incidents occurred from 13 to 4 years ago and ... there has been no repetition". The relevant facts, however, were that there had been two relevant incidents, the sexual assaults on Patients B and C, only a year apart, since when Dr Khetyar had only worked for about nine months. As regards the incident involving Patient B, the incident involving Patient C was itself a repetition of disturbingly similar behaviour. To my mind, para.97(f) of the guidance is expressed in the singular for a good reason: it did not apply here.

53 Properly considering its own findings as to what Dr Khetyar did to Patient B and Patient C, and as to Dr Khetyar's understanding of and attitude towards what he had done, therefore, in my judgment the Tribunal was bound to conclude: that Dr Khetyar had no insight, nor had he begun to take any steps towards developing insight; that there was evidence of, indeed the finding against him was of, repetition of similar behaviour; and that it could not be satisfied he did not pose a significant risk of further repetition. In my judgment, there was no reasonable basis for the Tribunal's conclusions that paras.97(f) and 97(g) of the guidance applied. On a proper analysis, neither applied.

54 The Tribunal's conclusion that suspension was the appropriate sanction is therefore undermined. Its logic was that since paras.97(f) and 97(g) applied, the case was one in which the steer from the Guidance was squarely towards suspension. The consideration of whether nonetheless erasure should be directed was in that context, and was therefore flawed. However, I also agree with Ms Richard QC's more general challenge under her Ground 1, that the Tribunal failed to have proper regard to the Guidance. Just as in *GMC v Stone* (supra), the Tribunal has provided a generalised assertion that erasure would be disproportionate without taking account of the very clear steer given by the Guidance that erasure, far from being disproportionate, would be both proportionate and probably appropriate. In that regard, the Tribunal's general reference in para.17 to having had "particular regard to the guidelines set out in SG" is equally inadequate to explain, let alone justify, a decision not to follow that steer.

55 According to para.29 of the decision, the paragraphs of the Guidance taken into account were those dealing with suspension, and although the Tribunal recorded when summarising the GMC's submissions on sanction that the paragraphs dealing with erasure had been referred to, they are nowhere mentioned, let alone considered, in the Tribunal's own reasoning. Of course, if those paragraphs did not provide a very clear steer, as I have put it, towards erasure, the Tribunal's failure to have regard to them might not vitiate its decision, although it would still have been preferable for that element of reasoning to be set out. As it is, however, the Guidance does indeed give the clearest possible steer, in my view, that erasure was proportionate and likely to be correct. Thus:

(1) The steer provided by para.109 of the Guidance is that erasure may be appropriate if any one of the factors listed is present. That does not mean erasure must follow whenever para.109 applies; it does, though, mean a tribunal ought to consider erasure very seriously when para.109 does apply, especially if it does so on multiple grounds, in which case

powerful case-specific reasons ought to be required if a decision against erasure is to be justified.

(2) In the present case, all of the following subparagraphs of para.109, to my mind, plainly applied:

(a) "*A particularly serious departure from the principles set out in* Good medical practice *where the behaviour is fundamentally incompatible with being a doctor."*

In contrast to para.97(a), as I observed earlier in this judgment, that language does not beg the ultimate question of appropriate sanction. It envisages the possibility that the commission of some behaviour that is by nature fundamentally incompatible with being a doctor might nonetheless in a particular case not result in erasure. For example, a case in which, whilst the behaviour was of such a nature, paragraphs such as paras.97(f) and 97(g) of the Guidance applied, as the Tribunal mistakenly thought they did in this case, might well lead in a particular case to a decision that erasure was not required to protect the public. As to the applicability of this factor in the present case, in my judgment it should go without saying (although Ms Horlick was not disposed ultimately to accept this in unqualified terms) that sexually assaulting patients in the guise of conducting medical examinations is indeed behaviour 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*."

If the Tribunal's conclusions had been that there was here inappropriate conduct but ultimately it was a matter of misunderstanding, this factor may not have applied. But the Tribunal's finding was, again, a finding of sexual assault in the guise of conducting medical examinations that were not indicated. They found deliberate conduct that in my judgment they were bound to regard as at least a reckless disregard for proper practice and patient safety.

(c) "*Doing serious harm to others (patients or otherwise), either deliberately or and through incompetence and particularly where there is a continuing risk to patients*..."

(d) "*Abuse of position/trust (see* Good medical practice, *para.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*..."

It seems to me no particular observation is required in relation to the obvious presence in this case of each of factors (c), (d) and (e).

(f) "*Offences of a sexual nature, including involvement in child pornography*..."

In my judgment, contrary to a submission of Ms Horlick, this factor is not limited to convictions in a criminal court for sexual offences. In this case, the Tribunal found conduct proved that was by nature, as I have said a number of times, the commission of sexual assaults. It was bound to proceed on the basis of those findings and not on the basis of whether a jury in criminal proceedings, if brought, had been persuaded so as to be sure, by evidence that may or may not have been identical in any event to the evidence before the Tribunal, that offences had been committed.

(i) "*Putting their own interests before those of their patients*..."

(j) "*Persistent lack of insight into the seriousness of their actions or the consequences*."

As regards that last factor, Ms Horlick submitted that even if the conclusion on appeal was, as it has been, that there was no proper basis for a decision that Dr Khetyar had or was developing relevant insight, I should read the decision of the Tribunal as indicating at least that he was capable of developing insight. In my judgment, there was equally no basis in evidence before the Tribunal for any conclusion of that kind; to the contrary, and for the reasons I have indicated already when dealing with Grounds 2 and 3, in my judgment this was a case in which the Tribunal, if it had had proper regard to this part of the Sanctions Guidance, was bound to conclude that there was here a persistent lack of insight on the part of the doctor.

(3) Furthermore, the Guidance contains the following pertinent advice about sexual misconduct:

> "Sexual misconduct
>
> 149. This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child pornography) to sexual misconduct with patients, colleagues, patients' relatives or others. See further guidance on sex offenders and child pornography at paragraphs 151-159.
>
> 150. Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases."

56 Overall, therefore, the proper approach to the question of sanction in Dr Khetyar's case was that erasure was squarely indicated by the Sanctions Guidance as proportionate and appropriate, absent powerful case-specific reasons to the contrary. The Tribunal's approach, in substance and to the contrary, was to say that suspension was squarely indicated by the Guidance as proportionate and appropriate, and having for completeness considered whether to impose erasure nonetheless it did not feel compelled to do so. That approach is flawed and wrong for the reasons I have identified.

57 Likewise, the Tribunal's view that suspension would send a sufficient signal to the profession and the public was a view based upon its flawed conclusion that the Guidance indicated that suspension was indeed sufficient, and had no regard to the advice in the Guidance upon multiple grounds that it was insufficient and that, to the contrary, erasure was indicated.

Ground 4

58 That brings me to the final ground of appeal. In the light of what I have already said, I can take this relatively briefly. As regards approach, if, despite the Tribunal's flawed approach, I can be clear that the correct sanction was nonetheless imposed, my final decision should be to dismiss the appeal. If to the contrary I can be clear that erasure was the correct sanction, my decision should be to allow the appeal, quash the Tribunal's decision and substitute a direction for erasure. If, however, I do not regard it as clear either that the suspension imposed was the correct sanction or that erasure was the correct sanction, then I should allow the appeal, quash the Tribunal's decision and remit the matter to the MPTS for a fresh decision on sanction in the light of this judgment. In that last case, a question would arise

whether there should be a direction on the remission that the new decision on sanction be taken by a differently constituted tribunal.

59 In relation to substituting my own direction of erasure, Ms Richards QC accepted the test stated by Jay J in *GMC v Stone* (supra) at [65], namely that I should do so only if the correct outcome is so clear that there would be no point in remitting. In my judgment, that test is satisfied here. It might have been a more difficult judgment if the case marginally engaged para.109 of the Guidance but at the same time several indicia of suspension only applied from para.97. As it is, para.109 was squarely engaged for multiple reasons, and none of the indicia in para.97 applied.

60 Ms Horlick submitted that I should regard the sexual assaults in this case as towards the lower end of a spectrum of possible conduct constituting sexual assault. Whatever force there may be in that, it seems to me not to engage with the relevant question, which is where sexually assaulting patients in the guise of conducting medical examinations falls in the sanctions spectrum (wherever the particular assaults might fall on any spectrum of sexual assaults), and the appropriate attitude of a tribunal to what is required therefore for the protection of the public, in particular having regard to the importance of maintaining the public's confidence in the profession. The only case-specific factor identified by the Tribunal as suggesting that erasure might be disproportionate – and this was not a factor concerning the relative seriousness of these particular sexual assaults – was a public interest in Dr Khetyar being able to serve geriatric patients in the future. However, there was nothing to indicate, with respect, that there is anything special about Dr Khetyar's case in that respect. It is a sadness to lose any otherwise good clinician from the profession, but it is a fundamental tenet of the sanctions regime, reflecting the statutory overarching objective, that the reputation of the profession as a whole is more important than the interests of any individual doctor. In my judgment, there is nothing in the case-specific circumstances of this appeal capable of justifying the Tribunal in departing from the very clear steer towards erasure it should have identified from the Sanctions Guidance. The proper sanction in this case was and is clear, having due regard to that Guidance, and that was and is erasure.

Conclusion

61 For all those reasons, this appeal is allowed. The Tribunal's sanction determination dated 26th October 2017 is quashed and I substitute for it a direction that Dr Khetyar's name be erased from the register. I shall hear counsel as to costs and any other consequential matters that may arise.

MR JUSTICE ANDREW BAKER: That is the end of the judgment. Now, having said what I've just said, I'm all ears as to whether you wish to deal with any of those consequential matters today or whether there's an application for that to be dealt with by counsel primarily instructed, in which case I would be happy to deal with it on paper. I'm in your hands.

MS HEARNDON: My Lord, I'm instructed to seek the Council's costs today. I've got a schedule in respect of the hearing on 13th March and on the 19th, and those have both been served. I don't know whether my Lord has a copy? If not, I can hand these up for speed.

MR JUSTICE ANDREW BAKER: I had for the hearing last week -- I don't know where I put it, mind you -- but I did have the -- yes, there it is. I had the schedule up to and including the day of argument, so I won't have had an update for today.

MS HEARNDON: There's a separate one just in respect of today.

MR JUSTICE ANDREW BAKER: Yes.

Mr Gledhill, any objection to my at least dealing with costs today?

MR GLEDHILL: No, my Lord. I am in a position to assist. Has your Lordship had an opportunity also to consider for comparative reasons the respondent's----?

MR JUSTICE ANDREW BAKER: I don't think I have seen if there was a schedule on your side, Mr Gledhill. I'm happy to have a look at that. Thank you. (Same handed). And what we're looking at by way of grand total sought is now £11,372. Yes, Mr Gledhill.

MR GLEDHILL: My Lord, although the GMC seeks its costs, Dr Khetyar finds himself here because of GMC's appeal. It's not an appeal that he's brought. Obviously he's been forced to defend the position of the Tribunal as best he can. Although your Lordship has allowed the appeal, the position is that Dr Khetyar will no longer be able to work as a doctor, that will cause significant hardship and previously he was without work for a considerable time. He has had to borrow money from a friend to be able to defend the position.

In the circumstances, we would respectfully invite the court to consider making no order for costs so that both parties meet their own costs. If your Lordship is against me on that, then I would wish to go through the costs schedule in short form.

MR JUSTICE ANDREW BAKER: Yes. Well, let me hear what you have to say as to numbers as well, entirely *de bene esse* as far as you are concerned as to what you say as to the principle. Yes.

MR GLEDHILL: I'm grateful. So there are two costs schedules from the GMC, one dealing with today and one dealing with the previous hearing, the previous work on the case. And if one compares the respondent's costs, they are somewhat lower. There's no additional fee charged for me today; that is being met by other counsel and the solicitor meeting my fee from the amounts that are already recorded there. There is obviously a significant difference in the costs that are asked for.

MR JUSTICE ANDREW BAKER: Yes. What I -- I should correct what I was just -- when I just identified what I thought we were looking at in total, I was adding up the wrong two bills, so I apologise for that. As far as the GMC's claimed costs are concerned, I'm looking at £13,800 plus the supplement for today, so we're looking at just over £15,000. Yes.

MR GLEDHILL: Indeed, and in all of the circumstances----

MR JUSTICE ANDREW BAKER: As compared to almost exactly £10,000 on your side, yes.

MR GLEDHILL: Yes, and in all of the circumstances I'm here unattended. My learned friend could have attended to take the judgment and deal with costs without the attendance of the instructing solicitor that has travelled down from Manchester, or a local solicitor could be instructed.

Overall, the costs seem rather steep in comparison to the respondent's costs. Today it should be noted only one hour has been claimed for court attendance, which is reasonable considering we've taken more than that period of time. The four hours of travel, obviously for the reasons I have set out, is contested.

MR JUSTICE ANDREW BAKER: Yes.

MR GLEDHILL: The earlier figures, again the charge-out rate is somewhat more, I'm instructed, than the solicitor instructed in this case. I'm also informed that a number of people attended from the GMC and sat behind counsel last week, and it would appear that any of those costs, if they are embedded within this, and it's not all that easy to say, shouldn't be allowed.

MR JUSTICE ANDREW BAKER: Yes. Thank you.

MR GLEDHILL: Those, in headline terms, are my submissions.

MR JUSTICE ANDREW BAKER: Thank you. But obviously, if I am awarding either costs generally or a percentage of recoverable costs, there's not going to be any objection to my dealing with the figures by way of summary assessment, because if I sent you off for a detailed assessment of bills of this size you're between you only going to start spending a few more thousands. Even if it's only a few thousand pounds it will be a few thousand pounds arguing over bills of the order of £10,000, £12,000, and that itself would be disproportionate.

MR GLEDHILL: It seems entirely in order to deal with it today----

MR JUSTICE ANDREW BAKER: Summarily.

MR GLEDHILL: -- to save costs in all of the circumstances.

MR JUSTICE ANDREW BAKER: Yes, thank you.

Ms Hearndon, what about the point of principle? Has there been any general practice since the GMC has started to be able to exercise this particular appeal power, which is only relatively recently, of costs typically following the event in this type of case? Because what obviously occurs to me as a slight concern is this: that it is one thing to say, as you will, quite rightly, the GMC has appealed, the GMC has been entirely successful; if it is a straightforward costs-follow-the-event type of analysis, the GMC has simply won. On the other hand, it's in a particular context where it would be an odd case in which a doctor subjected to a maximal period of suspension where the GMC then said, "We actually wish to contend on appeal in front of the court that the Tribunal has gone wrong,"

says, if I can put it this way, "Oh well, fair enough, strike me off then." That's put slightly colloquially, but you see the point: there is a real sense in which the GMC brings the appeal in the public interest because it criticises the Tribunal for failing adequately to protect the public interest; is it quite a normal costs-follow-the-event sort of analysis?

MS HEARNDON: Well, my Lord, the Council would say that it is, that we start in Part 44 of the CPR and there remains a discretion always on the facts to depart from that.

MR JUSTICE ANDREW BAKER: Yes.

MS HEARNDON: Insofar as the point has come up previously, I know that, for example, the *Stone* decision that your Lordship referred to was one where costs were ordered following the event. It doesn't feature, I'm afraid, in the -- I think in the transcript of the decision, but it follows from the order that was made on that occasion.

MR JUSTICE ANDREW BAKER: And in terms of bottom line, that was a similar case of suspension becoming erasure on appeal.

MS HEARNDON: Forgive me, I don't -- yes, yes it was.

MR JUSTICE ANDREW BAKER: It was suspension rather than only conditions originally, wasn't it?

MS HEARNDON: And, my Lord, part of the reason why that is legitimate and does not place the doctor in a particularly unfair position is that there remains a choice: one can contest a s.40A appeal and say, "No, the Tribunal got it right, that decision could stand," or, as has happened in some of the s.40A cases, the doctor says, "I accept that the appeal should succeed, but it should be remitted to a further tribunal to reconsider."

Now, that means the doctor doesn't have to, on your Lordship's analysis, put their hands up and say, "Fine, strike me off;" it gives them the opportunity to run their defence again in a context where procedural error, or whatever was the justification for the appeal succeeding in the first place, does not infect that second tribunal. And that has happened in some of the s.40A appeals.

And my Lordship will also be aware that, whilst the GMC's power is quite new, the PSA has had, in a sense, a prosecutorial appeal power.

MR JUSTICE ANDREW BAKER: It has had an Attorney-General's Reference type power, because I think it was the same test, wasn't it? It was the language of undue leniency, or something like it.

MS HEARNDON: Exactly, exactly, and so in that context you often see the practitioner playing little or no role and leaving it for the PSA and the regulator to fight on an appeal. In that situation I can see the analysis is different about whether the practitioner is the winning or

losing party so costs follow. Here, the appeal has been fully resisted. It has been argued, the court time has been taken and to that extent this is a winner or loser appeal.

Your powers to depart from the general rule are in CPR 44.2, I think it's subpara.(4), and that's where the court is invited to have regard to all the circumstances including the conduct of all the parties, whether the party has succeeded on part of its case even if it's not been wholly successful, and any admissible offers to settle. And, as I say here, the conduct of the parties is that the doctor has contested the case and lost.

The GMC, as the court observes, is duty-bound to operate in the public interest and has a duty to ensure that sound decisions are made by the tribunals. But it also has to manage and safeguard its resources as a charity. It operates in the public interest, and to that extent it should not, in my submission, be deprived of its costs of arguing an appeal which has been wholly successful.

I appreciate what is said about the doctor's present financial situation, but that, in my submission, is an unhappy position many defendants find themselves in; it's not a basis for departure, and indeed you don't have detailed evidence about means before you today in any event. So I would say on the principle, on these facts, the Council should be entitled to its costs.

On the detail of the figures, my Lord I can say that there is no other GMC attendance cost hidden within this. It is simply my instructing solicitor attending on both occasions. Of course, those costs do go up slightly by virtue of the GMC being based in Manchester and attending a hearing in London. Her attendance today has been necessary because, as you know, I was not counsel in the appeal itself, and had there been any significant consequential issues arising that required a bit more knowledge about the case as I say and the hearing on the 13th, her input may have been required. And to that extent, I suggest that they are proportionate and reasonable in what was a fully argued appeal which relies on----

MR JUSTICE ANDREW BAKER: Yes, well, parties and counsel always understand that judges have a particular diffidence about noticing these things and relying on them, but it is noticeable that -- I mean, in reality the difference between the two primary bills is essentially the GMC's decision to instruct Ms Richards. Given her seniority, she accounts for -- if my arithmetic is right -- she accounts for something just north of £8,000, whereas Dr Khetyar was content to be represented by Ms Maudsley, who'd appeared before the Tribunal for him, with Ms Horlick, who between them have only charged £5,000; and the £3,000-odd -- sorry, it's just, looking at that, therefore, one finds Mr Gledhill may be in some ways in slightly more difficult territory if he is identifying the level of solicitor costs involved on your side, because by definition it must therefore be about the same, even

though the GMC were appealing and therefore had the conduct, and, if anything, might have incurred more solicitor time. And so it looks like it's derived from a decision to go that little bit more senior with the counsel representation. Cost was no doubt kept, within that context, to a minimum by Ms Richards being willing to appear alone and not insisting on a junior. I have to look at that balance.

MS HEARNDON: And as my Lord observes, it is a relatively new power. There are not a wealth of cases on how the court has approached a GMC appeal, and to that extent it may be that in three years down the line it is a perfectly proper criticism to say this does not require leading counsel. Where we are at the moment, the Council, in my submission, has properly identified the seniority required, and particularly in a case involving -- concerning issues of sexual misconduct with a very real public interest imperative to getting it right on appeal.

MR JUSTICE ANDREW BAKER: Yes. If Dr Khetyar had taken a view that whilst, for his part, he did not seek to challenge on appeal the suspension that had been imposed, although in front of the Tribunal the contention on his behalf was don't even go as far as suspension just impose conditions, and whilst he or those acting for him see what is said, without expressing any comment, as to criticisms in the Tribunal did not regard it as being a matter for him effectively to criticise the Tribunal by way of in any way formally conceding the appeal, but it was a matter for the public interest if the GMC wishes to appeal, it should go ahead, he would take no active part, it would still have cost the GMC, maybe not as much as it has in fact cost, but it would have cost the GMC a not entirely insignificant amount simply to bring the appeal on, present it properly through counsel to the court, and it would have had to persuade the court. And if it had taken that course and Dr Khetyar had taken that course, I confess to having some intrinsic hostility to the idea that the GMC would then stand up and ask for its costs.

MS HEARNDON: My Lord, I haven't found myself in that position, so I can't say whether I ----

MR JUSTICE ANDREW BAKER: No, I know that.

MS HEARNDON: -- would or wouldn't be instructed to make that submission. I accept that my submission would be weaker in those circumstances, but happily for me we're not there, and this is an appeal that's been fully contested and to that end I say Part 44 applies.

MR JUSTICE ANDREW BAKER: Yes, thank you.

MS HEARNDON: Sorry, forgive me. Just a moment, my Lord. (After a pause). Sorry, my Lord, actually a separate point, just enquiring about whether a transcript of your judgment will be available in due course.

MR JUSTICE ANDREW BAKER: Yes, I certainly intend to perfect an approved version with all the quotes set out and have that made available in the usual way with a neutral citation number.

MS HEARNDON: And I can make enquiries with your associate about providing the documents you indicated.

MR JUSTICE ANDREW BAKER: One thing I was thinking in relation to that actually is that I had more than one of these cases last week, so I have ended up acquiring a spare copy of the Sanctions Guidance which I haven't marked at all, so I'm very happy for that to be passed down, and if I find where it starts -- there we go -- I also haven't marked this copy of the back end of the determination, so I'm just handing down the pages; the heading is "Determination on sanction", so the long section I asked to be set out can be taken from there. I have probably scribbled all over my copy of *Jagjivan*, so if somebody could just provide that.

MS HEARNDON: We can provide that by email after the hearing.

MR JUSTICE ANDREW BAKER: Yes. Thank you very much.

Mr Gledhill, anything to say very briefly?

MR GLEDHILL: It will be very brief, my Lord. My gown has been tugged by my client who asked me to remind -- and it's been implicit in my submission in any event -- to remind your Lordship that he's not funded by a medical defence organisation; he will have to meet any costs out of his own pocket.

In relation to the newness of this type of appeal, my instructing solicitor sought to survey the case law, and, colloquially, it's a mixed bag. There are decisions both in favour of the GMC obtaining their costs and there are decisions where costs have been left to be paid by the parties. I have one or two cases which go either way, but I don't know that it's necessarily of assistance to you when it's a discretion to learn that your brethren judges have, on some occasions, directed that the GMC's costs be paid in part or in full, or on other occasions that each party pay their own costs. But it would be our application that each party pay its own costs.

MR JUSTICE ANDREW BAKER: I am grateful.

I feel a sense of slight reluctance as to whether what I am about to say might end up being regarded as at all precedential (if that's a word) in relation to costs, but there it is. It does seem to me that appeals of this kind raise a slightly different consideration than an ordinary piece of litigation in the civil courts, with winners and losers and costs following the event. It does seem to me that, ultimately, the GMC, when concluding that an appeal is sufficiently properly arguable to be brought at all, for the purpose ultimately of seeking to persuade

a court, or if the matter is remitted a fresh tribunal, that an insufficient sanction has been imposed, is acting in the public interest in such a way that were the affected practitioner to take the view that it was not for him or her to concede the appeal, rather than to leave it for the court's judgment, either generally or, as Ms Hearndon says has happened in some cases, by making perhaps only an observation that the practitioner would invite the court to remit the matter rather than substitute its own decision, then it would be an unusual case in which it would be appropriate for the practitioner, if the appeal was ultimately upheld, to have to pay the GMC's costs.

That said, this, of course, is not such a case but a case in which the matter was fully contested. It does, therefore, mean that as a starting point Ms Hearndon is able to say that there has been a contested appeal in which the GMC has succeeded in full.

But it seems to me that, reflecting the first consideration, I ought to do justice between the parties by awarding a limited contribution towards costs, intended to reflect a summary assessment as best I can manage it, of the degree to which the reasonable costs incurred by the GMC have been aggravated or increased by the need to deal with a fully contested matter, rather than simply to ensure that its submissions were properly presented, with the doctor remaining neutral.

In those circumstances, and bearing in mind also a view I do have that the decision to engage leading counsel (which itself increased the GMC's costs) was a decision by the GMC to give a degree of Rolls-Royce service to an appeal that was not required, albeit I was very much assisted by Ms Richards' submissions, the just order in my judgment is that there be a payment by Dr Khetyar of £5,000 towards the GMC's costs by way of a lump sum payment.

I will hear briefly any submissions as to time to pay.

MR GLEDHILL: I'm without instructions on this, because it's unknown whether, if at all, that amount could be met.

MR JUSTICE ANDREW BAKER: The normal rule if I said nothing else would be 14 days.

Ms Hearndon, although you would be entitled in principle to say I've not been given hard evidence of the difficulties, I would invite you not to resist my allowing 28 days in the circumstances.

MS HEARNDON: Sorry, my Lord, may I take instructions? (After a pause). My Lord, I'm not going to resist you on 28 days. If I, simply to protect the position because I don't know what the GMC will want to say sort of policy-wise about the order on costs, if I may seek permission to appeal on costs.

MR JUSTICE ANDREW BAKER: What I'm going to say in relation to that, Ms Hearndon, is slightly different, and that is that rather than deal with a prophylactic or contingent submission not developed, what I will say is that if either party, that is to say in relation to the GMC as to costs or in relation to Dr Khetyar in relation to the substance of the decision, wishes to apply to me for permission to appeal, they should do so, please, in writing within this week. The reason I say that is because, as I did mention at the end of the hearing last week, I go in for further surgery myself next Wednesday, which will then put me out of action for a number of weeks, which will go well beyond the date for lodging any appeal with the Court of Appeal, and if you are, either of you, to seek permission to appeal from me, you'll want a decision therefore before the end of term. So if I can have any brief submissions in writing, if either party seeks permission to appeal, by the end of this week, I will then give you a decision on the papers before the end of term.

MS HEARNDON: I'm grateful. Thank you, my Lord.

MR JUSTICE ANDREW BAKER: Is there anything else I need to deal with this morning?

MR GLEDHILL: No, thank you.

MR JUSTICE ANDREW BAKER: Thank you very much. I will keep the rest of the papers until we have got the transcript done. Thank you.