Neutral Citation No [2011] NIQB 95

Ref: **GIR8326**

Judgment: approved by the Court for handing down
(subject to editorial corrections)

Delivered: **19/10/2011**

2011 No 94211

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

IN THE MATTER OF AN APPEAL UNDER SECTION 40 OF THE MEDICAL ACT 1983

BETWEEN:

DR LEO JOSEPH CASEY

Appellant;

and

THE GENERAL MEDICAL COUNCIL

Respondent.

GIRVAN LJ

Introduction

[1] This is a statutory appeal under section 40 of the Medical Act 1983 brought by the appellant Dr Leo Joseph Casey, a general medical practitioner ("the doctor"). He seeks to set aside the determination of a Fitness to Practice Panel ("the Panel") which investigated allegations of misconduct brought against the doctor by Patient A ("the patient"). The panel conducted a hearing pursuant to the General Medical Council (Fitness to Practice) Rules 2004 ("the 2004 Rules").

[2] The patient alleged that the doctor carried out an examination of her chest and abdomen in a sexually inappropriate manner. She alleged that in the course of the examination of the patient's chest the doctor had placed his hand inside her bra, placed the chest piece of the stethoscope onto her nipples when it was not clinically indicated and cupped the patient's breast with his hand. She further alleged that in the course of examination of her abdomen he pulled her knickers outwards from her

body to expose her pubic area when it was not clinically indicated and he placed his hand below the line of the knickers when it was not clinically indicated. The patient alleged that these actions were sexually motivated.

The panels' determination

[3] The panel in its determination of the facts concluded that the doctor had examined the patient's chest (and this was not in dispute). It found that he had examined the patient's abdomen. This was not admitted by the doctor who had not noted such an examination in his medical notes and his evidence was that he had no recollection of carrying out such an examination. It found that he had placed his hand inside the patient's bra (and this was not in dispute). It found as proven that he placed the chest piece of his stethoscope onto each of the patient's nipples when it was not clinically indicated. That allegation was denied by the doctor. It rejected the allegation that the appellant pulled the patient's knickers away from her body to expose her pubic area when it was not clinically indicated. It accepted that in conducting an examination which would necessarily extend to the pubic bone it would be necessary for the doctor to place his hand below the line even of low waisted knickers. It thus rejected the allegation that the doctor placed his hand below the line of the patient's knickers when it was not clinically indicated. The panel found as proven that the doctor's actions, both in placing his hand inside the patient's bra and in placing the chest piece of his stethoscope onto the patient's nipples, were sexually motivated.

[4] In giving its reasons the panel stated:

> "The Panel found Patient A to be a consistent, reliable and credible witness who gave her answers without embellishment and openly admitted when she could not remember detail……
>
> You told the panel that you have conducted a full and thorough chest examination because of patient A's reported flu like symptoms and history of long-term asthma. You stated that you would have needed to listen to her chest directly beneath the breast and that, to listen to the lower lungs and heart you might have put your hand inside the patient's bra whilst holding your stethoscope. You might have done this on both sides of the chest. You denied that you would have placed the stethoscope on her nipples and said that there was never any clinical indication to do so. You maintained that patient A may have misinterpreted your actions during

> examination, suggesting she might have felt the coldness of the metal rim of the stethoscope's diaphragm against the nipple as it [was] placed below the breast. Patient A was very clear in her evidence that you placed your stethoscope directly on her nipples, first on one side then the other and that she remembered feeling the coldness of the stethoscope on her nipples. The panel also takes into account the evidence of Mr PS that she told him what had happened immediately after the event and asked him whether listening to her heart through her nipple was the right thing to do. His report of her being upset after the consultation is consistent with her description of events. Patient A was subjected to detailed cross-examination and maintained her account throughout. Furthermore she did not consult you again. The panel finds it proved that on the balance of probabilities you placed your stethoscope onto patient A's nipples when it was not clinically indicated."

In making its finding of sexual motivation in relation to that finding the panel expressed its reasons thus:

> "… The panel has taken the legal assessor's [direction] that it should apply a two stage test. First it must consider whether your actions might have been sexually motivated. If it finds that they might have been, it must go on to consider whether the evidence as to the circumstances of your actions and of the purpose of your actions suggest that there was sexual motivation. The panel considers it to [be] self-evident that placing a hand inside a patient's bra and placing a stethoscope on her nipples might have been sexually motivated. In the context of medical practice it may be necessary quite properly to carry an examination involving touching the breasts and nipples but this does not form part of an orthodox examination of the lungs and heart. Dr Isaac in his expert evidence told the panel that placing a hand and stethoscope fully inside the bra is open to misinterpretation. In your own evidence, you said that there was definitely no clinical indication to place a stethoscope on the nipple. This was confirmed by Dr Isaac. You also said you did not teach medical students to examine the chest in this manner. Nevertheless in the

> absence of a chaperone you placed your hand into both sides of patient A's bra and placed the stethoscope onto both of her nipples. The panel has concluded that in these circumstances having noted the purpose of the examination and in the absence of any other explanation it is more likely than not that your actions were sexually motivated."

The doctor's challenge to the determination

[5] The doctor challenges the decision on a number of grounds. Mr Forde QC who appeared on behalf of the doctor with Ms Paterson argued that the panel was in serious error in finding that patient A was a consistent, reliable and credible witness. The panel was wrong to rely on the evidence of the patient's employer PS (to whom the patient complained following her visit to the doctor) when it concluded that PS's evidence corroborated her evidence. The panel failed to address the inconsistencies in the evidence of Mr L, the patient's subsequent partner, to whom the patient made allegations about her treatment by the doctor. The panel failed to explain why it rejected the appellant's defence and why it found him to be incredible and unbelievable which it must have done in order to justify its conclusions. Mr Forde criticised the direction given by the legal assessor to the panel on the proper way to approach the question of proof on a balance of probabilities in such a case. The panel had effectively reversed the burden of proof in relation to sexual motivation in relation to its determination whether the actions as found were sexually motivated.

Principles applicable to the appeal

[6] In approaching the appeal this court must remind itself of the relevant legal principles emerging from the authorities.

(a) A court asked to interfere with a lower court or tribunal's findings of fact and findings in respect of the credibility of a witness may only do so in limited circumstances. The appellate court is without the advantage of hearing the live evidence of witnesses and is restricted to what is contained in the transcript albeit with the benefit of argument. It will be slow to interfere with findings of fact. Where there is no question of a misdirection an appellate court should not come to a different conclusion from the tribunal of fact unless it is satisfied that any advantages enjoyed by the lower court or tribunal by reason of seeing and hearing the witnesses could not be sufficient to explain or justify its conclusions. The appellate court may take the view that without having seen or heard the witnesses it is not in a position to come to a satisfactory conclusion on the printed evidence. Either because reasons given by the panel are not satisfactory or because it unmistakably so appears from the evidence the appellate court may be satisfied that

the panel has not taken proper advantage of having seen and heard the witnesses and the matter then becomes at large for the appellate court. While, as a general rule, the appellate court will be slow to interfere with the findings of fact of the panel it will not defer to the judgment more than is warranted by the circumstances. These well established principles can be distilled from cases such as Thomas v Thomas [1947] AC 484, Ghosh v Ghosh [2001] 1 WLR 1915, Gupta v GMC [2002] 1 WLR 1691, Meadow v GMC [2007] QB 462, Raschid v GMC [2007] 1 WLR 1460 and Mubarak v GMC [2008] EWHC 2830.

(b) An appellate court will read the decision of a lower tribunal in bonam partem. A panel, such as the panel in the present instance, can be presumed to be reasonably qualified and aware of the proper standards of conduct of medical practitioners.

(c) As to the adequacy of reasons given, the authorities establish that in most cases, particularly those concerned with comparatively simple conflicts of factual evidence, it will be obvious whose evidence has been rejected and why, thus satisfying the duty to make it clear to the losing party why he had lost. Where the issue is not straightforward the practitioner is entitled to know why his evidence in the case had been rejected. A few sentences dealing with salient issues may be essential. While a finding of fact based on the assessment of witnesses will only be interfered with if it can be regarded as plainly wrong or so out of tune with the evidence properly read as to be unreasonable, the relevant issues must have been properly addressed (see Leveson LJ in Southall v GMC [2010] EWCA 407). In Selvanathan v GMC [2000] 59 BM Lord Hope stated that in practice reasons should now always be given by the panel in their determination. Fairness requires that this be done so that the losing party can decide in an informed way whether or not to accept the decision. In Selvanathan however the Privy Council concluded that there were no grounds for thinking that the appellant had suffered any prejudice due to the absence of reasons, the matter being relatively straightforward. In Gupta, the Privy Council finding that there was no duty in that case to give full reasons than had been given, declined to give further guidance though it reiterated what had been stated in Selvanathan namely that in cases where fairness requires reasons they should be given. In Southall v GMC Leveson LJ concluded that in straightforward cases setting out the facts to be proved and finding them proved or not proved will generally be sufficient to demonstrate why the party lost or won and to explain the facts found. When the case is not straightforward and can properly be described as exceptional the position is and will be different. In such cases at least a few sentences dealing with the salient issue is essential. In that case having regard to the rejection of the doctor's evidence and her defence, she, the doctor, was entitled to know why, even if only by reference to demeanour, attitude or approach to the specific questions posed to the doctor. In that case it was nothing to do with not being wholly convincing it was about honesty and integrity and if the panel were impugning her in those regards it should have said so.

Discussion

[7] Mr Forde compared the evidence as given by the patient to the panel with the allegations which had been made by the patient to the police as evidenced in a police statement taken by her which she had signed. So far as relevant the police statement stated:

> "Dr Casey asked me to sit on the bed and take off my overall. I sat up on the bed but I think just undone the buttons down the front fully. I was wearing a bra underneath my tunic. Dr Casey was standing next to me as I sat on the bed, he had the stethoscope held by his fingers in the inside of the palm of one hand, he then pulled my bra outwards with his other hand before placing the stethoscope onto my nipple cupping my breast in the palm of his hand inside my bra. I could feel the cold stethoscope against my nipple. He then asked me to breathe in and out; this seemed to last for approximately 30 seconds before he took his hand out. He then sounded my chest area above the breast with the stethoscope before moving to the other side where he again pulled my bra outwards then as before and placed the stethoscope onto my other nipple. Again this seemed to last for approximately 30 seconds. This type of examination did not feel right, I had never experienced that type of examination before, it felt a kind of creepy. I was feeling upset by this. Dr Casey then asked me to lie down on the bed so he could check my tummy. He asked me to undo the button of my trousers. I unbuttoned my trousers and pulled down the zip although my trousers remained up they were fully opened. I was wearing a pair of pants underneath Dr Casey then with one hand pulled my pants outwards before placing the other hand below by panty line pushing his fingers into my lower tummy 2 or 3 times on each side. The examination again made me feel very uncomfortable, no other doctor has examined me in that manner before. During Dr Casey's examination of my chest I felt I had pulled my bra outwards to the point of exposing my breasts before placing his stethoscope onto my nipple which I didn't feel was right at the time. I also feel that he pulled my pants forwards so as to look at me down below before

> examining me in a way that I have never been examined there before."

[8] The evidence given by the witness to the panel differed in a number of significant respects. She did not allege that the appellant had pulled out her bra to expose her breasts. She did not state that he had cupped her breast. Indeed, in response to the chair of the panel, she effectively rejected any suggestion that he had cupped her breast (see page D1-29 of the transcript). She withdrew her allegation that he had held the stethoscope against her nipple for as long as 30 seconds, blaming the police interviewer for leading her into making that allegation. She claimed that she was telling the police that she was not sure. The respondent opened the case to the panel alleging that the doctor had cupped her breast, a serious allegation of an overtly sexual act. In doing so it was to be assumed that counsel was acting consistently with her duty not to open a factual allegation unless there was going to be evidence to support it. The making of a serious allegation of a sexually inappropriate act in relation to the cupping of the breast to the police and its repetition to the panel at the outset of the case followed by an express disclaimer by the patient of any such event seriously calls into question the reliability of the patient as a witness of fact on key issues. The allegations that she was making at different stages were clearly inconsistent.

[9] Furthermore, as noted in her version of events to the police the doctor placed the stethoscope onto her nipple cupping her breast in the palm of his hand and he asked her to breath for 30 seconds before he took his hand out (the hand thus going into the bra, cupping the breast and then coming out). He then sounded her chest area above the breast before repeating the placing of the stethoscope on the other nipple. Her version of events to the panel significantly differed according to the sequence of events. According to her evidence to the panel he moved straight away from one nipple to the other nipple and the sounding of the chest was done by the stethoscope through the nipples alone. In her police statement she also alleged that he had pulled her bra outwards to the point of making her breast visible. In her evidence to the panel this became "he pulled the bra just enough so that he could put the stethoscope in." PS said that the witness said that the doctor had "just listened to my heart through my nipple … he put the stethoscope completely over my nipple." This appeared to refer to one nipple and the patient made no reference to him also sounding her chest in the area above the breast.

[10] The inconsistencies in her evidence in relation to the chest examination are followed by inconsistencies in relation to evidence in respect of the abdominal examination. In opening the case counsel for the GMC alleged that when the patient was on the examination table and after she had opened her trousers the doctor "got hold of the top of the knickers and effectively lifted them away from the body." The patient felt that he looked inside her pants at her pubic area. The opening was in

line with the police statement in which she stated that he had pulled the pants outwards so as to look at her down below before examining her in a way that she had never been examined before. This allegation suggested that not merely did she regard as inappropriate the way in which he dealt with her pants but also the examination itself. In evidence PS stated that the patient said that she felt really annoyed and upset because he *had* looked into her pants. In examination in chief after her evidence that he just pulled her pants out a bit so that he feel on her lower tummy on being asked why he had done it she said "I do not understand why he done it because they were quite low enough but I imagine it was to feel the lower tummy. I kind of felt that it was just a bit creepy, that is the feeling I felt at the time."

[11] It is evident from this resumé that the patient had over time presented a number of quite inconsistent versions of the same events. This should have been obvious to the panel as the decider of facts. The inconsistencies were serious ones. The earlier versions of events (which themselves had inconsistencies between them) were quite different from the evidence as presented to the panel. The earlier version painted a highly sexualised encounter between the doctor and the patient marked by improper handling of the breasts and an improper visualisation of the breasts and of the pubic area. By the time the patient was giving evidence the case was limited to the placing of the stethoscope on the nipples. The internal inconsistencies in her previous version of events and the complete and unexplained abandonment of serious allegations of sexualised misconduct should have raised serious concerns which should have been addressed by the panel in its analysis. The finding by the panel that the patient presented as a consistent, reliable and credible witness is one that no tribunal properly directing itself on the evidence could have made in the circumstances. In a case which turns on which of two contradictory witnesses a tribunal should believe a careful examination of important inconsistencies is necessary in evaluating reliability and credibility. While a witness who has presented contradictory evidence may ultimately be accepted as telling the truth on some one or more issues, a tribunal faced with such a witness should, in fairness to the party whose evidence is rejected, explain why the evidence of the witness who has given seriously conflicting and inconsistent evidence is to be preferred to the other witness. The evidential difficulty arising from serious inconsistencies and from making serious and ultimately unfounded allegations (evidenced by their abandonment and withdrawal) is one which the tribunal must demonstrably appreciate and rationally deal with. The unavoidable inference from the panel's decision in the present instance must be that it failed to take properly into account the importance and significance of the inconsistencies of the patient's evidence when looked at as a whole in its entire context. The tribunal was not entitled to consider the apparently consistent and persistent version of events in relation to the nipples divorced from the inconsistencies established in relation to the other serious and abandoned sexual misconduct allegations.

[12] Thus, the way in which the patient abandoned any suggestion of breast cupping and no longer asserted indecency in the visualisation of the pubic area should have excited in the panel a real concern as to whether the patient could be relied on in relation to her interpretation of the events in relation to the nipples. Questions which the panel should seriously have considered included:

(a) whether she was or might be a suggestible witness (vide her alleged adoption of the police's suggestion re timing of the nipple touching);

(b) whether she was a patient who was ready or liable to make exaggerated statements (vide her statement to PS that he *had* visualised her pubic area when on her later version she said that she *felt* that he had, an allegation which itself was dropped);

(c) whether she was someone who could have formed a genuine but unjustified feeling of an invasion of her sexual privacy and convinced herself, contrary to the facts, that there was a factual basis to justify her subjective feeling of "creepiness"; and

(d) whether she might have been a person who felt that having made so many allegations, she had to justify herself by standing over at least one allegation against the doctor, come what may.

The reasoning processes of the panel as it emerges from the laconic decision does not evidence any consideration of such issues, all of which may have been missed because the panel took the simplistic route of finding her credible because of apparent consistency and persistence in the nipple allegations.

[13] Furthermore the panel concluded that her case was supported by the evidence of PS and that his report of her being upset after the consultation is consistent with her description of events. The finding that PS's evidence was in effect corroborative of her allegations because of his report of her being upset and that it was consistent with her description of events failed to properly recognise a real difficulty in the evidence from the point of view of the GMC's case. As already noted PS stated that the patient said that what upset her was that the doctor had looked into her pants, an allegation which the patient declined to make good in her evidence.

[14] Mr Forde also relied on the panel's failure to address the inconsistency in L's evidence. L's witness statement to the police recorded a complaint by the patient of the stethoscope being placed on her breast. In his GMC statement he recorded that she referred to the stethoscope being on her nipple. Counsel argued that patient A

must thus have given L two different versions of events. This ground of appeal is very much interlinked to the main ground relating to general inconsistency and the panel's failure to grapple with the issues which it raised. L's evidence was a matter that touched on the question of inconsistencies. Had the panel properly addressed the problems of inconsistency in the patient's evidence the case that she had made to L would have required careful consideration in the context of the case.

[15] Mr Forde criticised the panel for failing to explain why it rejected the appellant's defence and failed to explain why it found the appellant to be incredible and unreliable. As was made clear in Southall in a case which is not straightforward and is exceptional a doctor is entitled to understand the basis on which his case has been rejected. The concept of exceptionality without definition is not a particularly helpful test to be applied by a panel or by an appellate court since different courts may have different views as to what is exceptional. However, the underlying principle emerging from cases such as Gupta is that reasons should be given if, in the circumstances of the individual case, fairness requires it. Ultimately the court is the arbiter of what procedural fairness requires. In the present case whether one applies a test of fairness a test of exceptionality or a test of lack of straightforwardness, the circumstances in this case called for an explanation as to why the evidence of the doctor was rejected. The assertion that the patient was a consistent, reliable and credible witness when the circumstances clearly undermined her consistency and reliability points to a lack of focussed reasoning as to why she should be considered reliable on the one remaining allegation that she had not abandoned. It calls into question the reasoning process that led the panel to conclude that, by necessary inference, the doctor was unreliable and incredible. It is not possible to see the chain of reasoning which led to this ultimate conclusion. This is one of those cases of which Leveson LJ spoke in Southall in which the doctor is entitled to some explanation dealing with the salient issues explaining why his evidence was rejected even if only by reference to his demeanour, his attitude or his approach to specific questions. As in that case, in this case the matter ultimately turned on the question of the honesty and integrity of the witnesses. In looking at the issue of honesty and integrity it was highly relevant to balance properly the way in which the patient had formulated and pursued her complaints over time and the way in which the doctor dealt with the case against him bearing in mind that sexual impropriety by a doctor is something which has an intrinsic unlikelihood.

[16] This brings into play the question whether the legal assessor correctly explained the proper approach to the question of proof in this case. It is the appellant's case that the legal assessor should have given the panel a fuller and more detailed direction on the law in the light of cases such as Re Doherty [2008] UKHL 37, which, it was argued, demanded a more focussed statement by the legal assessor on the way the panel should approach the evidence. Lord Carswell in Re Doherty makes clear that certain circumstances call for heightened examination of the

evidence. Situations which call for heightened examination include the inherent unlikelihood of the occurrence taking place, the seriousness of the allegation to be proved and the serious consequences which could follow an acceptance of the proof. A proper direction to the panel from the legal assessor who bears the responsibility ensuring that the panel understands the legal position should make the panel clearly aware of both the need and the reasons for heightened examination of the evidence in the case. All three of the examples given by Lord Carswell came into play in this case. While Re Doherty was indeed called to the attention of the panel by counsel and the panel should thus have been aware of what the law required, its analysis does not in fact point to a heightened examination of the evidence. This is particularly so in their conclusion that the patient fell to be treated as consistent and reliable when there was clear evidence that she was not.

[17] Counsel also argued that the legal assessor effectively reversed the burden of proof in relation to sexual motivation in his direction to the panel. In this case it was inevitable that if, indeed, the doctor placed the stethoscope onto the nipples as alleged by the patient that there would be a finding of sexual impropriety. Such a manoeuvre would have had no medical justification and it would have been a wholly inappropriate means of sounding the chest. If carried out as alleged, it was an inevitable conclusion that the doctor did so for sexual gratification. It would not have been a bona fide chest examination at all. In effect the doctor would have been going through the pretence of a chest examination. The key question for the panel was whether the evidence could properly satisfy it that he had carried out the procedure in the manner alleged by the patient. The second stage question ("whether the evidence suggests there was a sexual motivation") was not a felicitous way of formulating the central question. The key question was whether the panel was satisfied that he had placed the stethoscope on the patient's nipples for his own sexual gratification.

[18] In considering that question the panel had to bear in mind that the alleged placing of the stethoscope on the nipple was for a very short period of time (having regard to the patient's reformulated case when she abandoned the timing given to the police) and that the patient had abandoned her earlier case of a highly sexualised encounter (involving the pulling out of the bra to visualise the breasts, the cupping of the breasts, the placing of the stethoscope onto the nipples and the pulling out of the pants to make the patient's pubic area visible). There was no evidence of any of the normal indicia of sexual impropriety (heavy breathing by the doctor, inappropriate comment or lascivious facial expressions). There was clear evidence of the doctor carrying out an examination to sound the patient's chest (accepted by the patient and recorded in the notes). The decision as recorded by the panel shows no real analysis of the doctor's case, the reason why it should have accepted the proposition that he carried out the procedure for sexual gratification and the reasons

why it rejected the doctor's account in relation to the nipples when the evidence showed that he was correct in relation to his refutation of other sexual improprieties.

[19] In the result the decision of the panel must be set aside. I shall hear counsel on the appropriate relief to be granted.